Board of Directors - Public Meeting

Wed 17 June 2026, 10:30 - 14:40

Boardroom, Trust Headquarters

Agenda

3 min **1. Welcome and introductions**

Note *Prof Dame Robina Shah*

30 min **2. NHSE Resident Doctors' 10 Point Plan**

Sanjay Arya

2.1. Staff Story

Information *Joshua Lewis, George Rogers*

2.2. 10 Point Plan implementation progress report

Assurance *Sanjay Arya*

- 02.2. Resident Drs 10 Point Plan Update June 26.pdf (3 pages)
- 02.2a. Copy of RD 10 PP Board June 26.pdf (8 pages)

2.3. Guardian of Safe Working Hours Report

Assurance *Sanjay Arya*

- 02.3. GOSWH Annual Report 2025 to 2026.pdf (5 pages)

1 min **3. Apologies for absence and quorum**

Information *Prof Dame Robina Shah*

1 min **4. Declarations of interests**

Assurance *Prof Dame Robina Shah*

1 min **5. Minutes of the previous meeting**

Approval *Prof Dame Robina Shah*

- 05. Minutes_Board of Directors - Public Meeting _010426 (1).pdf (13 pages)

1 min **6. Matters arising and action log**

Assurance *Prof Dame Robina Shah*

- 06. Public Board Action Log 2026.pdf (4 pages)

5 min **7. Chair's report and stakeholder update**

Information *Prof DameRobina Shah*

15 min **8. Chief Executive's report**

Information *Mary Fleming*

08. CEO Board Report_Public_ June26_FINAL.pdf (4 pages)

10 min

9. NHS National Oversight Framework - Quarter 4 2025/26

Assurance *Richard Mundon*

10 min

10. Integrated Performance Report

Approval *Richard Mundon*

10. Board of Directors IPR M01 2627.pdf (3 pages)
10a. IPR_M01_2627.pdf (24 pages)

20 min

11. Board Committee Chairs' Reports

Assurance *Non-Executive Directors*

11.1. Quality and Safety Committee

Assurance *Francine Thorpe*

11.1. AAA Q&S May 2026.pdf (2 pages)

11.2. People Committee

Assurance *Mark Wilkinson*

11.2. People Committee - AAA.pdf (2 pages)

11.3. F&P Committee

Assurance *Julie Gill*

11.3. AAA - FP - May 2026 (1).pdf (2 pages)

11.4. Audit Committee

Assurance *Simon Holden*

11.4. AAA - Audit Committee - 05 May 2026.pdf (2 pages)

11.5. Remuneration Committee

Assurance *Prof Dame Robina Shah*

11.6. Research Committee

2nd June 2026 (Meeting deferred)

10 min

Break

15 min

12. Finance Report - Month 12 2025/26 and Month 1 2026/27

Discussion *Tabitha Gardner*

12. Board Cover Sheet - Finance Report M12.pdf (2 pages)
12a. Trust Finance Report 25-26 March Month 12 Board.pdf (15 pages)
12b. Board Cover Sheet - Finance Report M01.pdf (2 pages)
12c. Trust Finance Report 26-27 April Month 01 Board.pdf (15 pages)

15 min

13. Commitment to the Elimination of Corridor Care

Endorsement *Sarah Brennan*

- 13. 20260609 - Virtually Eliminating Corridor Care Paper.pdf (7 pages)

10 min

14. Freedom to Speak-up Board reflective tool results

Assurance *Tracy Narot*

- 14. FTSU reflective tool TB.pdf (8 pages)

30 min

15. Maternity reports

Approval *Kevin Parker-Evans*

15.1. Q4 Perinatal quality oversight report

Assurance *Kevin Parker-Evans*

- 15.1. Perinatal Quality Oversight Report Q4 25-26 Jan-Mar 2026 (For Board).pdf (22 pages)

15.2. Maternity complaints review

Information *Kevin Parker-Evans*

- 15.2. Maternity Complaints Overview Report 12 months Feb 25- Jan 26 V4.pdf (13 pages)

15.3. Maternity MIS update report

Assurance *Kevin Parker-Evans*

- 15.3. Maternity MIS update report june 26.pdf (12 pages)

15 min

16. Quality accounts

Approval *Kevin Parker-Evans*

- 16. Quality Accounts frontsheet.pdf (2 pages)
- 16a. WWL Quality Accounts FINAL.pdf (40 pages)

10 min

17. Health Inequalities Statement

Approval *Richard Mundon*

- 17a. Health Inequalities Statement.pdf (13 pages)
- 17. Board cover sheet_NHSE Statement on Information on Health Inequalities 2025_26.pdf (2 pages)

10 min

18. NHS Licence Conditions - Board Declarations 2025/26

Ratification *Katharine Dowson*

- 18. NHS Provider Licence Conditions Board Self-Certification 2025_26 - June 2026 FINAL100626).pdf (8 pages)

5 min

19. Equality delivery system

Approval *Tracy Narot*

- 19. EDS 2025 Executive Summary Board Meeting_June 2026.pdf (7 pages)
- 19a. EDS 2025 Report final subject to Board approval.pdf (34 pages)
- 19b. Appendix 1 CF Stakeholder Feedback report.pdf (20 pages)
- 19c. Appendix 1 COPD Stakeholder Feedback report.pdf (21 pages)
- 19d. Appendix 1 - Mortuary Stakeholder Feedback report.pdf (17 pages)
- 19e. Appendix 2 Equality Delivery System 2025 - Domain 2 - Evidence for report.pdf (10 pages)
- 19f. Appendix 3 Equality Delivery System 2025 - Domain 3 - Evidence for report.pdf (5 pages)

0 min

20. 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.

0 min

21. Maternity reports

Information

21.1. Maternity dashboard report and dashboards

Information

- 21.1. Maternity Dashboard report April 26.pdf (8 pages)
- 21.1a. Maternity Dashboard - April 26.pdf (2 pages)
- 21.1b. Neonatal Dashboard - April 26.pdf (3 pages)

21.2. Birthrate+ report

Information

- 21.2. Wrightington, Wigan and Leigh Final Birthrate Plus Workforce report - 19.02.2026.pdf (16 pages)

0 min

22. Use of the common seal report 2025/26

Ratification

- 22. Use of the common seal.pdf (4 pages)

1 min

23. Date and Time of next meeting

Information *Prof Dame Robina Shah*

Wednesday 05 August, 10:30am, Boardroom, Trust Headquarters

2 min

24. 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.

30 min

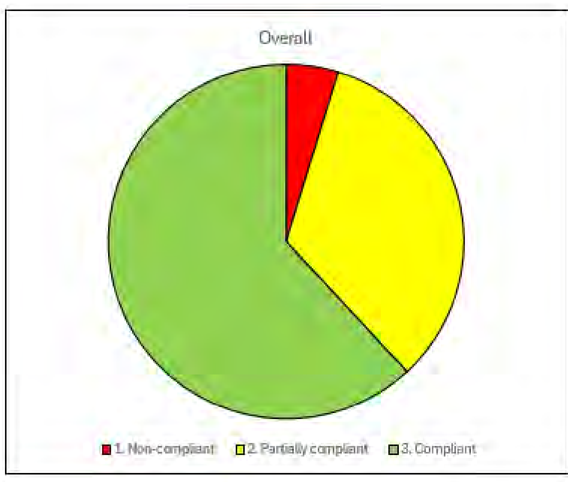
Break

Title of report:	Resident Doctors 10 Point Plan Update
Presented to:	Board of Directors
On:	17th June 2026
Item purpose:	Information
Presented by:	Prof Sanjay Arya, Medical Director
Prepared by:	Prof Sanjay Arya, Medical Director, Charlotte Wright, Deputy CPO
Contact details:	Charlotte.wright@wwl.nhs.uk

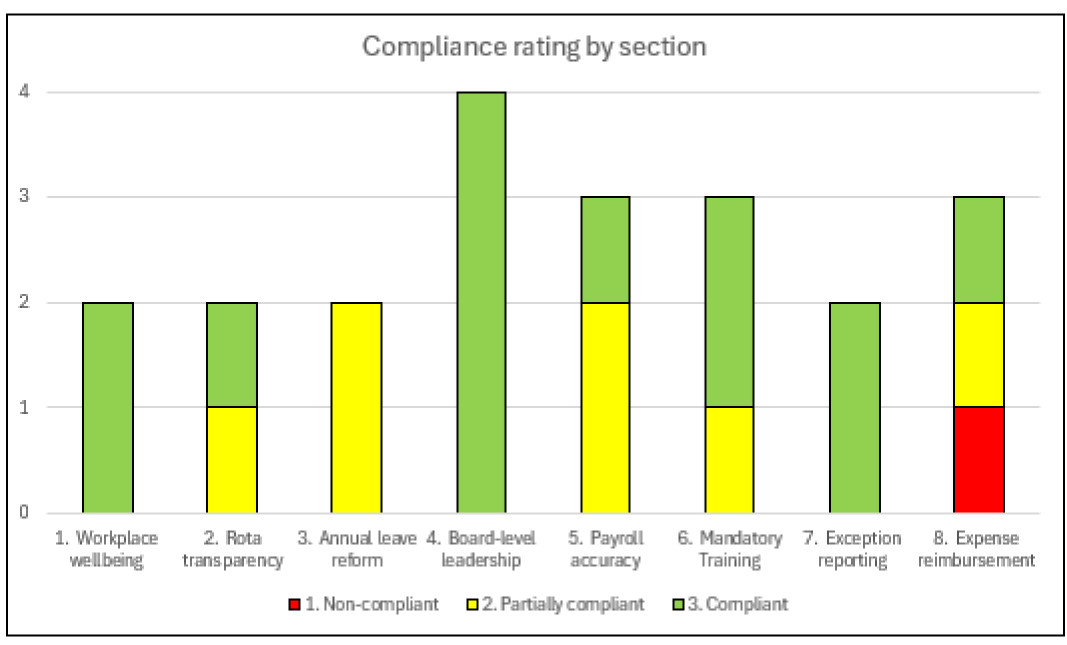
Executive summary

The Resident Dr 10 Point Plan was introduced in August 2025. A new Board Assurance tool was published on 23rd April 2026. This has been completed and is attached for information to outline the current level of compliance.

The tool also provides a graphical representation of compliance, which shows that we are either fully or partially compliant in the main areas of the plan. The tool covers 8 areas of the 10 Point Plan, as 2 areas are for NHS England to address, and relate to Resident Doctor rotations and Lead Employer employment models.



The tool also produces compliance rating by theme:



- **Area of non-compliance includes:**

Expense Reimbursement: doctors satisfaction meets 80% target
Actions in relation to expense reimbursement are being undertaken. In our next Resident Dr 10 Point Plan meeting on 23rd June 26, we will agree a mechanism for measuring the satisfaction of doctors in relation to this area to ascertain if we are achieving the 80% target.
Completion date: 31st August 2026

- **Areas of Partial Compliance**

For the areas of partial compliance, work is in progress to address the feedback from the Resident Doctors and ensure compliance with the 10 Point Plan. The actions to address areas of partial compliance have completion dates of 19th June 26 and 31st July 26.

- **Other areas of work to improve working lives of Resident Doctors:**

The assessment tool does not fully capture some of the other work and actions that have been undertaken to address some of the feedback from Resident Doctors – this includes:

- Making improvements to the doctors mess
- Assessing work spaces/environments on the wards and developing plans to improve these
- Addressing issues related to car parking/shuttle bus
- Addressing on-call rooms for overnight stay etc

The Resident Doctor 10 Point Plan Meeting, chaired by Prof Sanjay Arya, continues to meet, and maintains oversight of all improvement areas. The Board Assurance tool will be kept up to date as improvements occur and areas become fully compliant.

Link to strategy and corporate objectives

- People & Culture Strategy

Risks associated with this report and proposed mitigations

Risk: risk that the actions in the 10 Point Plan will not be fully implemented

Impact: Reputational risk, disengagement/loss of morale/productivity of RDs, increased sickness absence/turnover, financial impact of engaging locums, difficulty filling roles due to poor experience as a RD. Impact on clinical care

Mitigation: Resident Dr 10 Point Plan meeting regularly, involvement of RDs in making improvements, oversight from ETM/People Committee/Trust Board

Financial implications

Financial implications could arise from Resident Doctors being dissatisfied with the experience at WWL, which may lead to loss of productivity, low morale, increased turnover and absence. This may require the use of bank/agency locums to cover shifts, incurring a financial cost.

Legal implications

There are no legal implications identified.

People implications

If the 10 Point Plan is not fully implemented, this may lead to a loss of productivity, morale and engagement with Resident Doctors, which may lead to increased sickness absence and turnover, which has the potential to affect the quality of clinical care. This may also affect the reputation of the Trust and make individuals less likely to want to take up medical roles with the Trust in the future.

Equality, diversity and inclusion implications

No specific implications identified

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

ETM and People Committee

Recommendation(s)

The Board of Directors is requested to note the areas of compliance/partial compliance/no compliance as indicated in the Board Assurance Tool. The Board of Directors is recommended to receive assurance that direct oversight of these areas is provided by the Medical Director, and that action is being taken to address the areas in the 10 Point Plan, along with more general feedback provided by our Resident Doctors.

Resident Doctors Board Assurance Framework

Version 1.0 March 2026

Publication approval reference:

Introduction

The 10 point plan to improve the working lives of Resident Doctors Board Assurance Framework ("the framework") is issues by NHS England for use by organisation to enable them to respond using an evidence-based approach to ensure the working lives of Resident Doctors maintain improvement.
The framework is for use for all trusts with Resident Doctors and can be used to provide assurance in NHS settings or settings where NHS services are delivered.

This framework is compulsory and should be used by organisations to ensure compliance with the 10 Point Plan to improve resident doctors' working lives which aims to fix unacceptable working practices by getting the basics right for Resident Doctors.

The purpose of this framework is to provide assurance for boards against which the system can effectively self-assess compliance with the measures set out in the 10 Point Plan to improve resident doctors' working lives.

The aim of this document is to identify areas for improvement and outline a systematic framework to ensure improvements are implemented and maintained. Ensuring provider and regional teams collaborate to implement improvements and continued engagement with Resident Doctors.

The framework should be used to assure the executive board or equivalent of the assessment of the improvements. The outcomes can be used to provide evidence to support improvement to the working lives of Resident Doctors. The adoption and implementation of this framework remain the responsibility of the organisation and requires demonstration of compliance with the criteria outlined.

If the criterion is not applicable within the organisation or setting, then select not applicable option.

Links

NHS England » 10 Point Plan to improve resident doctors' working lives

Legislative Framework

Doctors and dentists in training terms and conditions (England) 2016 | NHS Employers

Instructions for use

The adoption and implementation of the 10 point plan to improve the working lives of Resident Doctors Board Assurance Framework ("the framework") remains the responsibility of the organisation and must demonstrate compliance with the 10 Point Plan to improve resident doctors' working lives.
The framework worksheet is ordered by the criteria of the 10 point plan principles and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Once options have been selected a summary plot for each criterion is generated automatically, which are displaced in the corresponding worksheet. The overall RAG status for an organisation across all criteria outlined in the framework will be relevant and applicable to all organisations with Resident Doctors'.

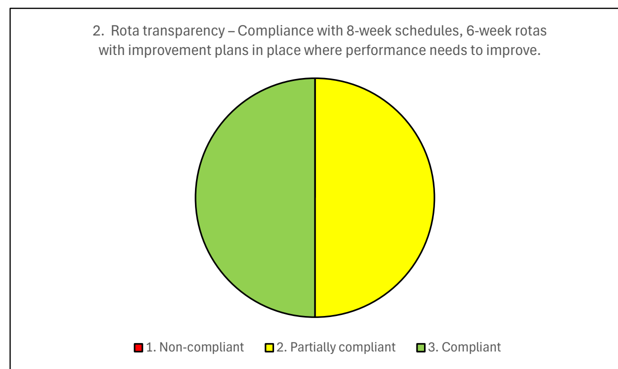
To note: use of the framework is compulsory and should be used by organisations through collaboration with their Resident Doctor Peer Leads, Resident Doctor Board Lead and Non-Executive Directors for Resident Doctors.

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
Resident Doctor Board Assurance Framework v1.0						
1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.						
Organisational or board systems and process should be in place to ensure that:						
1.1	Completed baseline audit	Baseline audit completed and submitted in line with national timescales				3. Compliant
1.2	Approved improvement plan in place	Improvement actions in place through Resident Doctor 10 Point Plan Group				3. Compliant
2. Rota transparency – Compliance with 8-week schedules, 6-week rotas with improvement plans in place where performance needs to improve.						
System and process are in place to ensure that:						
2.1	Compliant with 6- and 8-week rota standards	Work schedules/rotas submitted in line with timescales				3. Compliant
2.2	Clear monitoring of compliance and reported at Board sub-committee level		Not currently reported to Sub Board Level Committee	Work/schedule/rota compliance will be added to Workforce Dashboard in relevant months	21.7.26	2. Partially compliant
3. Annual leave reform – Adoption of national best practice initiatives						
System and process are in place to ensure that:						
3.1	Adopted the local annual leave local rules and process questionaire	Analysis has been undertaken of A/L declined and the reasons for this. This has been shared and discussed with RDs in RD 10 PP Meeting. These are currently being incorporated into an A/L SOP	A/L SOP being drafted with RD Peer Leads and Head of Medical Workforce	SOP development	19.6.26	2. Partially compliant
3.2	Completion of rota coordinator training	Discussions have taken place with rota coordinators. Further training to take place with Rota Coordinators once SOP finalised	Training on new SOP will be provided once SOP has been finalised	Training for Rota Coordinators	19.6.26	2. Partially compliant
4. Board-level leadership – Senior leads and peer representatives are in place						
System and process are in place to ensure that:						
4.1	Appointed Resident Doctor Senior Board Lead and a Non-Executive Director for Resident Doctors'	Prof Sanjay Arya - Board Lead, Mark Wilkinson Non Exec Director for RDs				3. Compliant
4.2	Appointed Resident Doctor Peer Lead and they are engaged in line with national guidance	RD Peer Leads - Joshua Lewis, George Rogers, Polly Noble, Muj Patel - all engaged in line with national guidance				3. Compliant
4.3	Robust progress updates in place which involve Resident Doctor	Monthly Resident Doctor 10 Point Plan Meeting chaired by Medical Director, RD Peer Leads key members of group				3. Compliant
4.4	Clear support plan in place to assist the RDPL (Resident Doctor Peer Lead)	Support required explored and discussed with Resident Dr Peer Leads. Agreed 2 hours per week to be distributed between RD Peer Leads to support their work on the RD 10 PP. This has also been added to individuals' rostering profiles for visibility. Clinical Supervisors informed by Medical Director. RD Peer Leads are able to raise any challenges regarding support through the monthly RD 10PP meetings, chaired by the Medical Director				3. Compliant
5. Payroll accuracy – Trusts have commenced payroll improvement activity and are monitoring						
System and process are in place to ensure that:						

5.1	Implementing payroll improvement methodology	Assessment undertaken, action taken in some areas, plan to be developed to action all improvement areas identified.	Actions not yet in place to address all areas of improvement	Meetings arranged with Payroll/People Services to develop plan to address remaining areas	30.6.26	2. Partially compliant
5.2	Reduction in payroll errors	Resident Dr Pay Errors - Sep 25 -18, Oct - 0, Nov - 2, Dec - 1, Jan 26 - 3, Feb - 3, March - 0. Payroll engaged in Resident Dr 10 Point Plan Meetings. Actions developed to reduce pay errors in response to RD survey feedback	A small number of pay errors are still occurring in some months	Actions underway to address RD survey feedback regarding pay errors. Analysis of pay errors being undertaken by Payroll Manager to identify themes. Regular meetings between payroll and Medical Workforce Team established to improve communication and reduce pay errors, and to plan for the next rotation of RDs	31.7.26	2. Partially compliant
5.3	Monthly error reporting compliance undertaken	Monthly National Payroll Reporting return submitted to NHSE. Pay errors monitoring included in monthly Workforce Dashboard. Lead Employer shares quarterly pay errors information for lead employer employed doctors				3. Compliant
6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs						
System and process are in place to ensure that:						
6.1	Signed MoU and processes in place for monitoring that no unnecessary training is being repeated	MoU signed	IAT ESR process to transfer learning being explored, as current process to transfer learning records is manual and can lead to training being repeated	Exploration of IAT ESR process. Head of L&D has met with RDs to discuss mandatory training requirements/reducing unneccessary duplication. RDs have been included on Terms of Reference for Mandatory Training Local Oversight Group (MLOG)	IAT ESR Process - 31.7.26	2. Partially compliant
6.2	Mandatory Training Local Oversight Group (MLOG) in place	MLOG in place, chaired by AD of OD & Inclusion				3. Compliant
6.3	The MLOG involves Resident Doctors in ensuring that local STATMAN (statutory/mandatory training) requirements are necessary and proportionate	MLOG engages with Subject Matter Experts, and takes into account national requirements to determine stat/mand training requirements. RD respresentation added to Terms of Reference for MLOG and RD rep will be invited when the next meeting is set up				3. Compliant
7. Exception reporting – Adoption of new national framework						
System and process are in place to ensure that:						
7.1	Clearly communicated new approach and local processes to all Resident Doctors	Information sent to existing Resident Doctors and process in place to share information for RDs who rotate into the Trust				3. Compliant
7.2	Implemented local and national data reporting requirements	In place				3. Compliant
8. Expense reimbursement – Adoption of fast-track course costs						
System and process are in place to ensure that:						
8.1	Adopted new reimbursement process	Medical Education confirmed reimbursement process in place for Resident Drs employed by the Trust (Lead Employer Resident Drs are reimbursed via the Lead Employer)			30.6.26	3. Compliant

8.2	Meeting target reimbursement time of 6 weeks.	Medical Education have confirmed process in place to ensure reimbursement takes place without delay	Sample audit to be undertaken to confirm compliance with 6 week reimbursement process	Sample audit currently underway	30.6.26	2. Partially compliant
8.3	Doctor satisfaction meeting ≥80% target		Process to measure satisfaction needs to be developed	Consideration to be given to this in next 10PP meeting	31.8.26	1. Non-compliant

1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.
1. Non-compliant
2. Partially compliant
3. Compliant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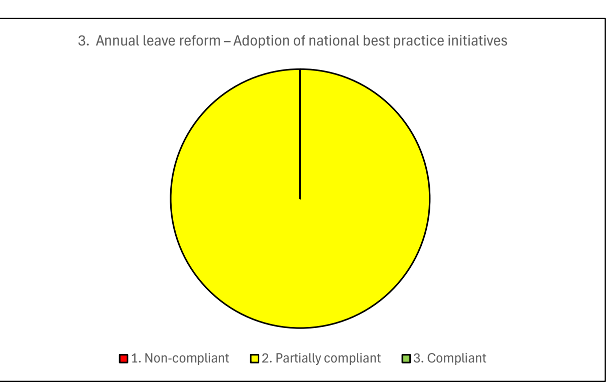
3. Annual leave reform – Adoption of national best practice initiatives
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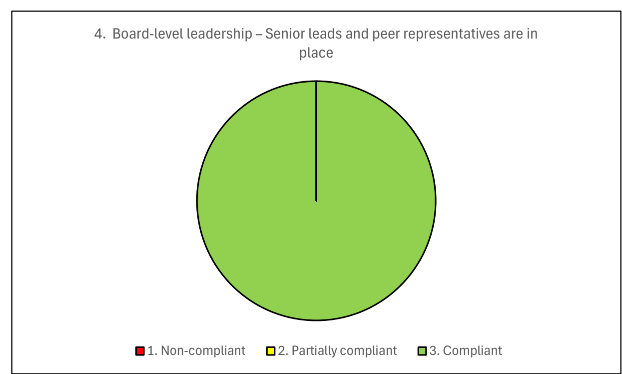
3. Compliant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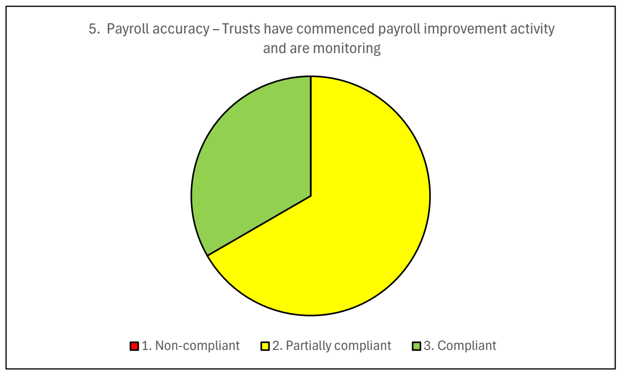
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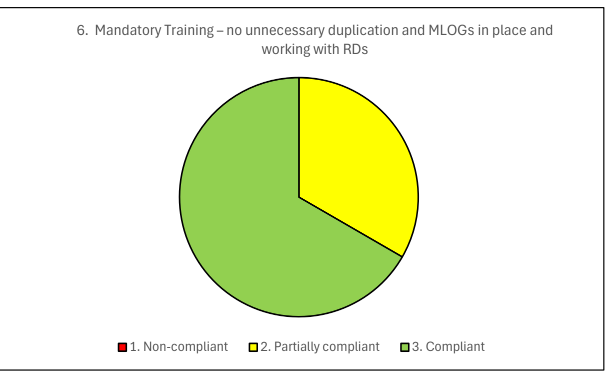
6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs
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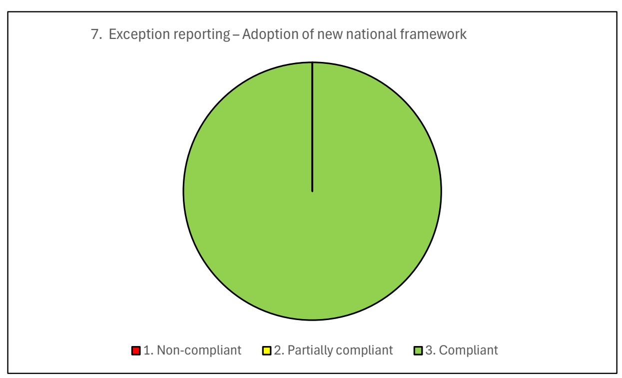
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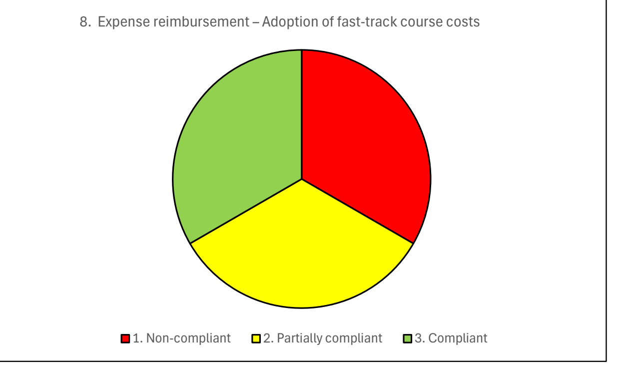
3. Compliant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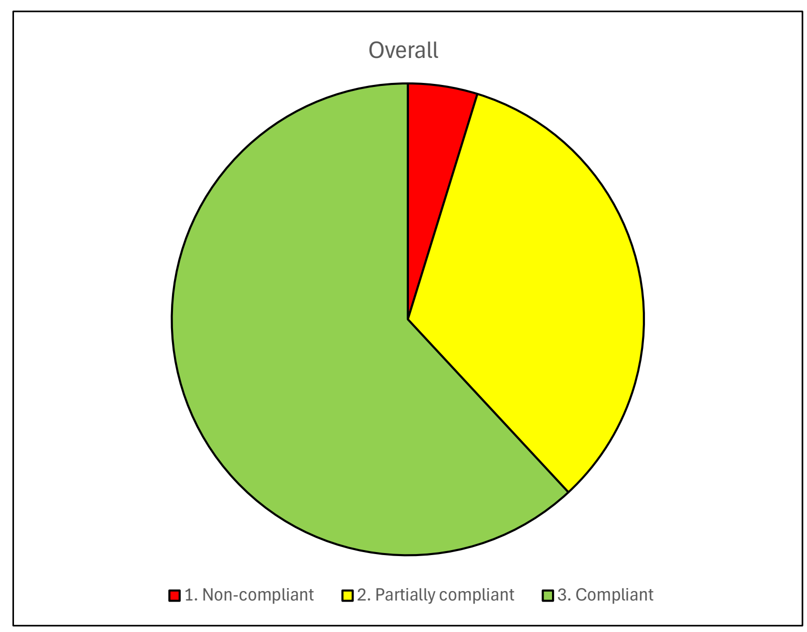
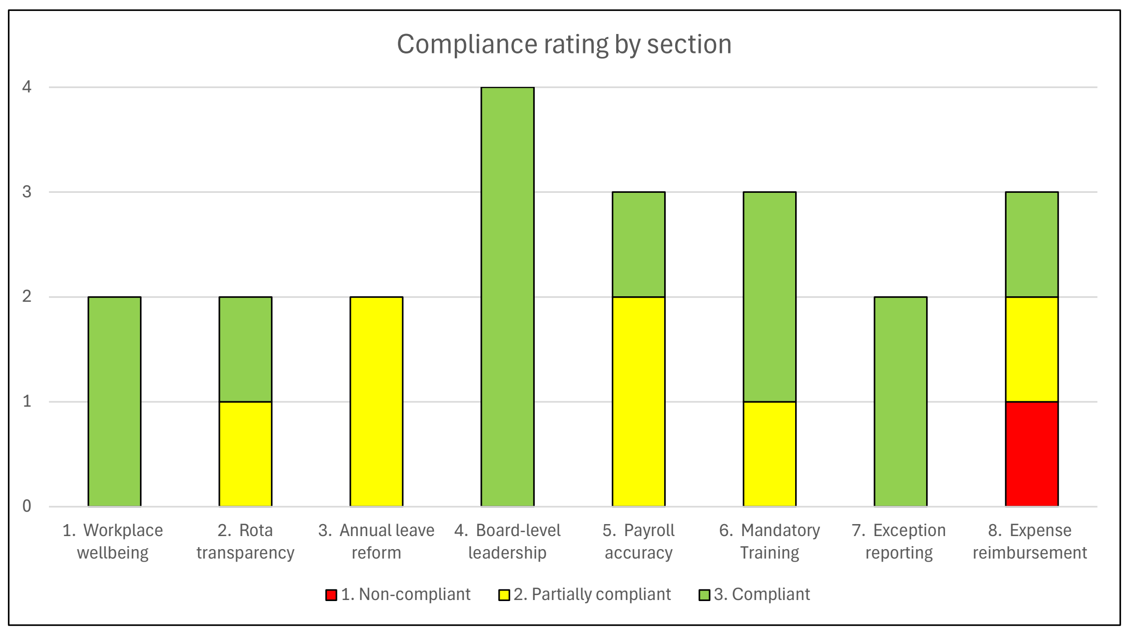

Overall
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by section
4
3
2
1
0
1. Workplace wellbeing
2. Rota transparency
3. Annual leave reform
4. Board-level leadership
5. Payroll accuracy
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7. Exception reporting
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NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	GOSWH Annual Report 2025/2026
Presented to:	Board of Directors
Date of paper:	17 June 2026
Item purpose:	Information
Presented by:	Abigail Callender-Iddon, Guardian of Safe Working Hours
Prepared by:	Abigail Callender-Iddon, Guardian of Safe Working Hours
Contact details:	T: (01942 822626) E: Abigail.callender-iddon@wwl.nhs.uk

Executive Summary

For the financial year April 2025 – March 2026, there have been:

- 416 exception reports submitted across the year.
- Submitted by resident doctors across all grades and specialties.
- 384 hours and 20 minutes of overtime claimed in total.
- FY1 doctors continued to submit the majority of exception reports across the year, although there was increased engagement from ST1–ST3 doctors during Quarter 3.
- General Medicine was the highest reporting specialty overall across the year.
- 5 Immediate Safety Concerns (ISCs) raised.
- 32 breaches recorded across the year.
- £1,562.00 accrued to the Guardian Fund across the year.

Metric	2024/2025	2025/2026	Change
Exception reports	345	416	+71 (+21%)
Overtime Hours	244h 20m	384h 20m	+140h (+57%)
Immediate Safety Concerns	13	5	-8 (-62%)
Breaches	41	32	-9 (-22%)
Guardian Fund	£1371.01	£1562.00	+ £190.99 (+14%)

Compared with 2024/2025, exception reporting activity increased during 2025/2026, with 416 exception reports submitted compared with 345 in the previous year. Total overtime recorded increased from 244 hours and 20 minutes to 384 hours and 20 minutes, reflecting sustained workload pressures across several specialties.
General Medicine remained the highest reporting specialty overall; however, Quarter 3 demonstrated a marked increase in reporting from General Surgery, highlighting significant service pressures within surgical services during this period.
Despite the increase in exception reporting and overtime hours, the number of Immediate Safety Concerns reduced from 13 to 5 and the number of contractual breaches reduced from 41 to 32.

This suggests improved rota compliance and management of working-hours issues, although significant operational pressures remain.
Recurring themes throughout the year included workload intensity, acutely unwell patients, staffing shortages, rota gaps, delayed handover, missed breaks and missed educational opportunities. The implementation of the Reform Framework Agreement during 2025/2026 also represented a significant development in the governance of safe working hours and exception reporting.

1.**Quarter by Quarter Exception Reports.**
Q1: 48
Q2: 69
Q3: 178
Q4: 121
Total: 416
Exception reporting increased throughout the year, peaking in Quarter 3 when surgical services experienced significant workload pressures. Reporting reduced in Quarter 4 but remained above Quarter 1 and Quarter 2 levels, suggesting ongoing service pressures and sustained engagement with the exception reporting process.

Overtime Hours Claimed
Q1: 39h 10m
Q2: 51h 29m
Q3: 193h 05m
Q4: 100h 36m
Total: 384h 20m
Overtime remained the predominant reason for exception reporting throughout the year. The marked increase in Quarter 3 reflects significant workload pressures, particularly within surgical specialties. Although overtime reduced during Quarter 4, it remained substantially above Quarter 1 levels.

Immediate Safety Concerns (ISCs)
Q1: 3
Q2: 0
Q3: 0
Q4: 2
Total: 5
The number of Immediate Safety Concerns was lower than the previous year. Reported concerns related primarily to staffing levels and inability to take breaks safely. Whilst encouraging, this reduction should be interpreted cautiously as it may also reflect changes in reporting behaviour.

Breaches
Q1: 2
Q2: 6
Q3: 15
Q4: 9
Total: 32
Breaches peaked during Quarter 3 and were largely associated with breaches of the maximum 13-hour shift length. Despite increased exception reporting and overtime, annual breaches reduced compared with 2024/2025, suggesting improved compliance with contractual safeguards.

2. Exception Report Type – Annual Distribution (April 2025 – March 2026)

Hours / Overtime Related Reports
Q1: 42
Q2: 63
Q3: 143
Q4: 99
Total: 347 reports (83%)

The majority of exception reports throughout the year related to additional hours worked beyond scheduled time. This demonstrates that workload pressures remain the principal driver of exception reporting across the Trust.

Educational Exception Reports
Q1: 3
Q2: 5
Q3: 9
Q4: 10
Total: 27 reports (6%)
Educational exception reports remained present throughout the year. Missed teaching sessions included Foundation teaching, Grand Rounds and self-development time. Service pressures continued to be the primary reason for missed educational opportunities.

Natural Break Reports
Q1: 5
Q2: 2
Q3: 16
Q4: 9
Total: 32 reports (8%)
Natural break exception reports became more prominent during the latter half of the year, highlighting challenges in maintaining rest and break compliance during periods of sustained clinical pressure.

Service Support Exception Reports
Q1: 3
Q2: 0
Q3: 2
Q4: 2
Total: 7 reports (2%)
These reports highlighted concerns regarding staffing levels, supervision and workload distribution. Although relatively few in number, they represent higher-risk concerns requiring continued monitoring.

Pattern Exception Reports
Q1: 10
Q2: 1
Q3: 5
Total: 16 reports (4%)
Pattern exception reports continued to highlight recurrent staffing pressures, rota adjustments and redeployment of resident doctors to maintain service delivery.

The overall distribution of exception reports demonstrates that:
• Workload and additional hours remain the dominant pressure across the Trust.
• Educational opportunities continue to be affected by service pressures.
• Break compliance remains challenging during periods of high demand.
• Service support concerns remain uncommon but represent potentially significant risks.

3. Speciality Trends Across the Year
General Medicine
General Medicine remained the highest reporting specialty overall and was the predominant contributor in Quarters 1, 2 and 4.

Themes included:
• Persistent staffing shortages and rota gaps.
• Large ward coverage and workload intensity.
• Acutely unwell patients requiring prolonged review.

• Delayed handover.
• Missed breaks and teaching opportunities.
• Junior doctors managing complex workloads with limited staffing resilience.

General Surgery
General Surgery demonstrated a substantial increase in reporting during Quarter 3 and became the dominant reporting specialty during that period.

Themes included:
• Urology hot-week pressures.
• Theatre commitments reducing registrar availability.
• Delayed ward rounds and handovers.
• Accumulation of ward jobs late in shifts.
• Increased breaches of maximum shift length.

Accident & Emergency
A&E reporting increased during Quarters 3 and 4.

Themes included:
• Acute patient deterioration close to shift end.
• Resuscitation activity delaying departure.
• Difficulty achieving safe handover.
• Break and rest compliance issues.

Trauma & Orthopaedics and Other Specialties
Although lower in volume, recurring themes included:
• Delayed transfers and referrals.
• Administrative workload.
• Staffing pressures.
• Difficulty completing urgent clinical tasks within rostered hours.

4. Grade Trends
FY1 doctors continued to account for the majority of exception reports throughout the year.
This reflects:
• Significant frontline service exposure.
• High ward-based workload.
• Strong engagement with exception reporting.
A notable increase in reporting from ST1–ST3 doctors was observed during Quarter 3, accounting for approximately 41% of exception reports during that quarter. This may reflect increased confidence in reporting concerns and greater engagement from more senior resident doctors.

5. Key Recurring Themes Across the Year
Missed Breaks
• Frequently reported across multiple specialties.
• Often due to workload intensity, staffing shortages and inability to hand over bleeps safely.
• Contributed to fatigue and reduced wellbeing.

Staffing Gaps and Rota Pressures
• Recurrent across medicine, surgery and emergency care.
• Sickness absence and rota gaps frequently cited.
• Reduced staffing resilience during evenings, weekends and high-pressure periods.

High Clinical Acuity
• Acutely unwell patients frequently required prolonged management.
• Emergency escalation often extended beyond rostered finish times.
• Doctors consistently prioritised patient safety over timely departure.

Delayed Handover
• Incoming teams often managing significant workload.
• Delayed handover contributed to overtime and breaches.
• Safe transfer of care remained a recurring challenge.

Missed Training Opportunities
• Foundation teaching.
• Grand Rounds.
• Self-development time.

Administrative Burden
• Referrals, discharge documentation and prescribing frequently contributed to late finishes.
• Complex documentation requirements added to workload pressures.

6. Financial Overview
Total Guardian Fund accrued during 2025/2026:

Q1: £197.59
Q2: £145.19
Q3: £948.87
Q4: £270.35
Total: £1,562.00

Total breaches across the year: 32
Although breaches reduced compared with 2024/2025, Quarter 3 generated a substantial increase in financial penalties due to multiple breaches of the maximum 13-hour shift length.

7. Impact and Assurance
This year demonstrates:
• Active engagement with exception reporting across specialties and grades.
• Increased utilisation of exception reporting compared with 2024/2025.
• Improved compliance with contractual safeguards, evidenced by a reduction in annual breaches.
• Reduced number of Immediate Safety Concerns compared with the previous year.
• Identification of ongoing workforce, rota and workload pressures.
• Successful implementation of the Reform Framework Agreement during the year.
• Continued financial accountability through the Guardian Fund process.

The exception reporting data demonstrates that significant service pressures remain across acute specialties. However, the reduction in breaches despite increased reporting activity suggests that exception reporting is becoming increasingly embedded within the Trust's governance processes and continues to provide effective oversight of safe working hours.

8. Priorities for 2026/2027

• Continued monitoring of General Medicine staffing and workload pressures.
• Review of surgical staffing models, particularly during Urology hot weeks.
• Strengthening end-of-shift handover arrangements.
• Improving staffing resilience during evenings, weekends and periods of sickness absence.
• Protecting educational opportunities and self-development time.
• Improving break compliance and rest facilities.
• Monitoring the impact of Reform Framework Agreement changes.
• Promoting continued engagement with exception reporting across all grades.

Board of Directors - Public Meeting

Wednesday 1 April 2026, 10:15 - 14:45

Boardroom, Trust Headquarters

Attendees

Board members

Robina Shah (Chair), Sanjay Arya (Chief Medical Officer), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director, Absent from: 36, 37, 38, 39, 39.1, 40, 41, 41.1), Simon Holden (Non-Executive Director), Mary Moore (Non-Executive Director), Kevin Parker-Evans (Chief Nursing Officer), Richard Mundon (Deputy Chief Executive), Francine Thorpe (Non-Executive Director), Mark Wilkinson (Non-Executive Director)

Absent: Sarah Brennan (Chief Operating Officer), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Charlotte Wright (Interim Chief People Officer)

In attendance

Joanne Bark (Deputy Director of Operations), Julie Dawes (Director of Governance), Rachel Gleave (Associate Director of Organisational Development and Wellbeing), Nina Guymer (Head of Corporate Gov & Deputy Company Secretary)

Presenters

Sophie Banks (Clinical Quality Lead), Nicola Dawber (Ward Leader(JHRU))

Meeting minutes

36. Chair and quorum — Information

Robina Shah

Dame R Shah opened the meeting, declaring a quorum was present and that the meeting was duly convened and constituted.

37. Patient Story — Information

Kev Parker-Evans, Sophie Banks

The Clinical Quality Lead for Intermediate Care Services, Ms S Banks and Jean Hayes Reablement Unit (JHRU) Ward Leader, Ms N Dawber joined the meeting to share the staff story.

They summarised a story about a gentleman who had experienced 20 ward transfers during the course of his admission, attributing to further damage in his skin condition, leading to a category 3 pressure ulcer.

The key point they wished to highlight was the systems which influence how patients spend their time in hospital, particularly on JHRU, as it is a nurse led ward. Where patients have a medical issue, they are required to go back through A&E and begin their pathway journey again, which removes their prescription data on the Health Information System and results in new prescriptions needing to be made. In this situation, this resulted in the patient having no medication for a full weekend. It was explained that it is an issue with HIS capability causing this problem.

Following queries it was summarised that, moving forwards:

- Advanced Care Practitioner prescribing is now being trailed on the unit for three months and will influence how this is moved forwards.
- All ward managers and matrons attend after action reviews so that shared learning happens live with teams across the organisation.
- Electronic tags are now used to monitor how many times patients are moved during one admission (with less than 5 times being considered acceptable).

The team explained that patients are usually admitted to JHRU at the end of their patient journey and staff have observed that patients within the last three months have not been moved more than 5 times, giving assurance that this mechanism is effective. Mr R Mundon added that the integrated performance report now includes a metric to show how many times patients are moved during their stay, which gives the Board appropriate oversight of this.

Ms M Fleming suggested that more consideration of the model is given to establish how the organisation can prevent JHRU patients needing to go back through A&E.

Directors agreed upon the need to ensure that technical issues such as those caused by the HIS system are not a barrier to good patient care.

The Chair thanked the JHRU team for joining and providing the story, for highlighting the issues at hand and for emphasising how well the unit works to care for patients, noting in particular a visit that herself and other non-executive directors made to the unit recently, where they witnessed this. She assured them that the actions outlined would be taken forwards and extended thanks to the full unit and the Board noted that an action plan to address the other matters highlighted is being progressed operationally.

ACTIONS:

- **Consider the model to establish how the organisation can prevent JHRU patients needing to go back through A&E and requiring medications to be represcribed - K Parker-Evans and J Bark**
- **Review the capabilities of the HIS system (in reference to patients on JHRU needing additional medical care) - R Mundon**

The Board further asked that several matters be **REFERRED** to its **Quality and Safety Committee,** being that it:

- **Receives assurance around the action plan having appropriately addressed the issues, risks and**
- **Receives a benefits realisation report on the effectiveness of the new ways of working implemented (Advanced Care Practitioner prescribing and other revisions to staff roles)**

  - K Parker-Evans

02. Patient Story JHRU - Feb 2026_.pdf

38. Apologies for absence — Information

Robina Shah

Apologies were noted from:

- Sarah Brennan
- Anne-Marie Miller
- Charlotte Wright

39. Declarations of Interest — Information

Robina Shah

The register was noted and no further declarations were made.

39.1. Register of directors' interests — Information

Robina Shah

Directors DoIs (Public) - Apr 2026 (FINAL 290326).pdf

40. Minutes of the previous meeting — Approval

Robina Shah

At 9.1 - Q&S Mrs F Thorpe highlighted positive progress with 2024/25 objectives, should refer to 2025/26.

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

41. Action Log

Assurance

Robina Shah

it was **AGREED** that action 10/26 could be closed.

06. Public Board Action Log 2026.pdf

41.1. University Teaching Hospital progress report

Information

Sanjay Arya

Prof S Arya sumarised the report pertaining to action 126/25.

Prof C Austin noted recognition from the university hospital association (UHA) that WWL do not necessarily need to be at the same level as some more longer established medical schools, noting this to be very positive for WWL as a new medical school and highlighted the importance of board level oversight of research.

A discussion ensued around the geography of Edge Hill University (not being in Greater Manchester (GM)). Note was made of the extensive work the university does with partner organisations across Greater Manchester, as well as its satellite site in Manchester, despite that its main campus is located in Ormskirk, Lancashire. A discussion ensued around the mission statement of the Mayor of GM who wishes to fund education and skills courses within GM and that moving forwards, every education institution must show how it is being inclusive and addressing the wider determinants of health.

Prof C Austin suggested that data on the local population, from an equality and health perspective, together with information on geographical study preferences, could be used to support and widen participation initiatives.

Prof S Arya added that WWL also serves populations across parts of Cheshire, Merseyside and Lancashire.

Dame R Shah observed that it is difficult for the Board to establish the requirements for the application and governance surrounding research and the UHA status without seeing the criteria and further detail. She asked therefore that Board is supported to have line of sight on this moving forwards. She further asked that the Board is also given the opportunity to have oversight of the process of the proposed partnership with Edge Hill.

Lady R Bradley pointed out that there is no clarity yet around how the ICB will be answerable to the Mayor of GM and that wider political position.

Note was made of WWL's offer to its workforce of the future being significantly improved due to its research status, including recruitment and retention.

Dame R Shah concluded that the University's location outside Greater Manchester does not undermine the Trust's ambition, provided the partnership delivers tangible benefits for the population served, supports widening participation and workforce development, and is clearly articulated within a place-based narrative.

The Board **NOTED** the progress made and **ACKNOWLEDGED** the plan for WWL to submit an application in

September 2026 and **AGREED** that the action could be closed.

06.1. University Hospital Status Progress Report April 2026 v4.pdf

42. Chair's report and stakeholder update

Information

Robina Shah

Mrs J Gill joined the meeting.

The Chair requested that colleagues noted the content of her report. She also wished to reference the WWL Long Service Awards ceremony, which had taken place the previous week. Dame Robina reflected on how humbled she felt and how delighted she was to present awards to colleagues who dedicated such long service careers at WWL and how important it is to acknowledge the impact that they have made to patient care, patient experience and patient outcomes. Positive feedback was echoed by Ms T Gardner.

She went on to read out a statement of thanks from Sir R Lees, which stated that as a system, GM is operating within budget and although not all performance targets have been met for 2025/26, significant progress has been made with compliance and further, the operational plan submitted by the system is compliant. She added her own thanks to colleagues for all of their hard work in shaping, drafting, revising and submitting the plan.

The Board received and **NOTED** the report.

7.0. Chair Board Report - April 2026 FINAL 310326).pdf

43. Chief Executives report

Information

Mary Fleming

Ms M Fleming summarised her report.

She invited input in terms of the urgent care performance, with Ms J Bark reporting an 11% improvement in emergency department (ED) performance for March 2026, with Mr K Parker Evans adding that nursing, medical and operational staff across the divisions have also been working exceptionally well together, with a shared view of no tolerance for patients being kept in hospital for longer than they need to be.

Ms M Fleming invited Mr R Mundon to comment on the work of the Healthier Wigan Partnership. He outlined that the Partnership is focusing on developing a bespoke Wigan approach to neighbourhood and place-based working, reflecting the borough’s population needs rather than adopting a national blueprint. He described the development of a clearer governance architecture, including the establishment of a place leadership team and a number of steering groups, initially covering Better Lives, pathway redesign, and children and young people, alongside a dedicated neighbourhood health steering group. He further noted the importance of strengthening enabling capabilities, including digital, organisational development, workforce, estates and finance, to support delivery, and clarified the distinction between the roles of the Healthier Wigan Partnership and the Health and Wellbeing Board.

She concluded by noting the upcoming resident doctors strike which would take place at short notice, during the Easter school holidays, making cover more challenging due to increased periods of annual leave taking place. The Chief Medical Officer reassured the Board that he has asked that no cancer cases are cancelled and that other elective cancellations are minimal.

A discussion ensued around the national oversight framework and how it applies to WWL, Ms M Fleming advised that where the trust has concerns or suggestions in relation to the framework, she has contacted colleagues such as Prof T Briggs.

A discussion followed about the need to ensure that WWL supports the upcoming left shift and the move towards population based care, with a need to ensure that the Wigan locality receives and then correctly

allocates the right levels of funding.

Dame R Shah welcomed the improvement in ED performance following the actions put in place to address previous challenges. She noted that the Board would need to continue monitoring this through triangulation across the Quality and Safety, Finance and Performance, and People Committees.

She was also pleased to see the developing work on neighbourhood models and emphasised the importance of ensuring that appropriate governance processes are in place to support and oversee this work.

The Board received and **NOTED** the report.

08. CEO Board Report_Public_ March26_FINAL.pdf

08a. Additional actions to virtually eliminate corridor care 4 March 2026.pdf

44. System Partnerships report

Information

Richard Mundon

Mr R Mundon presented the report.

In response to a question from Mrs F Thorpe regarding the ongoing relevance of the Bolton partnership, Mr R Mundon confirmed that the relationship remains strategically important, citing shared patient flows and service interdependencies, with collaboration supporting service resilience in areas such as urology and cardiology. He advised that partnership working with neighbouring trusts remains complementary to locality and GM system arrangements.

Ms T Gardner and Mr K Parker Evans reinforced the value of the partnership from a workforce and operational leadership perspective, highlighting benefits including shared learning, peer support and strengthened collective influence within system forums, particularly for organisations of similar scale.

Ms Fleming expanded on the rationale for the Bolton partnership, explaining that collaboration is driven by practical service need rather than structural integration. She emphasised that:

- The partnership is based on a clear principle to collaborate where it improves outcomes for populations.
- There is no intention to merge or integrate organisations, but to partner selectively where it adds value.
- Examples of collaboration include urology, cardiology, breast services, potential shared rehabilitation facilities, and exploration of paediatric elective activity.
- Bolton and WWL serve different but overlapping populations, and partnership helps address capacity, workforce and resilience challenges.
- She advised that these arrangements are consistent with wider regional expectations around neighbouring trusts working together where appropriate.

Mr S Holden questioned the ongoing relevance and prioritisation of the Bolton partnership in light of the move towards neighbourhood-based models, highlighting finite executive capacity and bandwidth. He also suggested that the partnerships report might, depending on audience, better reflect other partnership types (e.g. commercial or shared services) and consider how partnerships are framed.

M M Wilkinson commented that the partnerships report provided a strong narrative account, but queried whether the Board could be supported by the development of meaningful indicators or measures to understand the impact and value of partnership working, while acknowledging this would be complex and not straightforward to quantify.

Mr R Mundon responded that while partnership impact is difficult to measure empirically, this should be assessed through delivery of corporate objectives within the BAF, rather than standalone partnership metrics. He noted historic challenges in defining objective measures of partnership effectiveness and emphasised that Board assurance should focus on outcomes delivered through partnerships, rather than partnership activity itself.

The Board **RECEIVED** the system partnership report, **NOTED** the content and the range of partnership activity across Greater Manchester, Bolton and Wigan, and shared reflections on the future development of the report. The Chair, emphasised the importance of strengthening an outcomes-focused approach, clarifying governance and risk ownership arising from partnership interdependencies, and ensuring alignment with neighbourhood and place-based models. The Board highlighted the need for partnership working to support delivery of strategic objectives and population outcomes, with assurance provided through existing governance mechanisms.

09. Board - Partnerships Report April 2026.pdf

45. Committee chairs' reports

Information

Non Executive Directors

45.1. Quality and Safety

Information

Francine Thorpe

Mrs F Thorpe summarised the reports provided.

Mr K Parker-Evans WWL includes c-difficule cases linked to community / virtual ward / medically optimised-for-discharge patients within its infection reporting and acknowledged that other trusts may not be reporting these in the same way.

Lady R Bradley queried whether the Trust's reporting approach risked it appearing as an outlier compared to peer organisations, and sought assurance that data was being reported consistently and meaningfully to support appropriate oversight and action.

The Board was advised that work is underway through GM Chief Nurse and regional ICB forums to clarify definitions and achieve greater consistency and comparability in reporting across the system. It was emphasised that this work is intended to ensure data is meaningful, proportionate and supports learning and action, rather than creating misleading peer comparisons or performance distortion.

Dame R Shah raised a number of assurance-focused questions, specifically:

- She asked whether the Board would receive information on the effectiveness of Martha's Rule, particularly in relation to early warning scores, patient safety and family escalation and it was confirmed that this will be received at the next meeting.
- She queried the ongoing delays to the peer review of children's audiology services, noting the impact of delays on children and young people, including those with disabilities, sensory impairment or neurodivergence. She emphasised the importance of continued escalation and assurance, even where elements were outside the Trust's direct control.

Mr K Parker-Evans explained that the Trust has implemented a robust action plan in response to earlier findings and that the remaining delay relates specifically to external subject-matter expert reviews, which sit outside the Trust's direct control and are being undertaken across Greater Manchester. He advised that the matter has been escalated through provider oversight arrangements with the ICB, that no critical concerns have been identified to date, and that further updates will be sought and reported once the external reviews are completed.

10.1. AAA QS Mar 2026.pdf
10.1a. AAA Q&S Feb 2026.pdf

45.2. Finance and Performance

Information

Julie Gill

Mrs J Gill summarised the report and confirmed that the Committee considered the key financial, operational and cash-flow risks to be appropriately identified and mitigated at this stage. She highlighted the increased CIP requirement for 2026/27, the associated delivery and phasing risks, and the need for continued close oversight of cash balances, particularly in periods of forecast pressure. The Committee

also noted recent operational disruption arising from IT and supply chain issues and the actions taken to mitigate impact, alongside improving operational performance in March. The Committee was satisfied that risks were being actively managed and appropriately escalated.

10.2. AAA - FP - Mar 2026.pdf

45.3. People Committee

Information

Mark Wilkinson

Mr M Wilkinson summarised the report, drawing attention to key workforce risks and areas of assurance, including sickness absence, appraisal compliance and emerging national developments affecting nursing roles.

In response to a question from Dame R Shah, Mr K Parker-Evans explained the current national issue relating to the distinction between Band 5 and Band 6 nursing roles, because over time some roles have expanded beyond the original scope and a review is being carried out to ensue roles are correctly aligned to national role profiles. He advised that WWL has volunteered to be one of the first Trusts to undertake this review, supported by national resource, and that the exercise would be undertaken jointly by nursing and HR to ensure both professional and organisational oversight.

Mrs F Thorpe queried whether the review could create a financial and workforce risk, particularly if it resulted in upward pressure on banding. Lady R Bradley added that there was also a retention and equity risk, noting the potential for differential pay approaches across the system to drive workforce movement and instability.

Mrs T Gardner advised that the Board recognised the challenge created by larger organisations paying higher rates, particularly within Greater Manchester, which can place smaller Trusts at a competitive disadvantage despite comparable roles and responsibilities. She noted the importance of addressing this through system dialogue rather than unplanned local responses.

In summarising the discussion, Dame R Shah emphasised that the review must be approached carefully and strategically, ensuring consistency, affordability and fairness, while avoiding unintended consequences. She stressed the importance of maintaining clear governance, aligning outcomes to organisational need, and providing the Board with assurance on financial, workforce and retention impacts as the work progresses.

10.3. People Committee AAA March 2026.pdf
10.3a. People Committee AAA January 2026.pdf

45.4. Research Committee

Information

Clare Austin

Prof C Austin summarised the report.

It was noted that the General Medical Council's State of Education report, while appropriately reviewed by the People Committee, should also be brought to the Board to support statutory assurance on education and training.

Noting the repeated alerts from the Committee around clinical pressures preventing staff from undertaking research, Mrs M Fleming asked that 'time for research' is added to the upcoming Executive Team Meeting agenda.

Prof C Austin presented to the Board, highlighting progress and challenges within the Trust’s research portfolio. She drew attention to the pressure on clinical capacity and job planning, noting that operational demands continue to limit the ability of clinicians to undertake research activity within existing job plans. She also highlighted opportunities to strengthen the use of charitable funds to support research activity and improve sustainability.

Following the presentation, members discussed the decline in NIHR income, particularly the Trust's limited success in leading NIHR awards, and the implications this has for research growth and reputation. It was acknowledged that while overall research income remained broadly favourable, reliance on fewer funding streams presents a risk.

The discussion also focused on the visibility of education alongside research, with members noting that education does not currently have sufficient prominence at board level. Consideration was given to whether this should be strengthened through governance arrangements, including the potential future scope of the Research Committee.

Members welcomed progress on data infrastructure and secure data environments, recognising this as an important enabler for future research and commercial opportunities. The Board also discussed the need to better articulate the wider value and impact of research, including benefits to population health, service improvement and health inequalities, rather than viewing research solely through a financial lens.

In concluding the item, Dame R Shah emphasised that further work is required to address job-planned research time, strengthen Board-level oversight of education, and ensure that research priorities align with neighbourhood, population health and inequality agendas.

10.4. AAA - Research - Mar 2026.pdf

45.5. Audit Committee

Information

Simon Holden

Mr S Holden presented the report.

Ms M Fleming suggested that it would be helpful to have a way of triangulating the alerts raised via the AAA reports, noting that the People Committee had felt assured by the position on medical job planning and progress made, whilst the Audit Committee had wished to alert the board to the lack of progress with related high risk audit recommendations, noting that some staff did not have a job plan.

It was agreed that further work is required to align committee assurance, clarify whether progress against actions is sufficient to mitigate audit risk, and ensure that Board oversight is based on a shared understanding of risk, progress and residual exposure.

The Board requested that this be reviewed through executive governance, with a clarified position and consolidated assurance to be reported back via the People Committee and Audit Committee, with an update to the Board.

Mr M Wilkinson noted that actually, the raising of these issues at Board meetings by non-executive directors is how they come to the forefront and allows them then to be referred for executive review.

ACTION: Reconcile the position on medical job planning to provide a comprehensive update to the Board of the current position, given the disparity in assurance perceived between the People and Audit Committees - M Fleming

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46. National Staff Survey

Discussion

Rachel Gleave

Mrs R Gleave presented the National Staff Survey findings to the Board, highlighting the improved response rate and summarising key themes, including strengths around teamwork and leadership, alongside areas requiring further focus, particularly advocacy, psychological safety and learning.

Prof C Austin noted the range of avenues available for colleagues to speak up and raise concerns, emphasising the importance of ensuring staff confidence that issues raised through formal and informal routes would be heard and acted upon.

Prof S Arya acknowledged the ongoing challenge of engaging clinical staff, noting that while engagement can be difficult, this year's response rate of 66% represented a positive position. He also referenced discussion through the Local Negotiating Committee (LNC) as an important route for dialogue with medical colleagues.

Mr S Holden added reflections on the survey results, noting the importance of understanding staff perception as well as experience, particularly where views may be shaped by wider organisational pressures and external narratives.

Mr M Wilkinson asked whether there were specific learning points relating to communications and engagement. A discussion followed on the importance of "closing the loop" with staff, demonstrating that the time taken to complete the survey leads to visible action and tangible improvements, particularly in areas of dissatisfaction.

Ms M Fleming observed that the area with the lowest engagement and least positive responses remained what was previously known as the medical division. The Board acknowledged the need to focus efforts on both increasing engagement from this group and clearly demonstrating progress being made through operational and transformation programmes.

Mr K Parker-Evans added that sustained improvement would require targeted leadership engagement, practical follow-through on identified issues, and consistent messaging to reinforce trust in the process.
In summarising the discussion, Dame R Shah emphasised the need for the Board to monitor more robustly how the organisation responds to survey feedback, ensuring appropriate triangulation with other intelligence sources. She highlighted the importance of maintaining focus on the advocacy score, and confirmed that the Wider Leadership Team would support delivery of targeted operational plans. It was agreed that progress would be monitored through the People Committee, with updates returning to the Board.

The Board **NOTED** the report, having **DISCUSSED** its content.

11. NSS 2025 Results and Engagement Plan March 2026 for Public Board 01042026.pdf
11a. Staff Survey Board Presentation.pdf

47. Medium term plan 2026/27 re-submission to NHS England — Information

Richard Mundon

Mr R Mundon presented the report.

Mr M Wilkinson asked how WWL set out to deliver desired improvements in respect of referral to treatment (RTT) times, over three years, assuming that this would cost a lot and whether the improvement will be delivered in the most effective way and if sharper improvement in community services could help this to be better.

In response, it was explained that the RTT improvement approach is based on a multi-year recovery plan, combining targeted investment, productivity improvement and pathway redesign rather than reliance on short-term capacity expansion alone. Members noted that community and neighbourhood-based services form a key component of the strategy, with the intention of reducing unnecessary referrals, improving triage and managing patients earlier in the pathway. It was emphasised that this approach aims to deliver RTT improvement in a way that is clinically appropriate, financially sustainable and aligned with wider system transformation, rather than solely through additional acute activity.

The Board **NOTED** the final plan resubmission to NHS England on the 18th March 2026.

12. Public Board MTP Final Plan Resubmission 01.04.26.pdf

48. Finance Report — Assurance

Tabitha Gardner

Ms T Gardner commented that the financial position reflected the significant effort made by the organisation, but noted the ongoing challenge created by larger trusts being able to pay higher rates, particularly within Greater Manchester, which can place sustained pressure on recruitment, retention and affordability for WWL.

A discussion followed on the wider system impact of pay differentials, the risk of workforce movement driven by market pressures rather than role complexity, and the importance of system-level dialogue and triangulation to ensure financial sustainability is not undermined by inequitable competition. Members acknowledged the need to balance delivery of financial plans with workforce stability and service resilience.

Following comments on the extent to which the challenging financial position may have impacted staff morale and the staff survey results, Lady R Bradley asked whether the Board sufficiently understood how the organisation explains and contextualises financial discipline to staff, and whether there was clearer learning on how financial decisions and constraints are communicated and linked to improvements in patient care and staff experience.

In response, Mrs T Gardner and Ms M Fleming reflected that financial grip had been necessary but acknowledged the risk that, without clear narrative, this could be perceived by staff as cost-driven rather than improvement-led. They emphasised the importance of connecting financial control to tangible benefits, such as improved flow, reduced harm and service sustainability.

Ms T Gardner clarified however, that the organisation is mandated to submit plans in three areas: finances, activity and whole time equivalent (WTE) figures and pay, therefore reports to the Board must focus on the WTE figures.

Dame R Shah added that this reinforced the need for stronger triangulation between finance, workforce and quality intelligence, and for the Board to maintain oversight of how financial decisions are experienced on the frontline, including through the lens of the staff survey. She emphasised that financial recovery and staff engagement must be seen as mutually reinforcing priorities, rather than competing ones.

The Board **NOTED** the month 11 finance position.

On the request of Dame R Shah, who recalled a briefing on the capital plan at the March 2026 Board workshop followed by an agreement to accept the programme in principle, the Board **AGREED** to formally **APPROVE** the programme it had received.

13. Board Cover Sheet - Finance Report M11.pdf
13a. Trust Finance Report 25-26 February Month 11 Board.pdf

49. National Oversight Framework Q3 — Information

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

It was noted that this (NOF) report was provided to complement the Integrated Performance Report.

14. NOF Q3 25-26.pdf

50. Integrated Performance Report (IPR) — Approval

Richard Mundon

Quality and safety quadrant

Mr K Parker-Evans summarised three key points in relation to the Quality and Safety element of the Board Assurance Framework (BAF), highlighting ongoing oversight of deteriorating patient and sepsis themes, infection prevention and control risks, including reporting and consistency across care settings, and

assurance arrangements in relation to patient safety incidents and learning, including mortality and never events.

Mr M Wilkinson asked how the Board could be assured that alerts raised through different committees and AAA reports were being consistently triangulated, particularly where progress against actions and residual risk may be viewed differently across governance routes.

Dame R Shah noted the reported never event and sought assurance on the learning, escalation and mitigation arising from it. She also asked whether the issue had been appropriately reflected in the BAF and wider assurance processes.

Prof A Arya explained the circumstances of the never event, confirming that it had been fully reviewed, that no patient harm had occurred, and that learning had been identified and shared. He also outlined the robust mortality review processes in place, including regular mortality meetings and pathway-specific review where indicators trigger concern.

The discussion then turned to mortality oversight more broadly. Mrs F Thorpe advised that she attends Mortality Review meetings and is assured regarding the rigour of scrutiny, clinical engagement and learning, including how intelligence from mortality, incidents and audits is used to inform improvement.

In concluding, Mrs F Thorpe observed that the NOF report, IPR and AAA reports triangulate well, providing a consistent and accurate picture of the Trust's position across key quality and safety domains.

People quadrant

The People section of the IPR was noted, including workforce metrics such as staffing, sickness absence and appraisal compliance. Discussion in the meeting did not focus in detail on the IPR People metrics, as workforce issues were considered more substantively through the Staff Survey and People Committee items elsewhere on the agenda.

Performance quadrant

The Board noted the significant improvement in urgent and emergency care performance, particularly the uplift in the four-hour standard in March following targeted improvement actions. RTT and elective recovery performance were noted, with recognition of ongoing challenges and the need for sustained improvement over the medium term. The Chair emphasised the importance of delivering performance recovery in a way that is aligned with transformation and community-based services, rather than reliance on short-term capacity measures.

Finance quadrant

The financial position reported in the IPR was noted, including month 11 performance, delivery of the cost improvement plan and the ongoing cash-flow risk. Members acknowledged the improvement in month-end performance but recognised that significant risks remain, particularly in relation to CIP profiling, workforce cost pressures and medium-term sustainability. The Board noted the importance of continued close monitoring and triangulation with the Finance & Performance Committee and the BAF.

The Board **NOTED** the Integrated Performance Report, drawing assurance from its triangulation with committee reports and the Board Assurance Framework.

15. Board of Directors IPR M11 2526.pdf
15a. IPR_M11_2526.pdf
15b. M11 2526 Benchmark Access Standards.pdf

51. Board Assurance Framework — Approval

Julie Dawes

Mrs J Dawes presented the Board Assurance Framework report and invited comments from Board members.

Prof C Austin noted the position in relation to research, highlighting that research risks and controls should be accurately reflected to ensure the BAF remains aligned with current delivery challenges and opportunities.

Following discussion, it was **AGREED** that the BAF should be **amended** as follows:

- The research position should be updated to reflect the current status and governance arrangements discussed.
- The sepsis position should be noted as awaiting confirmation, pending receipt of final year-end data and assurance.
- It was acknowledged that the Integrated Performance Report (IPR) is currently reporting Month 11 data, and this context should be reflected when considering assurance ratings.

The Board **APPROVED** that the risk ratings for 2025/26, subject to these amendments.

16. BAF Report Board April 2026 FINAL.pdf

52. Proposed Corporate Objectives 2026/2027 — Approval

Richard Mundon

The Board reflected upon the importance of ensuring that it has strategic oversight of education and training and therefore asked that this is articulated through an additional corporate objective.

Further, it was clarified that the increase in band 8+ refers to to senior clinical and corporate leadership roles required to support transformation, delivery and regulatory requirements, rather than a broad or unplanned growth in management capacity.

Mrs F Thorpe added that the Quality and Safety Committee had requested that the metrics for CO3 be made more specific and asked that this is followed up.

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

53. Annual Risk Appetite Statement — Approval

Julie Dawes

Mrs J Dawes summarised that the statement had been presented for approval, in line with the annual requirement.

The Board **APPROVED** the Trust's risk appetite statement for 2026/27.

18. Risk Appetite 26-27 v2.pdf

54. Strategy 2030 refresh — Information

Richard Mundon

The Board received a verbal presentation on the proposed refresh of the Strategy 2030, outlining the rationale and approach. It was noted that the refresh is intended to update and strengthen the existing strategy, rather than replace it, ensuring alignment with recent national policy developments, emerging neighbourhood and place-based models, and the Trust's evolving operating context Mr R Mundon confirmed that the refreshed strategy would place greater emphasis on delivery ambitions and measurable outcomes, moving beyond high-level aspirations to articulate clearer indicators of success. The Chair welcomed this approach, noting that clearer delivery ambitions and measurable outcomes would support stronger Board oversight, provide a clearer basis for assurance, and enable the Board to better assess whether the strategy was making a tangible difference for patients, staff and local communities.

During discussion, the Board emphasised the importance of ensuring that the refreshed strategy:

- Reflects the Trust's role within system and locality partnerships, including neighbourhood working;
- Aligns clearly with corporate objectives, the BAF and transformation programmes;
- Gives appropriate prominence to quality, people, education, research and health inequalities; and
- Is grounded in what is deliverable and sustainable over the remaining strategy period.

It was confirmed that engagement with Board members, executives and wider stakeholders would continue as part of the refresh process, and that the updated strategy would be brought back to the Board for consideration and approval in due course.
The Board **NOTED** the presentation and supported the proposed approach to refreshing Strategy 2030.

Consent Agenda

55. Gender pay gap report

20. Gender Pay Report - Board April 26.pdf

56. Standing Financial Instructions — Approval

21. SFI amendments.pdf
21a. SFIs 25-26 February 2026.pdf

57. 7-day services report — Information

22. Seven Day Services Audit 2025 2026 Board Report.pdf

58. Meeting Evaluation — Discussion

Robina Shah

The Board having **AGREED** in advance to the items appearing on the consent agenda being only received and noted, **RECEIVED** and **NOTED** the items thereon.

Equality and health inequalities
Members reflected that equality and health inequalities were appropriately referenced throughout the agenda, with relevant consideration given to population needs, access and workforce impacts, though it was noted that continued focus is required to ensure this remains embedded across all areas of business. The Board noted the importance of all cover sheets being appropriately completed, including the ED&I section.

Agenda focus
The Board agreed that the agenda was appropriately focused on the Trust's key priorities, with a suitable balance between assurance, performance and strategic discussion.

Quality of papers
Members considered that the papers provided were appropriate, timely and of sufficient quality to support effective discussion and decision-making.

Quality of discussion
The Board agreed that discussion was constructive, appropriately challenging and supported effective scrutiny, enabling members to discharge their governance responsibilities.

Action Log: April 2026

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Feb 2026	12/26	Freedom to Speak Up	Revisit the Freedom to Speak Up reflection tool as a board, analyse the high number of anonymous concerns, and develop an action plan to address cultural and EDI-related gaps in staff confidence to speak up	T Narot	17 Jun 2026	Report on agenda. **Proposal to CLOSE action.**
1 Apr 2026	37/26	Patient story	a. Consider the model to establish how the organisation can prevent JHRU patients needing to go back through A&E and the number of patient moves per admission (plus the impact of prescriptions) b. Review the capabilities of the HIS system	K Parker-Evans & S Brennan R Mundon	17 Jun 2026	**Verbal updates to be provided at the meeting.**
1 Apr 2026	45.5/26	Audit Committee AAA	Clarify the position via the Executive Team Meeting on medical job planning to provide a comprehensive update to the Board of the current position, given the disparity in assurance	M Fleming (with S Arya and T Narot)	17 Jun 2026	Per People Committee AAA, the level of assurance remains below expectation and issues will continue to be monitored by the Audit Committee and raised with the People Committee where appropriate. There is now

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
			perceived between the People and Audit Committees			a plan in place to address risk areas raised in the audit. **Proposal to CLOSE action.**

Referrals Logs

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	13 May 2026	**Not yet due.**
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	TBC	**Not yet due.**

			(Advanced Care Practitioner prescribing and other revisions to staff roles)				

Agenda item: [08]

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	17 June 2026
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

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

Link to strategy and corporate objectives
There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations
There are no risks associated with this report.

Financial implications
There are no financial risks associated with this report.

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

People implications
There are no people risks associated with this report.

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

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

Recommendation(s)
The Board of Directors is recommended to receive the report and note the content.

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

Reflections on 2025/26
I would like to begin this report by expressing my heartfelt thanks to my Executive team, divisional leaders, and every colleague across WWL for their dedication, compassion, and teamwork over the past financial year. I also want to thank our system partners across the Wigan locality, particularly our place-based leadership, Primary Care, Mental Health, Social Care, and Voluntary Sector colleagues, for their continued support and shared commitment to our communities. Together, we have delivered a year of real progress across quality, performance, people, and finance, despite significant challenge and pressure.

Quality and safety
We have much to be proud of in the care we continue to provide. Over the year, we secured national recognition through awards, including the Nursing Times and Health Service Journal Awards, and were once again named the cleanest acute trust in the country for a third consecutive year. We were awarded the bronze accreditation of the Northwest Race Equity Assembly (formerly known as BAME Assembly) in February, reaffirming our commitment to ensuring that fairness, inclusion and equity are at the core of everything we do. We also launched and rolled out our Fundamentals of Care strategy and maintained excellent mortality indicators, including HSMR and SHMI, despite increasing demand and system pressure.

Operational performance
The Trust demonstrated impressive improvement and resilience throughout the year. In March 2026, we were the most improved trust nationally for urgent and emergency care performance, with a 13.2% improvement, and the second most improved trust overall across cancer, diagnostics, urgent and emergency care, and elective performance. Diagnostics performance improved by 11.5% in February, and outpatient did not attend rates reduced by 1.9%, making us the most improved trust nationally for DNAs that month. We also delivered planned activity in full and exceeded expectations through the March Sprint, supporting delivery of our financial position. This progress is a testament to the determination, adaptability, and collective effort of teams across the organisation.

Our people
Our people remain at the heart of everything we have achieved. We saw a 48% response rate in the National Staff Survey, a 13% increase year on year, alongside above-sector average scores and the highest ratings in Greater Manchester for staff morale and the 'We Are Safe and Healthy' People Promise. This reflects the strength of our culture, the commitment of our teams, and the pride colleagues take in the care they provide and the difference they make.

Financial and strategic delivery
This progress has been underpinned by strong financial discipline and strategic delivery. We achieved our financial plan, over-delivered against a £39 million Cost Improvement Programme, delivered our full capital programme, and invested £32 million to support patient experience, waiting list reduction, productivity, and digital maturity. We also progressed the most significant organisational redesign in ten years and submitted a fully compliant three-year plan. These are important foundations that will help us continue to transform services and strengthen care for the future. As a result of our sustained focus on safety, quality, productivity, and finance, we moved from Segment 4 to Segment 3 in the National Oversight Framework in the final quarter of the year. This is an important reflection of the progress we are making together on our journey to provide outstanding care. While there is still more to do, I am proud of how far we have come and of the spirit, commitment, and ambition shown across WWL. Looking ahead, we remain focused on building on these strong foundations and delivering our priorities for the year ahead in partnership with staff, patients, system partners, and our local community.

Appointments to the Board of Directors
I'm delighted to welcome two new senior leadership appointments to the organisation. Tracy Narot joined us in May as our new Chief People Officer, bringing a wealth of experience in leading large-scale workforce transformation, organisational development and staff engagement programmes across complex healthcare environments. Tracy will lead our people portfolio, including workforce strategy, organisational development, equality, diversity and inclusion, and staff wellbeing, playing a key role in ensuring we continue to build a high-performing, inclusive and supported

workforce. Earlier this month, we also welcomed Katherine Dowson as our new Director of Corporate Governance, further strengthening our leadership for quality governance and assurance as we move forward as an organisation.

Care Quality Commission Inspections
Since January, we have received two visits from the CQC, including an unplanned visit to our Thomas Linacre Centre site, and an unannounced inspection of our Urgent and Emergency Care Services and Acute Medical Wards at the Royal Albert Edward Infirmary (RAEI) in May.

Following the factual accuracy process, we welcomed the CQC's rating of 'Good' in their report on the Thomas Linacre Centre that was received last month. Inspectors praised our staff for their compassion and skills and highlighted a range of strengths across the service, including positive patient feedback, strong infection prevention and control standards, and effective multidisciplinary working to support a high-quality patient experience. This rating reflects the commitment, professionalism and compassion shown every day by our staff, who provide vital diagnostic, cancer, antenatal and paediatric services for patients in the heart of our community.
The findings of the unannounced visit to the RAEI are expected to be delivered in a timely way now that all aspects of the assessment have been completed. We look forward to sharing the findings with you once received.

Hub Optimisation Week
Our Leigh Infirmary and Wrightington Hospital Surgical Hubs participated in Hub Optimisation Week (HOW), designed to test what could be achieved when our elective hubs operate at optimal efficiency. Applying GIRFT best practice consistently across all specialties, the week focused on maximising theatre utilisation, reducing late starts, early finishes and on-the-day cancellations, and improving the overall reliability of elective pathways. The work also supported national elective recovery ambitions, including the requirement to return to 92% Referral to Treatment Time performance by March 2029. Throughout the week more patients were treated, fewer delays occurred, and there were smoother patient journeys overall. Every additional procedure completed has contributed to reducing waiting lists and strengthening the long-term sustainability of our surgical hubs. Senior clinical leaders and Executives were present on site to support teams and address issues promptly too.

JAG accreditation
Congratulations to Leigh Infirmary for achieving JAG accreditation, which recognises the progress being made in improving waiting times and a commitment to best practice. This reflects the sustained efforts and commitment of clinical and operational teams. My thanks to everyone involved for their hard work and continued focus on quality and improvement.

Professor Tim Briggs CBE visit
GIRFT Programme Lead and NHSE National Director for Clinical Improvement, Elective Recovery and Urgent and Emergency Care (UEC), Professor Tim Briggs CBE, visited WWL in May as part of the national review of providers within the UEC Tiering arrangements. Prof. Briggs met with WWL's Executive Team, had a walkthrough of our UEC pathways, and held a roundtable discussion with Clinical Directors to discuss internal professional standards and further opportunities to strengthen UEC delivery. We were given positive feedback on our progress achieved to date, particularly in relation to flow, clinical leadership, and performance improvement. My thanks go to all colleagues for their continued commitment as we maintain our focus on sustaining four-hour performance and eliminating 12-hour waits and corridor care.

Resident Doctors' Industrial Action
The organisation is currently managing a four-day period of industrial action by our Resident Doctors, the sixteenth one to date. Safe services have been maintained across all sites, with most elective activity proceeding as planned. Protected services - including urgent and emergency care, cancer pathways and maternity – also remain fully operational. I want to acknowledge the pressure this action places on staff and the impact on patients and, as always, my thanks go to all colleagues for their continued professionalism and flexibility, and the public for their understanding. While pay negotiations sit between Government and trade unions, the Trust recognises the strength of feeling

among Resident Doctors. We continue to value and support our workforce and encourage a timely national resolution to enable a full focus on patient care.

Celebrating our Nurses and Midwives

We held the annual International Day of the Nurse and Midwife celebrations in May, to mark both International Day of the Midwife and International Nurses Day. Kev Parker-Evans, Chief Nursing Officer, opened the event to celebrate our staff and their dedication to their patients, their community, and their professions.

A number of awards were given to individuals on the day, including the Nurse and Midwife Going Above and Beyond Award and the Patient Safety Excellence Award. A highlight of the event was honouring two members of staff who have worked for more than 100 years for WWL between them, with Janet Davenport, Practice Development Lead for District Nursing, and Anne Ollerton, Diabetes Specialist Nurse Manager, both being presented with Lifetime Achievement awards. Janet has worked for the NHS for almost 52 years, since starting as a cadet nurse at WWL at the age of 16, while Anne joined the NHS as a cadet nurse in 1972 and has 54 years of nursing experience at WWL. This event is truly special every year and reflects the pride, passion and commitment at the heart of our organisation.

In May, at the HSJ Digital Awards, WWL were *Highly Commended* in the *Improving Mental Health Through Digital* category for work led by Matron Alison Murphy. This is a fantastic achievement and recognition of the team's commitment to improving patient care through digital innovation.
Thank you to all our nurses and midwives for all that they do for our patients and each other.

Special Recognition

Finally, I would like to recognise the significant honour awarded to our Chair, Professor Dame Robina Shah, who has been granted the Freedom of the City of London. This is a prestigious accolade and a testament to her outstanding leadership, commitment to public service, and tireless advocacy for inclusion and equality. We are immensely proud to see Dame Robina's contribution recognised in this way, and it reflects positively on the values and leadership that underpin our organisation.

Agenda item: [10]

Title of report:	M01 26/27 Integrated Performance Report
Presented to:	Board of Directors
On:	17th June 26
Item purpose:	Information
Presented by:	Deputy Chief Executive
Prepared by:	Principal Data Analyst, Data Analytics and Assurance
Contact details:	BIPerformanceReport@wwl.nhs.uk

Executive summary

The latest month, for M1 April 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. A report highlighting the latest National Oversight Framework Benchmarking data has circulated separately.

The Trust has started 2026/27 with a broadly positive position in quality and safety, providing a strong foundation for delivery and, importantly, for patients to receive safer care. Mortality indicators remain reassuring, with HSMR, SMR and SHMI within or better than expected ranges, and there were no never events reported in month. This suggests that, overall, patients are receiving care outcomes consistent with or better than expected standards. This is offset by a number of areas requiring close oversight, including one MRSA case, continued pressure in healthcare-associated infections, sustained growth in complaints, and ongoing concerns relating to pressure ulcer harm, where incidence remains above threshold and is increasingly being used as a proxy indicator of system strain and flow pressure. For patients, these pressures can mean avoidable harm, poorer experience and less timely movement through care pathways.

Operationally, the picture is mixed but shows underlying improvement. In urgent and emergency care, 4-hour performance has been sustained at a level above the same point last year and delivered in line with plan, meaning more patients are being assessed, treated or admitted within expected timescales. However, 12-hour waits, ambulance handovers and paediatric flow remain fragile and continue to create patient safety and experience risks, particularly during periods of operational pressure, when patients may wait too long in suboptimal environments. Planned care also shows progress, with reductions in the RTT waiting list, fewer very long waiters, improved diagnostics and better faster diagnosis performance in cancer pathways. For patients, this indicates earlier tests,

quicker diagnosis and some improvement in access to treatment. However, delivery remains off trajectory in a number of key areas, including 18-week RTT, 31-day cancer treatment and 62-day cancer performance, with reduced theatre capacity and wider pathway constraints limiting the pace and sustainability of recovery. This means some patients are still waiting longer than intended for treatment, with the associated risk of anxiety, deterioration and poorer overall experience.

Our people metrics continue to show both organisational strengths and delivery risks. Staff engagement remains a notable positive, with staff survey response rates improving and morale comparing well across Greater Manchester. This matters at board level because engaged teams are more likely to deliver compassionate, responsive and consistent care for patients. At the same time, several workforce indicators remain below target, including mandatory training and appraisals, while sickness, turnover, vacancies and time to hire continue to place pressure on services.

The financial position in month is adverse to plan, with a £0.4m overspend driven by industrial action costs, lower than planned activity and under-delivery of recurrent CIP. Cash is ahead of plan, although this is primarily timing-related and does not yet represent a structural improvement. From a board perspective, the financial position matters because it affects the Trust’s ability to sustain capacity, invest in improvement and protect patient care delivery over the remainder of the year.

Taken together, the month shows encouraging momentum across core quality indicators, elements of flow, planned care recovery and staff engagement, but also highlights that resilience remains fragile. The overall board view is therefore one of cautious confidence: progress is evident and is beginning to translate into safer care and improved access for some patients, but sustained delivery discipline and continued focus on the most pressured pathways will be essential to reduce delays, improve experience and close the gap between current performance and year-end expectations.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations

There are no risks currently associated with the report.

Financial implications

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

Legal implications

None currently identified.

People implications

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

Equality, diversity and inclusion implications

None currently identified.

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

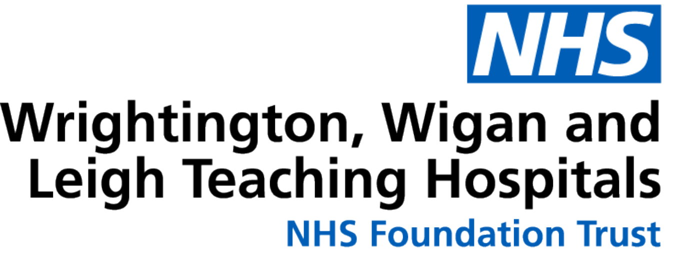
IPR Executive meeting 26.5.26, ETM 28.5.26 and 11.6.26.

Recommendation(s)

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

Report

Please see the attached M01 26/27 IPR report.



26/27 Integrated Performance Report

Meeting presented to:

Board: 17/06/26

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- Integrated Performance Report Overview Matrix
- Statistical Process Control (SPC) introduction
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- Finance Insight Report
- Finance Commentary

Trust Matrix : M01 26/27

VARIATION / ASSURANCE	Target is consistently met	Inconsistent performance compared to target	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	Reducing 3/4th Degree Maternity Tears Klebsiella Species Reduction in the Number of Patients who Transfer Between Wards More Than 2 Times Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test Elective Recovery Plan : Inpatient Activity Performance Agency Expenditure (£m)	SHMI Rolling 12 Months RTT Waiting List Percentage of Patients Waiting Over 52 Weeks for Elective Treatment Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under 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 Average Number of Days Between Planned and Actual Discharge Date Percentage of Patients who do not Meet the Criteria to Reside
No significant change	Price Cap Compliance - Non Medical Urgent Community Response (UCR) - 2-Hour Performance	Never Events Number of Patient Safety Incident Response Framework Priority Incidents Declared Which Triggered a PSI Investigation How Many Incidents Triggered a Patient Safety Review Reducing Post Partum Haemorrhage in line with Maternal Care Bundle 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-Susceptible Staphylococcus Aureus (MSSA) WWL Clostridium Difficile (CDT) Escherichia Coli (E.coli) Pseudomonas Aeruginosa Complaints Responses Patient Experience (FFT) - Patients who Would Recommend the Service Vacancy Rate Number of Whole Time Equivalent Posts Time to Hire Total Patients Waiting for First Attendance Total Patients Waiting Over 65 Weeks Percentage of Patients Waiting Over 52 Weeks for Community Services Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks Percentage of Patients Treated for Cancer Within 62 Days of Referral Elective Recovery Plan : Day Case Activity Performance Average Time to Ambulance Handover Overnight Total General and Acute Beds and the Number of Which are Occupied 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 %) Adjusted Financial Performance (£m) - Variance to Plan Cash (£m) API Income (£m) - Variance to Plan Total Cost Improvement Programme (CIP) (£m) - Variance to Plan Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan Bank Expenditure (£m) Capital Expenditure (£m) - Variance to Plan	Percentage of spells with at least one pressure ulcer diagnosis Mixed Sex Accomodation Breaches - Non Clinically Justified Price Cap Compliance - Medical Outpatient New : Follow-up Ratio Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department Average Daily Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days
Concerning Special Cause Variation	Number of handovers > 30 minutes	Methicillin-Resistant Staphylococcus Aureus (MRSA) Reduction in the Number of Complaints Mandatory Training Compliance Cancer 31 Day Treatment Standard Performance Elective Theatre Utilisation - Capped Touchtime Implied Productivity Better Payment Practice Code (BPPC)	Reduction in Category 2 and DTI HAPU and CAPU Overall Appraisal % Turnover Rate Sickness - Percentage Time Lost (%) - Rolling 12 months

Trust Matrix : M01 26/27

		ASSURANCE											
		Target is consistently met				Inconsistent performance compared to target				Target consistently failing			
		Q&S	People	Perf.	Finance	Q&S	People	Perf.	Finance	Q&S	People	Perf.	Finance
VARIATION	Improving Special Cause Variation	2 3		9		9 19 21		11 18	8	1		2 4 6 8 [illegible] [illegible] [illegible]	
	No significant change		4	31		4 5 6 7 9 10 13 14 16 17 18 20 24 25	6 7 9	1 3 5 12 14 17 19 25 26 30	1 2 3 4 5 6 9 10	12 22	3	15 22 27	
	Concerning Special Cause Variation			20		15 22	1	13 16	7 11	11	2 5 8		

	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 HAPU and CAPU Overall
12	Percentage of spells with at least one pressure ulcer diagnosis (L89)
13	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care
14	To reduce the total number of falls per 1000 bed days
	Q&S-2
15	Methicillin-Resistant Staphylococcus Aureus (MRSA)
16	Methicillin-Susceptible Staphylococcus Aureus (MSSA)
17	WWL Clostridium Difficile (CDT)
18	Escherichia Coli (E.coli)
19	Klebsiella Species
20	Pseudomonas Aeruginosa
21	Reduction in the Number of Patients who Transfer Between Wards More Than 2 Times
22	Mixed Sex Accomodation Breaches - Non Clinically Justified
23	Reduction in the Number of Complaints
24	Complaints Responses
25	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

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

Understanding the rules of SPC

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

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

These rules indicate *special cause variation*.

Data Quality Assessment Framework Overview

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

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

Trust Holistic Narrative: M01 26/27

The Trust has started 2026/27 with a broadly positive position in quality and safety, providing a strong foundation for delivery and, importantly, for patients to receive safer care. Mortality indicators remain reassuring, with HSMR, SMR and SHMI within or better than expected ranges, and there were no never events reported in month. This suggests that, overall, patients are receiving care outcomes consistent with or better than expected standards. This is offset by a number of areas requiring close oversight, including one MRSA case, continued pressure in healthcare-associated infections, sustained growth in complaints, and ongoing concerns relating to pressure ulcer harm, where incidence remains above threshold and is increasingly being used as a proxy indicator of system strain and flow pressure. For patients, these pressures can mean avoidable harm, poorer experience and less timely movement through care pathways.

Operationally, the picture is mixed but shows underlying improvement. In urgent and emergency care, 4-hour performance has been sustained at a level above the same point last year and delivered in line with plan, meaning more patients are being assessed, treated or admitted within expected timescales. However, 12-hour waits, ambulance handovers and paediatric flow remain fragile and continue to create patient safety and experience risks, particularly during periods of operational pressure, when patients may wait too long in suboptimal environments. Planned care also shows progress, with reductions in the RTT waiting list, fewer very long waiters, improved diagnostics and better faster diagnosis performance in cancer pathways. For patients, this indicates earlier tests, quicker diagnosis and some improvement in access to treatment. However, delivery remains off trajectory in a number of key areas, including 18-week RTT, 31-day cancer treatment and 62-day cancer performance, with reduced theatre capacity and wider pathway constraints limiting the pace and sustainability of recovery. This means some patients are still waiting longer than intended for treatment, with the associated risk of anxiety, deterioration and poorer overall experience.

Our people metrics continue to show both organisational strengths and delivery risks. Staff engagement remains a notable positive, with staff survey response rates improving and morale comparing well across Greater Manchester. This matters at board level because engaged teams are more likely to deliver compassionate, responsive and consistent care for patients. At the same time, several workforce indicators remain below target, including mandatory training and appraisals, while sickness, turnover, vacancies and time to hire continue to place pressure on services.

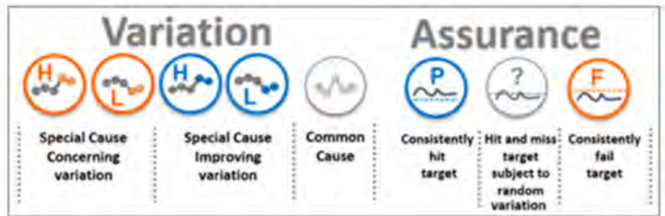
The financial position in month is adverse to plan, with a £0.4m overspend driven by industrial action costs, lower than planned activity and under-delivery of recurrent CIP. Cash is ahead of plan, although this is primarily timing-related and does not yet represent a structural improvement. From a board perspective, the financial position matters because it affects the Trust’s ability to sustain capacity, invest in improvement and protect patient care delivery over the remainder of the year.

Taken together, the month shows encouraging momentum across core quality indicators, elements of flow, planned care recovery and staff engagement, but also highlights that resilience remains fragile. The overall board view is therefore one of cautious confidence: progress is evident and is beginning to translate into safer care and improved access for some patients, but sustained delivery discipline and continued focus on the most pressured pathways will be essential to reduce delays, improve experience and close the gap between current performance and year-end expectations.

Quality & Safety Overview 1 of 2: M01 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	Dec 25	Yes	102.3	100.0			103.6	102.2	105.0	S	T	P
2	HSMR Rolling 12 Months	Feb 26	No	87.2	100.0			91.6	89.2	94.1	S	T	P
3	SMR Rolling 12 Months	Feb 26	No	85.1	100.0			89.4	87.3	91.6	S	T	P
4	Never Events	Apr 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	Apr 26	No	1	4			2	-3	7	S	T	P
6	How Many Incidents Triggered a Patient Safety Review	Apr 26	No	17	18			25	4	46	S	T	P
7	Reducing Post Partum Haemorrhage in line with Maternal Care Bundle	Apr 26	No	125.68	100.00			97.53	46.46	148.61			
8	Reducing 3/4th Degree Maternity Tears	Apr 26	No	1.16%	2.60%			2.97%	-1.37%	7.31%		Under development	
9	Reducing Caesarean Sections at Full Dilatation to ≤1% of all births	Apr 26	No	1.09%	1.00%			2.52%	-1.68%	6.73%			
10	No Category 3 or Category 4 HAPU or CAPU Developed as a Result of an Act or Omission in Care	Apr 26	No	0	0			2	-2	7	S	T	P
11	Reduction in Category 2 and DTI HAPU and CAPU Overall	Apr 26	No	88	46			81	62	101	S	T	P
12	Percentage of spells with at least one pressure ulcer diagnosis	Apr 26	Yes	1.6%	0.9%			1.5%	1.0%	2.0%	S	T	P
13	25% Reduction in Falls With Harm That Occurred as a Direct Result of Omissions/Lapses in Care	Apr 26	No	0	1			1	-2	4	S	T	P
14	To reduce the total number of falls per 1000 bed days	Apr 26	No	5.05	6.10			6.95	4.20	9.70	S	T	P

Summary icons key:



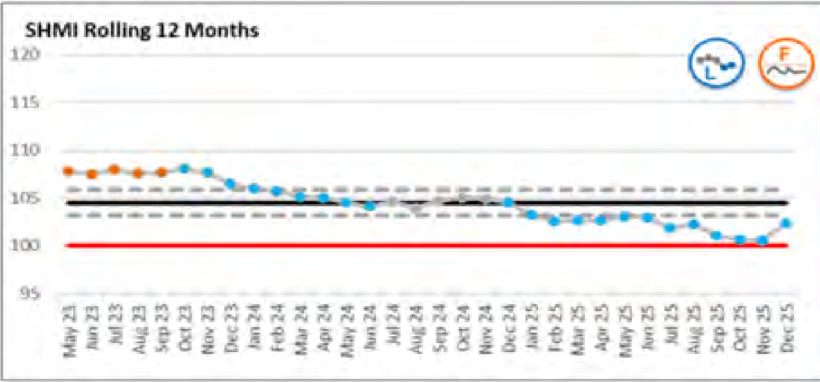
*Please note : NOF denotes the National Oversight Framework

Quality & Safety Overview 2 of 2: M01 26/27

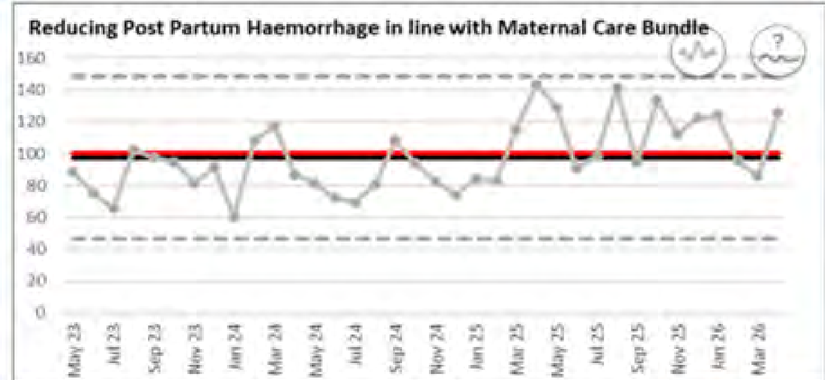
	KPI	Latest month	Metric included in NOF *	Measure	Threshold	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicators: Sign-off & Review	Data Quality Indicators: Timely & Complete	Data Quality Indicators: Process & System
15	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Apr 26	Yes	1	0			0	0	0	S	T	P
16	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Apr 26	No	2	0			1	-2	5	S	T	P
17	WWL Clostridium Difficile (CDT)	Apr 26	Rate	3	5			6	-3	15	S	T	P
18	Escherichia Coli (E.coli)	Apr 26	Rate	5	3			4	-2	10	S	T	P
19	Klebsiella Species	Apr 26	No	0	1			1	-2	4	S	T	P
20	Pseudomonas Aeruginosa	Apr 26	No	0	0			0	-1	2	S	T	P
21	Reduction in the Number of Patients who Transfer Between Wards More Than 2 Times	Apr 26	No	70	106			120	73	166	S	T	P
22	Mixed Sex Accomodation Breaches - Non Clinically Justified	Apr 26	No	19	0			19	4	34	S	T	P
23	Reduction in the Number of Complaints	Apr 26	No	95	40			50	24	75	S	T	P
24	Complaints Responses	Apr 26	No	66.7%	90.0%			72.0%	50.3%	93.7%	S	T	P
25	Patient Experience (FFT) - Patients who Would Recommend the Service	Apr 26	No	89.6%	90.0%			87.8%	82.4%	93.3%	S	T	P

*Please note : NOF denotes the National Oversight Framework

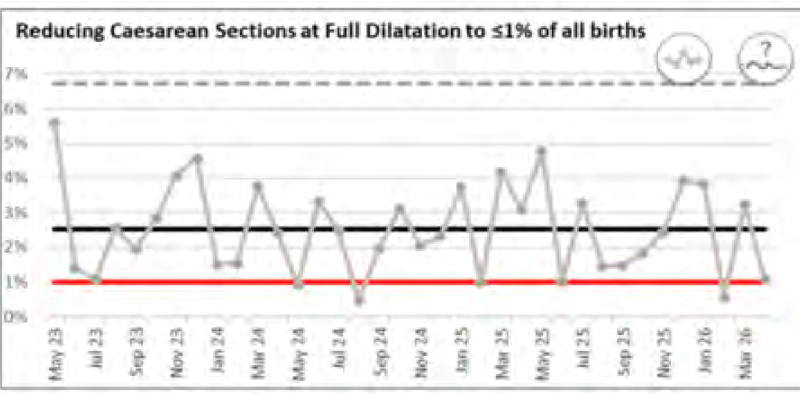
Quality & Safety Insight Report 1 of 2: M01 26/27



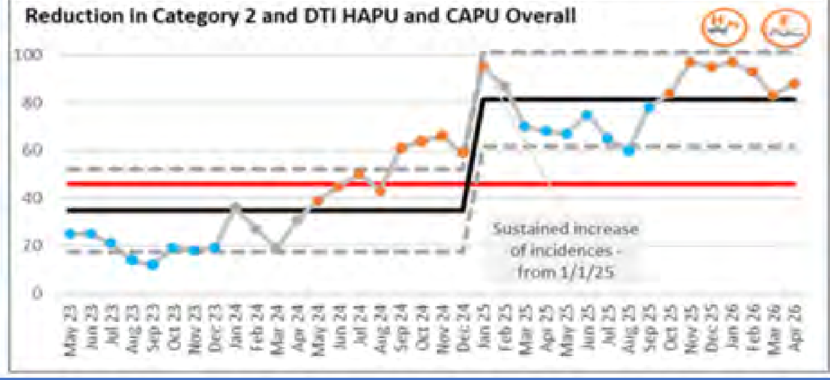
Dec-25
102.34
Variance Type
Special cause improving variation points
Threshold
100
Target achievement
Metric is consistantly missing the target/ threshold



Apr-26
125.68
Variance Type
Common Cause Variation
Threshold
100
Target achievement
Inconsistent performance compared to threshold/ target



Apr-26
1.09%
Variance Type
Common Cause Variation
Threshold
1.00%
Target achievement
Inconsistent performance compared to threshold/ target



Apr-26
88
Variance Type
Special cause concerning variation points
Threshold
46
Target achievement
Metric is consistantly missing the target/ threshold

Summary:

1 . SHMI : Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately. We remain well within the expected range for SHMI and better than the expected range for HSMR.

2. & 3. Maternity - TBC

4. Pressure Ulcers – category 2 and above: Whilst the Clinical Divisions continue to review all cases of Category 2 pressure ulcers, and along with divisional governance oversight, learning from these will be reports to the new Trust Safety, Quality and Assurance Group. Although a slight decrease was observed in March 2026, there is a small increase in April 2026.

Actions:

1. SHMI Continue improvement plans to ensure that patients are appropriately managed. Continue to work with system partners to ensure appropriate discharge placements for patients

2. & 3. Maternity - TBC

4.Pressure Ulcers – category 2 and above: Clinical Divisions have been requested to monitor their ward and departments compliance to the point prevalence pressure ulcer audit. Reporting and associated learning will be monitored via divisional governance processes and will; be reported into SQAG.

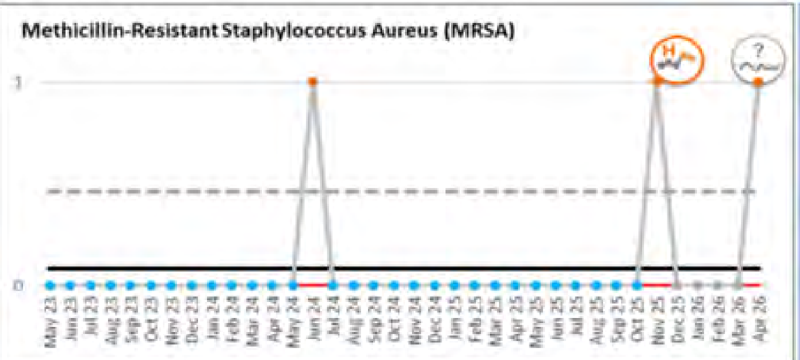
Assurance:

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

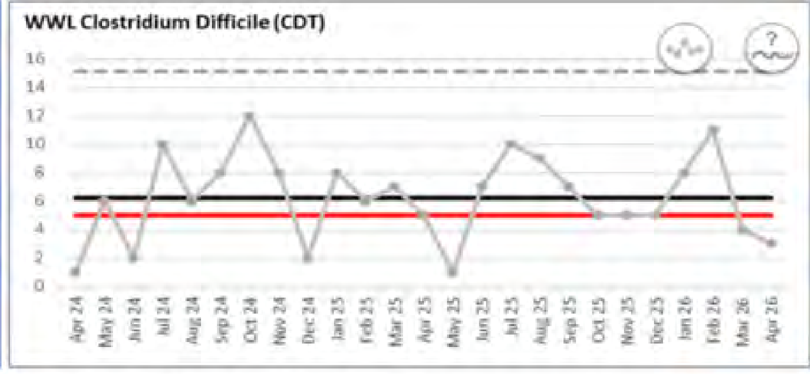
2. & 3. Maternity - TBC

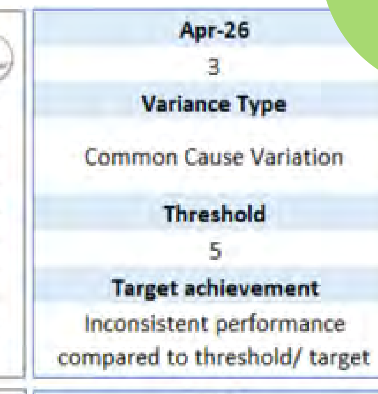
4.Pressure Ulcers – category 2 and above:: Divisional reporting to the Trust wide Safety, Quality and Assurance Group on learning from pressure ulcers is now in place.
The High Harm Pressure Ulcer Review Panel continues with enhanced oversight over 1 inpatient ward and receives a compliance report every 2 weeks with associated actions

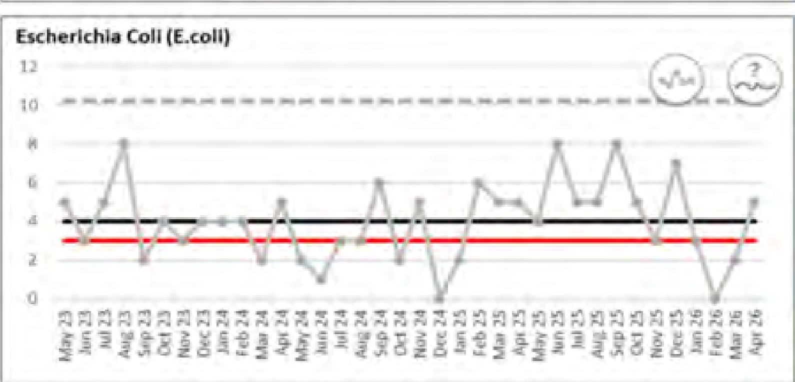
Quality & Safety Insight Report 2 of 2: M02 26/27

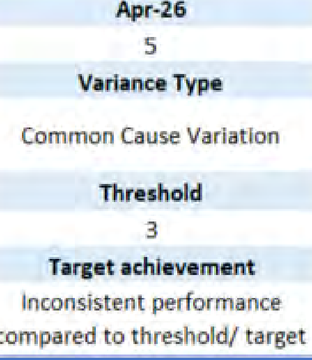


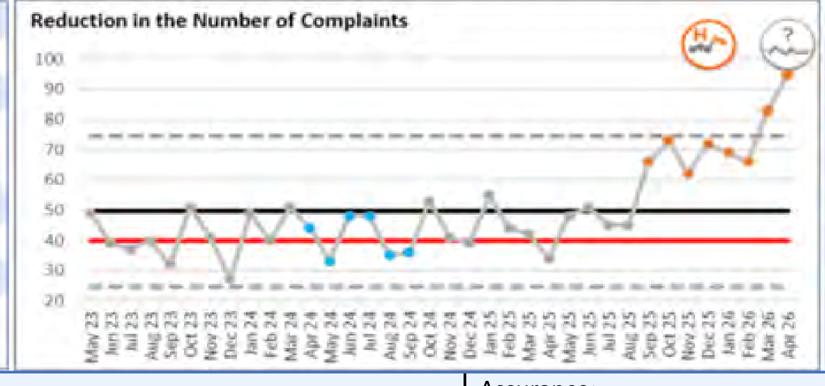
Apr-26
1
Variance Type
Special cause concerning variation points
Threshold
0
Target achievement
Inconsistent performance compared to threshold/ target

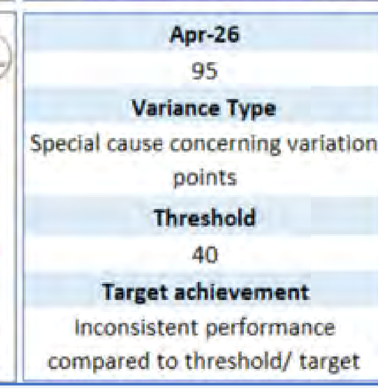












Summary:	Actions:	Assurance:
1. MRSA: There has been one reported case in April 2026, an increase from Zero cases in March 2026. **2. Clostridioides difficile (CDT): T**he number of cases decreased in month to three cases in April 2026 from four cases in March 2026. Total Cases: three at 30.04.2026. The NHSE Threshold is still awaiting publication for Year 2026/ 2027. **3. E-Coli: The** E.coli count increased to five cases in April 2026 from three cases in March 2026. **4.Complaints:** The Trust has continued to see a high and sustained increase in the number of complaints it receives.	**1. MRSA: The case is subject to the post infection review process to identify learning, good practice, and any areas for action.** **2. Clostridioides Difficile (CDT):** The CDI Review Process continues to identify learning, good practice, and areas for action. **3. E-Coli:** Surveillance of E.coli continues, with identification and analysis of themes and trends, with an aim to develop a robust post infection review process. **4.Complaints: Current measures are already in place to ensure that the performance of complaints responses remains a priority for the Trust. There are a number of improvement projects ongoing to take much more of an ascertive approach to patient feedback and attempting to deescalate concerns before they appear. Both surgery and medicine have improvements projects supporting this approach.**	**1. MRSA:** Surveillance and review of cases will continue during 2026/ 2027. **2. Clostridioides Difficile (CDT):** All CDT case reviews will be completed for Year 2026/ 2027 (Total of two cases reviewed at 19.04.2026). **3. E-Coli:** Reporting and surveillance continues for all Mandatory reportable HCAI organisms. **4.Complaints:** Learning from complaints continues to be a focus of the Patient Experience and Engagement Group. Monitoring of performance is being completed by both the complaints performance meeting and the SQAG group.

Quality & Safety Narrative: M01 26/27

Operationally, by the end of M12, performance had significantly improved together with associated positive outcomes for patient quality and safety. This positive position is influenced by the engagement and commitment of the clinical and support teams to implement the inpatient flow project and UEC improvement plans supported by NHS E through the GIRFT team and Better Lives programme.

There is evidence of good patient experience and outcomes in care, demonstrated through multiple discharge points happening through the day, increased discharges before 5pm, a reduction in length of stay, especially for patents staying over 14 days. Bed occupancy has also improved by 2% generating more inpatient flow, and capacity for Getting It Right the First Time (GIRFT). We also saw an 8% improvement in HO45 turnaround times with patients being seen in a timelier manner and therefore accessing necessary treatment more appropriately. We have seen a further reduction in the number of patients who are frequently moved, therefore reducing opportunities for harm to occur.

The latest HSMR position is 87.2, significantly below the 100 threshold and much better than many similar sized GM hospitals. The latest 12-month SHMI standardised position is 102.3 for the latest rolling 12 months to January 26, which is 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.

Within M1 the Trust escalated one incident for a Patient Safety Incident Investigation,relating to a baby requiring transfer to a tertiary centre for therapeutic cooling following delivery. Although initially a planned home birth, mum was transferred following concerns of an abnormal foetal heart rate and abnormal maternal observations. Following a normal vaginal delivery, the infant displayed signs of respiratory distress and neurological compromise, with abnormal cord blood gases. Despite initial improvement, ongoing concerns led to commencement of increased monitoring and escalation for therapeutic cooling and was transferred to an external Trust for treatment. Subsequent investigations and imaging were consistent with some atypical features of hypoxieischaemic encephalopathy (HIE), with further diagnostic work ongoing. The incident has been referred to the Maternity and Newborn Safety Investigations (MNSI) programme.

Healthcare associated infections remained mixed in April 2026. CDI reduced to 3 cases (from 4 in March), E. coli increased to 5 (from 3), Klebsiella reduced to 0 (from 1), Pseudomonas remained at 0, MRSA increased to 1 (from 0), and MSSA remained at 2. Surveillance and review processes continue across all mandatory organisms to identify learning and actions, while 2026/27 NHSE thresholds are still awaited.

Recent Moderate and Serious Harm Pressure Ulcer Panel reviews indicate that pressure ulcer harm continues to present a system level patient safety risk, primarily associated with prolonged Emergency Department stays, escalation area care and patient flow constraints, alongside some ward level failures. Staffing instability during periods of escalation, combined with inconsistent documentation and delayed categorisation of skin damage, has reduced the Trust’s ability to evidence timely prevention and learning in some cases. While improvement specific actions are in place in two areas further improvement work is also taking place across Divisions. All Clinical areas have been requested to complete the point prevalence audits and monitor via their Divisional governance architecture and include this and associated learning in Divisional reporting to SQAGs. A specific request has been to include a triangulation of pressure ulcer harm with ED wait times, strengthened documentation standards and targeted prevention work—the risk remains moderate and ongoing pending sustained improvement in flow, staffing stability and governance timeliness. The Trust is using pressure ulcer harm as a proxy indicator of system strain, with assurance focused on reducing prolonged ED boarding, improving escalation controls and strengthening oversight through SQAG. Although there has been a decrease of the category 3 and above hospital acquired pressure ulcers due to an omission of care in March, it should be noted that this may change with real time refresh as the pressure ulcer review process is followed The Chief Nursing Officer has commissioned a new group in which nurse specific safety indicators (for example pressure ulcer prevention) will be monitored and assurance will be sought. This group will commence in April 26. The pressure ulcer oversight dashboard which enables key metrics to be tracked and reviewed is now operational.

Complaints response times have deteriorated, and a factor is the increased volumes of new complaints. There is now additional oversight of the Trust's performance on complaints via the new Safety, Quality and Assurance Group.

People Overview : M01 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	Mandatory Training Compliance	Apr 26	No	92.0%	95.0%			94.6%	93.6%	95.7%	S	T	P
2	Appraisal	Apr 26	No	78.8%	90.0%			81.2%	79.7%	82.8%	S	T	P
3	Price Cap Compliance - Medical	Apr 26	No	0.2%	60.0%			0.6%	-0.7%	1.9%	S	T	P
4	Price Cap Compliance - Non Medical	Apr 26	No	100.0%	80.0%			96.6%	83.9%	109.3%	S	T	P
5	% Turnover Rate	Apr 26	No	9.6%	8.5%			8.9%	8.5%	9.3%	S	T	P
6	Vacancy Rate	Apr 26	No	6.1%	5.0%			5.5%	4.5%	6.6%	S	T	P
7	Number of Whole Time Equivalent Posts	Apr 26	No	-4.00	0.00			-101.29	-223.83	21.26	S	T	P
8	Sickness - Percentage Time Lost (%) - Rolling 12 months	Apr 26	Yes	6.2%	5.0%			5.6%	5.5%	5.8%	S	T	P
9	Time to Hire	Apr 26	No	68.3	65.0			59.3	48.1	70.5	S	T	P

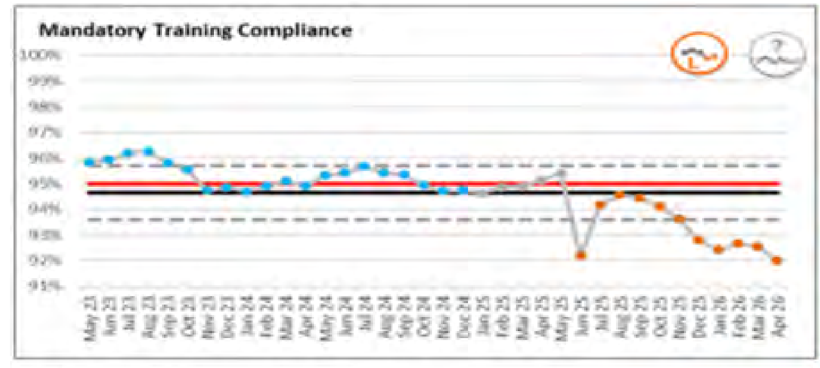
Summary icons key:

Variation: Special Cause Concerning variation; Special Cause Improving variation; Common Cause

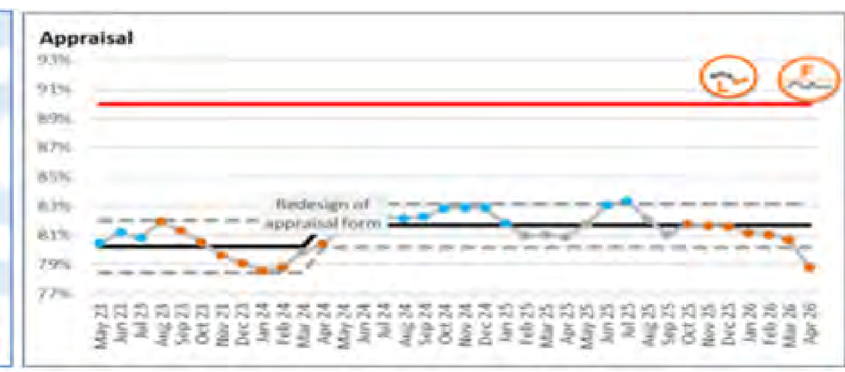
Assurance: Consistently hit target; Hit and miss target subject to random variation; Consistently fail target

*Please note : NOF denotes the National Oversight Framework

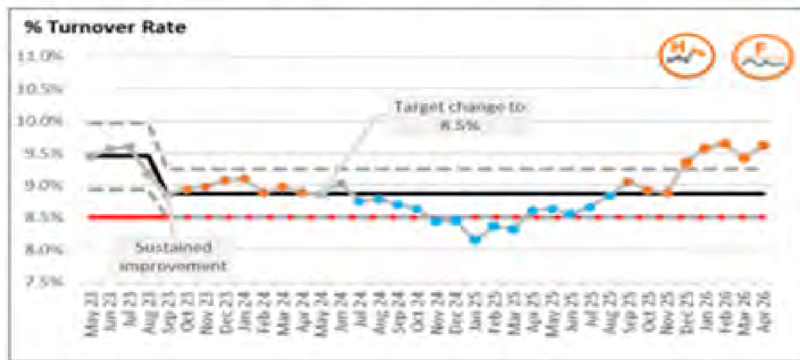
People Insight Report : M01 26/27

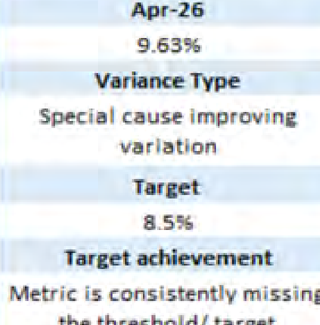


Apr-26
92.0%
Variance Type
Special cause concerning variation
Target
95%
Target achievement
Inconsistent performance compared to threshold/ target

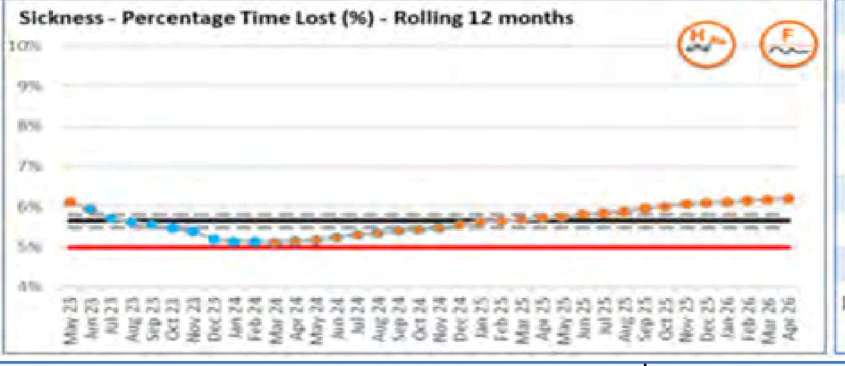


Apr-26
78.8%
Variance Type
Special cause concerning variation
Target
90.0%
Target achievement
Metric is consistently missing the threshold/ target





Apr-26
9.63%
Variance Type
Special cause improving variation
Target
8.5%
Target achievement
Metric is consistently missing the threshold/ target



Apr-26
6.20%
Variance Type
Special cause improving variation
Target
5.0%
Target achievement
Metric is consistently missing the threshold/ target

Summary:	Actions:	Assurance:
1. Mandatory Training: increased slightly to 92.9% but remains below 95 % target **2. Appraisal:** decreased to 78.8%, continuing to be below the target of 90% **3. Turnover:** increased to 9.6%, relocation, work life balance, and retirement were the top leaving reason, consistent with previous months **4. Sickness:** The 12-month rolling sickness absence rate remained consistent with previous months, at 6.2%. Longterm sickness absence being the main driver at 3.8% whilst short-term absence at 2.2%.	**1. Mandatory Training:** circulation of divisional reports, Learning Hub tracking, embedding values/behaviours into appraisal process. Review of local mandatory training modules ongoing. **2. Appraisal:** Continued focus for divisions to ensure appraisals are undertaken. Key area of focus for National Staff Survey, Multi-Disciplinary People Experience Team to ensure good quality appraisals **3. Turnover:** Whilst turnover is not of major concern, the Trust continues with delivery of the WWL People & Culture Strategy to support retention of staff. **4. Sickness:** Key area of focus, supported by the absence reduction plan. Proactive compassionate case management of long-term absence remains in place, along with promoting and supporting the wellbeing of our staff to prevent and reduce absence.	**1. Mandatory Training:** Divisional training data discussed at Executive Led Divisional Performance meetings. People Dashboard presented to Wider Leadership Team and discussed further at People Committee **2. Appraisal:** Divisional appraisal data discussed at Executive Led Divisional Performance meetings. People Dashboard presented to Wider Leadership Team and discussed further at People Committee **3. Turnover:** Divisional turnover information discussed at Divisional Performance meetings. People Dashboard presented to Wider Leadership Team and discussed further at People Committee **4. Sickness:** Absence reduction plan shared and supported at the Wider Leadership Team Meeting. The monthly Task & Finish group continues to meet. Oversight of absence levels and actions to address absence through Divisional Performance meetings, WLT and People Committee.

People Narrative : M01 26/27

Appraisals – appraisal compliance continues to decrease and is now at 78.8 %, which continues to be below the Trust's 90% target. Oversight of appraisal compliance continues through Divisional Performance meetings. National Staff Survey (NSS) data on the People Promise 'We are Always Learning' showed a small improvement, however indicated the need for continued focus to ensure the appraisal conversation is effective, which should support an improvement in compliance. This will therefore form part of the actions in response to the NSS.

Turnover- The Trust turnover increased slightly to 9.4%, above our target of 8.5% and the reasons for leaving remain consistent with previous months – relocation, work/life balance and retirement. Action taken as part of Divisional and Trust wide National Staff Survey action plans will be designed to improve staff experience, leading to a reduction in turnover.

Total workforce- stands at 6,887 WTE in April, 4 WTE above plan (6,883 WTE).

- Substantive workforce 6,498, 55 WTE below plan (6,553 WTE)
- Bank usage 348 WTE, 53 WTE above plan (295 WTE)
- Agency usage 41WTE, which is 6 WTE above plan (35 WTE)

Grip and control remains in place to control workforce growth, with a focus on supporting divisions with the development of workforce plans, which deliver cost improvements and address recruitment, retention and supply challenges.

Sickness –at 6.2% rolling sickness absence continues to be above the Trust target of 5%, despite a positive reduction in in-month absence over the last 2 months,(Feb 26 and March 26), in month absence in April 26 now at 6%. A new programme of training for managers has commenced, aligned to the new Wellbeing Policy. Supporting the mental health of our workforce remains a key priority, and a new Employee Assistance Programme has been launched, which can provide wellbeing and financial advice and support to staff, align with counselling and other support. Triangulation of sickness absence data and staff survey data is being undertaken, which will enable targeted support to be provided to services.

Performance Overview – Start Well & Planned Care : M01 26/27

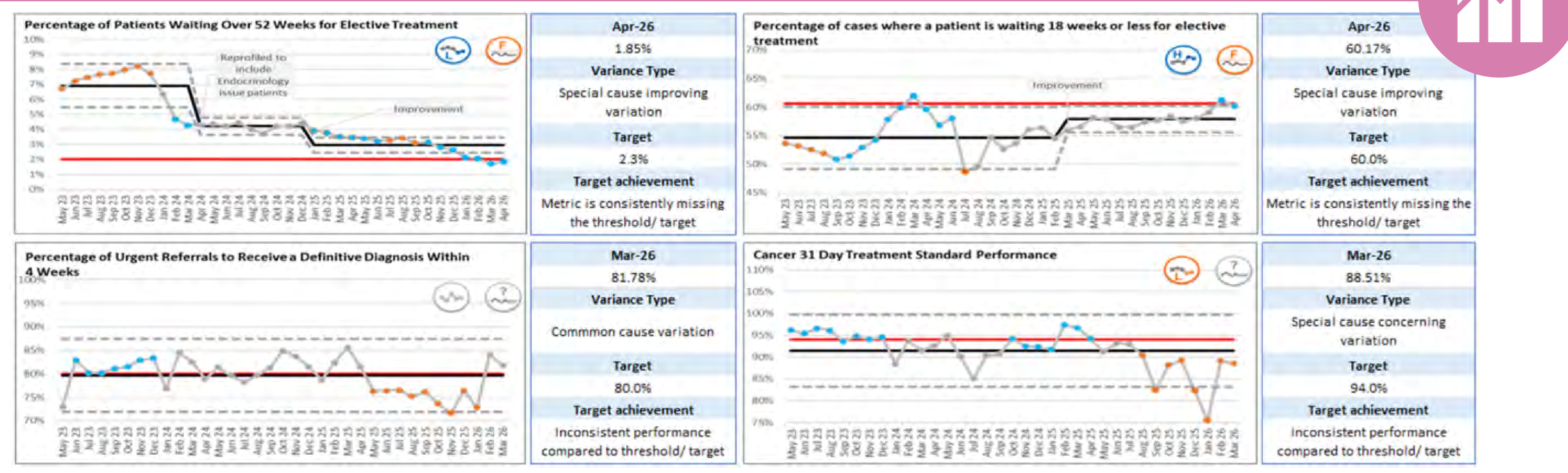
#	KPI	Latest month	Metric included in NOF *	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicator: Sign-off & Review	Data Quality Indicator: Timely & Complete	Data Quality Indicator: Process & System
1	Total Patients Waiting for First Attendance	Apr 26	No	25928	27337			32605	21465	43744	S	T	P
2	RTT Waiting List	Apr 26	No	44118	41770			48678	47125	50231	S	T	P
3	Total Patients Waiting Over 65 Weeks	Apr 26	No	14	0			25	-11	61	S	T	P
4	Percentage of Patients Waiting Over 52 Weeks for Elective Treatment	Apr 26	Yes	1.8%	2.0%			3.0%	2.5%	3.5%	S	T	P
5	Percentage of Patients Waiting Over 52 Weeks for Community Services	Apr 26	Yes	0.0%	0.0%			0.1%	0.0%	0.2%			
6	Percentage of Patients Waiting Over One Year, of Which Children Aged 18 Years and Under	Apr 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	Apr 26	No	2199	837			3246	#N/A	#N/A	S	T	P
8	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Apr 26	Yes	60.2%	60.6%			57.9%	55.6%	60.3%	S	T	P
9	Percentage of Patients Waiting Less than 18 Weeks for Community Services	Apr 26	No	91.0%	20.0%			86.7%	83.9%	89.6%			
10	Difference between planned and actual 18 week performance score	Apr 26	Yes	-0.41%	1.00%			1.26%	#N/A	#N/A	S	T	P
11	Percentage of People Waiting Over Six Weeks for a Diagnostic Procedure or Test	Apr 26	No	17.9%	26.6%			25.1%	16.3%	34.0%	S	T	P
12	Percentage of Urgent Referrals to Receive a Definitive Diagnosis Within 4 Weeks	Mar 26	Yes	81.8%	80.0%			79.6%	71.9%	87.4%	S	T	P
13	Cancer 31 Day Treatment Standard Performance	Mar 26	No	88.5%	94.0%			91.5%	83.2%	99.7%	S	T	P
14	Percentage of Patients Treated for Cancer Within 62 Days of Referral	Mar 26	Yes	79.0%	80.0%			75.1%	62.8%	87.4%	S	T	P
15	Outpatient New : Follow-up Ratio	Apr 26	No	2.2	2.0			2.2	2.0	2.4	S	T	P
16	Elective Theatre Utilisation - Capped Touchtime	Apr 26	No	69.9%	85.0%			81.3%	76.6%	86.0%	S	T	P
17	Elective Recovery Plan : Day Case Activity Performance	Apr 26	No	99.9%	100.0%			96.7%	86.5%	106.9%	S	T	P
18	Elective Recovery Plan : Inpatient Activity Performance	Apr 26	No	120.7%	100.0%			99.4%	76.2%	122.5%	S	T	P

Summary icons key:

*Please note : NOF denotes the National Oversight Framework

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

Performance Insight Report - Start Well & Planned Care : M01 26/27



Summary:	Actions:	Assurance:
1. **RTT 52WW:** Performance remains within planned levels. 2. **18-week RTT performance: Performance is demonstrating an improving position** 3. **28-Day FDS:** Achieved the target, normal variation 4. **Cancer 31 Day:** Failed the target	**1. RTT 52WW:** Specialty action plans are in place to support the delivery of the 52-week position, **2. 18-week RTT performance:** Specialty action plans are in place to support the delivery of the18-week position, Trajectories are being developed to ensure that the 67% target is achieved by March 2027 with and increasing focus on productivity and validation. **3. 28-Day FDS :** Ongoing cancer improvement actions **4. Cancer 31 Day:** Ongoing cancer improvement actions	**1. RTT 52WW:** Weekly PTL/ long waits week meeting with Deputy COO to review and track 65/52/18-week waits **2. 18-week RTT performance:** Performance is monitored fortnightly in the revised governance structure with reporting to ETM and F&P **3. 28-Day FDS:**. Likely to remain in target if the improvement actions to deliver diagnostic capacity and step-down decisions are maintained. **4. Cancer 31 Day:** Lower level of assurance due to pressures on theatre capacity and reduced capacity for some chemotherapy treatments for haematological malignancy.

Performance Narrative - Start Well & Planned Care : M01 26/27

RTT Waiting List: The April 2026 month-end position (confirmed on 13 May 2026) shows 44,118 incomplete pathways, with the majority of patients (60.17%) waiting under 18 weeks and a small proportion (2.17%) over 52 weeks; there are 13 pathways over 65 weeks across a limited number of specialties and one pathway over 78 weeks in Trauma & Orthopaedics, all of which are subject to targeted specialty-level actions and close operational oversight, with a clear focus on reducing long waits to zero.

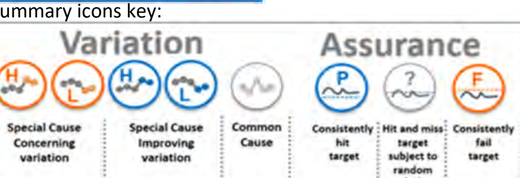
Cancer Performance: Cancer performance remains a significant organisational challenge; however, all three national standards have improved during the reporting period. The Faster Diagnosis Standard (FDS) has reached 81.8%, driven by pathway redesign within breast and lower GI services, including one-stop models and improved utilisation of straight-to-test pathways supported by increased endoscopy capacity. Strong clinical engagement, particularly through active management of patient tracking lists, has enabled improved flow and earlier identification of patients at risk of breach. As a result, 31-day performance has improved to 88.5% and 62-day performance to 79.3%, with continued FDS improvement expected to support further downstream recovery. Despite this progress, sustainability remains constrained by limited surgical capacity, particularly following the temporary decommissioning of theatres 5 and 6 at Wigan and the underlying backlog position. Ongoing prioritisation of cancer activity within reduced theatre capacity, alongside elective demand, continues to limit flexibility. Additional pressures within supporting services, including histopathology, also continue to impact pathway progression and timeliness of treatment.

Radiology: Radiology performance remains strong overall, with MRI and DEXA compliant with the six-week standard and activity levels delivered at or above plan, supporting improved diagnostic flow across pathways. Non-obstetric ultrasound continues to operate outside the standard; however, breach rates have stabilised following targeted interventions, including insourcing, agency deployment, and strengthened waiting list management, resulting in a more controlled operating position. Residual pressures remain within obstetric ultrasound and CT coronary angiography (CTCA). Obstetric capacity constraints, driven by wider antenatal service pressures, continue to impact timeliness and are being actively managed in partnership with maternity services. CTCA capacity remains limited, with demand exceeding available specialist workforce, contributing to ongoing breaches. A targeted recovery plan is in place, including additional weekend capacity and workforce development to improve flexibility and throughput.

Performance Overview – Live Well & Urgent Care : M01 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
19	Average Time to Ambulance Handover	Apr 26	No	00:29:35	00:25:00		?	00:28:46	00:20:58	00:36:34	S	T	P
20	Number of handovers > 30 minutes	Apr 26		41.5%	95.0%	H	P	25.7%	15.0%	36.3%			
21	Percentage of Emergency Department Attendances Admitted, Transferred or Discharged Within Four Hours	Apr 26	Yes	76.5%	82.0%	H	F	70.7%	65.8%	75.5%	S	T	P
22	Percentage of Type 1 Emergency Department Attendances Spending Over 12 Hours in the Department	Apr 26	Yes	20.2%	2.0%		F	18.9%	13.9%	23.9%	S	T	P
23	Instances of Corridor Care in ED	Under development											
24	Instances of General and Acute Corridor Care	Under development											
25	Overnight Total General and Acute Beds and the Number of Which are Occupied	Apr 26	No	92.3%	96.0%		?	92.8%	88.3%	97.4%	S	T	P
26	Virtual Ward Occupancy	Apr 26	No	72.5%	80.0%		?	74.6%	51.7%	97.5%	S	T	P
27	Average Daily Number of Specific Acute Non-Elective Spells in the Period With a Length of Stay of One or More Days	Apr 26	No	59	48		F	62	57	68	S	T	P
28	Average Number of Days Between Planned and Actual Discharge Date	Apr 26	Yes	0.5	0.5	L	F	0.9	0.6	1.2	S	T	P
29	Percentage of Patients who do not Meet the Criteria to Reside	Apr 26	No	23.1%	12.5%	L	F	23.3%	20.6%	26.1%	S	T	P
30	Average Daily Number of specific Acute Non-Elective Spells in the Period With a Length of Stay of Zero Days	Apr 26	No	45	52		?	45	33	58	S	T	P
31	Urgent Community Response (UCR) - 2-Hour Performance	Apr 26	No	78.3%	70.0%		P	82.3%	74.2%	90.4%	S	T	P

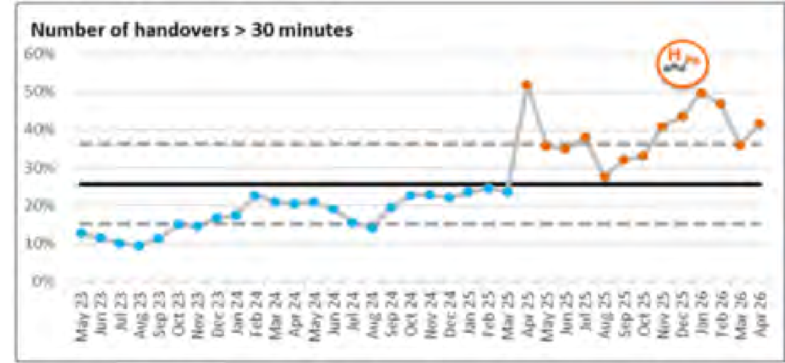
Summary icons key:

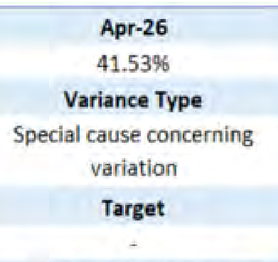


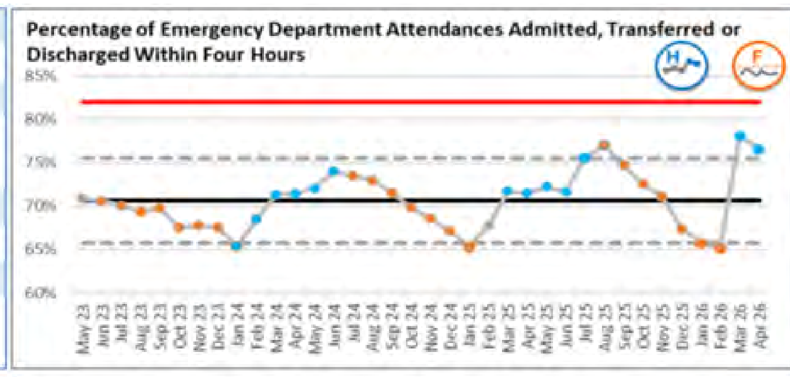
*Please note : NOF denotes the National Oversight Framework

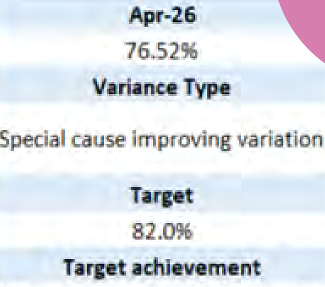
** Urgent Community Response (UCR) - 2-Hour Performance is reported 1 month in arrears

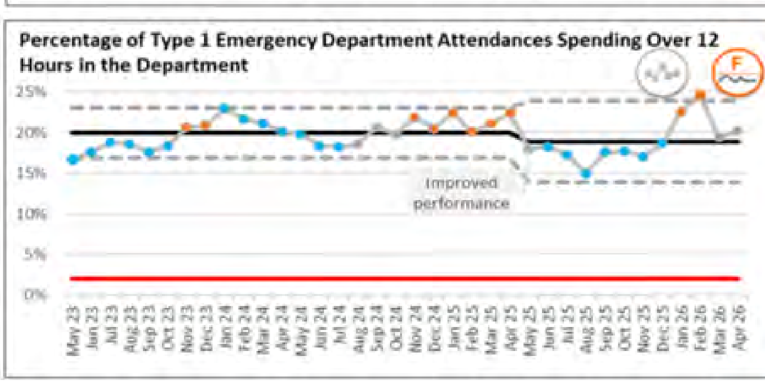
Performance Insight Report - Live Well & Urgent Care : M01 26/27

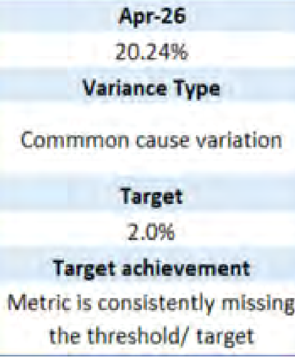












Summary:

1. Ambulance Handovers: The number of delayed handovers increased slightly from the improvement seen in March – to 41.53%

2. A&E 4 Hour Waits: 4- hour performance achieved 76.52% in April, falling short of the national standard but delivering against plan.

3. A&E 12 Hour Waits: Slight deterioration in the percentage of patients experiencing a 12-hour wait from March to April, and remains significantly higher than the standard of **10%.**

4. No Criteria to Reside Patients: The number of patients who do not meet the criteria to reside has moved into statistical improvement however there has been a reporting change to correct the collection of this dataset. May data is expected to show an increase as a result of this correction.

Actions:

1. Ambulance Handovers: ACP deployed to Jean Hayes to reduced re-admissions and ambulance transfers to ED. BetterLives programme – focus in H1 around supporting Care Homes to reduce conveyance of frailty and elderly patients.

2. A&E 4 Hour Waits: Continued focus on ED wait to be seen – this is a key determiner of 4-hour performance. Plans to develop a Paediatric Assessment Area to support an improvement in admitted 4-hour performance.

3. A&E 12 Hour Waits: Embed the Grand Rounds as BAU to maintain increase in discharges each day. Ongoing work through the BetterLives in-hospital flow programme – roll out Board round processes to next 4 wards.

4. No Criteria to Reside Patients: Establish May baseline as part of the new NCTR reporting arrangements. Reinforced focus on daily discharge meetings with system support and senior operational presence.

Assurance:

1. Ambulance Handovers: NWAS engagement meetings remain in place to ensure effective communication and proactive management of performance

2. A&E 4 Hour Waits: 4-hour performance is delivered plan at 76.52% in April. Actions from Sprint being embedded.

3. A&E 12 Hour Waits: 12-hour ED performance remains a concern in April however as a result of Grand Round actions, performance in May has delivered <5% on some days with performance to 18th May at 15.92%.

4. No Criteria to Reside Patients: Data continues to be scrutinised daily through both discharge escalation calls and patient flow meetings. Golden patient numbers are increasing demonstrating an improved grip and control as more patient are able to be identified for discharge for the following day.

Performance Narrative - Live Well & Urgent Care : M01 26/27

Urgent and Emergency Care performance deteriorated slightly in April versus March however remained significantly higher than levels of April 2025. This is primarily due to the 4 day Easter Bank holiday after which discharges were reduced. Towards the end of the month there was also a period of 7 days where ambulance attendances were statistically higher than normal levels. These 2 issues combined resulted in overcrowding in the Emergency Department after the bank holiday weekend. Unfortunately, this led to corridor care once again being utilised in the Emergency Department to ensure care could be provided to the incoming ambulance arrivals.

Despite these operational challenges, 4-hour performance delivered against plan at 76.52% and type 3 performance at Leigh Urgent Treatment Centre remained strong with most days, 100% of patients being seen, treated and discharged within 4-hours.

This position has primarily been delivered through the ongoing embedding of actions implemented as part of the Sprint. These actions include increased streaming from ED and step up pathways directly into Frailty Same Day Emergency Care, introduction of a substantive patient tracker role in ED (Mon/Tue only) and continued focus from the ED medical team on keeping the wait to be seen by ED medics under an hour.

12-hour performance deteriorated in month and remains an ongoing concern with over 20% of patients experiencing a 12-hour wait. A key action implemented to support an improvement in this measure is the Grand Rounds – a multi-disciplinary assessment of admitted patients across the wards. This approach has been instrumental in increasing pathway 0 discharges across the hospital which improves flow and reduces overall crowding in ED. This has successfully contributed to 12-hour waits in early May reducing to less than 5%. This approach is being embedded as business as usual.

Paediatric 4-hour performance remains a concern. Paediatric attendances were statistically lower in April (likely due to the Easter holidays) however performance remains just under 80%. This is primarily due to patients requiring admission. An improvement plan is in development with Start Well and Planned Care to create a Paediatric Assessment Area within Rainbow ward to improve this position.

This UEC improvement work is further supported by the BetterLives programme, with 3 internal workstreams focussed on reducing demand in ED. Priorities for Q1 and Q2 include a review and redesign of the Virtual Ward model, work with Care Homes to reduce avoidable conveyances to ED for frailty and elderly patients and development of our Acute Medical Model, where appropriate patients will be able to bypass ED to access Acute Medicine upon arrival. This is further supported by the in-hospital flow workstream which aims to reduce the length of stay for admitted patients. All this work is supported by best practice models and expert guidance from GIRFT (formerly ECIST).

Overall, April continues to demonstrates sustained improvement in safety and performance, despite the operational challenge of the Easter weekend.

Performance Overview - Finance : M01 26/27

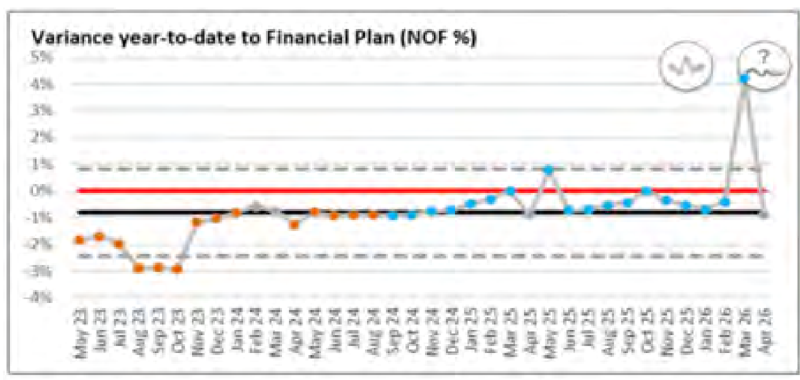
	KPI	Latest month	Metric included in NOF *	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit	Data Quality Indicator: Sign-off & Review	Timely & Complete	Process & System
1	Variance year-to-date to Financial Plan (NOF %)	Apr 26	Yes	-0.90%	0.00%			-0.80%	-2.43%	0.84%	S	T	P
2	Adjusted Financial Performance (£m) - Variance to Plan	Apr 26	No	-0.4	0.0			0.2	-3.5	3.9	S	T	P
3	Cash (£m)	Apr 26	No	26.4	13.1			17.5	6.9	28.1	S	T	P
4	API Income (£m) - Variance to Plan	Apr 26	No	-0.3	0.0			-0.2	-1.7	1.3	S	T	P
5	Total Cost Improvement Programme (CIP) (£m) - Variance to Plan	Apr 26	No	-0.2	0.0			0.2	-1.4	1.7	S	T	P
6	Recurrent Cost Improvement Programme (CIP) (£m) - Variance to Plan	Apr 26	No	-0.6	0.0			-0.5	-2.0	0.9	S	T	P
7	Implied Productivity	Mar 26	Yes	1.66%	2.00%			1.89%	0.59%	3.20%	S	T	P
8	Agency Expenditure (£m)	Apr 26	No	0.5	0.5			0.7	0.5	1.0	S	T	P
9	Bank Expenditure (£m)	Apr 26	No	2.3	1.6			2.2	1.6	2.8	S	T	P
10	Capital Expenditure (£m) - Variance to Plan	Apr 26	No	-1.0	0.0			0.8	-3.1	4.6	S	T	P
11	Better Payment Practice Code (BPPC)	Apr 26	No	74.7%	95.0%			93.6%	86.2%	101.0%	S	T	P

*Please note : NOF denotes the National Oversight Framework

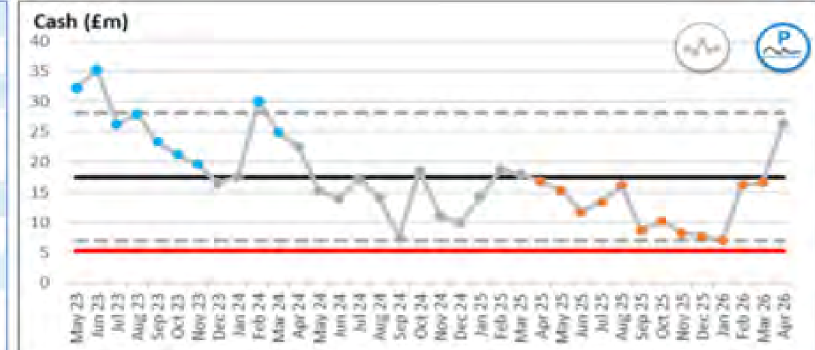
Summary icons key:

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

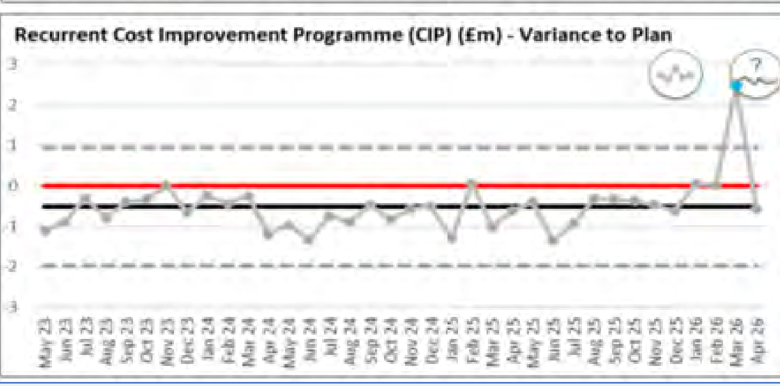
Performance Insight Report - Finance : M01 26/27



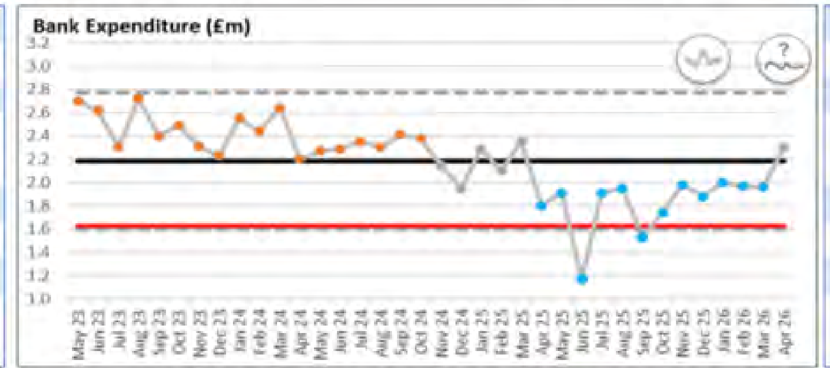
Apr-26
-0.9%
Variance Type
Common cause variation
Target
0.0%
Target achievement
Inconsistent performance compared to threshold/ target



Apr-26
26.40
Variance Type
Common cause variation
Target
13.1
Target achievement
Inconsistent performance compared to threshold/ target



Apr-26
-0.6
Variance Type
Common cause variation
Target
0.0
Target achievement
Inconsistent performance compared to threshold/ target



Apr-26
2.3
Variance Type
Common cause variation
Target
1.6
Target achievement
Inconsistent performance compared to threshold/ target

Summary:

1. Adjusted Financial Performance: We are reporting a deficit of £2.1m for April 2026. This is an overspend of £0.4m driven by the costs of industrial action, reduced levels of activity relative to plan and not achieving our CIP plan in month.
2.Cash: Closing cash at the end of April was £26.4m, an increase of £9.7m from March. The cash position is expected to reduce in line with capital expenditure. The current underlying run rate indicates external cash support may be required from Q3 2026/27.
3. Recurrent CIP: Recurrent CIP delivered in Month 1 is £0.1m, which is £0.6m below plan. This was partiallyitigated by a £0.4m over delivery on non-recurrent CIP in Month 1.
4. Bank: Bank spend is above the 10% reduction target set by NHSE, when adjusted for industrial action costs.

Actions:

1. Adjusted Financial Performance: CEO communications released to the organisation to emphasise the critical importance of the delivery of the financial plan.
2. Cash: This continues to be closely monitored. A temporary increase is expected to be sustained in May due to timing of payments for nationally funded capital projects and anticipated receipt of additional 2025/26 DSF in April. Forecast suggests that cash would become critical in December if the CIP programme is not achieved.
3. 26/27 CIP: Divisions continue to work at pace to develop and mobilise plans for 26/27 schemes aligned to the new operational structures with appropriate governance in place. Bi-weekly CIP huddles have been stepped up in Month 2 to provide support and assurance.
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.

Assurance:

1. Adjusted Financial Position: Senior Finance team, Divisional Assurance meeting, FIG, F&P, Board
2.Cash: Operational Cash Management Group, Finance and Performance Committee, recent internal audit review of cashflow forecast processes with substantial assurance.
3. 26/27 CIP: Weekly CIP updates are being provided to ETM which align to the weekly GM CIP returns. Robust governance processes and structures are in place within the Divisions to support and expedite development of schemes and governance documentation with bi-weekly CIP huddles stepped up in Month 2 for Divisions who are behind plan.
4. Bank: Executive Pay Control Group, Divisional Performance Reviews, Finance Improvement Group, Finance and Performance Committee, ETM

Performance Narrative – Finance : M01 26/27

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2026/27.	Red		We are reporting a deficit of £2.1m for April 2026. This is an overspend of £0.4m driven by the costs of industrial action, reduced levels of activity relative to plan and not achieving our CIP plan in month.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The cash balance at the end of April was £26.4m, increasing operating cash days to 16. Cash increased by £9.7m compared to last month. This is a temporary increase in cash balances as we expect payments to catch up in future months and reducing a reducing cash balance as we head into Q2.
API Income	Achieve the elective activity plan for 2026/27.	Red		Elective activity was £0.3m behind plan in month 1. Live Well and Urgent care is £50k behind plan and Start Well and Planned care is £257k behind plan.
Cost Improvement Programme (CIP)	Deliver Total CIP of £31.8m	Red		The Trust CIP target is £31.8m for 2026/27. In month 1, the Trust delivered CIP of £0.8m, which is £0.2m adverse to plan of £0.95m.
	Deliver Recurrent CIP of £15.3m	Red		
Agency expenditure	30% reduction in agency spend.	Amber		Agency spend is showing a 14% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M7 2025/26 FOT) which is below the 30% reduction required by NHSE.
Bank expenditure	10% reduction in bank spend	Red		Bank spend is showing a 14% increase relative to the NHSE baseline (taken as the M7 2025/26 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.
Capital expenditure	Achieve capital plan for 2026/27.	Amber		Capital expenditure in month 1 is £0.5m which is £0.9m behind the plan of £1.4m.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Red		BPPC performance in-month was 74.7% by volume and 36.9% by value. This was anticipated during the migration of invoices from Oracle to Centros and is expected to catch up over the course of the year.

Agenda item: 11.1

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	13 May 2026
Chair:	Francine Thorpe

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

ALERT

Right Patient, Right Ward: The Committee agreed to alert the Board to the low baseline position**,** particularly within specialist pathways including stroke and fractured neck of femur**,** recognising the risks associated with inappropriate patient placement and system-wide capacity pressures.

Cancer care – 104-day breaches: The Committee agreed to alert the Board to the 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.

Sepsis: The Committee agreed to alert the Board to 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.

Deteriorating patients: The Committee noted that deteriorating patients continue to feature as a recurring theme across PSIRF reporting and wider quality intelligence, requiring ongoing focus and oversight.

ASSURE

Right Patient, Right Ward: The Committee was assured that this is a defined 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.

Cancer care: The Committee was assured that 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.

Patient Safety Incident Response (PSIRF): The Committee was assured that 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.

Martha's Rule: The Committee was assured that Martha's Rule has been implemented across adult inpatient wards, with clear staff and patient escalation routes in place, emerging learning identified, and further rollout actions defined targeted at reducing variation between wards.

Maternity safety standards (Ockenden / CNST): The Committee was assured on 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.

CQC oversight: The Committee was assured by the Trust's open and transparent relationship with CQC**,** noting alignment between regulatory intelligence and internal assurance through committee scrutiny.

ADVISE

Right Patient, Right Ward: The Committee agreed to advise the Board that improvement will be delivered through sustained focus ahead of winter pressures, with continued scrutiny by the Committee and further triangulation of outcome measures to strengthen assurance.

Cancer care: The Committee agreed to advise the Board that wording in reports will be clarified to reflect "no clinical harm identified"**,** and that enhanced divisional deep-dive reviews, including equality considerations, will strengthen assurance.

Sepsis: The Committee agreed to advise the Board that the Sepsis Group has been asked t**o** refocus improvement activity**,** strengthen compliance with mandated practice, and continue enhanced monitoring following transition to local audit arrangements.

Martha's Rule: The Committee agreed to advise the Board that paediatric implementation remains in progress, with further work required to finalise escalation pathways and improve consistency of application across wards.

Patient safety and litigation: The Committee agreed to advise the Board that work will be undertaken to strengthen triangulation between PSIRF learning and clinical litigation intelligence**,** to enhance organisational learning and oversight

National oversight framework: The Committee reviewed the action plans that underpin the patient safety domain.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

Nothing was noted for escalation to the Board.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	19 May 2026
Chair:	Mr M Wilkinson

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

ALERT

- **Job Planning Internal Audit (Limited Assurance)**
  The Committee considered the outcome of the internal audit, which returned a **limited assurance opinion**, including two high-risk findings relating to system interoperability impacting pay accuracy, and compliance with Working Time Directive requirements.
  Whilst progress has been made and actions are in train, the Committee agreed that the **level of assurance remains below expectation**, and therefore this should be escalated as an alert and noted that progress will continue to be monitored via the internal audit tracker by the Audit Committee and escalated to People Committee where appropriate.
- **Freedom to Speak Up (FTSU) Arrangements**
  The Committee noted that there is currently an **interim FTSU service in place**, following the cessation of the previous ICB-provided arrangement. Although procurement is underway and expected to conclude shortly, the Committee recognised the **risk associated with a temporary gap in substantive provision**, and agreed this should be highlighted to the Board.
- **NHS Oversight Framework (NoF) – Sickness Absence Position**
  The Committee noted that the Trust remains in the **lowest segment (Segment 4)** for sickness absence. Whilst improvement actions are in place and further analytical tools are being developed, the Committee agreed that the **current position remains a concern** and should be clearly flagged.

ASSURE

- **Resident Doctors' 10-Point Plan**
  The Committee was assured on both the **progress made** and the **robustness of the delivery approach**, including strengthened engagement with resident doctors and improved RAG ratings across key actions.
- **Chief People Officer Update and Workforce Planning**
  The Committee noted strong alignment between local workforce planning and the **emerging national NHS workforce strategy**, with early consideration being given to health inequalities impacts.
  The approach was considered proactive and appropriately forward-looking.
- **People Dashboard**
  The Committee reviewed key workforce metrics, including agency usage, sickness absence and special leave. Members were assured that **risks are understood and actively managed**, with targeted work underway to improve data quality and consistency, particularly in relation to special leave.

- **Learning Needs Analysis and Training Governance**
  The Committee noted improvements in the **governance and central oversight of training budgets**, supporting more equitable and strategic allocation of resources aligned to organisational priorities.
- **Equality Delivery System (EDS3)**
  The Committee noted compliance with the annual assessment requirements and recognised progress made, whilst acknowledging that further work is required to demonstrate **sustained and embedded improvement**.

ADVISE

- **Job Planning – Divisional Performance Variation**
  The Committee noted variation in performance across divisions and specifically wished to highlight the **strong compliance achieved within urgent care (circa 96%)**, recommending this is recognised and used to inform improvement elsewhere.
- **NHS England Transforming People Services Programme**
  The Committee received a briefing on this national programme and agreed to advise the Board for **awareness**, noting that whilst implementation is not immediate, it represents a **significant future shift in how people services are delivered**.
- **EDI / Anti-Racism Strategy**
  The Committee endorsed the progress made and the strength of executive leadership in this area, advising the Board of the **clear strategic direction and ongoing development** towards a broader equity and inclusion approach.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- None

Agenda item: 11.3

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	27 May 2026
Chair:	Julie Gill

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

ALERT
• **Cash Position -** The reported cash balance is currently favourable due to non-recurrent timing factors; however, the underlying cash position remains constrained and presents an ongoing risk. Delivery of the financial plan is contingent upon successful implementation of the CIP and achievement of a sustained improvement in the underlying run rate. • **Corridor Care** – Corridor care is subject to increasing national scrutiny, with forthcoming public reporting. The use of corridor spaces presents a risk to patient safety, experience, performance standards and the Trust's regulatory and reputational position; the Committee therefore identified this as a priority area requiring enhanced oversight, sustained monitoring and continued escalation to Board. • **Elective Recovery – Long Waits (65 Weeks)-** The Committee noted a deterioration in long wait performance, particularly 65-week waits, driven by reduced theatre capacity from the planned closure of theatre 5 and 6, prioritisation of urgent and cancer activity, and wider capacity and productivity constraints. This presents a risk of regulatory escalation, including potential national tiering, and associated reputational impact. Recovery actions are being developed; however, these are likely to require utilisation of independent sector capacity, with consequent financial implications. • **SEND Neurodevelopment Pathways** - The Committee highlighted significant system pressures within neurodevelopment pathways, including long waiting times and increasing demand, alongside forthcoming changes to referral criteria and pathways across the system. These changes may materially impact reported demand and access, with implications for patient experience and equity of access. Given the complexity and cross-organisational nature of the issue, this represents an emerging area of concern requiring Board visibility and ongoing monitoring, particularly in relation to potential service, operational and financial impacts. • **CIP Delivery & Productivity** – The Committee highlighted a significant delivery risk associated with the Cost Improvement Programme, given the scale of savings required, alongside continued underperformance in productivity relative to national expectations and peer organisations, requiring sustained focus and improvement. • **NOF Performance** – The Committee noted continued underperformance across key NOF access domains, with limited movement in overall national positioning despite recent improvements. Performance remains inconsistent and not yet sustained, with interdependencies between urgent care, elective delivery and capacity pressures impacting progress. This presents an ongoing risk to regulatory standing and performance trajectory, requiring continued Board visibility, with improvement dependent on sustained delivery of recovery plans over time.

- **12-Hour Emergency Care Performance** – The Committee noted that 12-hour performance remains under sustained pressure despite some recent improvement, driven primarily by ongoing challenges in patient flow, bed capacity and operational processes. This continues to present a risk to patient experience, safety and overall system performance, and requires continued focus and Board oversight.

ASSURE

- The Committee was assured that the structure of discussions and the quality of reporting have improved, enabling clearer triangulation between finance, performance and operational delivery, thereby strengthening oversight and decision-making; further work is being progressed, including a Board workshop, to deepen understanding of productivity and its interdependencies.
- **National Cost Collection** – The Committee was assured that the Trust has achieved strong compliance with the National Cost Collection requirements, supported by robust governance, quality assurance processes and effective oversight, with performance exceeding peer benchmarks.
- **Supply Chain (Bone Cement)** – The Committee was assured that the previous supply disruption has been fully resolved, with learning captured and strengthened procurement and resilience arrangements implemented to mitigate future risk.
-

ADVISE

- **CNST Funding Pressure** – CNST cost increases have resulted in a residual unfunded pressure, highlighting a misalignment between the Trust's clinical risk profile and national funding mechanisms; whilst not material in isolation, this presents an ongoing financial and risk exposure requiring Board visibility and continued monitoring.
- **ED&I (Emerging Guidance)** – The Committee advised that emerging national gender guidance may have future operational and financial implications for the Trust and should therefore be kept under review with appropriate Board awareness as further clarity on requirements and impact develops.
- **CIP Delivery Approach** – The Committee advised that delivery of CIP will require a transition towards larger-scale transformational change, including digital and service redesign, and that organisational capacity constraints and delivery fatigue present ongoing challenges that may impact pace and sustainability.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- None.

Agenda item:11.4

Committee report

Report from:	Audit Committee
Date of meeting:	5 May 2026
Chair:	Simon Holden

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

ALERT

- Internal Audit identified that a number of medical staff contracted to work above 12 PAs had not yet formally signed an opt-out from the Working Time Regulations, with work ongoing to address this.
- Review of the risk register identified that point of care testing (CRR6) was the only risk triggering three red indicators, representing the highest level of concern and requiring further review by the Risk Management Group. They will consider whether the current impact and likelihood ratings appropriately reflect the nature of the risk.

ASSURE

- The draft annual accounts for 2025/26 were submitted to NHS England on 27 April 2026, in line with national guidance and the agreed timetable.
- Internal Audit (MIAA) provided substantial assurance on:
    - Appraisals
    - Fit and proper persons processes
    - Core financial systems

Internal Audit (MIAA) also reviewed the assurance framework and confirmed as robust and compliant with NHS requirements.

- The draft Head of Internal Audit Opinion for 2025/26 provided substantial assurance that the Trust maintains a sound system of internal control, consistent with the previous year.
- The Internal Audit Plan for 2026/27 was reviewed and approved by the Committee.

ADVISE

- The Centros financial ledger implementation is now live, with debt services brought back in-house
- Losses & special payments 2025/26 have seen 151 cases – worth £275k (comparator: 2024/25 – 165 cases – worth £505k)
- The Committee noted the Draft Accounts for 2025/26 and approved changes to accounting policies*(incl. The going concern treatment)*
- Ongoing assurance that LocSSIPs/NatSSIPs (*NHS Local Safety Standards for Invasive Procedures and National Standardised Procedural Interventions*) are being applied consistently in practice will now be monitored through the Quality & Safety Committee.
- The counter fraud work plan for 2026/27 was reviewed and approved.
- The counter fraud annual report for 2025/26 was reviewed and noted.
- The conflicts of interest, gifts and hospitality policy was reviewed and approved.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• Nothing in addition.

Agenda item: [12]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Financial reporting month 12 – Trust Finance Report
Presented to:	Board of Directors
On:	17 June 2026
Item purpose:	Information
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Senior finance team
Contact details:	Stephen.holt@wwl.nhs.uk

Executive summary

We have delivered our 2025/26 revenue control total as agreed with Greater Manchester and NHSE, subject to final sign-off by our external auditors. At year end, we are reporting an adjusted surplus of £3.3m. The final technical surplus or deficit will be confirmed following completion of year-end adjustments.

2025/26 CIP has over delivered by £0.7m, achieving £39.1m against a plan of £38.4m. Recurrent CIP has under-delivered by £2.8m in year which has been fully mitigated through non-recurrent measures. Full year CIP has over delivered.

March was a strong month for divisional elective API activity, and we are above plan by £0.6m in month and £1.1m full year. This includes the additional activity stepped up for the Q4 performance sprint. In month, Specialist Services is £0.3m favourable, Medicine is £0.3m favourable and Surgery is on plan.

The cash balance at the end of March was £16.6m, maintaining operating cash days at 10. Cash increased by £0.3m compared to last month. The cash position is expected to decline from April, reflecting the phasing of capital expenditure. The current underlying run rate would indicate we will require external cash support in Q2 2026/27.

NHSE has reallocated Deficit Support Funding (DSF) from systems that failed to deliver their 2025/26 plans to providers within systems that did deliver, subject to submission of a balanced 2026/27 plan. WWL has received £3.3m through this process. The funding is cash-backed and must be recognised as a bottom-line surplus.

Link to strategy

There are no direct links to strategy.

Risks associated with this report and proposed mitigations

There are no additional direct risks.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Equality, diversity and inclusion implications

There are no direct EDI implications in this report.

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

ETM reviewed the finance flash metrics on 16 April 2026. The full finance report was reviewed at the Financial Improvement Group on 27 April 2026.

Wider implications

There are no wider implications of this report.

Recommendation(s)

The Board is asked to note the month 12 financial position.

Trust Finance Report

Month 12 – March 2026

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Statistical Process Chart (SPC) Key

Key Financial Messages

We have delivered our 2025/26 revenue control total as agreed with Greater Manchester and NHSE, subject to final sign-off by our external auditors. At year end, we are reporting an adjusted surplus of £3.3m. The final technical surplus or deficit will be confirmed following completion of year-end adjustments.

NHSE has reallocated Deficit Support Funding (DSF) from systems that failed to deliver their 2025/26 plans to providers within systems that did deliver, subject to submission of a balanced 2026/27 plan. WWL has received £3.3m through this process. The funding is cash-backed and must be recognised as a bottom-line surplus.

We have delivered our capital control total of £32.0m for the 2025/26 financial year. This includes £14.5m of operational CDEL and £17.5m of nationally funded schemes.

2025/26 CIP has over delivered by £0.7m, achieving £39.1m against a plan of £38.4m. Recurrent CIP has under-delivered by £2.8m in year which has been fully mitigated through non-recurrent measures. Full year CIP has over delivered.

March was a strong month for divisional elective API activity, and we are above plan by £0.6m in month and £1.1m full year. This includes the additional activity stepped up for the Q4 performance sprint. In month, Specialist Services is £0.3m favourable, Medicine is £0.3m favourable and Surgery is on plan.

Despite good progress towards the end of the year, the underlaying run rate was £3.1m away from our planned year end position of £11.9m at £15.0m. This will make delivering the 2026/27 plan more difficult as the start position has worsened.

The cash balance at the end of March was £16.6m, maintaining operating cash days at 10. Cash increased by £0.3m compared to last month. The cash position is expected to decline from April, reflecting the phasing of capital expenditure. The current underlying run rate would indicate we will require external cash support in Q2 2026/27.

Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2025/26.	Green		We have delivered our 2025/26 revenue control total as agreed with Greater Manchester and NHSE, subject to final sign-off by our external auditors. At year end, we are reporting an adjusted surplus of £3.3m. The final technical surplus or deficit will be confirmed completion of year-end adjustments.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The cash balance at the end of March was £16.6m, maintaining operating cash days at 10. Cash increased by £0.3m compared to last month. The cash position is expected to decline from April, reflecting the phasing of capital expenditure. The current underlying run rate indicates we will require external cash support in Q2 2026/27.
API Income	Achieve the elective activity plan for 2025/26.	Green		March was a strong month for divisional elective API activity, and we are above plan by £0.6m in month and £1.1m full year. This includes the additional activity stepped up for the Q4 performance sprint. In month, Specialist Services is £0.3m favourable, Medicine is £0.3m favourable and Surgery is on plan.
Cost Improvement Programme (CIP)	Deliver Total CIP of £38.4m	Green		2025/26 CIP has over delivered by £0.7m, achieving £39.1m against a plan of £38.4m. Recurrent CIP has under-delivered by £2.8m in year which has been fully mitigated through non-recurrent measures. Full year CIP has over delivered.
	Deliver Recurrent CIP of £23.0m	Red		
Agency expenditure	30% reduction in agency spend.	Amber		Agency spend is showing a cumulative 11% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M8 2024/25 FOT) which is below the 19% reduction required by NHSE.
Bank expenditure	10% reduction in bank spend	Green		Bank spend is showing a cumulative 14% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 4% reduction required by NHSE.
Capital expenditure	Achieve capital plan for 2025/26.	Green		We have delivered our capital control total of £32.0m for the 2025/26 financial year. This includes £14.5m of operational CDEL and £17.5m of nationally funded schemes.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Green		BPPC performance in-month was 97.1% by volume and 95.8% by value. Ful year performance was 93.6% by volume and 96.4% by value.

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Financial Performance

Headlines

- We have delivered our 2025/26 revenue control total as agreed with Greater Manchester and NHSE, subject to final sign-off by our external auditors. At year end, we are reporting an adjusted surplus of £3.3m. The final technical surplus or deficit will be confirmed by 13 April following completion of year-end adjustments.
- Income is £79.5m, **£31.6m above plan** in month, mainly due to pensions adjustments of £22.6m offset in pay, API performance against plan £0.6m, DSF funding £3.3m and £2.0m of ICB support for Dermatology and UEC.
- Pay is £57.1m, **£24.3m adverse to plan**, including Pensions adjustments £22.5m, CIP underperformance £0.5m, medical staffing £0.3m, escalation £0.1m, Redundancy costs £0.1m (in forecast)
- Non pay is £26.3m, **£11.8m adverse to plan**. Valuation impairments £9.7m, Clinical supplies and services £1.4m, Stock adjustments are £0.6m, Insourcing £0.5m
- Actual CIP delivery in month is £7.7m, which is **£4.0m favourable to plan**.
- The National Oversight Framework (NOF) metric for variance YTD to financial is at segment 1 (Q1 segment 3, Q2 segment 2, Q3 Segment 3)

The technical deficit in our annual accounts is £6.2m.

- Our Adjusted Financial Performance (AFP), which is the measure used to assess system performance (akin to the control total) is £3.3m surplus.
- Specific technical adjustments are excluded from the AFP. This includes certain impairments and the impact of donated assets.

Key Financial Indicators	In Month (£000)			Full Year (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	79,430	47,847	31,583	614,739	572,943	41,797	572,943
Pay	(57,126)	(32,843)	(24,282)	(433,748)	(395,279)	(38,469)	(395,279)
Non Pay	(26,342)	(14,527)	(11,814)	(182,126)	(171,256)	(10,871)	(171,256)
Financing / Technical	(182)	(552)	370	(5,045)	(6,621)	1,576	(6,621)
Surplus / Deficit	(4,219)	(76)	(4,144)	(6,180)	(213)	(5,967)	(213)
Adjusted Financial Performance (AFP)	5,117	(58)	5,175	3,276	1	3,275	0
Memo							
Deficit support funding	(741)	(741)	0	(8,893)	(8,893)	0	(8,893)
AFP excluding deficit support funding	4,376	(58)	4,434	(5,617)	1	(5,618)	(8,893)

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

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Underlying Position

Quarter 4 Update

2024/25	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4	2026/27 Planning assumption
•Underlying run rate **£25.8m deficit** •£7.4m improvement on prior year	•Extrapolated underlying run rate **£21.3m deficit** •Improvement £4.5m on 2024/25 •Assumes all income other than DSF is recurrent	•Extrapolated underlying run rate **£20.6m deficit** •Improvement £0.7m on Q1 •Behind improvement trajectory by £1.8m	•Extrapolated underlying run rate **£17.2m deficit** •Improvement £3.4m on Q2 and £8.6m on 2024/25 •Behind improvement trajectory by £1.8m	•Underlying run rate **£14.5m deficit** •Improvement £2.7m on Q3 and £1.3m on 2024/25 •Behind improvement trajectory by £2.6m	•2026/27 Draft Plan assumes exit run rate of £11.9m deficit; our current forecast •**Variance to planned exit underlying position £2.6m**

Key messages

- **25/26 Forecast**: Assumed an underlying exit run rate is £11.9m deficit.
- **Methodology**: The regional NW NHSE team have standardised the methodology for the calculation of the underlying position as part of the oversight and assurance for the 2026/27 planning round. Our methodology has been aligned to this and verified by the NHSE team.
- **Medium-Term Planning**: The 2025/26 exit run rate will form the starting point for the medium-term financial plan.
- **Year-on-Year Improvement**: The 2024/25 exit run rate was a £25.8m deficit, demonstrating material improvement required in the underlying position during 2025/26.
- **Progress Tracking**: We assess the underlying position quarterly against the forecast trajectory. At Q4, the underlying deficit was £14.5m — demonstrating a continued improvement, but behind the forecast exit assumption of £11.9m.

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Income

Division	In Month (£000)			Full Year (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	1,430	415	1,015	7,466	4,970	2,496
Surgery	645	217	428	3,620	2,596	1,025
Specialist Services	1,956	(960)	2,916	19,885	16,614	3,271
Community Services	677	676	2	7,836	8,096	(259)
Non Divisional Income	50,607	46,493	4,114	538,627	528,654	9,973
Finance	(6)	17	(24)	161	193	(33)
People Services	69	71	(2)	1,056	853	202
Dir Of Strat & Planning	164	136	28	2,097	1,630	468
Chief Operating Officer	0	0	0	0	0	0
Medical Director	151	74	77	1,246	884	362
Estates & Facilities	470	404	65	5,418	4,807	611
Nurse Director	410	173	237	1,538	1,182	357
Trust Executive	0	(111)	111	0	(430)	430
Corporate	22,679	67	22,612	23,682	801	22,881
Digital Services	0	7	(7)	45	89	(44)
GTEC	178	169	9	2,062	2,005	57
Total	**79,430**	**47,847**	**31,583**	**614,739**	**572,943**	**41,797**

Headline

- Income is **£31.6m favourable** in month and £41.8m favourable full year. This includes £22.6m relating to pensions funding which is offset with expenditure. The normalised position excluding pensions is **£9m favourable** in month and £19.3m favourable for the full year.

Clinical divisions

- **Medicine**: Income is **£1.0m favourable** in month. Elective API income is £0.4m favourable in month including a £0.1m benefit relating to prior months coding. Unbundled drugs and devices income is £0.3m favourable and CDC income is £0.1m favourable in month.
- **Surgery**: Income is **£0.4m favourable** in month. This is predominantly due to additional CDC pathway income of £0.2m and education income £0.1m. Elective API income is on plan in month.
- **Specialist Services**: Income is **£2.9m favourable** in month. £2.6m relates to backdated CIP for Bespoke Prosthesis which is offset within Non-Divisional Income. Elective API income is £0.3m favourable in month; unbundled drugs and devices is £0.3m adverse in month and Education income is £0.2m favourable. .

Other

- **Non-Divisional Income**: Income is **£4.1m favourable** in month. This includes £3.3m of additional Deficit Support Funding (DSF) received from the ICB, reallocated from systems that have signalled they won't be delivering a balanced 2025/26 plan. A further £2.0m has been received relating to Dermatology support and UEC funding, alongside £0.3m of regional transformation funding to support RTT improvement. In addition, the Trust has agreed a final bespoke limb salvage settlement of £3.2m for 2025/26 with NHSE, including an in-month benefit of £0.9m. As this relates to Specialist Services, £2.6m of income net of costs has been recorded as CIP within Specialist Services, with the corresponding contra in Non-Divisional Income.
- **Corporate:** Income is **£22.6m favourable** in month due to pensions income which is offset by expenditure.
- **Nurse Director**: Income is **£0.2m favourable** in month due education income.

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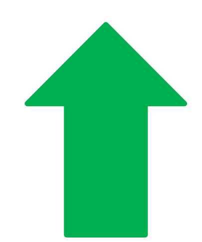
Divisional Elective API Activity and Income v Internal Plan

Division	POD	In Month Activity			In Month (£000)			Full Year Activity			Full Year (£000)		
		Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,822	1,681	141	1,180	1,114	67	18,400	19,333	(933)	12,282	12,809	(527)
Medicine	Electives	311	43	268	284	59	225	1,407	496	911	1,796	675	1,121
Medicine	OP Proc New	50	156	(106)	16	58	(42)	1,024	1,795	(771)	314	662	(348)
Medicine	OP Proc FUP	640	650	(10)	129	122	6	8,614	7,472	1,142	1,775	1,405	370
Medicine	OPA New	2,681	2,809	(128)	707	736	(29)	30,016	32,303	(2,287)	7,773	8,462	(690)
Medicine	A&G	568	276	293	122	60	63	6,000	3,306	2,694	1,299	716	583
Medicine Total		**6,072**	**5,615**	**457**	**2,438**	**2,148**	**290**	**65,461**	**64,705**	**755**	**25,240**	**24,730**	**510**
Specialist Services	Day Cases	898	791	107	1,540	1,402	138	9,768	9,365	403	16,350	16,650	(301)
Specialist Services	Electives	393	379	14	2,973	2,839	134	4,403	4,538	(135)	33,631	33,962	(331)
Specialist Services	OP Proc New	814	958	(144)	137	161	(25)	12,142	11,016	1,126	2,052	1,854	199
Specialist Services	OP Proc FUP	2,091	1,411	680	329	199	130	21,708	16,230	5,478	3,149	2,293	856
Specialist Services	OPA New	3,150	3,422	(272)	655	724	(69)	40,602	39,347	1,255	8,532	8,325	207
Specialist Services	A&G	230	171	59	50	37	13	3,763	2,055	1,708	815	445	370
Specialist Services Total		**7,576**	**7,133**	**443**	**5,684**	**5,362**	**322**	**92,386**	**82,551**	**9,835**	**64,529**	**63,529**	**1,000**
Surgery	Day Cases	1,105	1,147	(42)	1,669	1,598	71	12,355	12,594	(239)	16,302	17,300	(998)
Surgery	Electives	150	192	(42)	539	545	(6)	1,775	2,211	(436)	6,339	6,267	72
Surgery	OP Proc New	1,711	2,112	(401)	370	462	(92)	20,873	24,225	(3,352)	4,654	5,287	(633)
Surgery	OP Proc FUP	3,854	3,304	550	836	678	158	45,100	38,000	7,100	9,503	7,798	1,705
Surgery	OPA New	3,840	4,537	(697)	789	924	(134)	46,414	51,133	(4,719)	9,570	10,453	(883)
Surgery	A&G	223	107	116	48	23	25	2,690	1,287	1,403	582	279	304
Surgery Total		**10,883**	**11,401**	**(518)**	**4,251**	**4,230**	**21**	**129,207**	**129,449**	**(242)**	**46,950**	**47,384**	**(434)**
Divisional ERF Totals		**24,531**	**24,148**	**383**	**12,373**	**11,740**	**633**	**287,054**	**276,705**	**10,349**	**136,719**	**135,643**	**1,077**



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

Elective API Performance

- The Trust has overperformed against the elective API plan by £0.6min month and £1.1m full year.
- **Medicine** are £0.3m favourable to plan in month predominantly due to General Medicine £0.2m & Gastro £0.1m.
- **Specialist Services** are £0.3 above plan in month mainly due to T&O.
- **Surgery** are breakeven in month. Several specialties are favourable to plan including General Surgery £0.2m and Colorectal Surgery £0.1m and these are offset by a number of specialties behind plan in month.
- Advice and guidance income of £0.2m has been included in month. A&G is £1.3m above plan full year of which £0.6m relates to GM.

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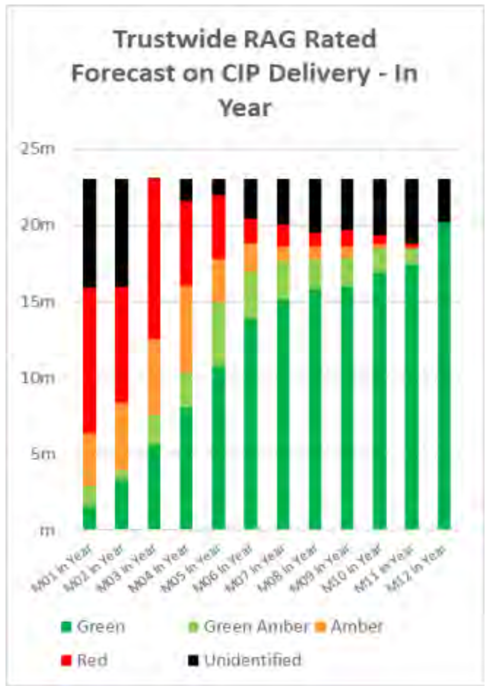
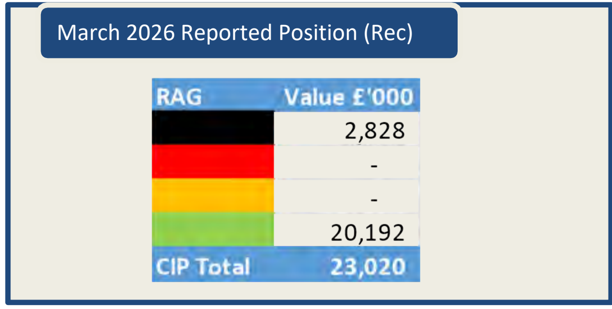
Trust Wide CIP Delivery 2025/26

2025/26 CIP Delivery

- Total CIP delivered in Month 12 is £7.4m, which is £4.0m above plan: £4.6m is recurrent (62%) and £2.81m is non-recurrent (38%).
- The full value of recurrent CIP transacted increased by £1.72m to £20.19m, with the final year to date position improving by £2.5m to £2.8m behind plan.
- At Month 12, £2.8m of the recurrent plan has slipped in year due to the delay in scheme start dates, this has been fully mitigated non recurrently to ensure the trust still met the full CIP target of £38.4m.

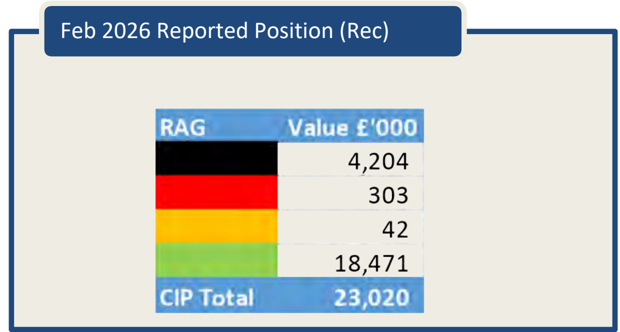


March 2026 Reported Position (Rec)



RAG	Value £'000
Black	2,828
Red	-
Amber	-
Green	20,192
CIP Total	23,020

Feb 2026 Reported Position (Rec)



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

CIP assumptions in the Scenarios

To ensure that we meet our mid case scenario, an assumption of delivering £17.18m of cash releasing CIP in year has been made. We have currently delivered and transacted £16.98m.

In total we have transacted £20.19m recurrent CIP in year with a full year impact of £25.48m.

	In Year		Full Year Impact	
Recurrent CIP	Included in scenarios (£m)	Reported at M12 Actual (£m)	Target (£m)	Actual Transacted at M12 (£m)
All Recurrent	18.00	20.19	23.00	25.48
Cash Releasing	17.18	16.98	20.00	22.20

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Workforce

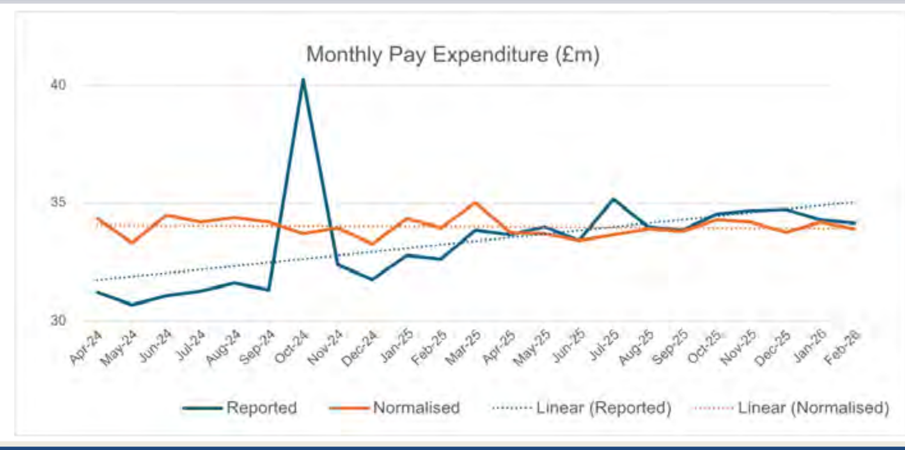
Pay expenditure

- The in-month pay expenditure is £57.1m which is £24.3m above plan in month. This is due to pensions adjustments £22.5m (offset in income) CIP underperformance £0.5m, Medical staffing £0.3m, Escalation costs £0.1m, Redundancy costs £0.1m

- The normalised pay expenditure has been rebased in line with 2025/26 rates and remains within the range seen since from Q4. January normalised pay is £34.2m compared to the 2024/25 Q4 monthly average of £34.5m.

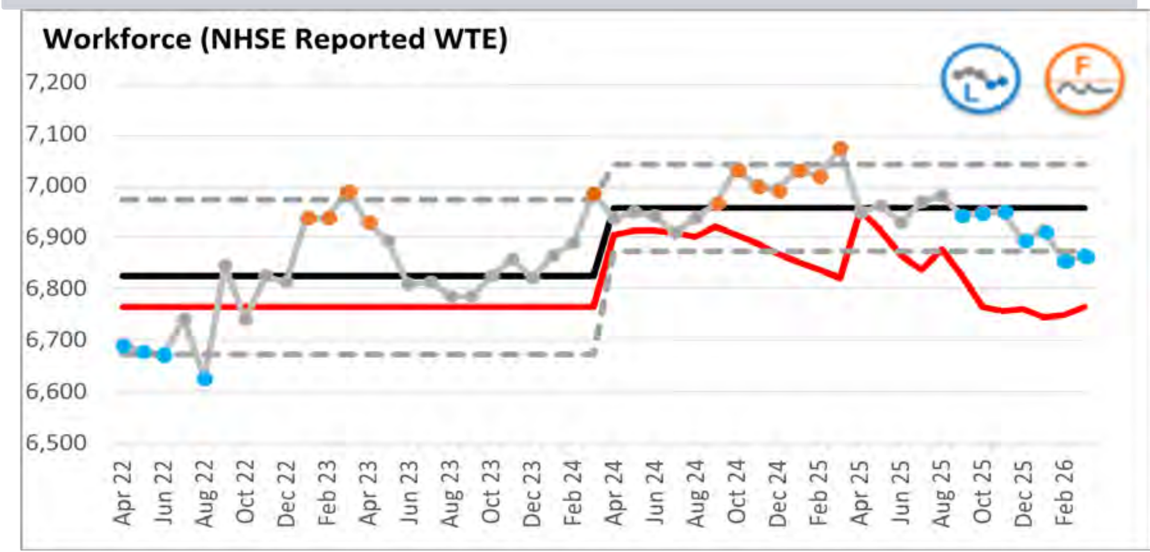
Workforce (WTE)

- Actual workforce 6,865 WTE in March. This is an increase of 11 WTE on February, with a reduction in bank and agency offset by increase in substantive and is 100 WTE above the workforce plan of 6,765 WTE.
  - Substantive staffing has increased by 31 WTE.
  - Bank staffing has decreased by 7 WTE.
  - Agency has decreased by 13 WTE compared to last month.



Pay £1.7m above plan in month

Normalised pay is reducing c£34.4m



WTE above plan by 100 WTE (at an average WTE cost this equates to £0.4m in month)

Normalised quarterly average

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

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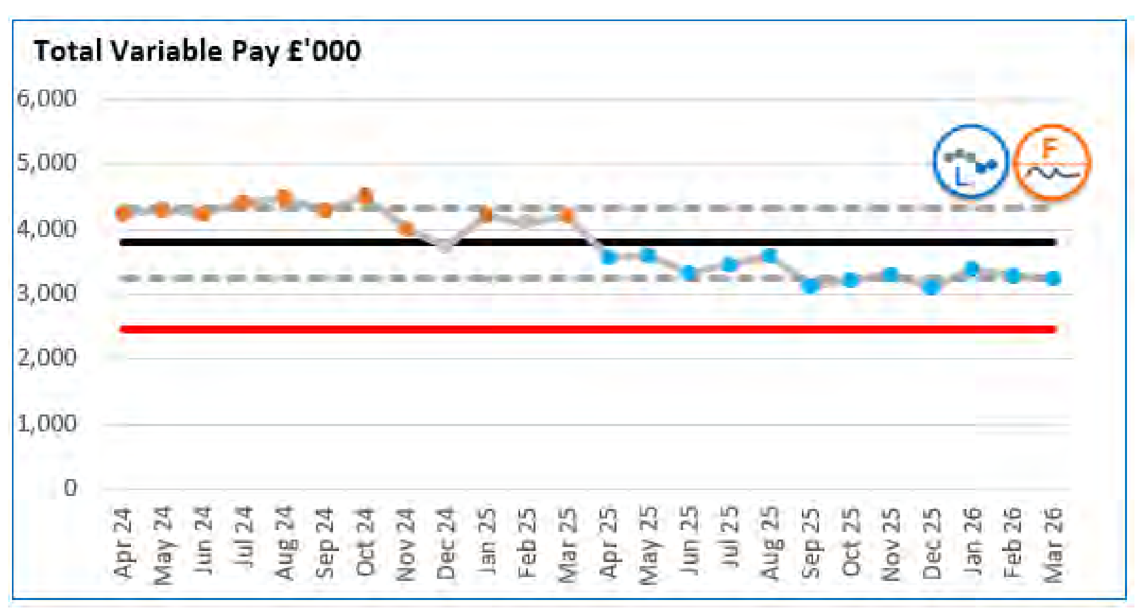
Variable Pay



Key messages

- Total variable pay is £3.2m in month, £40.2m full year; an average of £3.3m per month.
- The recovery plan includes several schemes aimed at reducing variable pay.
- March saw no decrease from the prior month.
- The spend split by staffing group is Medical £19.1m, Nursing £19.0m and Corporate £2.2m.
- Variable pay oversight taking place via the divisional performance reviews and financial improvement group.
- Note: Variable pay includes bank, agency, additional sessions, overtime, WOS, cost per reporting and LPVs.
- Note: Prior year spend has been normalised for pay award and July, November & December Industrial action costs have been removed

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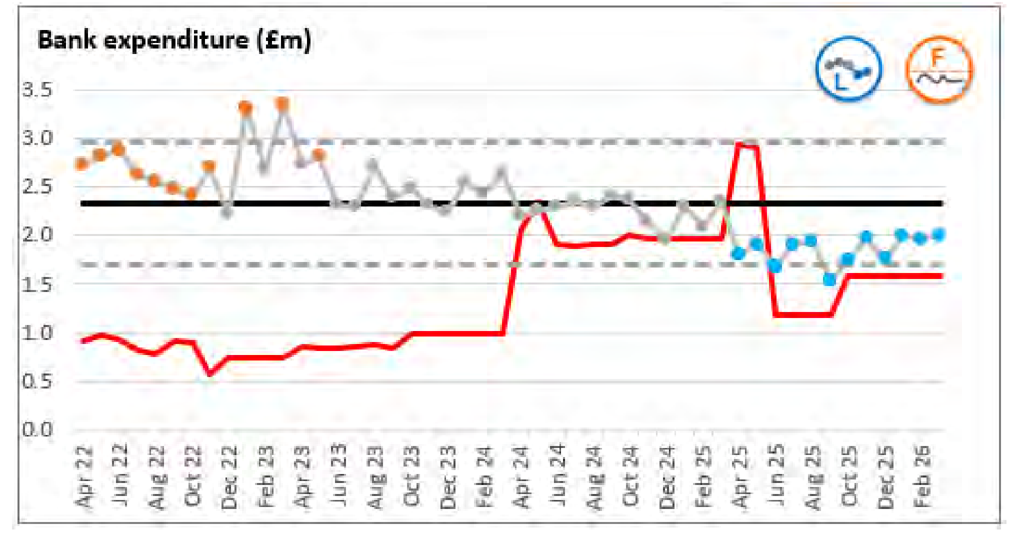
Bank & Agency Staffing

Bank expenditure

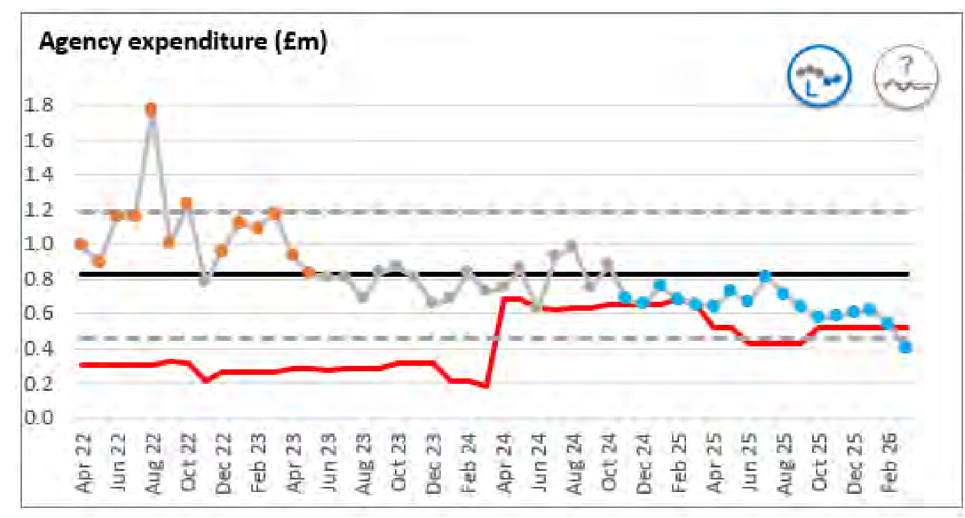
- Bank costs were £2.0m in March, the same as last month.
- The chart is showing a special cause improving variation.
- In March, Medicine (£1.1m) and Surgery (£0.4m) continue to be the biggest users.
- Bank WTE decreased by 7 WTE.
- Bank spend is showing a cumulative 14% reduction relative to the NHSE baseline (taken as the M8 2024/25 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.



Bank expenditure stabilised in month.

Agency expenditure

- Agency spend in month is £0.4m, with a £0.1m reduction on last month. The trend is still showing common cause improving variation.
- Agency WTE decreased by 13 WTE.
- Medicine (£0.2m) continues to have the highest level of agency within the Trust, spend in Specialist is (£0.1m).
- Agency spend is showing a cumulative 11% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M8 2024/25 FOT) which is below the 30% reduction required by NHSE.



Agency expenditure reducing compared to last month

Scrutiny remains high on agency spend

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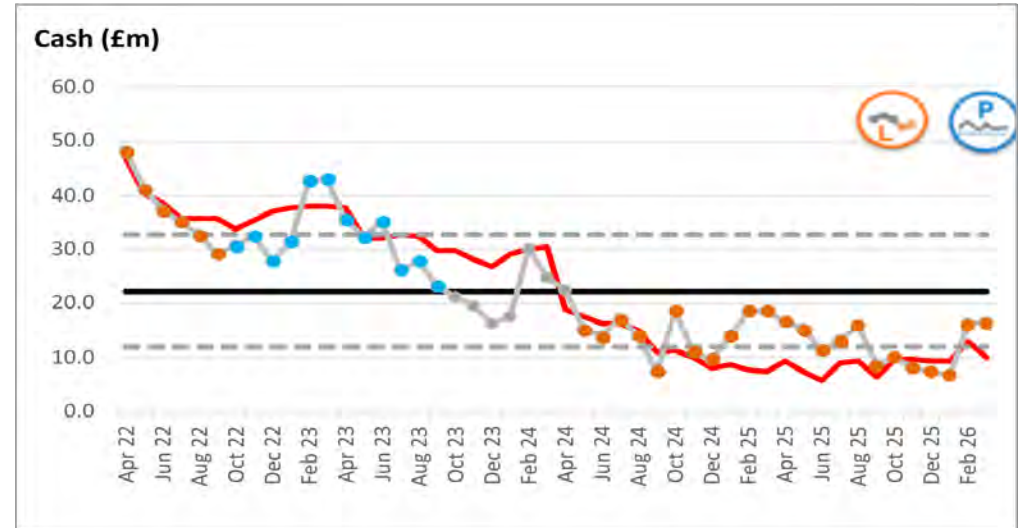
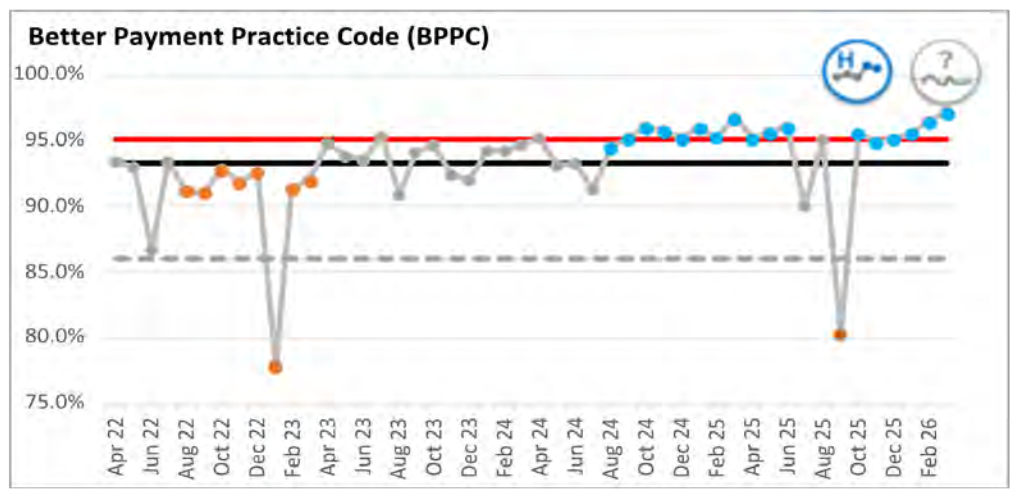
Cash and BPPC





Current cash position

- Closing cash at the end of March was £16.6m, an increase of £0.3m from February which is £6.3m above the plan. The balance has benefitted from additional income for £2.0m surge funding and £3.1m for bespoke prosthetics. £5.2m PDC capital funding was received which is a temporary benefit as the 2025/26 capital transactions will be concluded in quarter 1.
- Operating cash days at the end of March is maintained at 10 days.

Cash forecast

- Our underlying cash balance continues on a downward trajectory. Based on the current cashflow forecast and associated sensitivities, the current run rate forecast indicates that cash balances would be sufficient in quarter 1, mainly due to the temporary benefit of the capital cash funding, but it could become critical in quarter 2, potentially requiring cash support in September 2026.

Better Payment Practice Code (BPPC)

- The year-to-date performance is exceeding the target of 95.0% by value, the full year performance by volume has improved this month.
- The in-month performance was 97.1% by volume and 95.8% by value.
- The full year performance was 93.6% by volume and 96.4% by value

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Capital

Scheme	In Month (£000) Actual	Plan	Var	Full Year (£000) Actual	Plan	Var	YTD Actual of Full Year Plan (%)
Operational capital programme	2,340	2,115	(225)	14,598	15,150	552	96%
Over programming and over allocation	0	0	0	0	(672)	(672)	0%
Operational capital (CDEL)	**2,340**	**2,115**	**(225)**	**14,598**	**14,478**	**(120)**	**101%**
National funding (PDC)							
Solar Panels	534	215	(319)	1,686	2,148	462	79%
Diagnostics prioritisation	106	0	(106)	240	239	(1)	100%
UEC - Discharge Lounge capacity	(86)	63	149	616	635	19	97%
Elective prioritisation - Theatres 5&6	574	131	(443)	1,414	1,050	(364)	135%
Estates Safety bids (Backlog Maintainance)	221	133	(88)	3,063	2,744	(319)	112%
Estates Safety bids (Backlog Maintainance) Phase 2	152	595	443	324	595	271	54%
UEC (A&E Diagnostics)	(39)	0	39	3,673	3,747	74	98%
UEC SDEC	495	224	(272)	1,568	1,341	(227)	117%
CDC Pathway - Gynaecology	5	109	104	107	109	2	98%
Sound Treatment Rooms (audiology)	50	120	70	116	120	4	97%
RAAC - Leigh infirmary	19	391	372	378	391	13	97%
EV Chargers	(3)	19	22	30	31	1	96%
CDC Pathway - Urology	208	540	332	521	540	19	97%
Cyber Security Devices (Armis IT)	0	246	246	245	246	1	100%
Fibroscan	118	120	2	118	120	2	99%
ROP Camera	0	69	69	69	69	0	100%
CBRN Decontamination Equipment	0	17	17	17	17	(0)	100%
LED Lighting	677	2,764	2,087	2,523	2,764	241	91%
ENT Bundle	138	206	68	200	206	7	97%
Maternity & Bereavement Suite	286	206	(80)	286	206	(80)	139%
Community Paeds and Audiology	18	17	(1)	18	17	(1)	104%
Radiology	119	118	(1)	119	118	(1)	101%
Breast Screening Equipment	30	26	(4)	30	26	(4)	115%
Sub total national funding	**3,620**	**6,328**	**2,708**	**17,359**	**17,479**	**120**	**99%**
Total capital programme	**5,960**	**8,443**	**2,483**	**31,957**	**31,957**	**0**	**100%**

Month 12 Headlines

- Total capital expenditure in March is £6.0m which is £2.5m below plan.
- Year to date, total capital expenditure is £32.0m and on plan.
- £1.3m brokerage between financial years to mitigate slippage of the Pharmacy Robot (£0.6m), Solar Panels (£0.5m) and LED lighting (£0.2m).

Operational CDEL

- Operational capital expenditure in March is £2.3m
- The full year expenditure is £14.5m achieving the CDEL allocation.

PDC funded schemes

- Expenditure is £3.6m in month.
- The full year expenditure is £17.5m.

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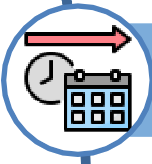
Forward look

We have set a **balanced financial plan for 2026/27**, delivering the **breakeven control total** without deficit support following the **full withdrawal of £8.9m of DSF funding received in 2025/26**. Delivery of the plan is underpinned by a 5.5% CIP requirement (£31.8m), and £5.8m of elective activity growth (4.2%) compared to the 2025/26 plan. Cash will continue to be a key risk going into 26/27 with operating days expected to fall as low as 1 in Q2.

The Trust is exiting 25/26 with an underlying deficit of £14.5m. The **medium-term financial plan shows a clear trajectory back to underlying sustainability**, with the underlying deficit reducing to **£4.2m in 2026/27** and a return to balance by **2027/28**.



Divisional budgets have been reset to forecast outturn, strengthening accountability and sharpening focus on run -rate control. The 2026/27 workforce plan reflects a 310 WTE (4.5%) reduction, aligned with 317 WTE savings assumed through CIP delivery.

The implementation of Integra Centros general ledger system is progressing well, with no significant issues identified following the go-live of the Sales and Purchase Ledgers. Migration of the General Ledger is nearing completion. The Bee Finance Systems team are providing support to Finance staff and end users during the go-live period, with Hypercare support scheduled to continue until mid-May. Regular comms have been issued to end users throughout implementation.

The Government has confirmed a 3.5% consolidated uplift for all medical staff in 2026/27, following full acceptance of the NHS Pay Review Body recommendation. The increase will be applied in June 2026 payroll, and further funded pay structure reforms are expected following discussions with trade unions and employers.

Resident doctors commenced industrial action in April, following the BMA's rejection of an offer on jobs and pay put forward by the Government. Senior secondary care doctors in England will be balloted for industrial action, simultaneous ballots of consultants and SAS doctors will run from 11 May until 6 July.

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Agenda item: [12]

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Financial reporting month 01 – Trust Finance Report
Presented to:	Board of Directors
On:	17 June 2026
Item purpose:	Information
Presented by:	Tabitha Gardner, Chief Finance Officer
Prepared by:	Senior finance team
Contact details:	Stephen.holt@wwl.nhs.uk

Executive summary

We are reporting a deficit of £2.1m for April 2026. This is an overspend of £0.4m driven by the costs of industrial action, reduced levels of activity relative to plan and not achieving our CIP plan in month.

The Trust CIP target is £31.8m for 2026/27. In month 1, the Trust delivered CIP of £0.8m, which is £0.2m adverse to plan.

Elective activity was £0.3m behind plan in month 1, driven by Start Well and Planned care under performance in ENT and gynaecology.

Closing cash at the end of April was £26.4m, an increase of £9.7m from March; £3.3m re-distributed deficit support funding, £3.8m education income for Q1, and c£3m lower value of payments in the month due to the migration of invoices to the new finance and procurement system. This is a temporary increase in cash balances as we expect payments to catch up in future months and reducing a reducing cash balance as we head into Q2.

Actual workforce 6,887 WTE in April which is adverse to the workforce plan by 4 WTE. Industrial action increased WTE by 16 in April. WTE was 22 more than the prior month or which 16 was industrial action

Implied productivity growth for month 1 is 1.7% versus 24/25 which is below the NHSE target of 2%. The Trust target is 5.5%.

Link to strategy

There are no direct links to strategy.

Risks associated with this report and proposed mitigations

There are no additional direct risks.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Equality, diversity and inclusion implications

There are no direct EDI implications in this report.

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

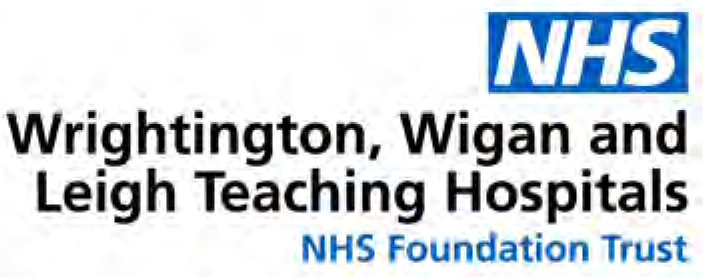
ETM reviewed the finance flash metrics on 7 May 2026. The full finance report was reviewed at the Financial Improvement Group on 18 May 2026 and the Finance and Performance Committee on 27 May 2026.

Wider implications

There are no wider implications of this report.

Recommendation(s)

The Board is asked to note the month 01 financial position.



Trust Finance Report

Month 01 – April 2026

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Capital (slide 14)

Forward look (slide 15)

Statistical Process Chart (SPC) Key

Key Financial Messages

We are reporting a deficit of £2.1m for April 2026. This is an overspend of £0.4m driven by the costs of industrial action, reduced levels of activity relative to plan and not achieving our CIP plan in month.

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Implied productivity growth for month 1 is 1.7% versus 24/25 which is below the NHSE target of 2%. The Trust target is 5.5%

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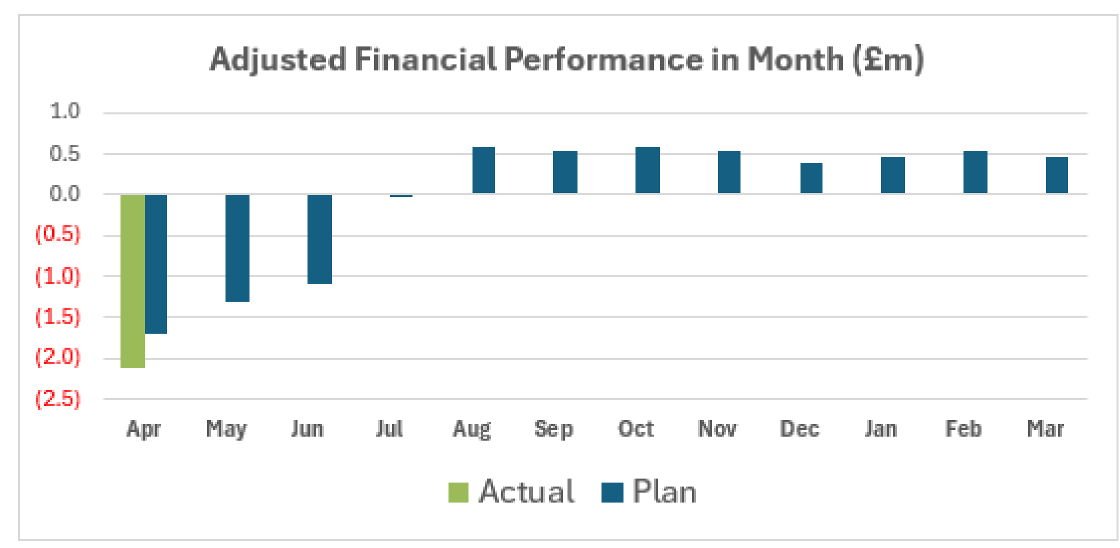
Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue plan	Adjusted financial position: Achieve the financial plan for 2026/27.	Red		We are reporting a deficit of £2.1m for April 2026. This is an overspend of £0.4m driven by the costs of industrial action, reduced levels of activity relative to plan and not achieving our CIP plan in month.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		The cash balance at the end of April was £26.4m, increasing operating cash days to 16. Cash increased by £9.7m compared to last month. This is a temporary increase in cash balances as we expect payments to catch up in future months and reducing a reducing cash balance as we head into Q2.
API Income	Achieve the elective activity plan for 2026/27.	Red		Elective activity was £0.3m behind plan in month 1. Live Well and Urgent care is £50k behind plan and Start Well and Planned care is £257k behind plan.
Cost Improvement Programme (CIP)	Deliver Total CIP of £31.8m	Red		The Trust CIP target is £31.8m for 2026/27. In month 1, the Trust delivered CIP of £0.8m, which is £0.2m adverse to plan of £0.95m.
	Deliver Recurrent CIP of £15.3m	Red		
Agency expenditure	30% reduction in agency spend.	Amber		Agency spend is showing a 14% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M7 2025/26 FOT) which is below the 30% reduction required by NHSE.
Bank expenditure	10% reduction in bank spend	Red		Bank spend is showing a 14% increase relative to the NHSE baseline (taken as the M7 2025/26 FOT) when adjusted for industrial action costs which is above the 10% reduction required by NHSE.
Capital expenditure	Achieve capital plan for 2026/27.	Amber		Capital expenditure in month 1 is £0.5m which is £0.9m behind the plan of £1.4m.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Red		BPPC performance in-month was 74.7% by volume and 36.9% by value. This was anticipated during the migration of invoices from Oracle to Centros and is expected to catch up over the course of the year.

Financial Performance

Headlines

- Our revenue plan for 2026/27 financial year is breakeven.
- In April (month 1), we have an actual deficit of £2.1m**,** which is £0.4m adverse to the planned deficit of £1.7m.
- Income is £48.2m, £0.4m adverse to plan due primarily to API Elective underperformance of £0.3m.
- Pay expenditure is £34.8m, £0.3m adverse to plan. This is predominantly due to costs incurred during industrial action.
- Non pay expenditure is £15.1m, £0.2m favourable to plan.
- The Trust CIP target is £31.8m for 2026/27. In month 1, the Trust delivered CIP of £0.8m, which is £0.2m adverse to the plan of £0.95m.



Key Financial Indicators	In Month (£000)			Full Year (£000)
	Actual	Plan	Var	Plan
Income	48,208	48,619	(411)	580,434
Pay	(34,817)	(34,560)	(257)	(397,779)
Non Pay	(15,105)	(15,260)	155	(176,829)
Financing / Technical	(432)	(503)	71	(6,041)
Surplus / Deficit	**(2,146)**	**(1,704)**	**(442)**	**(215)**
Adjusted Financial Performance (AFP)	(2,121)	(1,687)	(435)	0

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

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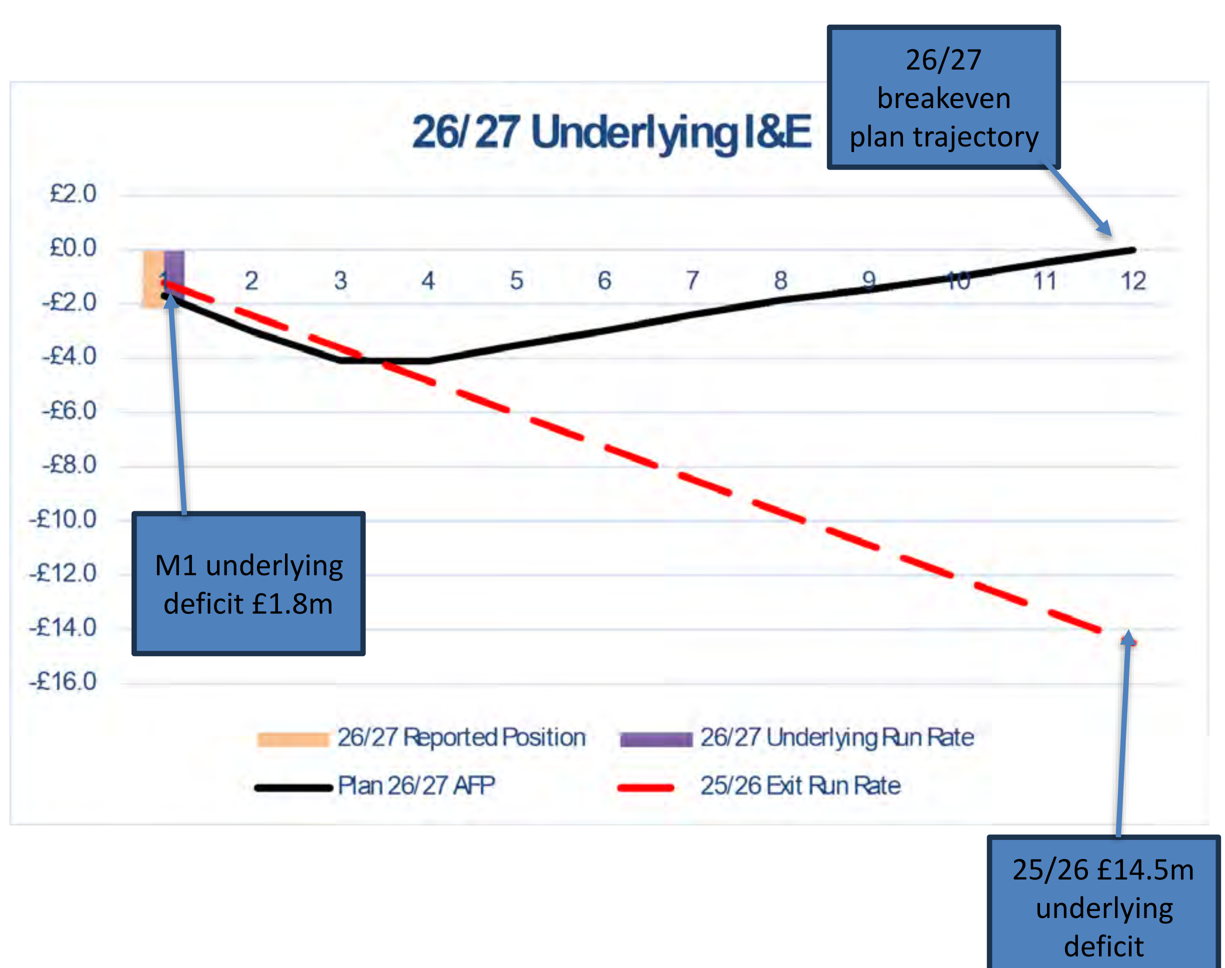
Underlying Position 26/27



Underlying Position

- The Trust underlying deficit at m12 25/26 was £14.5m.
- In month 1 26/27 the Trust reported a £2.1m deficit. Once adjusted for non-recurrent Industrial Action £0.4m and non-recurrent CIP savings of £0.1m the underlying deficit at month 1 is £1.8m, which is an underlying run rate of £21.8m. Our 26/27 planned exit run rate needs to be £4.4m.
- The Trust must deliver a significant improvement in its underlying run rate across months 2-12, primarily through the delivery of CIP, in order to achieve the 26/27 financial plan.

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Income

Division	In Month (£000)		
	Actual	Plan	Variance
LIVE WELL & URGENT CARE	1,040	1,018	23
START WELL & PLANNED CARE	1,499	1,833	(334)
CHIEF OPERATING OFFICER	0	0	0
DIGITAL SERVICES	3	3	0
DIR OF STRAT & PLANNING	144	144	0
ESTATES & FACILITIES	491	558	(68)
FINANCE	12	11	1
GTEC	197	180	17
PEOPLE SERVICES	83	76	8
MEDICAL DIRECTOR	104	74	30
NURSE DIRECTOR	68	83	(15)
TRUST EXECUTIVE	0	0	0
CORPORATE EXPENDITURE	92	72	20
NON-DIVISIONAL INCOME	44,475	44,567	(92)
Total	**48,208**	**48,619**	**(411)**

Headline

- Income is **£0.4m adverse** in month.

Clinical divisions

- **Live Well & Urgent Care**: Income is **on plan** in month. This includes £0.1m underperformance on elective API activity and a £0.1m overperformance on UEC.
- **Start Well & Planned Care**: Income is **£0.3m adverse** in month. This is predominantly due to under performances of £0.3m on Elective API activity and £0.1m on private patient income.

Other

- **Non-Divisional Income**: Income is **£0.1m adverse** in month due to a reduction in GM ICB block contract for UEC. The position includes £0.3m for bespoke limb salvage prosthesis, the Trust is still in dialogue with NHSE re the funding of this and is a risk.
- **Estates & Facilities**: Income is **£0.1m adverse** in month. This includes £0.1m under performance on car park income.

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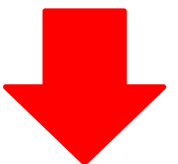
Divisional Elective API Activity and Income v Internal Plan

Division	POD	In Month Activity			In Month (£000)		
		Actual	Plan	Variance	Actual	Plan	Variance
Live Well & Urgent Care	Day Cases	1,678	1,545	133	1,135	1,052	83
	Electives	208	48	160	242	87	156
	OP Proc New	645	947	(302)	116	175	(59)
	OP Proc FUP	1,492	1,276	216	242	221	20
	OPA New	2,372	3,217	(845)	648	899	(251)
	Advice & Guidance	776	608	168	132	132	0
Live Well & Urgent Care Total		**7,171**	**7,641**	**(470)**	**2,515**	**2,565**	**(50)**
Start Well & Planned Care	Day Cases	1,750	1,794	(44)	2,517	2,657	(140)
	Electives	487	516	(29)	3,308	3,335	(27)
	OP Proc New	1,810	2,279	(469)	392	499	(107)
	OP Proc FUP	4,803	3,765	1,038	984	776	208
	OPA New	6,357	7,196	(839)	1,358	1,548	(191)
	Advice & Guidance	262	197	64	43	43	0
Start Well & Planned Care Total		**15,469**	**15,747**	**(278)**	**8,601**	**8,859**	**(257)**
Divisional Elective API Totals		**22,640**	**23,388**	**(748)**	**11,116**	**11,423**	**(307)**

- Live Well & Urgent Care (£50k)
- Start Well & Planned Care (£257k)



Elective API Performance

- The Trust has underperformed against the elective API plan by £0.3m in month.
- **Livewell & Urgent Care** are (£50k) behind to plan in month predominantly due to Gastro (£103k), Respiratory Medicine (£64k) and Cardiology (£61k) which is offset by over achievement in a number other specialties, mainly General Medicine £190k.
- **Start Well & Planned Care** are (£257k) behind plan in month mainly due to Gynaecology (£178k) and ENT (£112k).
- GM ICB have reduced the tariff for Advice and Guidance from £215 to £60 per case in line with other commissioners. However, in 26/27 the plan was set based on the 25/26 plan and they will pay the Trust based on the annual contract value of £2.1m on a block basis unless the value of activity x price at £60 exceeds the block.

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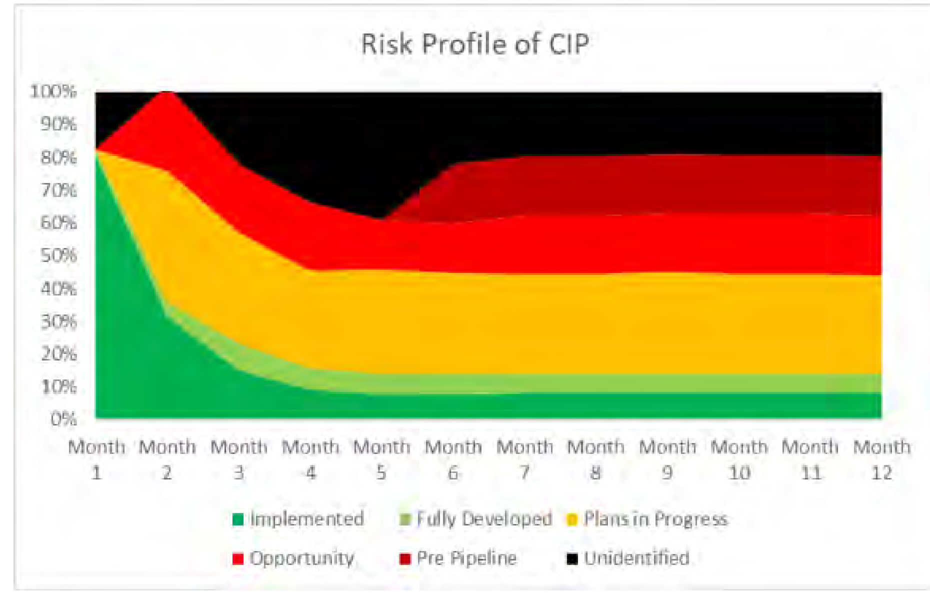
Trust Wide CIP Delivery 2026/27

2026/27 CIP Delivery

- Total CIP delivered in Month 1 is £0.8m, which is £0.2m behind plan: £0.1m is recurrent (15%) and £0.7m is non-recurrent (85%).
- 11% of the CIP schemes have now been implemented and a further 6% fully developed, which reduces the risk of non-delivery. However, pace to develop the remaining schemes and ensure that the gap is fully identified is pivotal to delivering the financial plan for 2026/27.

WWL Trust Wide	2026/27
CIP Plan - (£)	31,800
Implemented	3,668
Fully Developed	1,923
Plans in Progress	9,602
Opportunity	5,614
Pre Pipeline	4,000
Total Identified	24,808
Unidentified	6,992
Unidentified (%)	22%

Risk Adjusted Forecast	11,315
Risk Adjusted Gap (£)	20,485
Risk Adjusted Gap (%)	64%



	£000's				
In Month	Target	Delivered	Variance	Delivered %	(Gap)/Over %
Recurrent CIP	690	122	(568)	18%	(82%)
Non Recurrent CIP	264	668	404	253%	153%
Total In Month CIP	**954**	**790**	**(164)**	**83%**	**(17%)**

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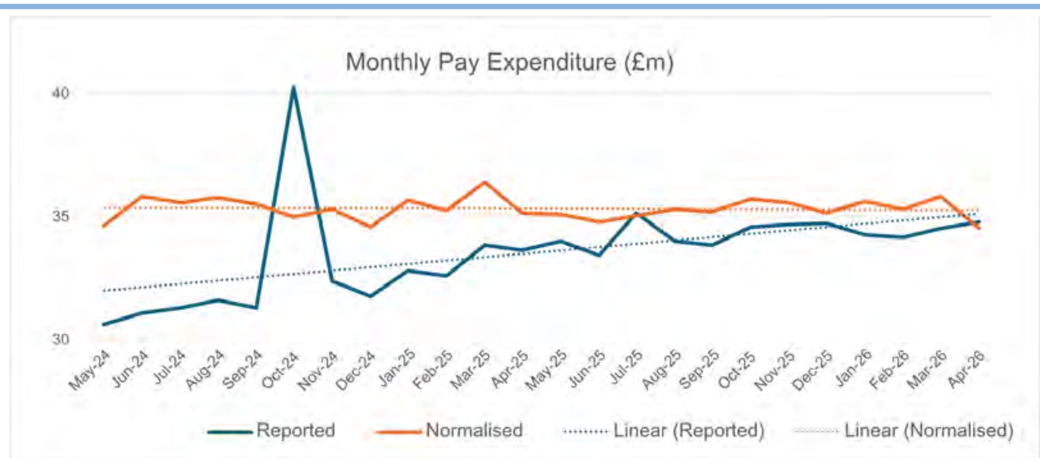
Workforce

Pay expenditure

- The in-month pay expenditure is £34.8m which is £0.3m above plan in month.
- Industrial action costs are £0.4m
- The normalised pay expenditure has been rebased in line with 2025/26 rates. April normalised pay is £34.6m compared to the 2025/26 Q4 monthly average of £35.2m.

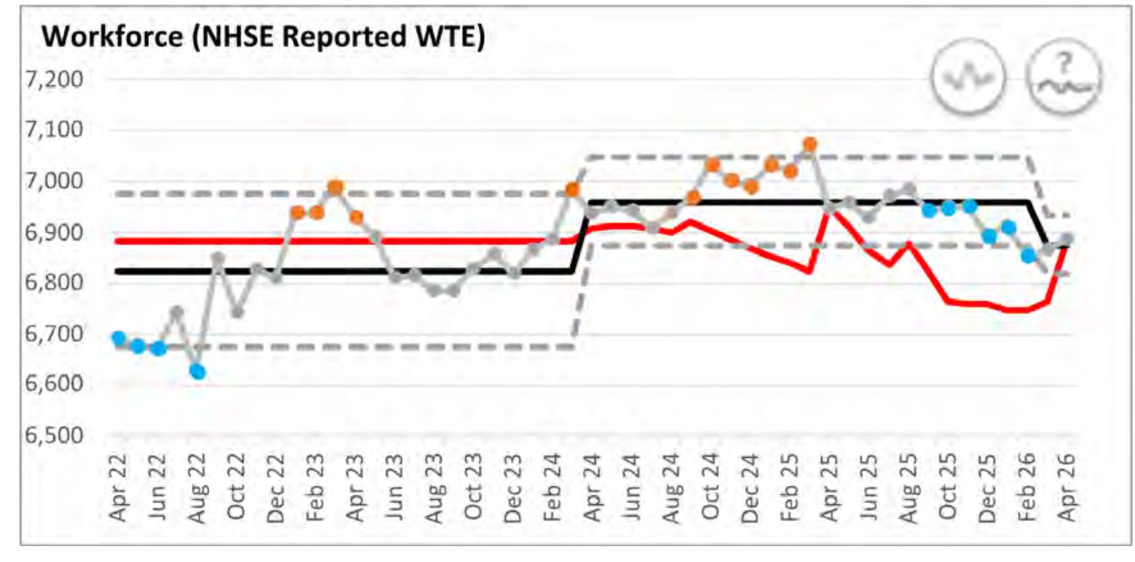


Normalised quarterly average

Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	April 26 £34.6m
£35.8m	£35.0m	£35.2m	£35.5m	£35.2m	

Workforce (WTE)

- Actual workforce 6,887 WTE in April which is adverse to the workforce plan of 6,883, by 4 WTE.
- Workforce has increased by 21.53 WTE compared to March.
  - Industrial action backfill contributed an additional 16 WTE.
- NB – The workforce plan has been rebased for 2026/27 in line with the medium-term planning submissions to NHSE.



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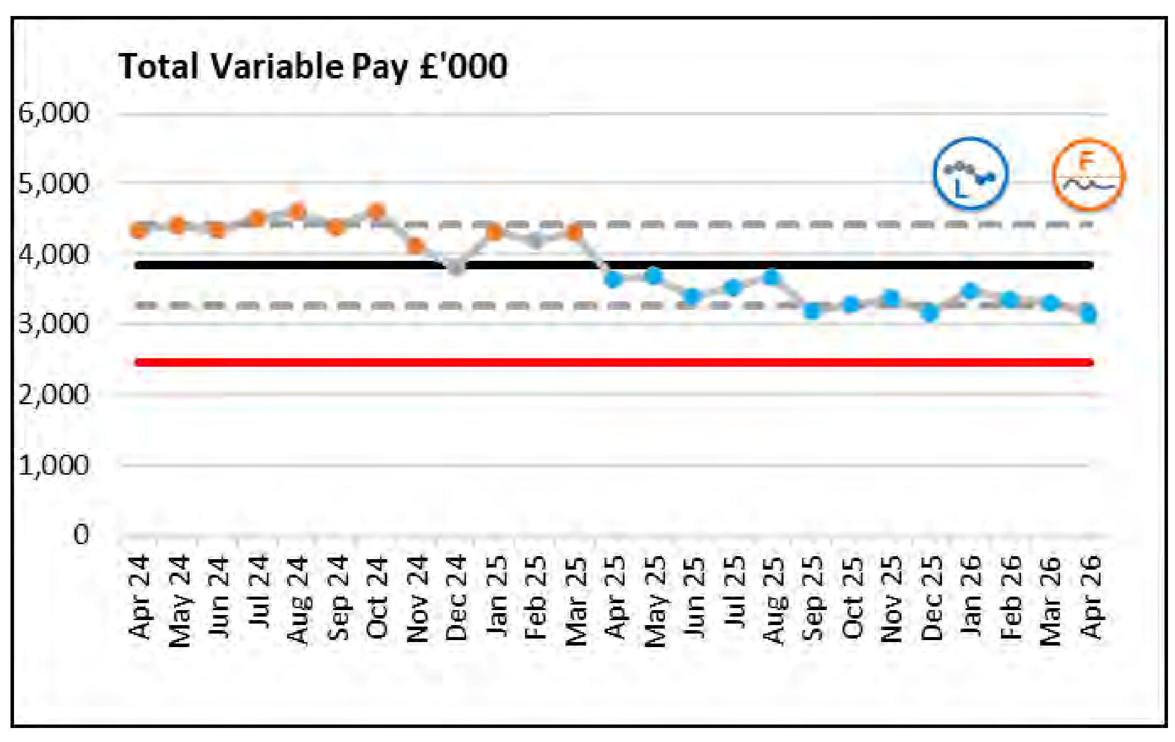
Variable Pay



Key messages

- Overall, SPC trend is positive and shows total variable pay reducing since 2024/25. However, 25/26 remained fairly static.
- There is an immediate focus on actions to reduce variable pay to support delivery of the 2026/27 position.

In month position

- Total variable pay is £3.1m in month.
- April saw a decrease of £0.2m from the prior month.
- The in month spend split by staffing group is Nursing £1.6m, Medical £1.4m, and Corporate £0.2m.

Notes

- 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.

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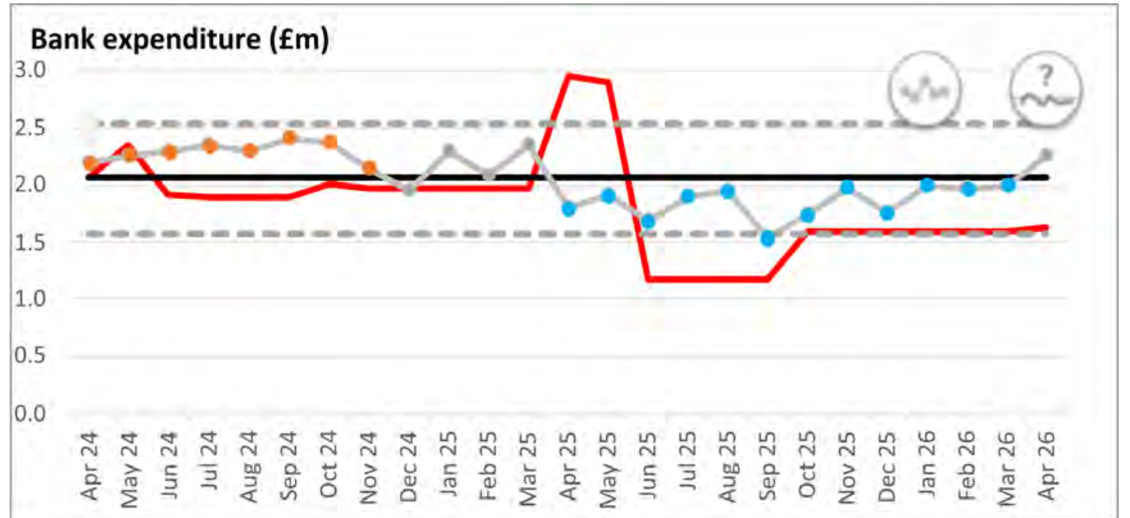
Bank & Agency Staffing

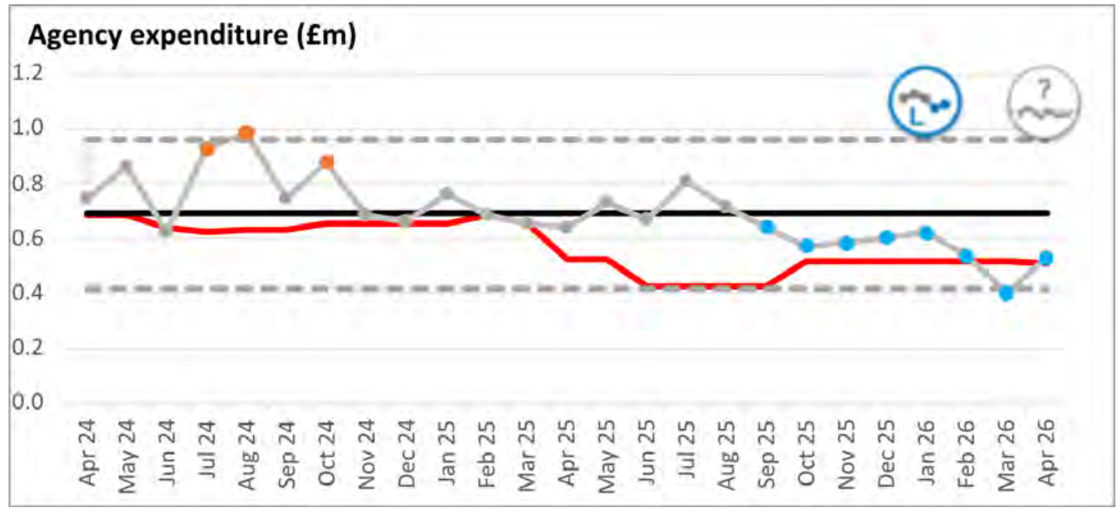
Bank expenditure

- Bank costs were £2.3m in April, an increase of £0.3m on March.
- Bank WTE increased by 6 WTE.
- Industrial action costs c£0.3m, 14 WTE.
- Bank spend is above the 10% reduction required by NHSE.
- NB – Rebased for 2026/27 plan.

Agency expenditure

- Agency spend in month is £0.5m, with a £0.1m increase on last month.
- Industrial action costs c£0.1m, 2 WTE.
  - Agency spend is showing a 14% reduction to the NHSE baseline (adjusted for industrial action costs) (taken as the M7 2025/26 FOT) which, whilst an improvement, remains below the 30% reduction required by NHSE.
  - NB – Rebased for 2026/27 plan.





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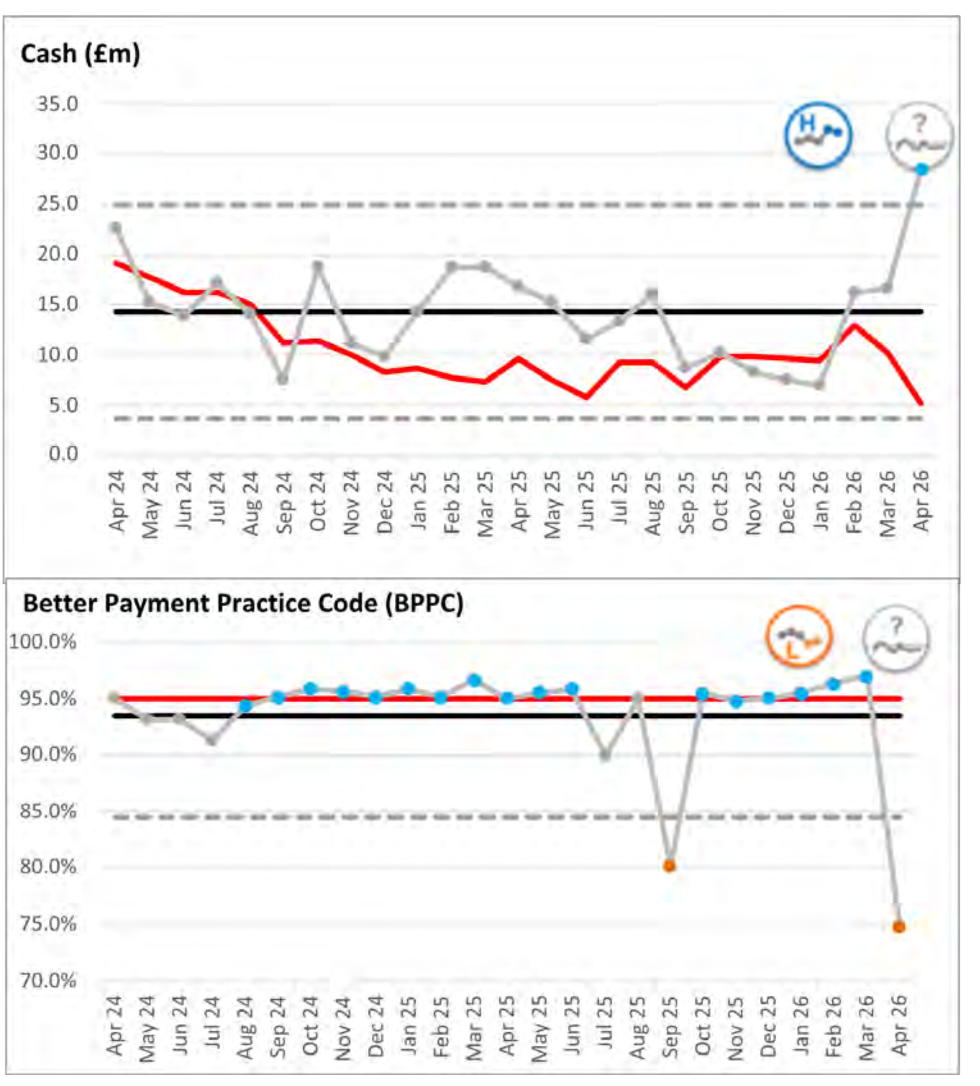
Cash and BPPC



Current cash position

- Closing cash at the end of April was £26.4m, an increase of £9.7m from March. This is due to receipt of £3.3m re-distributed deficit support funding, £3.8m education income for Q1, and c£3m lower value of payments made in the month, this was expected during the migration of invoices to the new finance and procurement system. This is a temporary increase in cash balances as we expect payments to catch up in future months.
- Operating cash days at the end of April was 16 days.

Better Payment Practice Code (BPPC)

- The year-to-date performance is below the target of 95.0%
- The April performance is 74.7% by volume and 36.9% by value.
- This was anticipated during the migration of invoices from Oracle to Centros and is expected to catch up over the course of the year.

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Capital

Scheme	In Month (£000) Actual	Plan	Var	Full Year (£000) Plan	YTD Actual of Full Year Plan (%)
Operational capital programme	266	781	515	14,130	2%
Over programming and over allocation			0	(673)	0%
Operational capital (CDEL)	**266**	**781**	**515**	**13,457**	**2%**
National funding (PDC) indicative allocations					
Estates Safety		0	0	6,272	0%
Diagnostics		0	0	4,405	0%
UEC Priorities	200	633	433	3,795	5%
Sub total national funding	**200**	**633**	**433**	**14,472**	**1%**
Leases	**0**	**0**	**0**	**900**	0%
Total capital programme	**466**	**1,414**	**948**	**28,829**	**2%**

Capital plan 2026/27

- Total capital plan submitted to NHSE is £29.5m comprising:
  - Operational CDEL: £14.1m.
  - PDC schemes: £14.4m.
  - Leases £0.9m
  - The plan includes a 5% (£0.7m) planning tolerance against operational CDEL. As a result, the net allocated CDEL expenditure is £13.4m given an adjusted overall capital plan of £28.8m.

Month 1 Headlines

- Capital expenditure in month 1 is £0.5m which is £0.9m behind the plan of £1.4m.

Operational CDEL

- Operational CDEL in month 1 is £0.3m which is £0.3m behind the plan of £0.5m
- The underspend in month largely relates to Digital and Theatres 5 & 6.
- There have been some delays on the LED scheme due to HSE requirements and planning approvals.

PDC funded schemes

- PDC expenditure is £0.2m against plan of £0.6m.
- Expenditure in month relates to SAL
- Variance to plan of £0.4m relates to an underspend against SAL £0.2m and SDEC £0.2m.

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Forward look

Whilst the cash position was temporarily high in month 1 at £26.4m (16 days) it will continue to be a key risk in 26/27 with operating days expected to reduce in Q2.

The Trust has a CIP target of £31.8m for the full year. The CIP profile increases significantly from Q2 onwards and the development of the schemes to ensure that the gap is fully identified is pivotal to delivering the financial plan for 2026/27. The Trust CIP plan significantly increases from quarter 2, which means we must keep up the pace to identify and deliver the CIP plan to sustain our financial performance, support the cash position and deliver efficient patient care.

Inflation remains a concern across our non pay and energy expenditure, with CPI on an upward trend at around 3.3%, against planning assumptions with near zero uplifts for non pay inflation.

Resident doctors commenced industrial action in April, following the BMA's rejection of an offer on jobs and pay put forward by the Government. Senior secondary care doctors in England will be balloted for industrial action, simultaneous ballots of consultants and SAS doctors will run from 11th May until 6th July.

The Trust remains in discussion with NHSE regarding funding for bespoke limb salvage prosthesis. The full-year income plan assumes £3.1m of funding, of which £0.3m is included in the Month 1 position and is currently at risk. As other providers are receiving funding for this prosthesis, the Trust considers it has a strong case for funding. In addition, there is also a financial risk associated with the re-negotiation of the Christie SLA from a block to cost based model.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Virtually eliminating corridor care
Presented to:	Board of Directors
On:	17th June 2026
Item purpose:	To provide assurance on the actions being taken to implement the Getting it Right First Time (GIRFT) Corridor Care Improvement Guide (March 2026) to support the virtual elimination of corridor care.
Presented by:	Sarah Brennan, Chief Operating Officer
Prepared by:	Sarah Brennan, Chief Operating Officer
Contact details:	T: 07933 487589 E: sarah.brennan@wwl.nhs.uk

Executive summary

Corridor care has become one of the most significant patient safety, quality and experience challenges facing the NHS. The publication of the Getting it Right First Time (GIRFT) Corridor Care Improvement Guide (March 2026) strengthens the national expectation that organisations should work towards the virtual elimination of corridor care through improvements in patient flow, admission avoidance, discharge optimisation, operational resilience and whole-system working. At Wrightington, Wigan

A comprehensive assessment has been undertaken against the GIRFT framework. The assessment demonstrates that many of the core capabilities required to support the virtual elimination of corridor care are already established or there planned actions. There is evidence of adherence to the required standards in a number of domains which include executive leadership, operational site management, initial assessment and streaming, Fit to Sit, Same Day Emergency Care (SDEC), Urgent Community Response (UCR), Virtual Wards, Clinical Operational Standards and escalation governance.

The assessment also identifies several important areas for further development. These include an integrated Single Point of Access (SPoA), frailty pathways, acute receiving area models, hot clinic provision, criteria-led discharge, length of stay management, specialty response standards and corridor care reporting and assurance. These areas are recognised nationally as key enablers of sustainable patient flow.

The Board is asked to receive assurance that a comprehensive assessment has been completed and that there are plans in place to review and address areas which have been identified as needing further action and implementation.

Link to strategy and corporate objectives

CO1 - To improve the quality of care for our patients and residents.

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CO2 - To ensure residents and patients have the best possible experience of care.
CO3 - To promote early detection and intervention, preventing avoidable ill-health.
CO4 - To make WWL a great place to work and ensure staff feel valued.
CO5 - To foster a sustainable, efficient and productive financial environment.
CO6 - To drive improvements in overall performance, placing patients at the centre of everything we do.
CO7 - To optimise delivery of elective and non-elective services.

The programme also aligns with BetterLives, Clinical Operational Standards, Patient Safety Improvement priorities and wider system transformation programmes focused on reducing avoidable admission, improving flow and supporting care closer to home.

Risks associated with this report and proposed mitigations

The principal risks relate to patient safety, patient experience, workforce wellbeing, operational resilience, regulatory scrutiny and organisational reputation. The assessment identifies particular risk in those domains where further maturity is required, including frailty, integrated access arrangements, hot clinics, criteria-led discharge, specialty responsiveness and corridor care assurance reporting.

Mitigations include the structured improvement programme, executive ownership, defined delivery leads, target completion dates, oversight through relevant Board committees and six-monthly assurance reporting to Trust Board.

Financial implications

There are no immediate financial implications arising directly from this assurance report. Some actions, particularly those relating to extended frailty provision, seven-day consultant-led models, hot clinics and enhanced discharge arrangements, may have workforce and financial implications. These will be assessed through the relevant governance and business planning routes before implementation.

Legal implications

No specific legal implications are identified from this report. The programme supports the Trust's statutory and regulatory responsibilities to provide safe, effective, timely and dignified care, and supports mitigation of risks associated with care delivered in non-standard environments.

People implications

The programme has significant people implications. Reducing reliance on corridor care supports staff wellbeing by reducing moral injury and operational stress. The assessment also identifies the need to further strengthen executive visibility, staff engagement and learning from operational pressure.

Equality, diversity and inclusion implications

The programme is expected to have a positive equality impact by improving access to timely, safe and dignified care for patients who may be disproportionately affected by overcrowding, including older people, people living with frailty, people with cognitive impairment and patients requiring additional privacy, support or observation. Further equality impact assessment should be undertaken as individual pathway changes are implemented.

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

N/A

Recommendation(s)

The Board is asked to:

1. Receive assurance on the findings of the assessment against the GIRFT Corridor Care Improvement Guide (March 2026).
2. Note the domains where the assessment demonstrates alignment with national expectations and the domains requiring further development.
3. Endorse the improvement priorities and governance arrangements to support the virtual elimination of corridor care.
4. Receive a further six-monthly assurance update to Trust Board.

1. Background and national context

The GIRFT Corridor Care Improvement Guide (March 2026) represents a clear national statement that corridor care should not be normalised. It sets an expectation that organisations should work towards the virtual elimination of corridor care through sustained improvements in patient flow, admission avoidance, urgent and emergency care pathways, inpatient processes and system collaboration.

The guidance reinforces that corridor care is not solely an Emergency Department issue. It is the visible consequence of flow constraints across the wider system, including delays in discharge, limited alternatives to admission, variation in specialty response, insufficient direct access routes and community capacity constraints.

The purpose of the assessment is therefore not only to describe the position in relation to corridor care, but to demonstrate how the organisation understands the wider flow, quality and patient safety factors that must be addressed to reduce and ultimately virtually eliminate reliance on non-standard care environments.

2. Assessment approach

A comprehensive assessment has been undertaken against the GIRFT Corridor Care Improvement Guide. The assessment reviewed the key domains described in the guidance and mapped current arrangements, executive ownership, delivery leads, target dates and committee oversight.

The assessment has been used to identify areas of established maturity, areas in development and areas requiring greater focus. This provides a structured framework for improvement and enables the Board to receive assurance that the response is being considered across the full patient pathway, rather than through an Emergency Department lens alone.

3. Organisational maturity against the GIRFT framework

The assessment demonstrates that the organisation is operating from a position of relative maturity against many of the core components of the GIRFT framework. Strong alignment is evident within operational management, urgent and emergency care processes, Fit to Sit, Same Day Emergency Care, Urgent Community Response, Virtual Wards, Clinical Operational Standards and site management.

The assessment also identifies a number of developing domains which are recognised nationally as critical enablers of sustainable patient flow. These include frailty, integrated access arrangements, direct admission pathways, hot clinics, criteria-led discharge, length of stay management, specialty response standards and corridor care reporting.

Domain	Assessment	Board-level summary
Executive leadership and oversight	Established	Executive accountability and escalation awareness are clear, with intolerance of corridor care and handover delays recognised.
Operational site management	Established	Experienced site management, flow dashboards, OPEL-aligned flow meetings and senior presence during escalation are in place.
Initial assessment and streaming	Established / developing	Initial assessment processes are in place; streaming policy, criteria-to-admit audit and UTC staffing model are under review.
Fit to Sit	Established	SOP, adequate seated areas, daily decision-making and discharge lounge transfer processes are in place.
Same Day Emergency Care	Established / developing	Core SDEC arrangements are in place; further review of 12-hour, seven-day operation and access routes is required.
Urgent Community Response	Established / developing	Access arrangements are in place; further work is required on missed opportunities, record access and ambulance stack visibility.
Virtual Wards	Established / developing	Virtual wards are operational; further work is required on step-up access, diagnostics and directory visibility.
Frailty	Developing	Capacity, frailty advisory service, acute frailty hours and system pathways require further development.
Hot clinics / urgent specialty opinion	Requires implementation	Hot clinic provision and specialty demand/capacity review require implementation.
Discharge optimisation	Developing	Board/ward round processes are being rolled out; criteria-led discharge and twice-weekly LOS reviews require further implementation.

4. Areas of good practice

The assessment demonstrates strong alignment in several areas that are central to the GIRFT guidance.

- Fit to Sit arrangements are well established, including the SOP, seated areas, daily decisions for bedded patients and discharge lounge transfer processes.

- Operational site management arrangements are mature, including 24/7 site management, access to flow dashboards, action-focused flow meetings and senior clinical and executive involvement during escalation.

- SDEC and UCR services provide important alternatives to admission and are already embedded within the urgent care model, although further optimisation is required.

- Virtual wards are operational and provide an important mechanism for admission avoidance and supported discharge, with further work required to strengthen step-up access and diagnostic support.

- Clinical Operational Standards have been reviewed against GIRFT standards and provide a strong foundation for consistent clinical decision-making and specialty escalation.

- The existing governance framework provides a basis for ongoing assurance, with actions assigned to executive owners, delivery leads, target dates and committee oversight.

5. Areas requiring further development

The assessment identifies a clear set of priorities where further work is required to strengthen the approach to virtually eliminating corridor care.

5.1 Integrated Single Point of Access

A fully integrated SPoA is not yet in place. This is a significant opportunity because a mature SPoA can support earlier clinical decision-making, simplify access to alternatives to admission and improve the visibility of capacity across health and social care. The improvement plan identifies this as a BetterLives priority, with further work required on shared care records, direct booking and visibility of ambulance demand.

5.2 Frailty

Frailty is a priority domain. The assessment identifies that frailty advice is currently more informal than formalised, that acute frailty hours require review and that care home, falls, long lie and advance care planning pathways require further development with system partners. Strengthening frailty is likely to be one of the highest-impact actions for reducing avoidable admissions and improving flow.

5.3 Acute receiving areas and specialty responsiveness

Acute receiving areas require further development, particularly in relation to the 48-72 hour model, direct receipt of patients without defaulting to ED, specialty response standards and consultant-led review models. These actions are central to reducing crowding, improving flow from the front door and ensuring that patients are managed in the most appropriate clinical environment.

5.4 Discharge optimisation and length of stay

Discharge optimisation remains one of the highest-impact opportunities. The assessment identifies further work to embed daily board and ward round processes, post-round huddles, criteria-led discharge, twice-weekly length of stay reviews and specialty demand and capacity review. Improving discharge reliability will be fundamental to reducing reliance on escalation arrangements.

5.5 Hot clinics and urgent specialty opinion

Hot clinic provision is a material development area. The assessment identifies a need to implement hot clinics, retrospectively review inpatient referrals suitable for outpatient management and undertake demand and capacity reviews by specialty. This will support both admission avoidance and earlier discharge.

7. Risks and mitigations

The assessment identifies a number of risks if the developing domains are not progressed at pace. These risks are not limited to corridor care itself; they relate to patient safety, flow, staff wellbeing, operational resilience and regulatory confidence.

8. Governance and assurance

It is proposed that the improvement work required will be monitored through established governance arrangements. This ensures that actions are overseen through the groups / committees with the appropriate remit.

- Operational delivery will be monitored through the ***BetterLives Delivery Group***
- ***Quality and Safety Committee*** will oversee patient safety, frailty, Clinical Operational Standards and discharge-related actions.

- ***Finance and Performance Committee*** will oversee patient flow, SPoA, SDEC, acute receiving areas, UCR, virtual ward optimisation and hot clinic actions.

- ***People Committee*** will oversee workforce, engagement and executive visibility actions.

- ***Executive Management Team*** will maintain executive oversight of overall delivery and alignment with organisational priorities.

- ***The Board of Directors*** will receive six-monthly assurance reports outlining progress, risks and further actions required.

Agenda item: [14]

Title of report:	Freedom to Speak Up Reflection Tool Report 2026/27
Presented to:	Board of Directors
On:	17th June 2026
Item purpose:	Information/Assurance
Presented by:	Chief People Officer
Prepared by:	Associate Director of OD and Inclusion, Head of Staff Experience
Contact details:	Angelique.hartwig@wwl.nhs.uk

Executive summary

The purpose of this paper is to summarise themes from the Freedom to Speak Up (FTSU) reflection tool. The paper also highlights a current risk regarding the sustainability of the FTSU service model, with interim arrangements in place. The report outlines the work underway to procure a permanent solution, with this risk reflected on the Corporate Risk Register and subject to Executive oversight.

The Freedom to Speak Up reflection tool is designed to help organisations identify strengths in the leadership team and organisation – and any gaps that need work. The reflections were triangulated with National Staff Survey data and FTSU activity in the past quarter Q4 2025/26 to inform a high-level FTSU improvement action plan.

Members of the Executive Team and the Non-Executive colleague with responsibility for FTSU were asked to complete the reflection tool independently. Respondents assessed statements across six speaking-up principles, with the majority rated as generally well applied, although areas for improvement and some gaps were identified.

Following the reflection tool assessment, the Executive Team has agreed a high-level improvement plan to strengthen the effectiveness, visibility and impact of the Freedom to Speak Up (FTSU) service. This focuses on ensuring a resilient and well-resourced provision, building confidence and capability for local resolution, improving intelligence and learning from concerns, and addressing barriers such as fear of detriment and anonymity. The plan also strengthens governance and aligns FTSU improvements with the Trust's wider People and Culture Strategy.

People Committee has reviewed and endorsed the high-level improvement plan. Detailed actions will be finalised with the new FTSU provider and progress regularly reported through People Committee to the Board.

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Link to strategy and corporate objectives

WWL People and Culture Strategy

Risks associated with this report and proposed mitigations

Risk: That the actions identified in the reflection tool are not implemented, and a FTSU culture does not become fully embedded in the organisation
Impact: Potential reduced staff confidence in speaking up, reduced wellbeing, morale, engagement and productivity, leading to an impact on the quality and safety of the services we provide to patients.
Mitigation: ETM/People Committee oversight of progress made in implementing agreed actions. Evaluation of Quarterly Pulse Survey Responses to FTSU questions

Risk: The absence of a substantive FTSU service model, with reliance on interim arrangements
Impact: Potential reduced staff confidence, non-compliance with NHS expectations, and reduced independence/resilience
Mitigation: Interim MFT provision, internal oversight, formal procurement process underway, Corporate Risk Register entry and ETM oversight

Financial implications

Financial implications in terms of increased turnover, lack of productivity due to reduced morale and engagement, increased absence rates, should a speaking up culture not be fully embedded.

Legal implications

As an NHS provider Trust, we are required to offer a Freedom to Speak Up Guardian service under the NHS standard contract. It is important that the service maintains independence, provides a safe speaking up route for staff at the organisation. The reflection tool will support our aim to continuously improve our FTSU service provision and remain compliant with the FTSU requirements.

People implications

The Freedom to Speak Up Guardian service is one of the fundamental mechanisms of supporting a speaking up culture – it allows staff to safely raise concerns and protect them in doing so. Speaking up cultures are linked with positive outcomes for staff experience and patient safety as it allows staff to share what is not working well and for leaders to build trust by taking actions that encourage learning and improvements.

Equality, diversity and inclusion implications

We must ensure that our FTSU offer supports all staff to feel safe to speak up regardless of protected characteristic, and to take action should quantitative and qualitative data indicate that staff with particular protected characteristics do not feel able to speak up.

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

ETM and People Committee have reviewed the reflective tool/actions and endorsed the proposed high level improvement plan to strengthen our FTSU speaking up provision and culture. ETM and People Committee are also sighted on the current risk in relation our lack of substantive Freedom to Speak Up Service and the plans underway to commission a new provider.

Recommendation(s)

The Board of Directors is asked to note the content of the report and the proposed high level FTSU improvement plan, previously endorsed by ETM and People Committee.

The Board of Directors is also asked to note the current interim FTSU arrangements in place, the risk that not having a substantive solution in place creates, and the process being undertaken to identify a new provider.

Future progress reports will be brought to People Committee and the Board for assurance.

FTSU Reflection Tool

Summary of the reflection tool and responses from the exec team

The Freedom to Speak up reflection and planning tool was launched in June 2022 and requires the senior lead for FTSU in the organisation to take responsibility for completing this reflection tool, at least every 2 years.

The improvement tool is designed to help organisations identify strengths in the leadership team and organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Methodology

To ensure a robust and informed process, the Interim CPO sent the FTSU reflection tool to each executive member of the board and the Non-Executive Director with a responsibility for FTSU for completion and scoring on an independent basis. The reason for this is that each executive member will have a different relationship with the FTSU process, and it was important that collective thoughts, experiences and feedback were considered when developing the areas of focus. Overall, 6 responses were received. The collective scoring and comments can be found in the accompanying reflection tool document and are summarised below. This will then be developed to be taken forward as the FTSU action plan for 26/27 with the new FTSU provider once formally agreed via People Committee and Board.

Summary of reflection tool themes and actions

The reflection tool is divided sections of statements of reflection under six principles of Freedom to Speak Up arrangements. Please find a summary of the respondents' ratings and suggested actions below.

1. ***Role-model speaking up and set a healthy freedom to speak up culture***

   Average rating of 3.5/5, indicating that the principle is an evidenced strength (e.g., through data, feedback) and a strength to build on

   This section asks to reflect to what extend leaders understand and promote FTSU, role model speaking up behaviours and support guardians to embed a speaking up culture. The leadership team has sought to enhance FTSU model over the last few years to ensure staff feel confident to confidentially raise concerns and that these are listened to. Over the past 2 years, the FTSU service was extensively promoted across the organisations, using all available communication channels and senior leadership forums. However, the respondents reflected that the FTSU service requires appropriate resource and time to sustain culture change and that FTSU reports would benefit from being discussed at senior leadership and board meetings to ensure organisational learning and triangulation with other staff feedback (e.g., National Staff Survey).

2. ***Make sure workers know how to speak up and feel safe and encouraged to do so***

   Average rating of 3.3/5, indicating that the principle is generally applied well but there are areas of improvement or gaps

   This section invites respondents to reflect on the effectiveness of communications to advertise FTSU offer to staff. There was recognition for the FTSU champion network which helped to promote the FTSU service, and the respondents had confidence that all available communications channels have been used to ensure staff are aware of the offer. However, there is limited evidence for positive speaking up stories which resulted in change through staff engagement and addressing concerns raised. Future actions should include promoting all routes of speaking up to widen awareness and focus on sharing FTSU stories about ongoing improvements which will encourage more staff to speak up.

3. **When someone speaks up, thank them, listen and follow up**
   Average rating of 3.3/5, indicating that the principle is generally applied well but there are areas of improvement or gaps

   This section invites respondents to indicate to what extent managers and leaders receive support and training to understand the value of speaking up and how they can learn and lead on improvements in response to raised concerns. The FTSU e-learning is assigned to be completed by all staff and regular compliance reports are available to monitor uptake, however it is unclear how the learning is transferred to actions to promote speaking up. Respondents were concerned about the large number of anonymous FTSU cases which indicates that staff may not feel confident raising concerns with their managers. Future actions will include a review of how FTSU training is reported and how learning transfer can be assessed. Further work needs to be undertaken to understand reasons for reporting to FTSU above other routes of resolution and how confidence in leadership can be strengthened.

4. **Use speaking up as an opportunity to learn and improve**
   Average rating of 3.2/5, indicating that the principle is generally applied well but there are areas of improvement or gaps

   This section invites reflections about mechanisms for triangulating data to inform overall improvement programmes, using processes to respond promptly to concerns whilst maintaining confidentiality. The respondents indicated good oversight of FTSU concerns, however there is scope to strengthen data triangulation with grievances, patient experience and safety data in formal reporting.

5. **Identify and tackle barriers to speaking up**
   Average rating of 2.7/5, indicating that the principle is generally applied well but there are areas of improvement or gaps

   This section considers reflections on how we identify and reduce barriers to speaking up. The respondents felt that there is no reporting currently on barriers in the reporting process and that the Trust has high number of anonymously reported concerns. Future work should focus on understanding why staff do not feel safe to disclose their names to the guardian and what other barriers exist in the reporting practice.

6. **Continually improve our speaking up culture**
   Average rating of 3/5, indicating that the principle is generally applied well but there are areas of improvement or gaps

   This section asks respondents to reflect on how the FTSU plan fits into the overall cultural improvement strategy and ensuring that there are comprehensive routes for speaking up available, beyond FTSU. The respondents were mixed in their views of this principle, and it may require more work to develop a comprehensive FTSU culture improvement plan and ensure that the FTSU plan aligns with the cultural improvement strategy.

Triangulation with National Staff Survey feedback and Speak Up activity:

The reflections from Executive Team members and Non-Executive Director responsible for FTSU are broadly consistent with the National Staff Survey 2025 results. These indicate a decline in staff confidence that the organisation will act on concerns and respond effectively to errors, near misses and incidents. Scores relating to feeling safe to speak up have continued a slight downward trend and remain below the sector average.

In contrast, Freedom to Speak Up (FTSU) activity has continued to increase over the past year, providing reassurance that staff are increasingly confident in using the FTSU service as a safe route

for raising concerns. This is further supported by the establishment of 35 FTSU champions across the organisation, improving local visibility, access and signposting to the Guardian service. Many cases still require escalation to senior leadership teams or HR and staff side involvement, suggesting a lack of confidence in local, informal resolution routes which was highlighted in the reflections above.

In line with findings from the reflection tool, anonymous speaking-up rates remain above 25% (Q4 2025/26), although this represents an improvement from 46% in Q3 2025/26. This positive trend warrants further exploration to better understand and address the remaining barriers to reporting openly.

In the most recent quarter (Q4 2025/2026), Speak Up concerns were predominantly centred on leadership and management behaviours, staff wellbeing, and the misapplication of policies, particularly in the context of sickness absence and return to work. Recurring themes of incivility, lack of support, and perceived unfair treatment highlight ongoing risks to psychological safety, staff retention, and equality compliance. While support and escalation routes are being utilised appropriately, the volume and nature of cases indicate a need for strengthened people-management capability, earlier intervention, and a more consistent, compassionate approach across divisions. Any improvement plan should focus on strengthening trust in speaking-up mechanisms, while also proactively addressing recurring themes that signal underlying cultural issues across the organisation.

High level FTSU improvement action plan:
Following the assessment using the reflection tool, the Executive Team formulated the following high level action plan to continuously improve the FTSU guardian provision:

- **Ensure a resilient and effective FTSU service**: Confirm the FTSU service is appropriately resourced, including protected guardian capacity, with resourcing reviewed in line with the new service model and demand.
- **Enhance engagement, visibility and communication:** Promote the refreshed FTSU service, expand champion coverage, clarify multiple routes for speaking up, and share themed learning and improvement stories to reinforce positive cultural change.
- **Build confidence, capability and local resolution**: Support managers through targeted training and development to respond to concerns early and effectively, reducing escalation where local resolution is appropriate.
- **Improve intelligence and learning**: Enhance triangulation of Freedom to Speak Up (FTSU), grievances, patient experience and staff survey data within formal reporting, enabling clearer identification of themes, barriers, and targeted organisational learning.
- **Address barriers, detriment and anonymity:** Deepen understanding of why staff raise concerns anonymously or via the Guardian, using insight to tackle barriers, reduce fear of detriment, and strengthen a consistent “speak up, listen up, follow up” culture.
- **Strengthen governance and oversight:** Review and refresh leadership forums in which FTSU is considered, ensuring appropriate visibility and collective ownership across the Board, People Committee, and Wider Leadership Team.
- **Align improvement with wider culture strategy:** Develop a comprehensive FTSU culture improvement plan with the new provider, fully aligned to the Trust’s overarching People and Culture Strategy, with clear assurance reporting to the Board.

Changes to the National Guardian’s Office (NGO)
From 1st July 2026, NHS England will assume responsibility for some activities previously undertaken by the National Guardian’s Office, meaning that Trusts will be required to take on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

NHS England will:

- support existing guardian networks and individual guardians, including managing general enquiries through the national contact centre and escalating specialist queries to the NHS England Freedom to Speak Up team
- provide and maintain the platform for free online guardian foundation training
- collect Freedom to Speak Up data nationally and use both qualitative and quantitative insights to strengthen system learning. Insight will be shared routinely with guardian networks
- review national Freedom to Speak Up policy and guidance across all sectors, starting with primary care organisations

NHS healthcare providers and commissioners will:

- have sole responsibility for ensuring that information about how to contact their Freedom to Speak Up guardian is kept accurate, made publicly available and is accessible
- routinely submit Freedom to Speak Up data through NHS England's national data collection system (for 2026/27, this will be trusts and ICBs only)
- ensure that any guardian appointed completes the mandatory guardian foundation training before starting their role and support their continuing professional development
- ensure appropriate psychological support is available for guardians once the nationally sourced independent Employee Assistance Programme ends on 31 December 2026

WWL Freedom to Speak Up Service

Our FTSU service was previously provided by GM ICB, which ended in March 2026. An interim arrangement is currently in place with MFT, supported by internal oversight from the Associate Director of OD & Inclusion and Associate Director of People Advisory Services to maintain continuity of provision.

While this ensures a service remains available, the current model is not sustainable and presents a number of risks, including:

- reliance on an interim external provider without long-term contractual certainty
- potential limitations in organisational knowledge and relationship-building with staff
- capacity and resilience pressures across a shared service arrangement
- potential impact on staff confidence in speaking up, particularly given the external and interim nature of the provision

A corporate risk has been developed to reflect the absence of a substantive, sustainable FTSU model.

Work is underway to procure a permanent solution. Discussions have progressed with Bolton NHS FT, alongside benchmarking with MFT and an independent provider to assess service quality, independence, capacity and value for money. A safe procurement process is being undertaken, with evaluation criteria and governance aligned to Trust procurement requirements.

A potential implementation date of July 2026, this remains subject to completion of procurement, agreement of costs, and contractual arrangements. The Trust will prioritise securing a robust, compliant and sustainable model over pace.

In the interim, arrangements with MFT will continue, with oversight and contingency planning in place to maintain service continuity until a substantive provider is appointed and mobilised.

In terms of the actions identified in the FTSU Reflection Tool, we will ensure detailed actions and a timeline for improvement is agreed with the new Freedom to Speak Up provider, along with ensuring the changes following the closure of National Guardian's Office are adhered to.

Recommendations

The Board of Directors is asked to note the content of the report and proposed high level improvement plan to strengthen our FTSU speaking up provision and culture, previously endorsed by ETM and People Committee.

The Board of Directors is also asked to note the current interim FTSU arrangements in place, the risk that not having a substantive solution in place creates, and the process being undertaken to identify a new provider.

Future progress reports will be brought to People Committee and the Board for assurance.

Agenda item: [15.1]

Title of report:	Perinatal Quality Oversight Report (Q4 2025-2026, Jan-Mar 2026)
Presented to:	Trust Board
On:	17 June 2026
Purpose	Information, Oversight and Assurance
Presented by:	Kevin Parker-Evans Chief Nursing Officer
Prepared by:	Eve Broadhurst Head of Governance Maternity and Child Health
Contact details:	T: 01942 822993 E: eve.broadhurst@wwl.nhs.uk

Executive Summary – Maternity and Neonatal Services Quarter 4 (Q4)

Reporting Overview

Incident reporting trends in Q4 were stable, with no significant change in overall reporting volume.

Moderate and Above Harm Incidents (Outcome-Based)

Maternity / Obstetrics

- Five incidents classified as moderate harm or above were reported in Q4.
- One incident was logged on StEIS in Q4 for monitoring purposes (maternal peripartum cardiomyopathy).
- One case met criteria for MNSI referral and is awaiting triage outcome.
- Statutory Duty of Candour has been served in all applicable cases.
- No recurring themes indicative of systemic care failure have been identified.

Neonatology

- One incident classified as moderate harm or above was reported in Q4.
- The level of harm subsequently progressed, with the baby sadly dying in April 2026.
- The case is eligible for joint PMRT review with the tertiary centre and will be considered for concurrent PSII at LfPSE.
- Statutory Duty of Candour has been served.

Antenatal and Newborn Screening

- One antenatal and newborn screening incident required completion of a Screening Incident Assessment Form which was supported by Specialist Services (laboratory error).
- Maternity fail-safes have been strengthened, and recommendations are underway.

PSIRF Activity

In alignment with the Patient Safety Incident Response Framework (PSIRF), learning from incidents continues to inform targeted quality improvement priorities. Active workstreams include:

- Term admissions to the Neonatal Unit
- Postpartum haemorrhage (>1500mls)
- Obstetric anal sphincter injury (OASI)
- Local Safety Standards for Invasive Procedures (LocSSIP)
- Impacted fetal head.

In Q4 six Patient Safety Investigations were finalised and the learning is documented in the report.

At the end of Q4, seven investigations are open and being progressed through governance processes..

Legal and Regulatory

No Regulation 28 notices were issued in Q4.

One new maternity claim was received relating to a medication administration error.

Patient Experience

Triangulated feedback from multiple sources (Patient and Public Engagement Midwife, MNVP, FFT, Complaints and Birth Thoughts sessions) demonstrates consistently strong confidence in staff care and compassion, alongside recurring system vulnerabilities relating to communication, continuity and postnatal follow-up, particularly for women experiencing emergency or complex care pathways.

Workforce, Culture and Staffing

Staff Culture

SCORE survey findings highlighted themes around burnout, communication and team working. Culture coaches were trained and listening events delivered. The maternity and neonatal MDT are now ten trained Culture Coaches strong and engagement sessions commence June 2026.

Safe Staffing

- 99 validated maternity staffing red flag events were recorded in Q4.
- The increase compared to Q3 reflects improved identification and reporting, not increased harm.
- No harm has been reported in association with these events.
- Current data reflects Delivery Suite activity only, which may under-represent ward pressures.

Mitigations focus on strengthened reporting consistency, leadership oversight, vacancy management and workforce planning.

Assurance Updates

- MIS Year 7: Full compliance confirmed.
- MIS Year 8: Preparations underway.
- Picker survey results (2025) show an improvement in National ranking from 55th in 2024 to 28th in 2025, indicating sustained improvement in relative performance despite a lower response rate.
- Ockenden: One outstanding action remains; workforce succession planning is progressing.
- Consultant attendance: Compliance maintained at 82%; 2 cases where no documented evidence of Consultant attending for PPH >2 litres.

- Three Year Plan – three outstanding actions remain and are on track.
- No maternity diverts occurred in Q4.
- No Maternity Outcomes Signals were received in Q4.
- SPC charts show continued improvement for KPIs.
- A rise in mortalities was noted in Q4; however, this was associated with unavoidable clinical complexity, including medical terminations of pregnancy (MTOP).
- Training compliance has been significantly affected by anaesthetist new starters and resident doctor industrial action. The training team are working to schedule all staff on training.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations
The risk associated with release of staff for training and education

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

Legal implications
Supports compliance with National recommendations and standards for Perinatal care.

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

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

Which other groups have reviewed this report prior to its submission to the committee/board?
None at present

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

Perinatal Quality Oversight Report

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

1.0 Obstetrics/Maternity Patient Safety Events reported in Q4 (data pull 21/04/2026 - DATIX)

Q4	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
No Harm	38	36	35	55	56	76	68	56	57	54	42	57
Low	12	8	7	6	9	9	8	4	6	5	1	6
Moderate	1	0	1	1	1	1	1	0	2	2	0	5
Severe	0	0	0	1	0	0	0	0	0	1	0	0
Death	0	0	0	0	1	0	0	2*	2*	0	0	3*
Total	**51**	**44**	**43**	**63**	**67**	**86**	**77**	**62**	**67**	**62**	**43**	**67**

*death not as a result of incident

Reporting Trends:
Incident reporting trends in Q4 are stable.

Moderate and Above Harm Incidents:
There were **five** incidents classified as moderate harm or above (outcome-based) in maternity/obstetrics during Q4:

- **One incident involved transfer to ICU** following peripartum deterioration and diagnosis of acute peripartum cardiomyopathy. The case occurred in the context of significant clinical complexity and remains under review via PSII.

- **Two incidents related to third-degree perineal trauma** and were managed in line with established OASI pathways. In one case, documentation relating to postnatal analgesia and discharge medication (TTOs) was not available at the time of review, highlighting an opportunity to strengthen documentation consistency. Closed.

- **Two incidents involved neonatal therapeutic cooling**. The cases are under review, with themes relating to consistency of intermittent fetal monitoring, environmental factors (including home birth risk assessment and a bed awaiting repair), and impacted fetal head management, which is a focus within MIS Year 8, with MDT training commencing in September; one case has been referred to MNSI and is awaiting triage outcome.

- No recurring themes indicative of systemic care failure have been identified.

- Statutory Duty of Candour served in 3 cases. A new Duty of Candour template letter for 3rd and 4th degree tears is being drafted by the Perineal Health Midwife.

1.1 Neonatal Patient Safety Events reported in Q4 (data pull 21/04/2026 – DATIX)

Q4	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
No Harm	10	2	15	9	9	11	10	22	17	18	8	6
Low	0	3	1	2	2	0	0	0	1	2	1	1
Moderate	0	0	0	0	0	0	0	1	0	0	0	0
Severe	0	0	0	0	0	0	0	0	0	0	0	1*
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**10**	**5**	**16**	**11**	**11**	**11**	**10**	**23**	**18**	**20**	**9**	**8**

Moderate and Above Harm Incidents:

There was one incident classified as moderate harm or above (outcome-based) in neonatology during Q4:

- The incident related to the **transfer of a pre-term infant to another unit for a higher level of care.**

  The baby was born at 32 weeks' gestation by emergency caesarean section, which was uncomplicated, in the context of maternal pre-eclampsia, small for gestational age, and CTG concerns. The infant was born in good condition; however, a depressed skull fracture was noted on the Resuscitaire. The baby subsequently deteriorated on the neonatal unit following less invasive surfactant administration (LISA), necessitating transfer for escalation of care.

The level of harm associated with this incident subsequently progressed, and the baby sadly died in April 2026. Reviews are ongoing through established governance processes to ensure appropriate learning and oversight. Eligible for joint PMRT with tertiary. To discuss concurrent PSII at LfPSE.

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Incidents reported to 'StEIS' via LfPSE	0	1	0	0	1	1	0	0	0	0	1	0
MNSI referrals	0	0	1	0	0	0	0	0	0	0	0	1
Accepted MNSI referrals	0	0	0	0	0	0	0	0	0	0	0	0*
Cases referred to NHSR	0	0	0	0	0	0	0	0	0	0	0	0
SIAFs (Antenatal and newborn screening)	0	0	1	0	0	2	3	1	0	0	0	1

Statutory Duty of Candour served.

1.2 Incidents reported to 'StEIS' and external agencies Q4 25/26

* Await MNSI triage

One safety incidents was logged on StEIS for monitoring purposes during Q4 (Maternal peri-partum cardiomyopathy).

One Antenatal and Newborn Incident Assessment form completed in Q4 – partner haemoglobinopathy screening taken and sent to lab. Not taken – human error. Not picked up on maternity fail-safe – strengthened. Recommendations underway. Response to NHS England due on 30/4/2026.

No exceptions

1.5 MNSI overview

HSIB/MNSI cases to date	
Total Referrals	28
Referral / cases rejected	14
Total investigations to date	13
Total investigations completed	13
Current active cases	1
Exception reporting	0

In Q4 one case of a cooled baby at term met the MNSI referral criteria. Awaiting outcome of MNSI triage process.

1.6 MNSI /NHSR assurance - Maternity Incentive Scheme.

Advise, Resolve, Learn – MNSI / NHSR

MIS Year 8 reporting period 1.12.2025 - 30.11.2026

MNSI REF	Criteria	Date of incident	SPEN Notification	MNSI /NHSR Duty of Candour complete	Accepted / Rejected by MNSI	Details to legal for NHSR referral	NHSR REF
MI-056302	Cooled baby	31/03/2026	Yes	Yes	Awaiting response		

All cases meeting the MNSI criteria are notified via SPEN and referred via HIMS secure portal

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

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

1.7 PSIRF activity

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

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

- Impacted Fetal Head

In Q4, six Patient Safety Responses were finalised and the learning is documented in the table.

WEB number	Date	Incident	Investigation tool/s	Learning
WEB189093	July 25 Reported Oct 25	Antenatal and newborn Screening – missed haemoglobinopathy screen	SIAF	Gap in fail-safe. Antenatal and Newborn Screening fail-safes strengthened to identify when no result on system.
WEB188319	Sep 25 Reported Oct 25	Antenatal and newborn Screening – FAS	SIAF	Gap in fail-safe. Antenatal and Newborn Screening fail-safes strengthened to flag when women have not had a scan between a certain date range.
WEB189509	Sep 25 Reported Oct 25	Antenatal and newborn Screening – FAS	SIAF	Single point of failure. When Fail-Safe Officer is not available, data bases not consistently checked. Training undertaken by team to ensure consistency in officer's absence.
WEB191802	Dec 25	Readmission within 28 days (surgical complication)	Detailed Rapid review with timeline	Excellent MDT antenatal and intrapartum planning for a complex surgical patient. Postnatal care followed standard caesarean pathways; no documented MDT postnatal plan. Bowel perforation considered related to pregnancy-related adhesions and subsequent postnatal physiological involution of uterus. Opportunity identified to strengthen postnatal monitoring and senior oversight for complex cases through a clear MDT plan
WEB194029	Jan-26	3rd degree tear associated with 2.4 litre loss	OASI audit/themed analysis	Excellent care. OASI discussed antenatally. Manual Perineal Protection (MPP) applied at delivery. Good recognition of postpartum haemorrhage (PPH). Prompt identification that bleeding was traumatic in origin, rather than atonic. Timely escalation and transfer to theatre, supporting haemorrhage control.

				Appropriate use of obstetric early warning tools, including UK Obs. Targeted coagulation assessment undertaken (TEG performed at 1.5 L blood loss). One unit of blood transfused in theatre, reflecting responsive and proportionate management.
WEB194073	Jan-26	3rd degree tear	OASI audit/themed analysis	OASI pathways followed. Postnatal analgesia and discharge medications were not documented in the available records. No evidence that they were given.

At the end of Q4, seven investigations are open.

WEB number	Date	Incident	Progress	Stage	Plan
PSIRF					
WEB183547	Jul-25	Fractured leg – difficult LSCS	RR complete	Addressing family's questions via PALS in investigation.	Complete and arrange meeting.
WEB186268 2025/5281	Aug 25	Neonatal death – Twin 1	Final PMRT held	Finalising report	Arrange meeting with family to share report once finalised.
WEB194066 2026/637	Jan-26	Transfer to ICU – maternal cardiomyopathy	Rapid Review complete	PSII commissioned	Complete PSII
WEB183547 WEB188453 WEB191612 WEB187480	Dec 25	Cluster of birth injuries	Themed analysis commissioned	Draft copy received. Further cases identified – to incorporate.	Governance team supporting investigator
WEB197703	Mar-26	Antenatal and Newborn Screening Incident – partner screening not tested in lab. Not picked up on maternity fail-safe.	SIAF	Investigation complete in conjunction with laboratory	Recommendations for submission to NHS E 30/4/2026
	Mar-26	Neonatal transfer out for higher level of care post LISA	Rapid review with timeline	Final QA	For LfPSE
WEB199381	Mar-26	Therapeutically cooled pre-term baby	Rapid Review	In progress Review needs work	For LfPSE
WEB198062	Mar-26	Therapeutically cooled term baby	Rapid Review with timeline MNSI referral	MNSI triage Presented at LfPSE.	Await MNSI triage. For StEIS

2.0 Regulation 28
There were no Regulation 28s issued in Q4.

2.1 New claims
There was one new claim received for maternity services in Q4.
HS/LT/CN4228 – Medication error – Depo Provera 150mg IM administered to wrong patient.

3.0 Patient Experience
A wealth of feedback has been collated from multiple sources, including the Patient and Public Engagement Midwife, MNVP 'Walk the Patch' visits & Thank you Thursday initiatives, complaints, Friends and Family Test and Birth Thoughts sessions and triangulated below.

Theme	P&PE Midwife	MNVP	FFT	Complaints	Birth Thoughts	Triangulated Insight for Board
Compassionate staff & kindness	Strong, universal praise	Strong and consistent theme	Dominant positive theme	Minority concerns	Noted when absent	Staff compassion is a core strength; isolated lapses have disproportionate impact
Communication – clarity, tone, explanation	Mostly positive; raised by 25%	Recurrent concern	Minor but present	Most common theme	Central driver of trauma	Primary cross-cutting risk across all sources
Emergency & complex birth care	Very positively described	Generally positive	Very positive	Concentrated complaints	Major driver of distress	Clinical care trusted, but emotional safety depends on communication
Trauma-informed care & emotional safety	Strong positive theme	Increasingly highlighted	Not explicit	Evident where absent	Core service focus	Strength in practice; needs consistency across pathways
Instrumental / operative births	Positive experience when supported	Raised indirectly	Not prominent	Present in complaints	Key trauma driver	Known high-risk experience needing structured follow-up
Continuity & care coordination	Noted indirectly	Ongoing concern	Occasional	Clear theme (passed between services)	Impacts confidence	System unreliability undermines good individual care
Postnatal follow-up	Limited commentary	Recurrent concern	Low volume	Self-discharge, early discharge	Drives distress	Consistent system gap after discharge
Infant feeding support	Not prominent	Recurrent concern	Not highlighted	Occasional	Not central	Inconsistent availability rather than quality
Partner inclusion	Strong positive	Strong positive	Positive	Rarely referenced	Supportive when present	Embedded strength with high experiential value

Neonatal care	Strong praise	Strong praise	Very positive	Rare concerns	Amplifies trauma if complex	Neonatal expertise trusted; parental communication key
Professionalism & behaviours	Isolated issues	Occasionally raised	Very minor	Prominent theme	Important in retrospection	Behavioural standards critical during stress
Psychological distress / mental health	Noted when present	Implicit	Not captured	Sometimes evident	Central theme	Post-birth psychological impact requires proactive offer
Future pregnancy planning	Not prominent	Occasionally raised	Not captured	Occasionally implied	Major motivator	Highlights value of debrief and closure

What aligns across all sources:

- Women trust staff competence and compassion
- Communication quality is the single most influential factor in determining experience
- Emergency and complex births are high-risk moments for both trauma and complaints

What differs by feedback type:

- FFT and P&PE Midwife feedback show overwhelmingly positive experience
- MNVP feedback surfaces system and pathway fragility
- Complaints and Birth Thoughts reflect harm when communication, continuity or emotional support fail under pressure

Triangulation demonstrates consistently excellent care delivered by staff, with strong appreciation from service users. However, all feedback routes converge on a small number of recurrent system risks, particularly communication, continuity, and postnatal follow-up, which disproportionately affect women experiencing emergency or complex births. Themes will feed into co-produced action plans.

3.1 Demographic Profile of Patient Feedback Sources

Feedback Source	Volume	Deprivation	Ethnicity	Gender	Age
FFT	155 service users	Not captured by system	Not captured	Not captured	Not captured
P&PE Midwife	24 service users	56% below Decile 3 48% below Decile 2	33% from minority ethnic groups	Not recorded	0–29: 50% 30–39: 42% 40–49: 8%
MNVP	89 service users	Decile 1–2: 23% Decile 3–4: 19% Decile 5–6: 15% Decile 7+: 43%	White British: 61% Asian: 21% Black: 13% Other: 5%	Female: 79% Male: 21%	18–30: 34% 31–60: 66%
Complaints	16 complainants	Decile 1: 8 Decile 2: 1 Decile 3: 1	White British: 13 Unknown: 3 (complainant none-patient)	Female: 15 Male: 1	20–29: 5 30–39: 8

		Decile 6: 2 Decile 7: 2 Decile 8: 1 Decile 9: 1			Unknown: 3
Birth Thoughts	25 attendees	38% below Decile 2 44% below Decile 3	8% from minority ethnic backgrounds	Not recorded	20–29: 35% 30–39: 65%

Taken together, the combined feedback sources offer reasonable assurance that patient experience intelligence reflects a diverse population, with no single dataset relied upon in isolation

3.2 National Picker Maternity Survey

 2025 Picker survey response rate: 35% (103 service users), representing a 4% reduction compared with the 2024 survey.
 Results are reported against both the Picker benchmark average and the Trust's historical performance.
 The Trust achieved an overall positive score when benchmarked against 55 Picker organisations.
 National ranking improved significantly, from 55th in 2024 to 28th in 2025, indicating sustained improvement in relative performance despite a lower response rate.

A 16-action improvement plan has been co-produced with the MNVP and is being progressed with ward, team and matrons' support, with 1 action completed, 9 underway and awaiting evidence, and the remaining 6 scheduled for agreement with outpatient teams in early May.

3.3 Staff Culture work

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

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

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

Q4 Update: Ten staff across maternity and neonatology have undertaken MOMENTS training. The first of six new staff engagement sessions will commence in June 26.

4.0 Triangulating data – Claims, Incidents, Complaints

Triangulated intelligence from complaints, incidents and claims points to consistent system pressure around recognition of deterioration, monitoring reliability, and communication in complex cases. No maternity outcome signals are identified, and improvement activity is aligned to these known risk areas.

System Theme	Aligned Evidence
Recognition of deterioration	Complaints (symptoms not acted on), Incidents (PMRT, cardiomyopathy), Claims (delay/failure to treat)
Monitoring consistency	Complaints (concerns not responded to), Incidents (IA variability), Claims (failure to monitor)
Complex care coordination	Complaints (complex history, diabetes), Incidents (MDT cases), Claims (inappropriate treatment)
Escalation and flow	Complaints (passed between services), Incidents (ICU & neonatal transfer), Claims (delay admitting)
Communication & relational care	Complaints (dismissive, poor explanation), Claims (psychological harm)

5.0 Risk register – High Scoring Risks in Maternity and Neonatal services

e Risk Register	Significant (15+)	High (8-12)	Moderate (4-6)	Low Risk (1-3)
	2	11	5	0

Approved	MAT	3772	Euroking System Error	16
	MAT	4267	Delay in Prescribing Antenatal Prescriptions	15
	MAT	4274	Theatre List Availability does not cover demand for Caesarean Sections	12
	MAT	4170	Lack of End-to-End Maternity Patient Record	12
	MAT	3802	Obstetrics/Gynaecology Tier 2 Staffing Shortages	12
	MAT	3732	Entonox Risk	12
	MAT	3362	Midwifery Staffing Shortages	12
	MAT	3669	Potential Inability to undertake more than 1 Emergency Delivery at a time due to number of theatres available	12
	NEO	1977	Specialist AHP services should be available in all units for neurodevelopment and family integrated care	12

At the end of Q4 25/26,
0 risks under review or awaiting approval.
0 risks approved.
2 risks **closed:**
3400: Screening for GBS at 36 Weeks Gestation
Current local guidance follows NICE guidance and does offer women with previous GBS testing between 35-37 weeks.
4181: Lack of provision to be able provide CPAP / BiPAP to children on Rainbow Ward.
New equipment has been sourced and training has been disseminated to over 90% of staff on the new equipment.
Horizon scanning – Home Birth Service.
No exceptions

6.0 Ockenden 2 progress update

At the end of Q4 there is 1 outstanding action from the original 96 Ockenden actions.

Exception - 1.10 All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.
In progress: Workforce review (s) with GAP analysis and Band specific development pathways.

7.0 Maternity Incentive Scheme

In Q4 WWL Perinatal services received confirmation of full compliance with MIS Year 7. Preparations are underway for MIS Year 8.

8.0 Delivery of the 3-Year Plan

There are 3 outstanding actions from the total 55. All on track.

9.0 Avoiding Term Admissions into Neonatal Units (ATAIN)

The ATAIN team has revised its case review methodology to work concurrently on current and historic cases, enabling real-time learning and earlier identification of improvement opportunities. Audit findings from this approach will be reported in the next report.

10.0 Mortality Data and Perinatal Mortality Review Tool (PMRT)

onthly data	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Total births	**195**	**209**	**198**	**183**	**205**	**201**	**217**	**205**	**204**	**210**	**178**	**186**
Total Stillbirths ≥ 24 weeks	**3**	**0**	**4**	**0**	**0**	**1**	**1**	**2**	**0**	**0**	**0**	**3**
Stillbirths (excluding MTOP)	3	0	3	0	0	1	1	2	0	0	0	1
Total late fetal loss 22 – 23+6	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**
Total Neonatal Deaths (≥ 20 weeks)	**0**	**1**	**1**	**0**	**0**	**1**	**1**	**0**	**1**	**0**	**0**	**1**
Early neonatal deaths (0-7 days)	0	1	1	0	0	1	1	0	0	0	0	1
Neonatal deaths (excluding MTOP)	0	0	0	0	0	1	1	0	1	0	0	0
Total Maternal Deaths	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

10.1 Stillbirths

2026	Type Stillbirth	Gest	Ethnicity	Dec	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/service delivery issues	PMRT grading
Mar	Antenatal (Twin 2)	25+1	White British	9	40	20	No	No	0.0	No issues with service delivery.	For PMRT review
Mar	MTOP (Twin 1)	30+5							5.8	No issues with service delivery.	Notification only
Mar	MTOP	29+3	White British	2	37	30	No	No	23.6	No issues with service delivery.	Notification only

Stillbirths Q4: Three stillbirths occurred during the quarter, comprising one twin pregnancy and one singleton pregnancy.

Governance and learning: Expected care review processes are being followed, including PMRT for Twin 2. To date, no learning has been identified from the reviews of these cases.

Themes from Stillbirth Data (3 stillbirths, 2 mothers)

Findings are descriptive due to small numbers.

- Both mothers were recorded as White British.
- Mothers lived in areas of Decile 2 and Decile 9, showing variation rather than clustering.
- One baby had fetal growth below the 10th centile.
- One mother had a BMI ≥30.
- Both mothers were aged over 30 years.

With only two mothers involved, no demographic trends or over-representation can be concluded. Data is reviewed over time.

10.2 Neonatal Deaths

2026	Type of NND	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
March	MTOP	21+6	White British	6	32	20.9	No	No	NA	Incidental: Earlier FAS could have reduced delay to fetal medicine confirmation of prognosis following PPROM.	Notification only

Neonatal deaths Q4: 1 neonatal death following spontaneous rupture of membranes at just 18 weeks. Unavoidable outcome although tighter diagnostic pathways could have improved patient experience. No themes due to low numbers. Data is reviewed over time

10.3 PMRT Case Completion

In Q4, 1 case was finalised at PMRT.

Case 1: Stillbirth at 25+1 Joint review with DGH.

- **Cause of Death**: Placental
- **Care Grading**:
- **Prior to Birth**: Grade **C** – care issues which may have made a difference to the outcome.
- **After Birth**: Grade **A** – no issues identified.
- **Family Support**: Bereavement midwives involved; findings shared with the family.
- **Key Learning**: The review found inconsistent advice for women with reduced fetal movements in the regional guidelines and the Tommy's patient information leaflet. There remains a lack of clarity for management of women with reduced fetal movements <26 weeks. Escalated by WWL Saving Babies Lives team. Regional response in progress.

No exceptions: Compliant with MIS Year 7 requirements.

11.0 Saving Babies Lives Audit

Element		Compliancy/ Improvement Plan
Element 1- Reducing smoking in pregnancy		Compliant for CO @ Booking = 98%, CO @ 36 weeks = 96%. Number of pregnant smokers who had a referral to an inhouse service is 100%. Quit data is 56% for last quarter as data is captured after period of weeks to allow for patient uptake; parameter is 60%. Regular teaching sessions of CO monitors are undertaken- staff training 89%. Audit regularly undertaken.
Element 2- risk assessment and surveillance for fetal growth restriction		Audit completed and compliant within SBL parameters. Babies at risk of FGR and SGA are detected within antenatal period is 76% - Target is >50%. Number of babies born <3rd centile and > 37+6 is 20%; parameter is <70%. Women who assessed for Risk, aspirin, Vitamin D is 100% - target is 80%. UTAD completed is 90% parameter is >80%. Staff are in date with Serial Fundal Height training- 89 %
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman CTG 100% within SBL parameters. Next working day scan is 77% which does not meet parameter of 80% minimum. Next working day scan figures were impacted by sonographers being on annual leave and further impacted by the reduction in scan capacity in TLC and RAEI scan departments.
Element 4- Effective fetal monitoring during labour		Quarter four data for GMEC parameters are all above compliance of 90%. CTG Interpretation and assessment is 95% and IIA competency assessment is 93%. Training compliance is 95%. There have been 9 CTG clubs held within the quarter and 29 attendees.
Element 5- Preterm Births.		Quarter four parameters were mostly met for Preterm birth; all passport criteria was met apart from breastmilk which was 60% - parameter is 62%. Awaiting data for IVH 3 or 4 and cPVL.
Element 6 – Diabetes in Pregnancy.		One stop clinic template in use, SBL parameters at present just below standard due to lack of dietician. All other parameters above GMEC

		required standards @ 100% compliance for CGM use in pregnancy and HbA1c completion.
SBL training Elements 1-6.		99% doctors and midwives compliant with online element module – 3 yearly. All staff attend a full day face to face SBL day yearly including SFH and assessment, CO training and information and case studies related to WWL and all 6 elements.
Equity and Equality.		Wigan is a predominantly White British borough, with an increasingly diverse maternity population, including a growing number of women from ethnic minority and migrant communities. The borough includes identifiable pockets of deprivation, with several areas within lower deprivation deciles. WWL Maternity Services operate an Enhanced Team to support women with complex health and social needs, delivering targeted, individualised care across community and inpatient settings. The team works closely with Smoking Cessation and Perinatal Mental Health services to ensure coordinated and continuous care. Local data show that women living in the most deprived areas (Decile 1) are twice as likely to smoke during pregnancy, and unemployed women are 2.48 times more likely to smoke and less likely to successfully quit. Among women who gave birth to small-for-gestational-age infants, 60% lived in areas of low socioeconomic status, 15% were unemployed, 12% were Black, 8% were Asian, and the majority were White British. Q4 local data indicate that preterm births predominantly occurred in White British women, with common associated risk factors including residence in lower deprivation deciles and smoking during pregnancy.
OVERALL		Significantly Assured overall

11.1 Saving Babies Lives Care Bundle (3) Progress

WWL Maternity services are 96% compliant with the implementation of the SBL 3 Care Bundle.

Exceptions

- A dietetic service is available, but the dietitian does not attend the one-stop diabetes clinic and does not review women with pre-existing Type 1 diabetes.
- National best practice advises that women with pre-existing diabetes should be managed in a dedicated clinic, separate from those newly diagnosed during pregnancy. Given the relatively low numbers of pre-existing diabetics within our service, delivering separate clinics is challenging.

The Diabetes Lead Midwife is liaising with the Performance manager to address these issues which are preventing full compliance with the SBL Care Bundle.

12.0 Mandatory Training Compliance

Q4 25/26	Midwives	Obstetricians		MSWs	Anaesthetists	Neonatal medics		Neonatal nurses / ANNP
		Cons	Other			Cons	Other	
*Fetal monitoring and surveillance	96%	93%	100%					
*Maternity Emergencies and multi professional training	92%	100%	100%	98%	*86% Maternity specialist anaesthetists			

					*46% General anaesthetists			
*Neonatal Life Support training	91%	*100%	*100%	93%	*86% Maternity specialist anaesthetists *46% General anaesthetists	100%	100%	100%
Saving Babies Lives Care Bundle SBL Face to face	90%	87%	13%	93.5%	*86% Maternity specialist anaesthetists *46% General anaesthetists			
SBL Online	97%	100%	20%					
Equality/ equity and personalised care (3-Year programme)	82%	13%	13%	80%	0%			
Care during labour and immediate post-natal period (3 Year programme)	87%	100%	100%	*98%	*86% Maternity specialist *46% General anaesthetists			
Qualified in Speciality - QIS								93%

*Role specific training

Exceptions (Training Compliance)

- **PROMPT:**
  Compliance reduced due to anaesthetic new starters joining the rota. All new starters have been contacted via email to arrange attendance.
- **Neonatal Life Support (NLS):**
  Anaesthetists complete role-specific neonatal scenarios within PROMPT; compliance similarly affected by anaesthetic new starters. All have been emailed to book training dates.
- **Saving Babies Lives (SBL):**
  Obstetric registrar attendance has been partially affected by the resident doctors' strike. **Sixteen registrars are scheduled** to attend training over the next three months.
- **SBL Online:**
  Reminder emails have been issued to chase outstanding compliance.
- **Equity and Personalised Care:**
  All medical staff are expected to attend cultural competency training, delivered via SBL days

since January. Compliance is currently low due to reduced SBL attendance but is expected to improve over the next three months as attendance increases. Anaesthetists are not currently included; an **e-learning alternative is being considered**.

- **Care in Labour (CiL):**
  Anaesthetists complete a role-specific case study within PROMPT; compliance impacted by recent rota changes and the addition of new starters.

13.0 Safe Maternity Staffing

Q4 Fill rates – Source BI

Midwifery/Nursing staffing

Area	January		February		March	
	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate
Maternity	106.9%	102.4%	98.1%	93.5%	97.4%	90.7%
Neonatal	112.6%	111.3%	95.4%	92.9%	98%	93.1%

Midwifery/Health Care Support Worker staffing

Area	January		February		March	
	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate	Daily Fill Rate	Nightly Fill Rate
Maternity	88.2%	97.8%	103%	102.2%	95%	102.6%
Neonatal	55%	-	56.3%	-	54.1%	-

The maternity team met with BI to review Q3 data after fill-rates did not reflect actual staffing pressures. Data collection tools were updated, and matrons continue to review e-roster templates to improve data accuracy.

13.1 Maternity Staffing Vacancy Rates

Staff group	Vacancy rate
Midwifery	0.0 WTE (2.86 WTE staffing gaps due to Maternity Leave)
Midwife Support workers	0.0 WTE
Obstetric consultants Resident doctors	0.0 Consultant vacancies 0.0 Tier 1 vacancies 0.0 WTE Tier 2 vacancies (1.6 WTE shift gaps due to 1 WTE supernumerary and 1 extended phased return).
Neonatal Nurses	0.8 WTE (currently out as Fixed Term Contract)

Neonatal HCA	0.0 WTE
Neonatology consultants Resident doctors	0.0 Neonatal doctor staffing vacancies
Obstetric anaesthetists Resident doctors	6 anaesthetic vacancies across the Trust – maternity rota is covered as priority – no rota gaps.

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

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

Maternity staffing red flag events are actively monitored, validated, and escalated through the Birthrate Plus, with 99 validated red flag events recorded in Q4 2025/26.

- 70 % of the occasions when missed or delayed care
- 16% delay between admission for induction of labour and beginning of process
- 11% delayed or cancelled time critical activity
- 2% Coordinator unable to maintain supernumerary status NOT providing 1-1 care.

The increase in red flags compared to Q3 reflects improved identification and reporting of staffing pressures rather than any increase in patient harm. No harm has been reported in association with these events.

Red flags predominantly relate to ongoing workforce pressures, including vacant shifts, short-notice sickness, and redeployment to maintain service flow, compounded by skill-mix fragility and reduced support workforce availability.

Escalation and mitigation processes are routinely applied; however, sustained workforce pressures continue to challenge the ability to maintain a supernumerary Delivery Suite Coordinator during periods of high demand.

Exceptions

- The dataset is limited to Delivery Suite activity and may under-represent staffing pressures in ward areas. This reinforces the need for consistent maternity staffing red-flag reporting and continued strengthening of Birthrate Plus® compliance to ensure accurate Board assurance.
- Ongoing actions focus on strengthening reporting consistency, leadership oversight, vacancy management, and workforce planning to restore operational resilience.

13.3 RCOG Locum doctor compliance

WWL remains compliant with RCOG requirements from short-term locums in 2026. A full report has been provided to Board for assurance of adherence to MIS Year 7 Safety Action 4.

13.4 RCOG Consultant attendance

At the end of MIS Year 7 reporting period we were 100% compliant with consultant attendance in line with RCOG guidance. A separate report is provided to Board.
In Q4, consultant attendance was 82%, meeting the expected standard of 80%.

Exceptions
Although overall compliance was maintained, consultant attendance declined compared to previous quarters. In two daytime cases of post-partum haemorrhage >2 litres, emergency protocols were initiated; however, there was no documented evidence that the on-call consultant obstetrician was contacted.

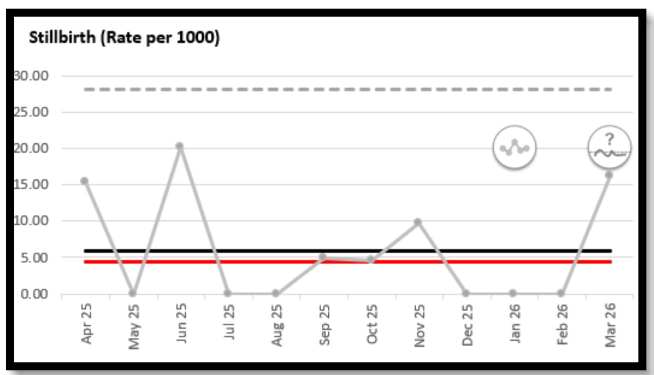
The Clinical Director and Delivery Suite Matron have been informed to support monitoring and communications to the team.

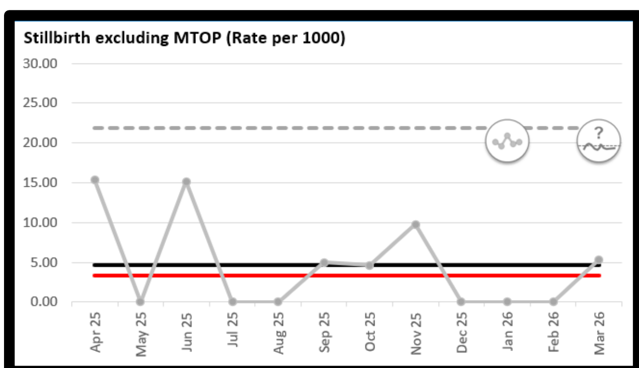
13.5 Maternity Unit Diverts

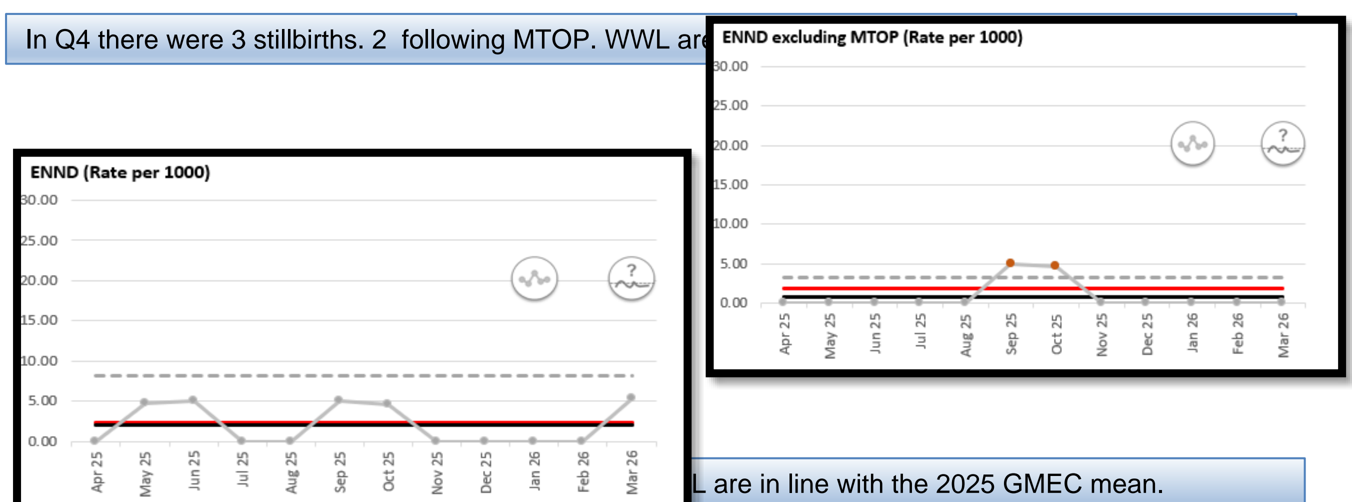
There were no maternity diverts in Q4.

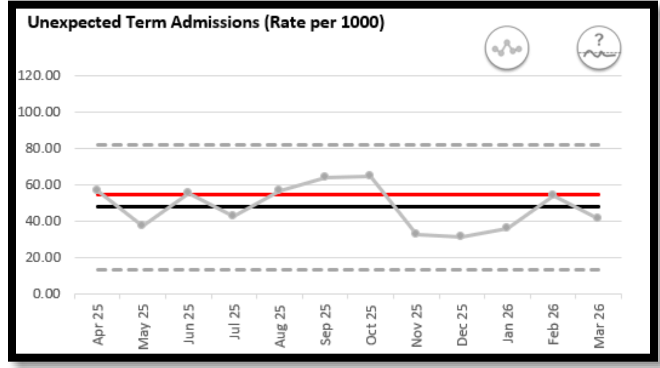
14.0 Statistical Process Control charts

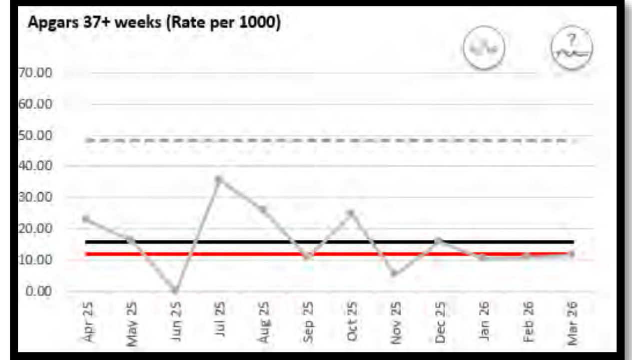
Statistical Process Control (SPC) charts have been provided below. These offer a reliable and current view of performance over time, including comparison against the GMEC 2025 mean, and provide assurance of ongoing improvement across key metrics.



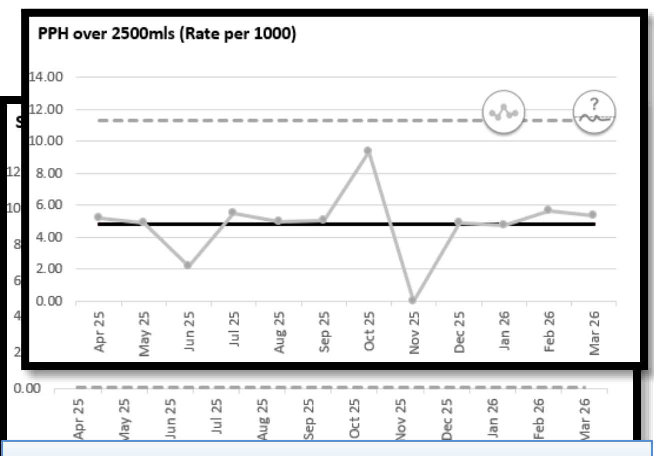


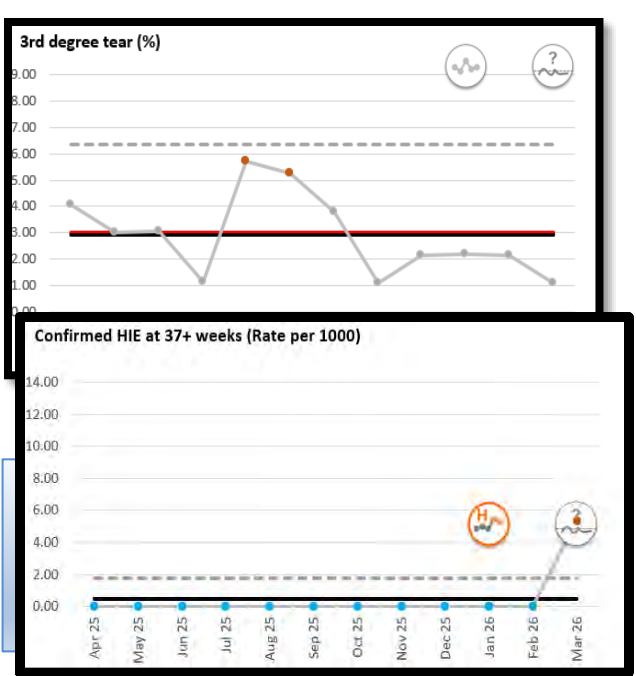






Positive downward trend continues. QI work for ATAIN and SBL has had positive impact on Apgars <7@5 data.





Data outcomes are steady for PPH >2500 mls. The PPH working group is starting to become embedded and learning collated via audit. Obs UK research trial continues. Outcomes in line with 2025 GMEC mean.

14.1 Maternity Outcomes Signal System

SATOD data continues downward trend. Issues with BI data have been identified – data likely lower. WWL average better than both 2025 GMEC and National averages.

There were no babies with confirmed HIE 2/3 (37 weeks +) in Q4.

* 1 baby upgraded to HIE 2 in early Q1 26/27. Data has been amended to reflect.

(MOSS)

There were no Maternity Outcomes signals in Q4.

Summary

Q4 data provides reasonable assurance that maternity and neonatal services remain safe, with stable incident reporting, no maternity outcome signals identified, and SPC evidence demonstrating continuous improvement across key safety metrics. Five moderate and above harm incidents were reported in maternity, which is higher than the service's usual baseline and reflects a local move towards outcome-based harm reporting to strengthen transparency and learning. This approach differs from current Trust-wide practice and has been highlighted for discussion at Trust-level governance forums.

One moderate and above harm incident was reported in neonatology, with appropriate review and governance processes in place, including Duty of Candour.

Triangulated intelligence from complaints, incidents, claims and formal reviews identifies predictable system pressures in complex care pathways, particularly related to recognition of evolving deterioration, monitoring consistency, multidisciplinary coordination and communication during high-pressure scenarios. These themes align with known national maternity risk areas and are being addressed through PSIRF-aligned improvement work. Workforce culture activity, informed by SCORE feedback and supported by listening events and targeted training, provides assurance that system learning is underpinned by active staff engagement, with no evidence of systemic care failure or deteriorating safety trends.

Agenda item: 15.2

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Complaints – A 12-month Look Back in Maternity and Child Health
Presented to:	Board of Directors
On:	17th June 2026
Presented by:	Kevin Parker Evans Chief Nursing Officer and DIPC
Prepared by:	Steven Bailey, Governance Facilitator Maternity and Child Health Eve Broadhurst, Head of Governance Maternity and Child Health
Contact details:	Eve.broadhurst@wwl.nhs.uk

Executive summary

(Feb 2025 – Jan 2026)

127 complaints were received across the Directorate (Maternity 37, Neonatology 1, Paediatrics 89), with 35% resolved as concerns, demonstrating strong early-resolution practice.

Communication remains the strongest cross-cutting theme, driving dissatisfaction in both Maternity and Paediatrics and significantly affecting patient experience and trust.

Maternity complaints highlight repeated systemic issues, particularly communication failures (32), staff attitude/compassion (28), delays in assessment (22) and documentation accuracy (19).

Maternity services have implemented meaningful improvements, including strengthened postnatal analgesia processes, enhanced NIPE pathways, MEDUSA training, perinatal mental health access improvements, and updated personalised-care information.

Paediatric complaints are dominated by pathway and referral concerns, with 76 complaints (85%) relating to navigation issues within ADHD, autism and neurodevelopmental pathways.

Long waits, delays, missed results and diagnostic clarity continue to be major sources of parental frustration within Paediatrics, reflecting demand and capacity pressures.

Targeted improvements within ADHD services—including caseload validation, prescription-process redesign, additional staffing and implementation of CLEO—have reduced complaints and strengthened safety.

Neonatology received only one complaint; however, while the service gathers family feedback through its own mechanisms, these do not currently feed into formal Trust reporting or governance structures, limiting visibility of experience themes.

Learning from complaints is being embedded across the Directorate, through Morbidity & Mortality discussions, strengthened pathways, updated guidance, enhanced workforce training and improved patient information.

Patient-voice triangulation is improving across services, with Maternity demonstrating strong multi-source insight (MNVP, Birth Thoughts, FFT, Picker), while Neonatology's feedback processes remain the main gap for future alignment.

While feedback from complaints provides important learning, the volume of positive patient feedback received across the Directorate substantially exceeds the number of concerns raised, reflecting strong overall satisfaction with care.

1. Maternity complaints 12 Month look back (February 2025 – January 2026)

1.1 Maternity: 37 Complaints received within this time period, with one additional case recorded on Datix that was passed to Human Resources (HR) and not progressed as a complaint.

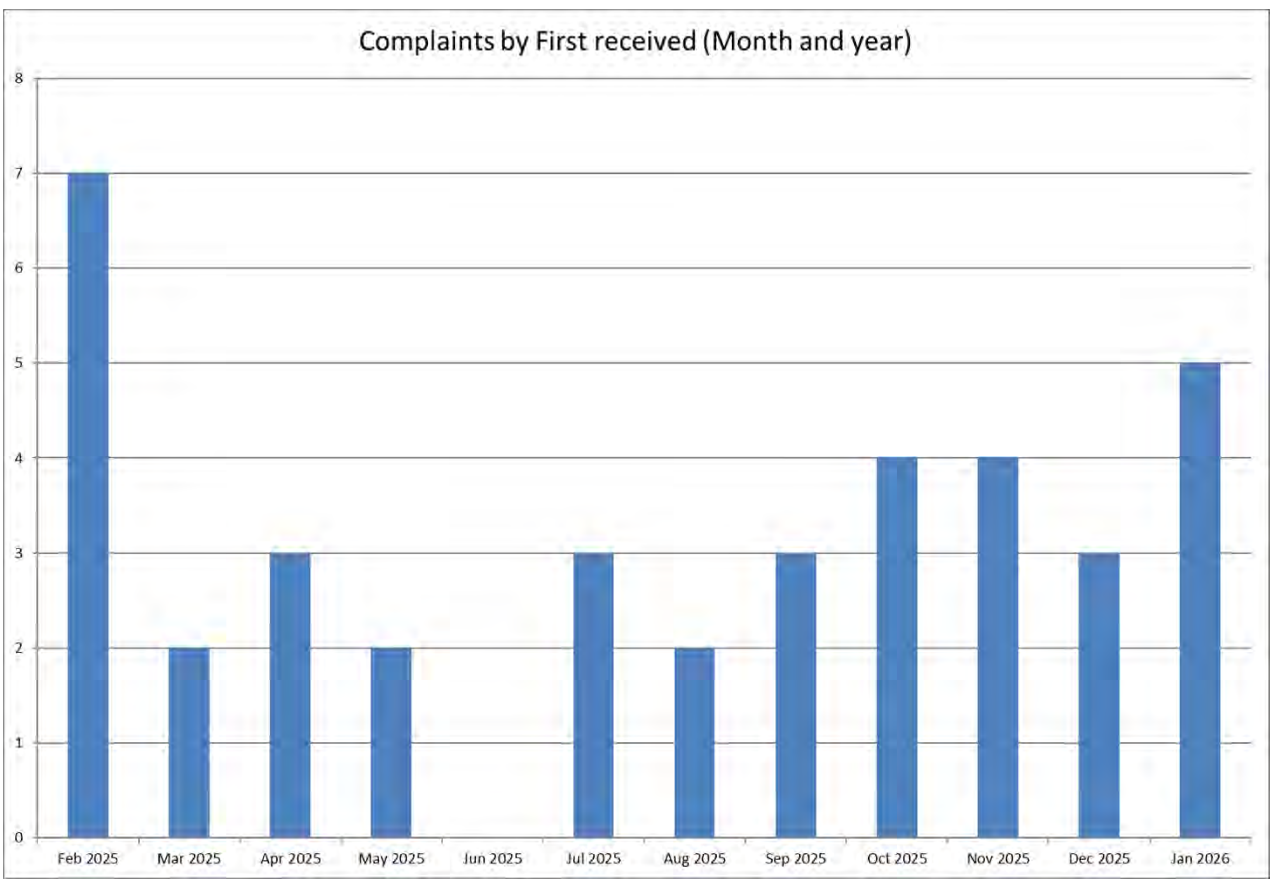


Fig 1: Maternity complaints via month these were first received into the Patient Relations Department

1.2 Overview of Maternity Concerns and Complaint Outcomes

Of the 37 complaints received within the reporting period, 9 were resolved as concerns, 1 as a request for information, and 1 was withdrawn by the complainant.

Of these complaints (removing those that were progressed as a request for information withdrawn or resolved as a complaint and those that remain ongoing), the most common outcome was a Partially Upheld Complaint:

Not Upheld	Partially Upheld	Upheld	Ongoing
2	9	6	7

An analysis of all 37 maternity complaints received between 2025 and 2026 identifies recurring themes relating to communication, clinical practice, staff behaviour, documentation, and coordination between services. While individual circumstances differ, the consistency of these themes indicates underlying systemic issues affecting patient experience and, in some cases, patient safety.

1.3 Key Themes Identified Across Maternity Complaints

The following themes were identified most frequently and therefore represent the highest-priority areas for leadership action.

a) Communication Failures (Most prevalent theme)

Communication issues are the strongest and most consistent pattern, appearing in 32 of the 37 complaints. Concerns include:

- Lack of clear explanations or updates during care
- Inconsistent or contradictory information
- Poor communication during delays
- Failure to explain or communicate clinical decisions
- Miscommunication between services (e.g., triage → labour ward → community)
- Inaccurate, missing, or unclear documentation of communication

This is the primary Directorate-wide issue, contributing significantly to loss of confidence, emotional distress, and perceived or actual safety concerns.

b) Staff Attitude, Behaviour and Compassion

This theme appears in 28 complaints and reflects widespread concerns about staff interactions. Issues include:

- Perceived rudeness, dismissiveness, or lack of empathy
- Not listening to women or birthing people
- Judgmental or insensitive comments
- Limited compassion during pain, emergencies, or distressing events

This suggests a broader cultural and behavioural issue requiring system-level focus.

c) Delays in Assessment and Missed/Incomplete Clinical Review

Present in 22 complaints, this theme directly relates to patient safety. Issues include:

- Delays in induction of labour process
- Perceived failure to act on abnormal observations
- Perceived late diagnoses (e.g., pre-eclampsia, infection, fetal concerns)
- Expectations regarding need for escalation to obstetric doctor
- Perception of and actual, late recognition of maternal or fetal condition / deterioration

These concerns indicate variation in clinical vigilance and escalation processes – actual and perceived.

d) Documentation and Record-Keeping Errors

Identified as a core theme in 19 complaints, documentation issues contribute to both safety risks and poor patient experience. Problems raised include:

- Incorrect details recorded (e.g., demographics, baby weights, sex)
- Missing information
- Conflicting entries from different clinicians
- Incomplete theatre documentation
- Lost results or missing tests

This points to systemic weaknesses in governance and processes.

e) Consent, Autonomy and Respect for Choice

Although not within the majority, this theme appears in 12 complaints and remains significant due to its close relationship with communication and personalised care. Issues include:

- Feeling pressured into induction or certain treatments
- Emergency procedures undertaken without adequate consent
- Limited involvement in decision-making

- Insufficient explanation of risks and benefits
- Lack of consideration for mental health, or neurodiversity

This indicates inconsistent application of respectful and personalised maternity care principles, central to the 3 Year Maternity Plan.

1.4 Maternity Complaints Heat Map

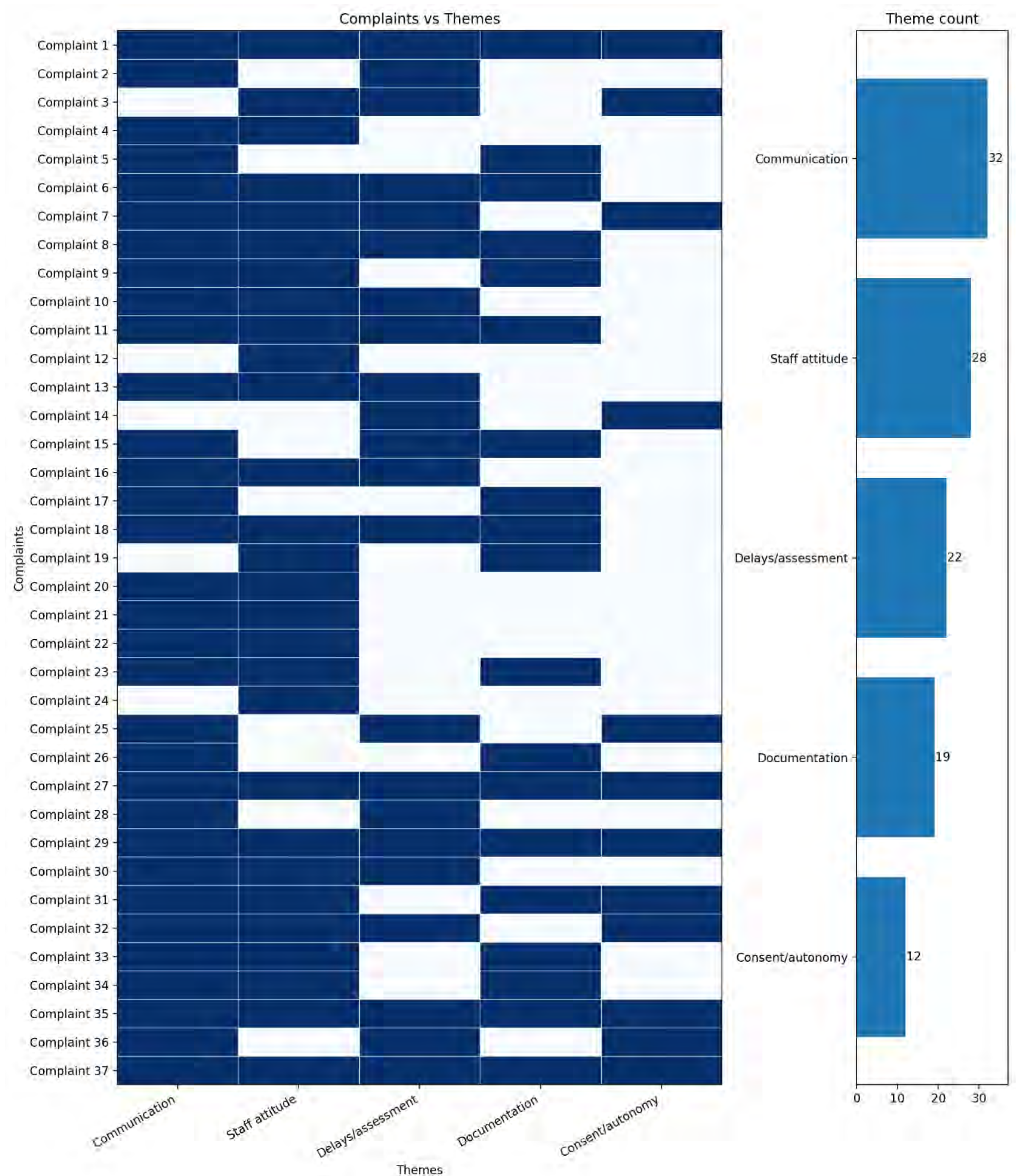


Fig 2: Heatmap aligning each complaint to the five themes above.

1.5 Learning from Maternity Complaints

An effective complaints process is a critical component of robust governance, providing a direct insight into how services are experienced by women, children and families. Each complaint offers an opportunity to identify gaps, strengthen systems, and drive measurable improvements in quality and safety. By examining themes, understanding contributory factors, and acting on learning, the organisation can enhance trust, reduce risk, and promote a culture of transparency and continuous improvement. The following section outlines key learning points identified from complaints received over the past year and how the service has responded (February 2025 – January 2026).

1.6 Improvements Implemented in Response to Maternity Complaints (Feb 2025–Present)

These actions directly address the dominant themes highlighted through complaints analysis — notably communication, clinical oversight, documentation quality and personalised care — demonstrating how patient feedback is actively driving service improvement.

Complaints represent just one element of the patient-feedback system within Maternity; insight is also gathered through direct engagement with women and families via Birth Thoughts sessions, MNVP engagement activities, the Public and Patient Engagement Midwife, the Picker survey and Friends and Family Test feedback. These sources are triangulated quarterly, with themes reviewed alongside complaints and shared with all staff groups to ensure a cohesive and aligned approach to learning and improvement.

Perinatal Mental Health

- The Perinatal Mental Health Team has introduced a voicemail message specifying hours of availability, following feedback from a woman who felt unsupported when calling outside service hours. This ensures clearer expectations and reduces the risk of perceived abandonment.

Postnatal Care and Pain Management

- The Postnatal Ward has strengthened its analgesia process. Instead of a single staff member completing twice-daily medication rounds, each midwife now has responsibility for providing pain relief to the women in their care, with three scheduled rounds per day. This change improves timeliness, continuity, and responsiveness to individual need.

Workforce Competency and Clinical Safety

- An anaesthetic staff member has been supported through a structured development plan to gain additional obstetric experience, with a clear pathway to safely re-enter the obstetric rota once competencies are demonstrated.

Newborn Infant Physical Examination (NIPE)

- NIPE guidance has been updated to clearly outline options available to families when discharge is required before the examination is completed. Staff have been briefed on the agreed processes for arranging return appointments or Community Midwife completion, ensuring consistency and improved parental understanding.

Medication Safety (MEDUSA System)

- Midwifery staff have now been trained in the use of the MEDUSA medication reference system, enhancing clinical decision-making and supporting safe and effective responses to extravasation injuries in maternity settings.

1.7 Actions Completed in last 12 months from Maternity Complaints Prior to February 2025

Community Midwifery and Wound Care

- Assessment and management of caesarean section wounds has been formally integrated into the community midwifery training package, following a case where deterioration was not recognised promptly.

Antenatal Scanning Information

- The WWL antenatal scanning information leaflet has been updated to reflect that ultrasound scans are not 100% diagnostic, supporting more realistic expectations and informed consent.

Hyperemesis Guidance

- The guideline for managing hyperemesis gravidarum has been reviewed and adopted by Maternity (previously under Gynaecology). This includes implementation of the Pregnancy-Unique Quantification of Emesis (PUQE) tool to standardise severity assessment.

Respectful Disposal of Fetal Tissue

- Guidance has been revised to ensure staff have a clear framework for discussing options with parents sensitively and consistently, improving documentation and supporting families through bereavement pathways.

Ventriculomegaly Information

- A new patient information leaflet on ventriculomegaly has been created to address previous gaps in communication and improve parental understanding after antenatal diagnosis.

1.8 Ongoing Complaints Actions in Progress

Post-Caesarean Activity Advice

- A standardised information form is in development to support women at discharge following caesarean section. This will outline recommended activity restrictions (e.g., driving, lifting, sexual activity) and reinforce safety advice during recovery.

Extravasation Training Standards

- The Trust's Vascular Access Lead will attend maternity extravasation training to ensure that the local training content aligns with organisational standards and supports safe clinical practice.

Labour Education Materials

- A series of informational posters are being developed for the Delivery Suite to explain the physiological changes experienced during the latent and active phases of labour. These resources aim to enhance patient understanding and act as visual support tools for staff.

2.0 Neonatology complaints 12 Month look back (February 2025 – January 2026)

Within the same reporting period, only one complaint was received relating to Neonatology. This concerned an error in neonatal discharge paperwork, which led to misconceptions about the baby's condition at birth and subsequently caused unnecessary parental worry and dissatisfaction with aspects of the maternity care. With a single complaint, it is not possible to draw meaningful themes for this service area.

The very low number of neonatology complaints is acknowledged and is indicative of the consistently high standard of care delivered within the department. However, it is also recognised that further work is required to understand how neonatal feedback is systematically collected and reviewed, particularly as the service does not currently participate in the Friends and Family Test. Strengthening feedback mechanisms will provide a more comprehensive understanding of family experience and ensure opportunities for learning and improvement are consistently captured.

3.0 Paediatrics complaints 12 Month look back (February 2025 – January 2026)

3.1 Paediatrics: 89 Complaints received within this time period.

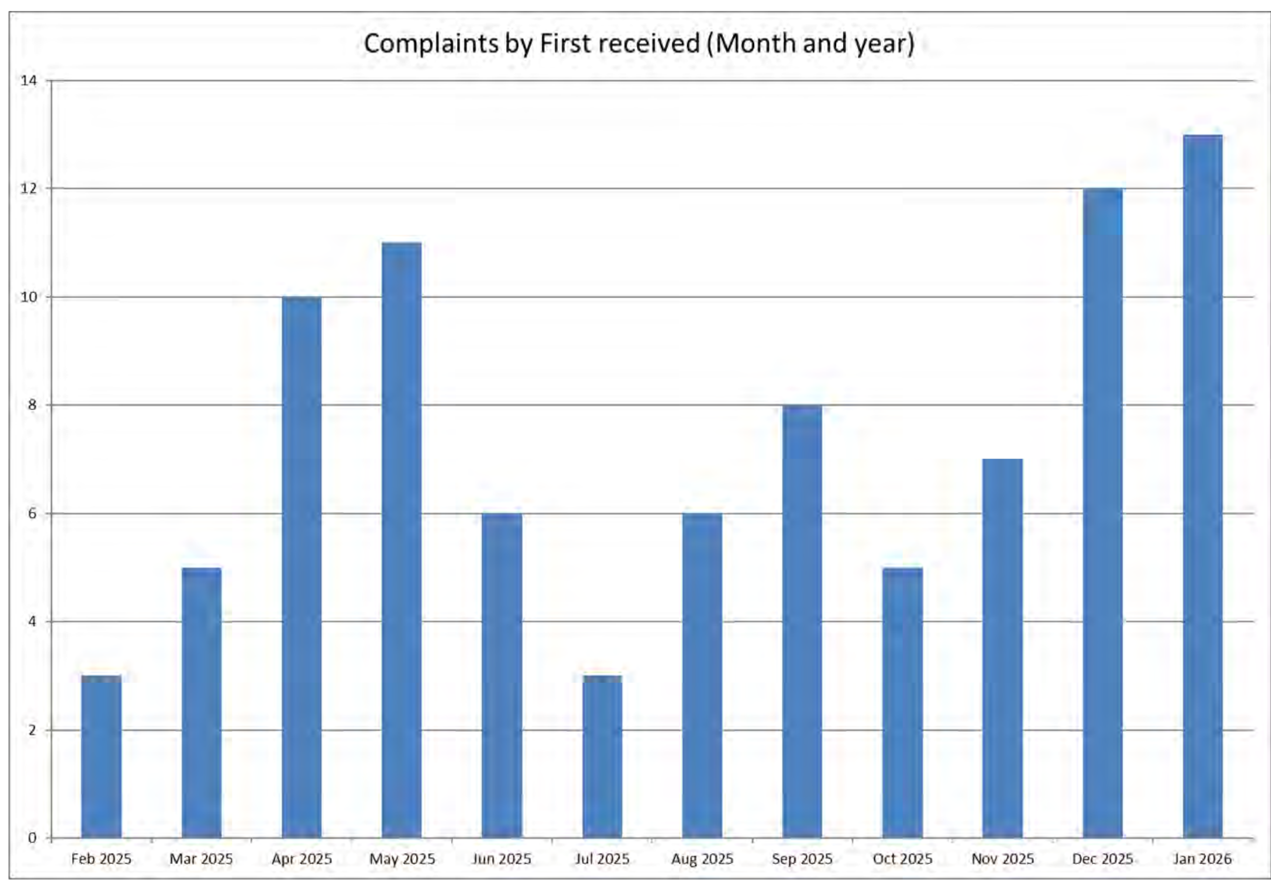


Fig 3: Paediatric complaints via month these were first received into the Patient Relations Department

3.2 Overview of Paediatric Concerns and Complaints Outcomes

Of the 89 complaints received within this reporting period, 35 were resolved as concerns and 1 was withdrawn due to the Trust not receiving consent to proceed and was not included within these figures.

Of these complaints (removing those that were resolved as a concern or withdrawn) the most common outcome was a Partially Upheld Complaint:

Not Upheld	Partially Upheld	Upheld	Ongoing
17	18	1	18

Analysis of these 89 complaints (2025–2026) highlights a concentrated set of recurring issues. The majority relate to referral processes and pathways within Paediatrics, particularly Community Paediatrics, Neurodevelopmental Services and ADHD pathways—alongside concerns regarding long waits, delayed assessments or diagnoses, misplaced results, and inconsistent or ineffective communication with parents and carers.

3.3 Key Themes Identified Across Paediatric Complaints

a) Referrals and Pathway Navigation

76/89 complaints (85.4%)
This is the most prominent theme and indicates significant system-level issues (Risk register -15). Concerns include:

- Referrals being misdirected, stalled, or not progressed
- Unclear or inconsistent pathway information
- Parental uncertainty about next steps across Neurodevelopment, ADHD, Autism and CAMHS pathways
- Lack of clarity regarding who is responsible for case progression

This theme reflects a need for improved pathway transparency, clearer written materials, and strengthened operational oversight.

b) Access, Waiting Times and Delays

44/89 complaints (49.4%)
Families frequently raise concerns about:

- Prolonged waits for assessments, including Qb testing
- Delays in panel scheduling
- Missed or overdue follow-up appointments

This theme demonstrates the impact of demand pressures and operational constraints on timely care.

c) Diagnosis and Assessment (Quality and Decision-Making)

37/89 complaints (41.6%)
Complaints in this category relate to:

- Disagreement with or lack of clarity around thresholds for diagnosis
- Perceived inconsistency in how criteria are applied
- Questions about the robustness or rationale behind clinical conclusions

These concerns suggest a need for improved explanation of clinical decision-making and better expectation-setting with families.

d) Investigations, Tests and Results (Including Qb Testing)

37/89 complaints (41.6%)
Common issues include:

- Missed or overdue investigations
- Misplaced, unshared or delayed results
- Result delays contributing to prolonged uncertainty or stalled care

This theme indicates weaknesses in administrative processes and result-handling systems.

e) Communication and Contactability

32/89 complaints (36.0%)
Families report:

- Lack of response to calls or emails
- Incorrect or conflicting information
- Difficulty reaching the appropriate team

These recurrent issues influence trust, satisfaction and perceived reliability of services.

3.4 Paediatric Complaints Heat Map

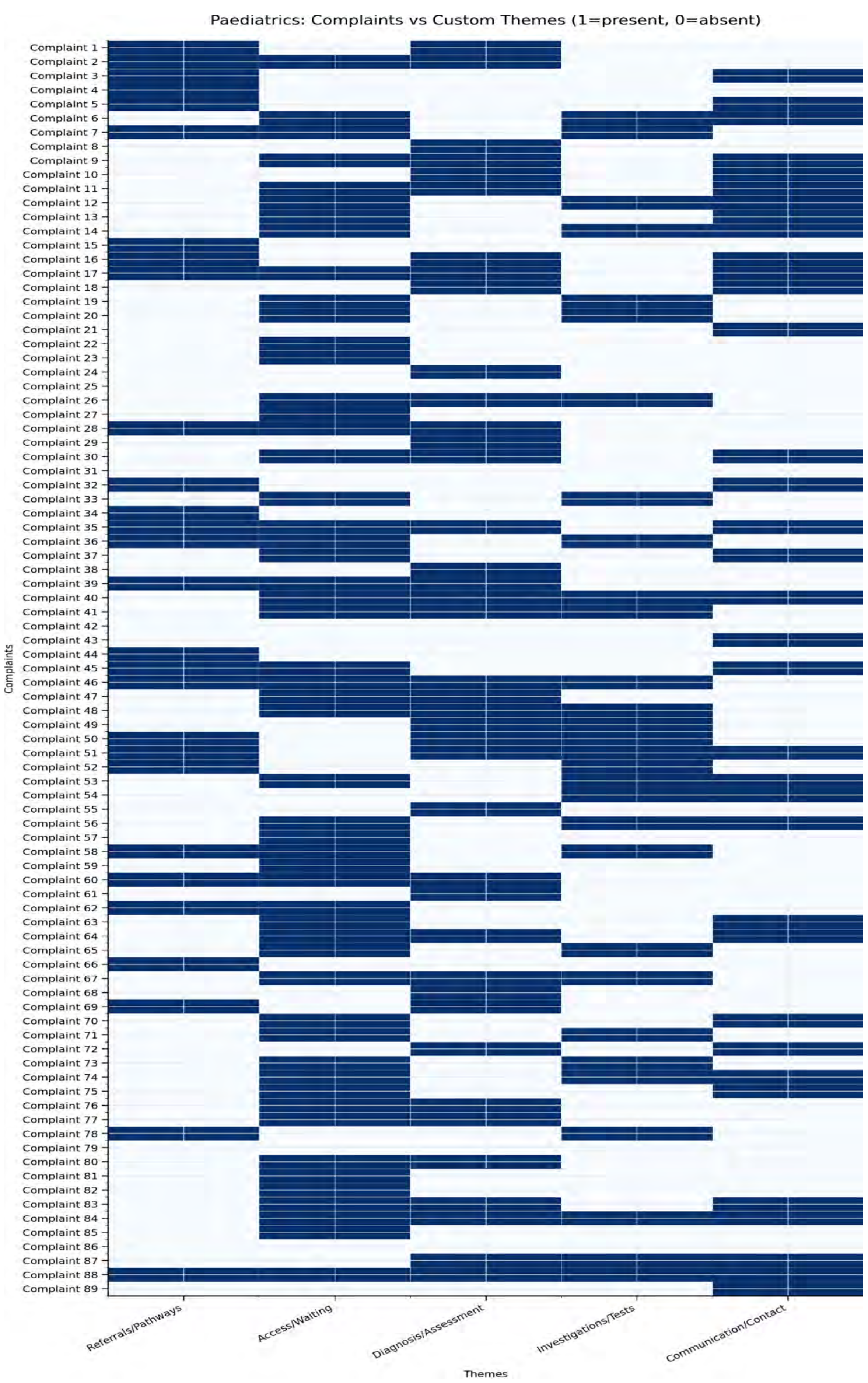


Fig 4: Heat Map of Paediatric complaints compared to the Top 5 Themes identified.

3.5 Learning from Paediatric Complaints

The following section outlines key learning points identified from complaints received over the past year and how the service has responded (February 2025 – January 2026). These actions directly address the dominant themes highlighted through complaints analysis — notably referrals and pathway navigation, access and waiting times/delays, diagnosis and assessment, investigations and test results and communication and contactability - demonstrating how feedback from complaints is actively driving service improvement.

3.6 Improvements Implemented in Response to Paediatric Complaints (Feb 2025–Jan 2026)

Shared Learning Through Mortality & Morbidity Governance Meeting

- A recent complaint was formally presented at the Paediatric Mortality and Morbidity meeting by the registrar involved in the child's care. This supported wider organisational learning, increased awareness of the rare genetic condition identified, and enabled multidisciplinary reflection on clinical decision-making.

Strengthened Processes for Prolonged Jaundice Results

- Processes within the Prolonged Jaundice Clinic have been strengthened following the recruitment of additional Advanced Neonatal Practitioners. Test results are now pooled and monitored collectively, ensuring timelier review and reducing delays previously caused by staff absence.

Updated NIPE Hip Screening Guidance

- Local NIPE guidance has been revised to align with updated NHS England recommendations, ensuring clarity on required actions for hip screening. This will reduce variation, support consistent practice and promote early detection of hip abnormalities.

Review of Appointment Text Reminder Functionality

- A review with Healthcare Operations explored the feasibility of including appointment locations in automated text reminders. Following assessment, this enhancement was deemed not technically feasible within the current system configuration.

ADHD Pathways

Given the significant proportion of complaints relating to the ADHD pathway, all cases are routinely cross-referenced with Risk 3592: ADHD/ASD Service on the divisional risk register. This ensures that complaint themes directly inform risk controls and that actions are monitored through established governance processes.
Recent improvements include:

- **Validation of Consultant Caseloads.** A full caseload validation exercise has been completed for every Consultant contributing to the ADHD pathway. This enabled removal of children who were appropriate for discharge (e.g., following Shared Care Agreement completion or transfer to Adult ADHD services), thereby improving waiting-list accuracy and reducing unnecessary operational demand.

- **Reallocation of Capacity to Meet Prescription Demand.** In response to increased prescription activity and related parental concerns, nurse-led ADHD clinics have been temporarily

paused. The released capacity has been redirected to prescription processing, resulting in safer, timelier management of medication requests and a reduction in related complaints.

- **Additional Resource to Support Community Prescribing Workload.** An additional staff member has been redeployed from Rainbow Ward to support the Community Prescriptions inbox. This has improved responsiveness to parent queries and reduced pressure on ADHD nursing staff, enabling them to focus on clinical work and pathway progression.

- **Implementation of CLEO for Electronic Prescribing.** CLEO has now been fully implemented across Child Health to support electronic prescribing. This has strengthened prescription safety by reducing human error, improving processing times, and enabling fulfilment through Community Pharmacies. The system alleviates pressure on the hospital pharmacy and offers families improved convenience.

3.7 Ongoing Complaints Actions in Progress

Paediatric Allergy Pathway

- The newly appointed Paediatric Allergy Leads are undertaking a comprehensive review of all allergy-related guidance, in direct response to complaints from families reporting confusion about testing, result interpretation, and clinical advice. Updated guidance will standardise pathways and improve the clarity of information provided to families.

- Recruitment of a Paediatric Allergy Nurse (January 2026) will support the reinstatement of pin-prick testing and hospital-based food challenges, helping to reduce pathway-related delays.

Collaborative Work with Radiology on SWI Imaging

- Paediatrics and Radiology are working jointly to determine how best to embed Susceptibility Weighted Imaging (SWI) into the assessment of suspected non-accidental injury in non-mobile infants. The aim is to strengthen diagnostic quality while potentially reducing the length of safeguarding observation required for families.

Development of Patient Information on Laryngomalacia

- A new patient information leaflet is being developed to provide clear explanations of laryngomalacia, including severity, expected symptoms, and red-flag indicators. This follows feedback from families who felt inadequately informed and aims to support parental confidence and timely escalation of concerns.

Additional Learning

As part of standard governance practice, all complaints are shared with the individuals involved to support reflection and development. In several cases, actions have involved ensuring an appointment date is provided, arranging for test results to be reviewed by a clinician, or facilitating a request for a change of consultant.

3.8 Summary

Across Maternity, Neonatology and Paediatrics, the analysis of complaints over the past 12 months provides valuable insight into how women, children and families experience our services. While the volume and themes of complaints highlight areas requiring continued focus—particularly communication, pathway clarity, waiting times and documentation—there is clear evidence that learning from complaints is actively driving improvement.

It is important to note that the improvement work detailed related solely to complaints and other QI work is underway particularly relating to patient feedback received from co-production in maternity services with the MNVP, such as partner overnight stay and strengthened information resources.

The Directorate has responded constructively through pathway redesign, strengthened clinical processes, enhanced patient information, improved prescribing systems, and targeted workforce development. These actions demonstrate a strong commitment to transparency, reflection, and continuous improvement.
Importantly, complaints represent only a small proportion of overall patient feedback, and positive feedback far outweighs the concerns raised, offering assurance that the majority of service users continue to report positive, compassionate and effective care.

However, the consistency of themes—especially within Paediatrics and some areas of Maternity—indicates the need for ongoing system-level work to strengthen communication, reduce delays, improve pathway navigation, and enhance administrative reliability. Further development of Neonatology's patient-feedback reporting structures will also help ensure a more complete understanding of family experience across the Directorate.

Overall, this 12-month review demonstrates a Directorate that is listening, learning, and taking action. Sustained focus on embedding improvements, monitoring impact, and triangulating patient-experience data will be essential to ensuring high-quality, safe, and person-centred care for all families we serve.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	MIS Year 8 update report
Presented to:	Board of Directors
On:	17 June 2026
Purpose:	Assurance
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

- Safety actions have been reduced from 10 to 6 to improve focus and reduce administrative burden.
- There is greater emphasis on outcomes over process, equity and the reduction of inequalities, board ownership and accountability, and flexibility for local implementation.
- There is an explicit equity focus across all standards, with a strengthened expectation of triangulated evidence through enhanced assurance approaches, including peer review, service-user validation, and system oversight.
- The scheme continues to provide the same financial incentive through the CNST rebate, linked to demonstration of compliance with all core safety actions

To achieve compliance, Boards must demonstrate that:

- Systems are effective, not just in place
- Variation is understood and acted on
- There is clear evidence of improvement over time
- Evidence is triangulated across data, audit, feedback, and outcomes

The 6 Core Safety Actions (Year 8)

A. Workforce and Capacity

- Ensuring safe staffing levels and workforce sustainability
- Focus on aligning workforce supply to demand and acuity

B. Training

- Assurance that staff training is:
- Up to date
- Effective
- Impacting clinical practice and outcomes

C. Learning from Reviews and Investigations

- Evidence of:
- Robust incident review systems
- Effective learning

- Demonstrable improvements following learning

D. Service-User Voice and Equity

- Strengthening: Co-production with women and families
- Focus on reducing health inequalities

E. Care Bundles

- Implementation and embedding of evidence-based care bundles (e.g. Saving Babies' Lives and other national programmes)

F. Board Oversight, Governance, Culture and Leadership

- Strong Board visibility and ownership
- Effective governance structures supporting safety, quality, and culture

Year 8 places explicit emphasis on triangulated assurance rather than reliance on a single source of evidence.

The paper will identify any current gaps / non-compliance risks. Any possible impact on patient safety and or CNST funding and any time-bound mitigation plans that would need to be considered.

This will be supported by triangulated evidence, as the standards are clear that each safety action must draw on multiple sources of assurance, including:

- Data (e.g. outcomes, compliance metrics)
- Audit findings
- Incident / investigation themes
- Workforce metrics
- Service user feedback (MNVP, complaints, experience)

Boards are required to have assurance that training has led to demonstrable changes in practice and improved outcomes. Reviews should evidence embedded learning, reduced recurrence of incidents, and workforce plans that support the maintenance of safe staffing levels.

Equity & Inequalities Assurance

This should include consideration of outcomes by deprivation, ethnicity, and vulnerability, together with clear evidence of the actions being taken to reduce unwarranted variation and strengthen oversight of the health inequalities strategy.

Board Visibility & Governance.

The report aims to provide assurance that MIS is fully embedded within the Quality and Safety Committee and maternity governance structures. Risks are captured on the risk register and/or Board Assurance Framework, where appropriate, and regular reporting is provided through the Quarterly Perinatal Oversight Report and Maternity Dashboard, both of which are received by the Quality and Safety Committee and the Perinatal Safety Champions.

External & System Assurance

Where available, this will include assurance from the LMNS and ICB, peer review activity, benchmarking, and service-user validation.

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

Noncompliance against the standards can result in patient harm and therefore litigation.

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 of Directors are asked to review the findings of this report and note that it provides an appropriate level of assurance. This is a requirement of the NHS Resolution Maternity Incentive Scheme in relation to Safety Actions A and F.

The Board is asked to note that MIS Year 8 introduces a more outcomes-focused and principles-based framework, requiring strengthened triangulation of evidence and clear demonstration of improvement across all safety actions.

While the Trust has established systems in place across the six domains, ongoing work is required to ensure consistent evidence of impact, particularly in relation to workforce sustainability, equity of outcomes, and learning from investigations.

The Board is asked to note the update on MIS Year 8 progress and to acknowledge that a number of new metrics remain under review and in development. While many measures are now business as usual and well embedded, further work will continue to ensure alignment with the "What Good Looks Like" framework and to demonstrate measurable improvement and impact, rather than process alone.

Summary/ Rag Rating

Safety Action	Current Status	Evidence	Risk (RAG)	Mitigation	Board Assurance
A. Workforce and Capacity	Current shortfall of 3.3wte	Workforce metrics Birthrate+ Acuity tool and staffing model. Workforce KPI's and fill rates		Current shortfall of 3.3+ WTE	Request to review April staffing paper and note shortfall as identified by Birthrate+ and to note MIS requirements for compliance
B. Training	Training needs analysis in place in line with National, Regional and local recommendations	Data / outcomes, compliance metrics		Plan in place for anaesthetic attendance	Support requested from anaesthetic leads to release staff. Expected to have compliance in June
C. Learning from Reviews and Investigations	Embedded in practice. PSIRF Framework	Themes and Trends. Audits Pt Feedback			Thematic reviews and annual reports in place for morbidity and mortality
D. Service-User Voice and Equity	Fully embedded and supported MNVP in place	Service user feedback MNVP, complaints/ patient experience		Patient engagement lead Midwife in place who also supports MNVP	All MNVP recommendations met consistently and remain in place currently
E. Care Bundles	Some embedded bundles in place new metrics in development.	Data / outcomes, compliance metrics		Compliance with current Care Bundles, new maternal bundle will involve MDT and wider system partners	Awaiting confirmation of regional guidelines and service developments and any collaborative working
F. Board Oversight, Governance, Culture and Leadership	Governance and reporting structure in place with identified service leads and executive oversight	Perinatal Quality Oversight Report. Dashboards Heat Maps		New reporting metrics in development which not only identify process and outcomes but identify change and improvements	Triangulation of reporting and assurance processes under review to clearly demonstrate compliance

Safety Action A – Workforce and Capacity

The most recent Birthrate+ report was finalised in February 2026. It identified a significant increase in the acuity of women using maternity services, with 84% assessed within the two highest acuity categories. Contributory factors include increasing co-morbidities, such as diabetes, mental health needs, and raised BMI, alongside a higher induction of labour rate in line with national clinical guidance and an increase in operative deliveries.

The Birthrate+ acuity tool is utilised across the maternity floor (completed 4hrly) and this identifies if staffing levels are appropriate to the levels of activity and acuity.

In Q4:

- 99 validated maternity staffing red flag events were recorded
- The increase compared to Q3 reflects improved identification and reporting, not increased harm.
- No harm has been reported in association with these events

Mitigations focus on strengthened reporting consistency, leadership oversight, vacancy management, and workforce planning. Staff are redeployed to areas of highest acuity wherever possible. Staffing red flags continue to relate predominantly to missed or delayed care. Current reporting reflects Delivery Suite activity only and may therefore under-represent pressures across the wider maternity ward environment.

Pages 19–21 of the Q4 Perinatal Quality Oversight Report provide a detailed breakdown of staffing red flags, vacancies by staff group, and planned versus actual fill rates.

A biannual staffing paper is presented to the Board twice within the MIS reporting period and includes vacancies, turnover, and sickness absence. One-to-one care in labour and compliance with the supernumerary shift coordinator standard are also reported monthly through the maternity dashboard.

Annual neonatal staffing reports must demonstrate a fully funded neonatal medical and nursing establishment aligned to the relevant BAPM standards for a Local Neonatal Unit (LNU), which applies to the WWL neonatal unit. Although changes have been made to these standards, MIS Year 8 recognises that these are newly introduced, and compliance against the Year 7 standards will continue to be accepted where achieved.

Service Redesign & Workforce Realignment
Active work is underway to redistribute the workforce and optimise skill mix, including:

- Transition of staff into different service areas (e.g. inpatient/community)
- Phased movement of women into the enhanced team to avoid destabilisation of team and maintain continuity of care.

Teams have engaged positively with these changes, with recognition that continued flexibility and oversight are required to embed the transition safely and sustainably.
Actions

Correlation between staffing gaps and safety incidents will be reviewed prospectively and incorporated into the monthly PSIRF report, which is currently in development.

Capacity to deliver planned and emergency care

This is a new Year 8 metric. Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity and neonatal care. They must also demonstrate that delays are identified, analysed, and reported, and that any persistent issues are escalated appropriately.

This will include:

- Annual demand capacity review
- Use of the Regional SitRep
- Summary of recurring delays inclusive of where planned c/sections were carried out on emergency lists

- Evidence that capacity mapping has informed the service planning with increased lists or improved scheduling
- Evidence of routine monitoring of same day delays with clear escalation for when capacity affects emergency or urgent workload.
- Regular discussion of c/s birth capacity at maternity and theatre forums.

Maternity services currently have two full-day elective lists per week. Women are booked through a local scheduling process, with capacity and demand fluctuating from week to week and managed on a daily basis. There is currently no dedicated resource allocated to support this function, which is being managed at risk within the maternity compliance team by the Pregnancy Loss/Compliance Coordinator, despite this sitting outside the substantive remit of the role. At times, significant negotiation is required to secure additional theatre capacity to meet demand.

Actions

This metric will require weekly review and routine data capture. Plans are currently being developed to support the associated reporting and escalation process.

Safety Action B – Training

MIS training requirements are set out below and attendance is monitored monthly. A well-established multidisciplinary training programme is in place, including obstetric emergency workshops and scenario-based simulation training.

Obstetric and midwifery staff remain consistently compliant and above the 90% threshold. Anaesthetic teams are currently below compliance, primarily due to a high number of new starters entering the service.

All new starters have been contacted directly by email and offered training dates to support timely compliance.

Anaesthetists also complete role-specific neonatal scenarios within PROMPT, and compliance in this area is similarly affected by anaesthetic new starters. All relevant staff have been contacted to book a training date.

Learning arising from PROMPT is translated into clinical scenarios and incorporated into both formal mandatory training sessions and ad hoc simulation exercises delivered within clinical areas.

CTG audits are undertaken monthly by the Fetal Surveillance Lead Midwife and include both electronic fetal monitoring and intermittent auscultation. Results demonstrate consistent compliance with required standards and are currently reported through antenatal and labour care forums, in addition to audit meetings.

Actions

In line with the new MIS requirements, harm events must be triangulated with training data to identify any concerns relating to non-attendance or areas where training has not yet been fully embedded in practice. This work is currently under review and will require retrospective analysis to determine whether any correlation exists, particularly in serious incidents where this was not identified during the initial rapid review.

To strengthen the sharing of learning and discussion of findings, quarterly updates will be presented through the Safety Champions Forum. This will support identification of any correlation between emerging themes and trends, training compliance, and occasions where appropriate actions were not taken, enabling targeted improvement plans to be developed and implemented.

Trusts are required to set a local compliance checkpoint, notified in advance through governance processes to either the Quality and Safety Committee or the Trust Board. A further mandatory national checkpoint is set for 30 November 2026.

WWL's local checkpoint is the end of June 2026. Compliance at this point will be reported through the monthly reporting cycle and submitted to the Quality and Safety Committee in July 2026.

Q4 25/26	Midwives	Obstetric Staff		MSWs	Anaesthetists	Neonatal medics		Neonatal nurses / ANNP
*Fetal monitoring and surveillance	96%	93%	100%					
*Maternity Emergencies and multi professional training	92%	100%	100%	98%	*86% Maternity specialist anaesthetists *46% General anaesthetists			
*Neonatal Life Support training	91%	*100%	*100%	93%	*86% Maternity specialist anaesthetists *46% General anaesthetists *46% General anaesthetists	100%	100%	100%

Safety Action C – Learning from Reviews and Investigations

Q4 data provides assurance that maternity and neonatal services remain safe, with stable incident reporting, no maternity outcome signals identified, and SPC evidence demonstrating continuous improvement across key safety metrics. Five moderate and above harm incidents were reported in maternity, which is above the service's usual baseline and reflects a local move towards outcome-based harm reporting to strengthen transparency and organisational learning.

One moderate and above harm incident was reported in neonatology, with appropriate review and governance processes in place, including compliance with Duty of Candour.

In Q4, one case involving a term baby requiring therapeutic cooling following a labour at home met the MNSI referral criteria and has now been accepted for review by the MNSI team. All cases meeting the MNSI criteria are notified via the SPEN portal and referred through the HIMS secure portal.

In alignment with the Patient Safety Incident Response Framework (PSIRF), incident data, outcomes, and learning continue to inform local priorities and targeted quality improvement initiatives. Current workstreams include:

- Term Admissions to the Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH >1500mls)

- Obstetric Anal Sphincter Injury (OASI – 3rd and 4th degree tears)
- Local Safety Standards for Invasive Procedures (LocSSIP)
- Impacted Fetal Head

Triangulated intelligence from complaints, incidents, claims, and formal reviews identifies predictable system pressures within complex care pathways, particularly in relation to recognition of evolving deterioration, consistency of monitoring, multidisciplinary coordination, and communication during high-pressure events. These themes align with known national maternity risk areas and continue to inform PSIRF-aligned improvement work.

Please see pages 5–10 and 12–14 of the Q4 Perinatal Quality Oversight Report for detailed analysis of incident numbers, reviews undertaken, and identified learning outcomes.

Safety Action D – Service-User Voice and Equity

Feedback is gathered from multiple sources, including the Patient and Public Engagement Midwife, MNVP 'Walk the Patch' visits, Thank You Thursday initiatives, complaints, the Friends and Family Test, and Birth Thoughts sessions, and is triangulated within the Perinatal Quality Oversight Report (pages 10–11). This demonstrates consistently compassionate and high-quality care delivered by staff, with strong appreciation expressed by service users. However, all feedback routes highlight a small number of recurrent system issues, particularly communication, continuity, and postnatal follow-up, which disproportionately affect women experiencing emergency or complex births. These themes will inform co-produced action plans.
A 12-month review of maternity complaints has been undertaken in response to a sustained month-on-month increase in complaint numbers. This will be presented as a June 2026 Board agenda item.

A Health Inequalities Lead Midwife has commenced in post to support the ongoing delivery of enhanced continuity of care for women who are most vulnerable and at greatest risk of health inequalities within the borough. The service currently has one enhanced continuity of care team, which has been expanded to include women who would previously have met the criteria for the Daisy Team, following its disestablishment.

The expansion of the enhanced continuity team is aligned to the Maternity and Neonatal Three-Year Delivery Plan and is intended to improve outcomes for the most vulnerable mothers and babies. The team focuses care on women at greatest risk of poor outcomes, including women and families living in the most deprived neighbourhoods (IMD deciles 1 and 2), and also provides care for women who do not speak English as a first language.

Actions

The Board is advised that service-user voice continues to inform service delivery and that targeted actions are in place to address inequalities in outcomes with the expansion of the Enhanced care team and the introduction of the Health Inequalities' Midwife.

Safety Action E – Care Bundles

WWL has received significant assurance from the Local Maternity and Neonatal System (LMNS) in relation to the implementation of the Saving Babies' Lives (SBL) Care Bundle. Full compliance with Elements 1–5 was achieved in June 2025, with Element 6 subsequently achieved in April 2026.

Intervention Elements	Description	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%
Element 2	Fetal growth restriction	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%
Element 6	Diabetes	Fully implemented	100%
All Elements	TOTAL	Fully implemented	100%

The Saving Babies lives Care Bundle is reported quarterly within the Perinatal Oversight Report.
WWL Maternity services are 96% compliant with the implementation of the SBL 3 Care Bundle.

Exceptions

- A dietetic service is available, but the dietitian does not attend the one-stop diabetes clinic and does not review women with pre-existing Type 1 diabetes.
- National best practice advises that women with pre-existing diabetes should be managed in a dedicated clinic, separate from those newly diagnosed during pregnancy. Given the relatively low numbers of pre-existing diabetics within our service, delivering separate clinics is challenging.

The Diabetes Lead Midwife is liaising with the Performance manager to address these issues which are preventing full compliance with the SBL Care Bundle.

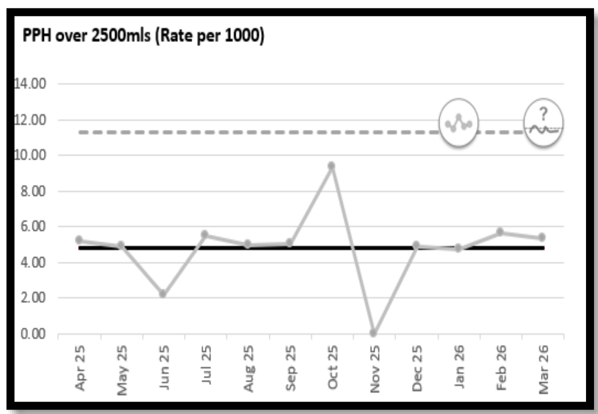
The following key metrics have been removed from GM 26/27 ambition

- Intrapartum Stillbirth
- Early Neonatal Death (ENND)
- Maternal Death (up to 42 days postnatal)

GM has chosen to set ambitions this year for the recognised contributing factors to these original metrics – working on the principle that improving the metrics in these contributing factors will improve overall safety and ultimately improve outcomes across GM:

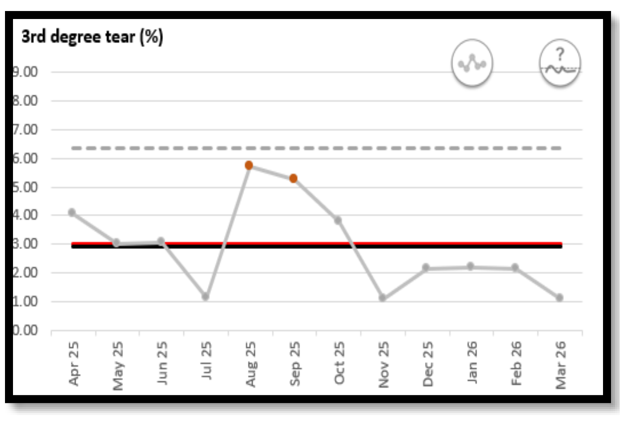
- **Reducing maternal mortality & morbidity**

Reducing PPH between >1litre & <2.5litres by 10% (In line with Maternal Care Bundle).



- **Reducing third- and fourth-degree tears** to meet national average of 2.6% of all births.

Sustained work in place to reduce the incidence of Obstetric Anal sphincter Incidents and thereby reduce harm and maternal morbidity. Ongoing improvements are being achieved through intensive staff training and implementing the Oasis care Bundle. with ongoing support in place for women who do have perineal trauma to improve long term outcomes.



Stillbirth & Early Neonatal Death

Both of these are reported on the Maternity Dashboard monthly and Quarterly within the Perinatal Quality Oversight report

A rise in mortalities was noted in Q4; however, this was associated with unavoidable clinical complexity, including medical terminations of pregnancy (MTOP). In Q4 there was 1 neonatal death following MTOP. WWL are in line with the 2025 GMEC mean

Reducing Caesarean Section at full dilatation to ≤1% of all births.

This is a new metric and will be included within maternity reporting and SPC charts which are under development

Neonatal Pulse Oximetry.

This is a new Metric for Year 8. Trusts must develop a standardised, equitable and governance approved guideline for neonatal pulse oximetry aligned to the BAPM framework for all birth settings with clear escalation processes.

Actions

Pathways are currently in development by neonatal colleagues and will be processed through the maternity and neonatal governance forums and guideline groups for ratification. Training will then be rolled out to all staff and additional equipment to support will be sourced.

The Maternal Care Bundle (implementation Plan)

This is a new Metric and is a structured set of evidence-based interventions designed to reduce maternal morbidity by improving the recognition, prevention and management of key causes of harm, and other complications associated with pregnancy and birth.

There are 5 elements which are

- Element 1: Venous thromboembolism
- Element 2: Pre-hospital and acute care
- Element 3: Epilepsy in pregnancy
- Element 4: Maternal mental health
- Element 5: Obstetric haemorrhage

All NHS trusts providing maternity services and ICBs are responsible for fully implementing the MCB by March 2027. Full implementation of the MCB means implementing all interventions for all 5 elements.

Actions

In collaboration with all services, providers must agree a plan with the Trust Board to implement this by March 2027. Progress is to be reviewed quarterly through established governance routes

The Trust board are required to be assured that care bundles are embedded in practice, with evidence of improved outcomes and reduced variation.

Safety Action F – Board Oversight, Governance, Culture and Leadership

The Quarterly Perinatal Oversight Report sets out the locally and nationally agreed measures used to monitor maternity and neonatal safety, in line with the NHSE Perinatal Quality Oversight Model (August 2025). Its purpose is to provide the Trust Board with assurance regarding current or emerging safety concerns and the actions being taken to maintain safe care, while supporting a two-way flow of intelligence from ward to board across the multidisciplinary maternity and neonatal workforce.

This report is also a requirement of the Clinical Negligence Scheme for Trusts (CNST). In addition, maternity assurance papers are routinely received by the Quality and Safety Committee and the Perinatal Safety Champions. Executive oversight is provided by the Chief Nursing Officer and Medical Director, supported by a dedicated Non-Executive Director who champions maternity and neonatal services.

Reporting

Regular assurance reports received through these governance arrangements include, but are not limited to:

- Quarterly Perinatal Oversight report
- Maternity Dashboard and Report
- Thematic analysis and deep dives as identified
- ATAIN Audits
- Mortality and Morbidity reviews
- Staffing papers
- Saving Babies Lives
- Ockenden actions
- Maternity and neonatal 3-year delivery plan
- Culture and leadership developments
- MNVP/ Patient experience.

These reports are designed to triangulate intelligence across key domains, including demographics, health inequalities, incidents, and litigation, in order to strengthen oversight and support early identification of emerging risks.

Culture

The SCORE survey findings highlighted themes around burnout, communication and teamwork. Workforce culture activity, informed by feedback and supported through listening events and targeted training, provides assurance that organisational learning is underpinned by active staff engagement.

There is no evidence of systemic care failure or deteriorating safety trends. The maternity and neonatal multidisciplinary team now has 10 trained Culture Coaches, with further engagement sessions commencing in June 2026.

Incidents

In alignment with the Patient Safety Incident Response Framework (PSIRF), learning from incidents continues to inform targeted quality improvement priorities. Current workstreams include:

- Term admissions to the Neonatal Unit
- Postpartum haemorrhage (>1500mls)
- Obstetric anal sphincter injury (OASI)
- Local Safety Standards for Invasive Procedures (LocSSIP)
- Impacted fetal head.

Feedback

Triangulated feedback from multiple sources, including the Patient and Public Engagement Midwife, MNVP, Friends and Family Test, complaints, and Birth Thoughts sessions, demonstrate consistently strong confidence in the care and compassion shown by staff. It also highlights recurring system vulnerabilities relating to communication, continuity, and postnatal follow-up, particularly for women who experience emergency or complex care pathways.

Agenda item: [16]

Title of report:	Quality Accounts 2025/26
Presented to:	Board of Directors
On:	17 June 2026
Item purpose:	Approval
Presented by:	Chief Nursing Officer
Prepared by:	Associate Director Governance & Patient Safety
Contact details:	Ehsan.haqqai@wwl.nhs.ul

Executive summary

The 2025/26 Quality Accounts have been developed in line with statutory requirements and NHS England guidance, providing a comprehensive overview of the Trust's quality performance and priorities.

The Accounts set out:

- A review of 2025/26 quality priorities, highlighting areas of progress, delivery against key metrics, and where further improvement is required
- The proposed quality priorities for 2025/26, focused on patient safety, patient experience, and reducing variation in clinical outcomes, aligned to Trust and system priorities
- Statements of assurance covering data quality, clinical audit participation, safeguarding, and regulatory compliance.
- National datasets on key metrics required by statute and the position of the Trust at the time of the data release (to note, some datasets have been discontinued and others have not been update nationally to date)

Link to strategy and corporate objectives

Links to Patient Safety Corporate Objectives for 2025/26 and 2026/27

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

None

People implications

None

Equality, diversity and inclusion implications

None

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

Quality & Safety Committee

Recommendation(s)

It is recommended that the Board:

- **Review** the 2025/26 Quality Accounts
- **Approve** the accounts for publication.

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust
Quality Accounts 2025-26

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Part 2.3 Reporting against core indicators

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Part 3.2 Quality Initiatives

Conclusion

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Annex A: Statement of Directors' Responsibility in respect to the Quality Account

Annex B: How to provide feedback on the account

Foreword

What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual Quality Account to the public about the quality of services they deliver. This includes the requirements of the NHS (Quality Accounts) Regulations and subsequent Amendment Regulations. This publication aims to increase public accountability and drive quality improvement within NHS organisations. Within this document we will review our performance on quality over the previous year, identify areas for improvement, and commit to new quality objectives for the new financial year.

Quality consists of three areas that are essential to the delivery of high-quality services:

- How safe the care is (patient safety)
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

Scope and Structure of the Quality Account

This report summarises how well the Wrightington, Wigan and Leigh NHS Teaching Hospitals Trust (WWL) did against the quality priorities and goals we set ourselves in 2025/2026. It also sets out the quality priorities we have agreed for 2026/27 and how we intend to achieve them.

The report is divided into three parts:

Part One: includes statements from our Chief Executive, Chairman and Chief Nurse.

Part Two: Looks at our performance in 2024/2025 against our quality priorities we set for the year and also sets out the quality priorities for 2025/2026. Part two also includes statements of assurance relating to the quality of services and describes how we review them.

Part Three: Looks at how we identify our own priorities for improvement and gives examples of how we have improved services to patients.

This document is available in an Easy Read version. If you would like this document in another language, large print or braille, please email:

Part 1: Statement from the Chief Executive on Quality

I am delighted to introduce the 2025/26 Quality Account Report for Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

We are proud to provide healthcare services to both the people of Wigan and those from further afield and we set high standards in relation to the care we provide and the services we offer.

The Trust is always strengthening its focus on quality and continuous improvement, and we welcome this opportunity to outline highlight our achievements over 2025/26 that includes the launch of our new Learning, Experimenting, Applying Perfecting, LEAP programme which replaced the previous continuous Improvement drive. More detail on this exciting new programme is contained within this Account and I am proud that this furthers our sustainable improvement capability model aligned to national best practice.

It is fair to say that there have been some challenges through the year, particularly due to the number of patients needing admission with seasonal illness such as flu, norovirus and COVID at peak times for these illnesses. Whilst this was a country wide issue, our teams have worked tirelessly to enhance patient outcomes, improve service accessibility and ensure that the care patients receive meets the highest standards. I want to recognise the hard work of our staff in ensuring safety, driving innovation, and adapting to changes. As a Board, we are clear that the use of escalation beds and temporary spaces is not to be normalised practice in our hospitals and are only used as a last resort and our teams have worked hard to restrict any uses of these escalation spaces to support good patient experience outcomes for those we treat.

The delivery of quality is dependent on several factors, the most significant of which is our workforce. We believe in the importance of fostering and maintaining a positive culture and we aim to be the employer of choice in the borough and beyond. Every interaction with patients, relatives, carers and beyond by our staff contributes to the excellent patient care we provide and I am proud of every team's effort in ensuring that these interactions are overwhelmingly positive.

I also recognise the importance of learning lessons when things do not go as planned and during the year. This focus has been further embedded during the financial year 2024/25, using the Patient Safety Incident Response Framework, and we have embraced this systematic change. 2025/26 marked the second year of implementation of this and we are able to see that incidents are investigated quicker and more efficiently, whilst ensuring that vital is still identified, which allows us to then implement changes sooner following incidents.

This report sets out our performance in detail and I am pleased to confirm that, to the best of my knowledge, the information it contains is an accurate and fair reflection of our performance.

Mary Fleming

Chief Executive and Accounting Officer

Part 2: Our Priorities for Improvement and Statements of Assurances from the Board

Part 2.1: Our new priorities for Improvement in 2026/27

Quality Priorities for 2026/27

WWL has four strategic areas that have priorities around them. These surround our patients, our people, our performance and our partnerships. These have been updated for 2025/26, taking into consideration the changing requirements of the NHS and recognising the dynamic nature of the communities. This section outlines the improvements we plan to take over the next year.

All quality priorities have a timescale for achievement by the 31st of March 2027 and progress to achieve them is ultimately monitored by the Board of Directors.

Our Patients Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience		
Objective purpose	**Focus of objective**	**Lead Executive**
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/specialty, within the right time for patients presenting with heart attack, acute abdomen, stroke or fractured neck of femur	**Medical Director**
	✓ 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	
To ensure that our residents and patients have the best possible experience of our care	✓ Putting patients and residents at the heart of decision making; about their care and about the design of services ✓ Developing a culture among our teams which empower our patients and their families ✓ Support patients to manage their own care, particularly making use of digital approaches (e.g. patient initiated follow ups, digital apps, self-booking) ✓ Improving our communication with patients and residents of the Borough, ensuring it is inclusive of population needs ✓ Review our estates through the eyes of our patients, staff including volunteers and residents ✓ Develop a deeper understanding of patient experience by making it easier for them to provide	**Chief Nurse**

	feedback, e.g. provide digitally enabled feedback via QR codes	
To promote early detection and intervention, preventing avoidable ill health	✓ Endorse the development of the Health Inequalities and Prevention Plan, recognising it as a strategic priority for the Trust and a key enabler of equitable care and improved population health. ✓ Support the establishment of a Health Inequalities and Prevention Group, with appropriate reporting lines and senior leadership chairing arrangements, to provide oversight and assurance on delivery. ✓ Endorse and enable activity against each of the priority areas outlined ✓ Ensure alignment with statutory duties and system-wide priorities, and advocate for the integration of health equity principles across Trust strategies and programmes	**Chief Nurse**

Part 2.2: Statements of Assurances from the Board

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts.

2.2.1 Participation in Clinical Audits

During 2025/26, WWL participated in 46 National Clinical Audits and 8 National Confidential Enquiries covering relevant health services that WWL is eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that WWL participated in and for which data collection was completed during Participation in clinical audit 2025/26 is listed in **Appendix 1.**

The reports of National Clinical Audits were reviewed by the provider in 2025/26 and WWL intends to take the following actions to improve the quality of healthcare provided. Other national reports will be presented once published.

National Audit	Reported Outcomes
National Paediatric Diabetes Audit NPDA 2021-2022	For completion of health checks, the Trust are 99.3% compliant in HbA1c. This is following an improvement plan to increase compliance. The Trust are 100% compliant in offering additional appointments/advice /training, screening at diagnosis.
National Paediatric Diabetes Audit of PREMS 2021 - 2022	90% of patients would recommend clinic to friends or family if they had diabetes. Our results are higher than England and Wales who scored 89%. Most of the comments from parents/carers were positive. Both parents/carers and children felt face to face appointments were better.
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Plans are in place to improve on appropriate first paediatric assessment, to ensure ECG is done in all children presenting with convulsive seizures and to adhere to NICE recommendation that children and young people presenting with suspected seizure are seen by a specialist in the diagnosis and management of epilepsies within 2 weeks of presentation (Quality statement 1).
National Neonatal Audit Programme (NNAP)	When giving antenatal steroids to mothers who deliver babies between 24-34 weeks we achieved a rate of 65% compared to 57% in the NW and 52% nationally in 2022. Improvement has been seen in 2022 in the number of babies <32/40 who had their temperature taken within an hour after birth; the result of which was in target range of 36.5-37.5. In 2022 we were 9% higher than the national and regional rate. There are improvement projects underway, including a ward care bundle.

National Audit	Reported Outcomes
The National Asthma and COPD (chronic obstructive pulmonary disease) Audit Programme	The COPD national audit showed WWL to have a low number of patients who received the discharge bundle. An improvement plan was put in place which has shown an improvement.
TARN audit (Trauma Audit and Research Network) now NMTR (National Major Trauma Registry)	Data showed that WWL did not have good case ascertainment, an improvement plan has been put in place to increase the number of patients submitted, however, results will not be evident for a while due to the changes made to the national audit.
Child Health Clinical Outcome Review Programme 1 - Transition from child to adult health services	Report shared at Divisional Quality Meeting and improvement plan implemented to meet the recommendations of the report.

The reports of 320 Local Clinical Audits were reviewed by the provider in 2025/26. A selection of these audits outlined below show improvements which have taken place from previous audits.

Speciality	Title	Success
Community	Diagnosis & Treatment of Community Acquired Pneumonia within the Community React Team	Improvement from 55% to 100% in patients prescribed the correct dosage and duration of doxycycline following improvement work to highlight awareness of NICE guidance and latest practice.
Audiology	Implementation of Hearing Aid Verification – community audiology paediatric	Improvement from 44% to 92% in patients receiving real ear measurements following improvement work to ensure patients receive new ear moulds prior to annual review.
Orthopaedic	Assessing bone health referral in acute vertebral fractures under Orthopaedic care	New referral pathway instigated for patients with osteoporosis. Teaching and awareness sessions implemented. IT changes to electronic patient record to allow recording of scoring, resulting in improvement in the number of patients attending specialist clinics (11% to 56%), patients initiated on bone protection (28% to 80) resulting in improved care with the potential to reduce fractures.
Urology	Audit of documentation of bladder cancer diagnostic information at flexible cystoscopy	A change in pathway and introduction of bespoke proforma led to improvement from 71% to 97% for documentation of stratification located tumours.
Neonatal	Shoulder Dystocia Audit	Documentation of anterior shoulder / occipital position was only recorded for 56% of cases, improvement plan instigated to include an IT solution to promote improvement documentation, seeing an increase to 100%.

Speciality	Title	Success
Endocrinology	Inpatient audit on use of IV insulin	Only 65% of patients had insulin prescribed and correctly administered. Extensive bespoke training, and generalised training to around 200 staff saw an improvement to 85%. The remaining 15% was in one area, which has now had bespoke intensive training.
Gynaecology	VTE Audit	VTE reassessment had markedly declined to 6%, improvement work put in place including VTE champion. Subsequent audit showed an improvement to 98%.
Orthopaedic	Pre-operative hydration of patients undergoing elective orthopaedic surgeries	Only 64% of patients had a fluid plan in theatre, improvement work including creating designated staff role and standardised proforma saw an improvement to 78%.
General Medicine	AKI Mortality Improvement Plan	Mortality rates for AKI were higher than expected (SHMI value over 100). Improvement work regarding care of patients with AKI alongside work around documentation and coding led to a decrease in mortality relative risk of 32 which is markedly below average.
Ophthalmology	Glaucoma Follow up Appointments	Only 47% of patients were being seen in the required time-period. Improvement plan initiated including local database of high-risk patients. Re-audit showed an improvement to 71%, improvement work is still on-going and further re-audits planned.
Anaesthetics (Pain Team)	Care of Patients with Fractured Ribs	Standards for patients with fractured ribs needed to improve, improvement plan including change of culture, increased education, change of practice and cohesive MDT working led to a pronounced improvement in all metrics, including rib fracture score completed in A&E from 10% to 61%, completed during admission 20% to 96% and admitted directly to surgical ward 50% to 85%.

Speciality	Title	Success
Care of the Elderly	Improving Advanced Care Planning in Severe Frailty – Two Year Summary.	An initial audit had shown that no patients with a Clinical Frailty Score of 7 or over had an element of an Advanced Care Plan completed as recorded on the discharge letter. An improvement plan including education, awareness, MDT working, IT solutions and prompts led to an overall improvement to 56%. Work is still ongoing.
Orthopaedic	Reducing Length of Stay in Hip Replacement	Length of Stay following hip replacement was 3 days. An improvement plan using GIRFT recommendations was instigated involving an MDT approach, improving mobilisation and pain relief, which saw an improvement to 1.9 days.
Corporate	Improving Sepsis Care at WWL using AQ (Advancing Quality)	The Trust recognised a need to improve care of sepsis, and an improvement plan agreed to improve compliance of the sepsis 6 bundle. This saw an improvement in all areas, most notably an increase in blood cultures from 8.7% to 50%.

2.2.2 Research

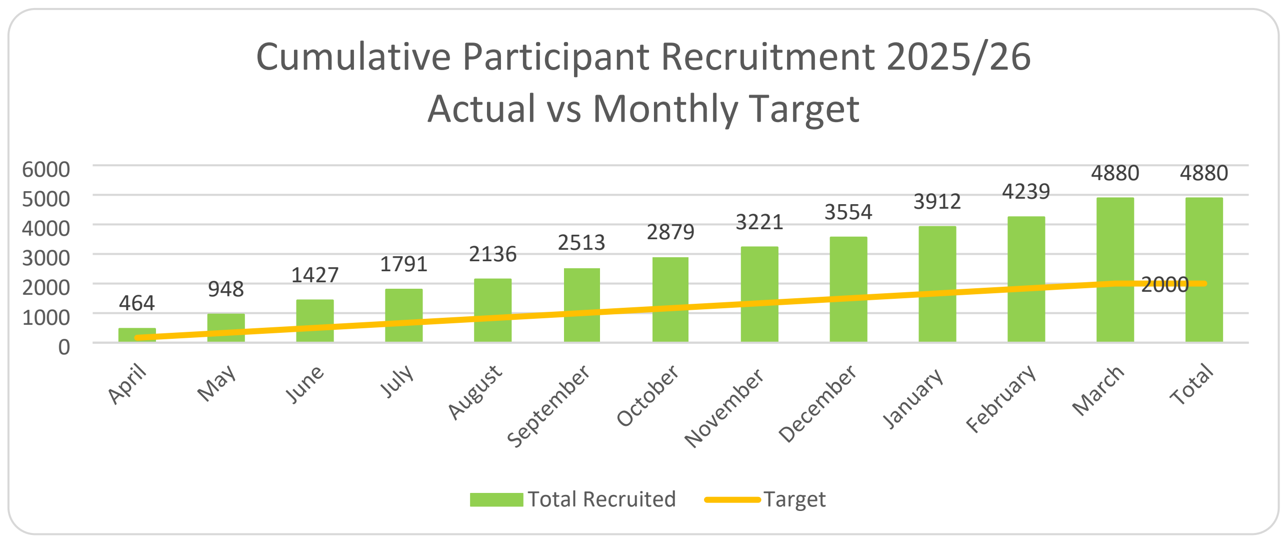
Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement and offering *Research for All*. Our clinical staff are continually invited to express interest in new NIHR Research Delivery Network (RDN) Portfolio studies and growth in research is a core aim of WWL's 5-year Research Strategy (*Research for All* 2022-26).

It is globally recognised that a commitment to clinical research leads to better outcomes for patients. Reflecting these objectives to:

- ✓ **Increase research taking place across the Trust and Primary Care.**

Currently, there are 20 different specialities delivering 96 RDN Portfolio adopted clinical studies.
The number of WWL patients that were recruited to participate in research during 2025/2026 (approved by the HRA and adopted onto the RDN Portfolio was 4880 (a substantial increase to the previous report for 2022-23 of 2467 recruits), an average of 406 patients per month (compared with 196 patients per month in 2022/23). The Trust target agreed with the NIHR Clinical Research Network (CRN) for the 2024/25 financial year was 2000 recruits. WWL has therefore substantially exceeded the Research Network set target.

The chart below illustrates target versus actual participant recruitment to research studies in 2025/26.



The portfolio of studies continues to thrive in 2025/6 as the current figures demonstrate, following a period of fluctuation during the COVID-19 pandemic (2020-21) where the number of studies reduced from 100 to 79 and in 2022-23 restoring to pre-pandemic levels.

Our Research Strategy aims to increase the research capacity and capability, and the number of clinical staff involved and interested in research has grown. The number of clinicians acting as Principal Investigators increased from 55 in 2019-20 to 77 in 2022-23, with 61 currently delivering 96 active studies in 2025-25.

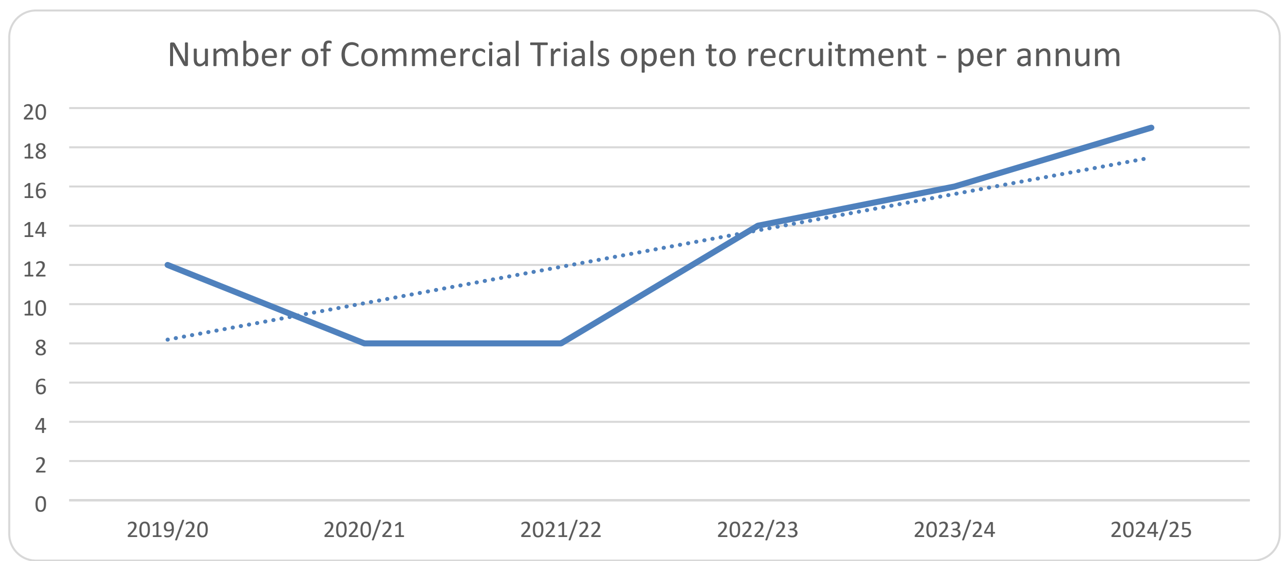
Research active specialties include: Ageing & Complex Needs, Cardiology, Cancer, Critical Care, Diabetes, Ear Nose and Throat (ENT), Emergency Medicine, Gastroenterology, Orthopaedics, Reproductive Medicine, Respiratory and Surgery. Areas of focus for improvement in research activity include: Dermatology, Rheumatology, Paediatrics and Community Services.

Primary Care - A strategic project was delivered in 2025 across our health and care providers in the Wigan Borough, developing relationships and partnerships for research, links with GP practices, Primary Care Networks and GP Federations have been initiated and subsequent collaboration in the delivery of research is planned.

A Wigan Health and Care Research Forum, established in 2024 and continues along with Wigan Borough Council Public Health Team and including all interested stakeholders across the Borough. Four forums have been held with the latest event focussing on diabetes. There are 77 current members registered and each meeting attracted around 35-45 delegates from across health and care sectors and the voluntary sector.

- ✓ **Increase number of commercial trials delivered with high performance meeting national KPIs.**

The number of commercial trials has increased each year since 2019-20.



The portfolio is monitored and delivered to achieve the national Key Performance Indicators (KPIs) e.g.

- Initiation of Research (set-up time and to opening – 60 days following HRA approval)
- First participant recruited (within a further 30 days)
- Research delivered to Time and to recruitment Target (RTT >80% of studies achieving RTT)

✓ **Increase research knowledge and capability to deliver research.**

All staff that support clinical research activity are trained in Good Clinical Practice (GCP) which is an international quality standard transposed into legally required regulations for clinical trials involving human subjects. Additional induction and training/development opportunities are provided by the Research Department to support staff in conducting quality research studies in a safe and effective manner reducing the inherent risk of research delivery.

The clinical research team supports all clinical teams conducting research studies across the Trust.
The Community Clinical Research Hub, established in 2023 brings research closer to patients' homes and provides a more accessible venue for our patients to engage and take part in research (with favourable feedback), and provides open access to the facility to our healthcare partners across the Healthier Wigan Partnership.

The Research Team provide expert support and advice to all colleagues ensuring the safe care of patients when they are recruited to research at WWL, and ensure adherence to the European Directive, Good Clinical Practice guidelines and data protection and all relevant laws. As a result of this expert support, the larger clinical community within the Trust is enabled to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

The ongoing development of our Research Patient Public Involvement (PPI) group influences the way that research is designed and to encourage more awareness and interest, we continue to engage with Wigan residents to continue to expand the diversity of the patient and public involvement. The numbers contributing to our research have increased in the last 2 years from 17 to 60+ individuals with topic specific lived experiences. Members help to identify which research questions are important and help to influence the way research is carried out to help WWL improve the experience of people who take part in research.

Publications are encouraged to ensure research knowledge and outputs are shared in multiple ways with the healthcare sector across the world and with our patients and staff.

- ✓ **Increasing NIHR funded research studies/programmes led by WWL.**

It is important that we continue to support both pilot studies in preparation for grant submissions to the National Institute for Health Research (NIHR), and to support this aim, the Research Team has developed links with Edgehill University and other universities to build new collaborations and locally provide initial advice and support via our grant support service. The Sponsorship of research has also been strengthened with the development of the Sponsorship Policy and review process and the team currently manages 9 WWL Sponsored studies. These improvements demonstrate our commitment to patient safety, assurance and to improve patient outcomes and experience of research in the NHS.

Over the last 5 years, the Trust has attracted 3 NIHR project grants (1 trial is still active) and has submitted at least 2 project competitive grant submissions to the NIHR annually, with no new project grant successes as yet. The Trust has however been very successful in attracting NIHR fellowships/training funding (NIHR Pre-doctoral Fellowship x1, preparation for NIHR Doctoral Fellowships x2, NIHR INSIGHT x1, NIHR Credentials x1, NIHR Senior Research Leader Nursing and Midwifery x1, NIHR Developing Research Leader x1 submitted pending.

WWL, through its NIHR research capacity funding, funds protected time for 5 Clinical Research Leads across the Trust working to improve research engagement within the clinical divisions, community and the non-medical professions. The latter 2 Clinical Leads, alongside the Sponsorship Team, have established a Research Incubator of staff interested in research and in developing research careers, and hosts ~70 interested individuals who receive training and newsletters/communications about research training, funding opportunities and research stories, awards, publications and conference presentations to be celebrated. Around 40 of this group also volunteer to promote research in their departments as Research Champions. Five of these professionals have been supported to apply to the aforementioned training and fellowship schemes with successful funding/protected time to develop their research knowledge and academic skills/careers.

- ✓ **Increasing the number of WWL honorary clinical academics employed substantively with EHU.**

The Trust has increased the number of clinical academics (substantively employed by a University) from 1 in 2021, to 5 in post in 2024-25.

The Trust's ambition is to increase the number of University substantively employed clinical academics holding an honorary contract with WWL, and as such, is in close discussion with our main partner Edgehill University and other universities to achieve growth in this area. There are numerous clinicians who hold honorary appointments with Edgehill University and other Universities.

2.2.3 What others say about WWL

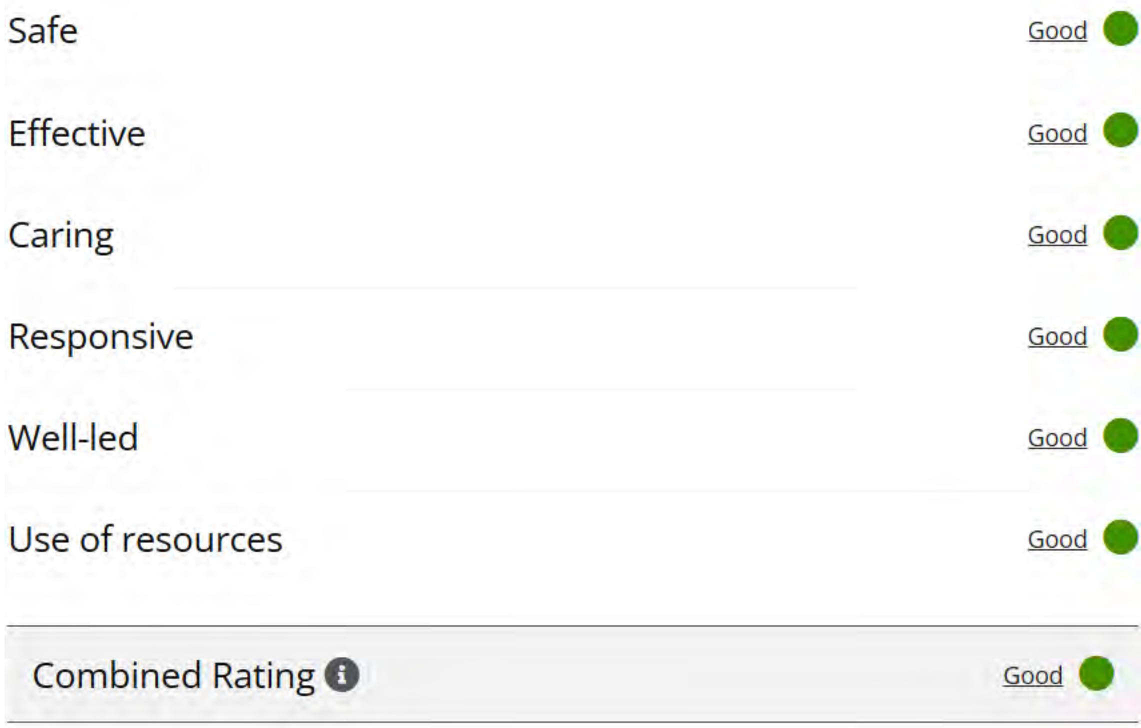
Feedback from the Care Quality Commission (CQC)

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2025/26, is registration without any compliance conditions. The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2025/26.

Within 2025/26, WWL we had one any onsite inspection at the Tomas Linacre Centre underwent a comprehensive assessment of both the outpatient department and diagnostic imaging services. The assessment was unannounced and triggered due to the age rating from the previous inspection (2015). An inspection team crossed the threshold 6 January 2026 and spent two days on site. This was followed up with online well led interviews and an extensive request for information; the information was returned on time. There was high level feedback on 8 January 2026, this did not highlight any regulatory breaches from the assessment at that point. The full report is expected to be received during the first week of April 2026, the outcome has the potential to affect our overall Trust rating.

The Trust underwent a focused CQC inspection within our of Nuclear Medicine services under the Ionising Radiation (Medical Equipment) Regulations IR(ME)R assessment in December 2025, this report has been received and the action plan to mitigate gaps has been accepted. There were no enforcement or improvement notices issued from this assessment. Whilst this assessment does not influence our overall rating, we are pleased that our services are externally validated.

The Trust's latest overall CQC rating for WWL is **GOOD** and WWL has maintained a rating of **GOOD** for every domain (safe, effective, caring, responsive and well-led). Our Use of Resources is also rated as **GOOD**



The Trust has continued to carry out a schedule of internal inspections through our ASPIRE ward accreditation process and we therefore believe that is still reasonable to expect that these ratings are valid. We are currently working through the areas of the sites not covered by ASPIRE to assess them against CQC standards and support staff in hosting an external assessment; these are predominantly consisting of outpatient and diagnostic imaging.

We continue our improvement journey to be Outstanding in everything that we do, working together to ensure that our patients and community continue to receive the best possible care. We work closely with our regulators and despite frequent changes in the CQC we have managed to maintain good relationships with our CQC Point of Contact with monthly point of contact meetings, in addition to quarterly relationship meetings. We work hard to be responsive to all enquires from the CQC and we are very timely to provide a quality response to each enquiry. We also have an open line of communication with the CQC Point of Contact, and we are proactive in raising any concerns as they occur. The positive working relationship we have with our regulators has streamlined the number of enquiries we manage; the CQC understand how we are managing our pressures, as well as having a good understand of what is going well.

We are expecting further CQC assessments over the next two years as many of our services have not been inspected since 2016, this is a national drive by the CQC to review services where the ratings are significantly old and do not always reflect any specific risks for inspection of a site or service.

2.2.5 Information Governance Toolkit Attainment Levels

WWL's Data Security Protection Toolkit was submitted in June 2025. The assessment was scored as Standards Met. For 2025/26 the Trust will be submitting an improvement plan on June 2026, with an improvement plan submitted to NHS England for approval.

2.2.6 Statement on relevance of Data Quality and your actions to improve your Data Quality

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Over the last 12 months the Trust has continued its programme of work for the development and improvement of the Data Quality.

The Trust has been working on improving the series of DQ Apps launched last year which supports a more comprehensive picture of how the Trust is performing against key data quality metrics. The key focus for this year in regard DQ iterations is Community Data. The purpose of the app is to provide frontline services with clear visibility on where there are issues or areas of concern. Again, this will allow the individuals and services entering the data to investigate and remedy any issues, as well also learning for the future and review.

This supports the NHS "Get It Right First Time" (GIRFT) approach and is aligned to Article 5 of the General Data Protection Regulation (GDPR)

WWL will be taking the following actions to improve data quality:

The Trust will continue to develop and roll out the next iteration of DQ app ensuring that Key Performance Indicators across all services are reviewed, amended, added to and utilised to support the Trusts ability to give assurance and continue improvement against the DQ Programme.

The Trust will look at ways in which we can identify data quality issues earlier, utilising automation technologies with a view to reduce the amount of retrospective fixing of data.

2.2.6 Statement on relevance of Data Quality and your actions to improve your Data Quality

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Over the last 12 months the Trust has continued it's programme of work for the development and improvement of the Data Quality.

The Trust has been working on improving the series of quality apps launched last year which supports a more comprehensive picture of how the Trust is performing against key data quality metrics. This has progressed further and there are a number of apps where data is either manually validated and inputted or automatically inputted from systems within the Data Warehouse where data accuracy can be guaranteed.

WWL will be taking the following actions to improve data quality:

The Trust will continue to develop and roll out the next iteration of DQ app ensuring that Key Performance Indicators across all services are reviewed, amended, added to and utilised to support the Trusts ability to give assurance and continue improvement against the DQ Programme.

The Trust will look at ways in which we can identify data quality issues earlier, utilising automation technologies with a view to reduce the amount of retrospective fixing of data.

2.2.7 Learning from Deaths

During the calendar year 2025 there were 1339 deaths in hospital under the care of WWL. Included are deaths within A/E, but not community deaths where the patient dies out of the hospital but still within community care.

Since 2008, there has been a process for reviewing deaths and the process is structured in a way that meets the Learning from Deaths Guidance published in 2017.
The Learning from Deaths team reviewed 696 deaths approximating to half of the deaths within the organisation. These were done within a week of each death occurring and learning is shared widely on a weekly basis. Within the deaths reviewed, there were 7 deaths that were highlighted as being potentially preventable. This represents approximately 1% of the reviewed cases. It is significantly below the academically predicted 5% of cases considered to be predictable in similar retrospective case reviews.

The learning is summarised as an annual report and this is shared widely within the organisation. This year the report highlighted:

- Whilst the population is aging, the number of deaths has remains surprisingly stable.
- In order to accommodate an increasingly dependent population the organisation has grown by about 1/3 in the last 10 years.
- Whilst 24 hour waits in A/E are always unacceptable, they have fallen a little in the last year.
- Long stay patients are important causes of the need for increased capacity, but most of the increase was caused by greater need for healthcare and increased provision in all areas.
- Elective clinical care is remarkably safe with all deaths after elective admission being reviewed. There were just 5 deaths from 18,000 operations.
- Problems with clinical care included issues raised with Chest Drain insertion, Corridor waits, Internal bleeding and capacity issues.

Within the weekly audits issues are raised about individual patients and then further investigation happens through the divisional clinical governance teams. These have addressed issues on a wide range of problems but included:

- Chest Drain
- Deterioration
- Diabetes care
- Bladder perforation
- Internal bleeding
- Pericardial effusion

Whilst monitoring care for problems there is also the opportunity to monitor standards of care. Sepsis and Acute Kidney Injury are just such standards, and the work indicates that the standard of care in both these areas is maintained with improvement seen in the care of patients with Sepsis. 69% of patients with sepsis were judged to have care that fulfilled all the components of good sepsis care. The commonest problem remains the failure to send blood cultures.

2.2.8 Seven Day Services

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals. The standards have been reviewed in 2021 by a clinical reference group that confirmed they remain relevant and important in the NHS today.

Clinical Standard 2-
This standard states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

- Summary of Standard 2:
  - 120/122 patients (98.4%) seen by a consultant within 14 hours of admission to the ward
  - 2/122 patients (1.6%) seen by a consultant over 14 hours after admission to the ward
  - 100% of patients were seen by a consultant
  - There were two patients who did not get seen within 14h of arrival to the ward by a consultant. However, both patients had appropriate review.

Clinical Standard 5-
This standard states that emergency and urgent access to appropriate consultant-led diagnostics tests and reported results should be available every day.

For all of the Emergency Diagnostic Tests all are available at weekends either directly or via a network, as in the case of Microbiology

Clinical Standard 6-
This standard states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

For all of the interventions it has been shown that they are available on site at weekends either directly or via a network as in the case of interventional radiology and interventional endoscopy.

Clinical Standard 8-
This standard states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

This has been determined by analysing the notes of each of the 122 patients and determining if they had been reviewed by a consultant or a delegate on each day of their admission, up to 7 days after admission. Day 2 has been taken on the day following arrival, rather than day following admission. Patients who were transferred to Jean Heyes Unit, Bryn Ward or Highfield Ward are not included.

Patients are considered to have been reviewed within the expected timeframe if they are seen within 14 hours of admission to the ward. Historically, most patients would leave the Emergency Department within four hours and then be admitted to a ward, meaning the total expected time from ED arrival to consultant review was effectively 18 hours (4 hours in ED plus 14 hours on the ward). As current practice shows that relatively few patients are admitted to a ward within four hours, an additional 18-hour ED-to-review standard has been introduced to reflect the full patient journey more accurately.
The average length of stay for patients in the emergency department prior to admission to the ward is 36 hours 2 minutes.

The average time to be seen from arrival is 18 hours 50 minutes. 51 patients were seen within 18 hours of arrival.

2.2.9 Speaking up

The Trust aims to ensure that staff feel comfortable and safe to raise concerns with their line managers in the first instance. Concerns may relate to quality of care, patient safety or bullying and harassment. We recognise that by valuing our staff who raise concerns, listening and acting on the issues, speaking up can really make a difference to staff wellbeing and patient safety. When a concern is raised with managers it is important that they know how to handle the concern and have the correct escalation processes to ensure action is taken to resolve those concerns.

If staff do not feel able to raise concerns with their managers or they are unsatisfied with any feedback they have been given there are other routes available to staff. Staff can raise concerns with their Union, Human Resources or with the Freedom to Speak Up Guardian. One of the critical roles of the Freedom to Speak Up Guardian is to ensure that staff raising concerns do not suffer detriment. The Freedom to Speak Up Guardian can also provide the following support:

- an independent route and safe space for staff to raise concerns
- report or escalate concerns on the behalf of the staff
- act as an advocate for staff and protect identity of staff wishing to remain anonymous
- obtain information or act as a 'go between' within any investigation into a concern
- agree support, ongoing communications and feedback on the progress of any escalated concern.

2.2.10 NHS Doctors in Training

This section is intended to illustrate the number of exception reports raised against the vacancy rate by the grade of doctor. Fill rates for ad hoc shifts are provided to illustrate how successfully vacant shifts are filled. This section also illustrates the actions taken to mitigate the risk of having unfilled shifts and any adverse impact on the training experience of Doctors in Training whilst on rotation to WWL

High level data

Number of doctors and dentists in training (total): 178

Number of doctors and dentists in training on 2016 Terms and Conditions of Service (total): 178

Annual data summary

Specialty	Grade	Exception Report Raised				Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
		Q 1	Q 2	Q 3	Q 4			
General Surgery	F1	2	39	39	31	0	1	N/A
General Surgery	F2/ST 1-2	15	3	7	4	2	118	2
General Surgery	ST3+	0	0	0	0	0	5	N/A
General Medicine	F1	4	38	28	31	0	7	N/A
General Medicine	F2/ST 1-2	3	14	19	0	0	837	16
General Medicine	ST3+	0	0	0	0	0	585	11
Emergency Medicine	F1	0	0	0	4	0	0	N/A
Emergency Medicine	ST1/2	2	6	2	0	0	66	1
Orthopaedics	F1	0	2	3	1	1	0	N/A
Orthopaedics	F2/ST 1-2	0	0	0	0	1	5	N/A
Orthopaedics	ST3+	0	0	0	0	0	6	N/A
Ear Nose and Throat	ST3+	0	0	0	0	0	6	N/A
Paediatrics	F2/ST 1-3	0	1	2	2	1	12	N/A
Obstetrics and Gynecology	F1	0	0	0	0	0	**0**	**N/A**
Obstetrics and Gynecology	F2/st1-2	6	4	5	0	0	**1**	**N/A**
Obstetrics and Gynecology	ST3+	0	0	0	0	0	**2**	**N/A**
Psychiatry	ST1/2	1	2	0	0	0		**N/A**
Anesthetics	ST1/2	0	0	0	0	0	**22**	**N/A**
Anesthetics	ST3+	0	0	0	0	0	**31**	**N/A**
Urology	ST3+	1	2	0	0	0	**0**	**N/A**
Total		**34**	**111**	**105**	**73**	**5**	**1,704**	

This report contains a full year's result of exception reports, vacancies and unfilled shifts.

The Trust has few doctors in training vacancies however there are vacancies for the non- training grade doctors who participate on the training grade rotas.

Issues arising:

Increased educational exception reports

Q4 demonstrated an increase in exception reports for educational reasons, mainly for FY1 in Medicine. The doctors had been complaining about missed training and teaching opportunities however there was

not the evidence in exception reports to back up the complaints. Following discussions at the junior doctor's forum it was agreed that the doctors would exception report so that this could be captured.

Actions taken

The Exception Reports for missed educational opportunities relate to three key areas:

1. Missed Clinics
2. Missed Protected Teaching (PT)
3. Missed Self-development Time (SDT)

- Medical Education has raised the issue of missed clinics with rota co-ordinators to raise awareness of the Clinic requirements, particularly for trainees on BtFP track. Medical Education and Rota Co-Ordinators are working together to ways in which clinical attendance can be improved.
- Post Foundation Doctors (PFD) have now completed their 3-month settling in period. PFDs will be available to provide ward cover for HEE trainees for attendance at PT session (including mandatory teaching on Tues/Wed afternoons and Fri lunchtime); SDT and clinic attendance.
- Medical Education are working with the Allocate Project Team to ensure PT and SDT is built into the new e-rota and e-roster platform. This will make it easier for Rota Co-Ordinators to ensure safe staffing levels can be maintained during the times when trainees are unavailable due to teaching requirements.

Medical Education closely monitor missed teaching opportunities as reported via Exception Reports and via Clinical and Educational Supervisor Meetings. The governance structure for Medical Education allows issues and concerns to be escalated to DMDs, CDs and the MD quickly and accurately. In addition, the DME has built strong relationships with service leads to allow for an open and response environment in relation to trainee concerns.

Part 2.3: Reporting against core indicators

We are required to report performance against a core set of indicators using data made available to us by NHS Digital. For each indicator, the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods, is presented in the table below. Where the required data is made available by NHS Digital, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS Trusts indicators with:

a) National average for the same, and;
b) Those NHS Trusts with highest and lowest for the same.

Please note that not all data included within this report is for 2023/24, this is due to publishing timescales from national data collection agencies.

Indicator	Reporting Periods	Trust Performance	National Average (for last reported time period)	Benchmarking (NHS Trusts with highest and lowest for the last reported time period)
Mortality				
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	December 2023 – November 2024	Value: 1.0492 Banding – 'as expected'	Value: 1.0041	Best: Imperial College Healthcare NHS Trust – Value 0.7016
				Worst: East Lancashire Hospitals NHS Trust – Value 1.2849

	December 2024 – November 2025	1.0058	Value: 1	Best: Imperial College Healthcare NHS Trust – Value 0.7194
				Worst: Blackpool Teaching Hospitals NHS Trust - Value 1.3183
Patient Reported Outcome Measures Scores (PROMS)				
i) Groin Hernia Surgery	National PROMs benchmarking for groin hernia surgery ceased in 2018; however, procedural activity and outcomes continue to be monitored using HES data			
ii) Varicose Vein Surgery	National Patient Reported Outcome Measures (PROMs) data for varicose vein surgery were discontinued by NHS England from October 2017 following a national consultation. As a result, national comparative PROMs data are no longer available for inclusion in Quality Accounts			
iii) Hip Replacement Surgery	April 2023 - March 2024	24.381	22.303	Best: SPIRE WASHINGTON HOSPITAL (NT333) - Value: 26.6038
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 6.95254
	April 2024 – March 2025	24.381	22.189	Best: WINFIELD HOSPITAL (NVC22) - Value: 25.583
				Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 16.1743
iv) Knee Replacement Surgery	April 2023 - March 2024	23.412	16.815	Best: DROITWICH SPA HOSPITAL (NT412) - Value: 20.1149
				Worst: THE YORKSHIRE CLINIC (NVC20) - Value: 11.445
	April 2024 - March 2025	17.375	16.666	Best: IMPERIAL COLLEGE HEALTHCARE NHS TRUST (RYJ) - Value: 21.5593
				Worst: SPIRE GATWICK PARK HOSPITAL (NT308) - Value: 12.4107
Hospital Readmission				
The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2023 - March 2024	7.9	13.2	Best: BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RYW) - Value: 1.6
				Worst: WORCESTERSHIRE HEALTH AND CARE NHS TRUST (R1A) - Value: 69.1
	April 2024 - March 2025	8.6	13.0	Best: BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RYW) - Value: 1.2
				Worst: THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 48.1

The percentage of patients readmitted to a hospital which forms part of the trust within 30 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	April 2021 - March 2022	15.1	14.7	Best: BMI - THE HAMPSHIRE CLINIC (NT418) - Value: 2.1
				Worst: TEDDINGTON MEMORIAL HOSPITAL (NNV2J) - Value: 142.0
	April 2022 - March 2023	15.8	14.4	Best: HUMBER TEACHING NHS FOUNDATION TRUST (RV9) - Value: 2.5
				Worst: ORTHOPAEDICS & SPINE SPECIALIST HOSPITAL SITE (NQM01) - Value: 46.8
Responsiveness to Personal Needs				
The Trust's responsiveness to the personal needs of its patients during the reporting period	April 2023 - March 2024	18.0	15.1	Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) - Value: 1.7
				Worst: YOUR HEALTHCARE (HOLLYFIELD HOUSE) (NNV01) - Value: 99.6
	April 2024 - March 2025	15.8	14.9	Best: NUFFIELD HEALTH, BRIGHTON HOSPITAL (NT436) - Value: 0.6
				Worst: NUFFIELD HOSPITAL OXFORD (THE MANOR) (NT244) - Value: 40.3
Friends and Family Test (Staff)				
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	National NHS Staff Survey 2022	62.43%	62.95%	Best: Alder Hey Children's NHS Foundation Trust (RBS) Value - 86.38%
				Worst: The Shrewsbury and Telford Hospital NHS Trust (RXW) - Value: 39.27%
	National NHS Staff Survey 2023	62.47%	64.97%	Best: Alder Hey Children's NHS Foundation Trust (RBS) Value - 88.82%
				Worst: United Lincolnshire Hospitals NHS Trust (RWD) - Value: 44.31%
Venous Thomboembolism				
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	*July 2019 - September 2019*	*96.64%*	*95.40%*	*Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) & LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (RY5) - Value: 100%*
				Worst: BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 71.72%
	October 2019 - December 2019	*96.40%*	*95.25%*	*Best: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) & LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST (RY5) - Value: 100%*
				Worst: NORTHERN DEVON HEALTHCARE NHS TRUST (RBZ) - Value: 71.59%
ClostridiumDifficile (C. difficile)				

The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	April 2023 - March 2024	21.08	20.94	Best: LIVERPOOL WOMEN'S NHS FOUNDATION TRUST (REP), BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (RQ3) & QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST (RPC) - Value: 0.00 Worst: THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 63.12
	April 2024 - March 2025	36.89	23.29	Best: BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST (RQ3) - Value: 1.79 Worst: THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 80.97
Patient Safety Incidents				
The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage if such patient safety incidents that resulted in severe harm or death.	April 2020 - March 2021	8333 Incidents Reported (Rate per 1000 Bed Days 61.9) / 8 Serious Incidents (0.10%)	1550533 Incidents Reported / 6767 Serious Incidents (0.44%)	Best: MEDWAY NHS FOUNDATION TRUST (RPA): Incidents Reported 3169 (Rate per 1000 bed days 27.2) / 56 Serious Incidents (1.77%) Worst: NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RM1): Incidents Reported 32917 (Rate per 1000 bed days 118.7) / 67 Serious Incidents (0.20%)
	April 2021 - March 2022	7428 Incidents Reported (Rate per 1000 Bed Days 47.67) / 17 Serious Incidents (0.23%)	1767264 Incidents Reported / 7116 Serious Incidents (0.40%)	Best: MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RD8): Incidents Reported 3839 (Rate per 1000 bed days 23.67) / 18 Serious Incidents (0.47%) Worst: PENNINE ACUTE HOSPITALS NHS TRUST (RW6): Incidents Reported 11903 (Rate per 1000 bed days 205.52) / 49 Serious Incidents (0.41%)

PAY & DISPLAY
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Christopher Home Building

Part 3: Other Information

Part 3.1: Review of performance against out Patient Safety Objectives from 2025/26

This section of the Quality Account provides information on our quality performance during 2025/26. Performance against the priorities identified in our previous quality account and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of several initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Patient Safety

Objective:	**To improve the quality of care for our patients and residents.**
Where we are at the end of 2025/26	We always work hard to ensure we provide high quality for all. To do this we have worked on: ✓ Right patient, right ward, right professional, right time for 80% of patients with heart attack, stroke, acute abdomen or fractured neck of femur to reduce harm and mortality ✓ Fundamentals of care – we completed a successful annual programme of reviewing one quality metric per month over the financial year. Divisions and Teams rose to the challenge and launched a variety of programmes such reviewing nutrition and hydration, infection control and safeguarding ✓ Harm free Care work continued and we saw a reduction in the number of avoidable high harm falls over the year ✓ Introduction of Martha's Rule work has seen staff and families alike use the service to support our patients. The introduction of daily questionnaires has also helped in ensuring individualised care to all our patients

Objective:	**To ensure that our residents and patients have the best possible experience of our care**
Where we are at the end of 2025/26	✓ Putting patients and residents at the heart of decision making; about their own care and about design of services – in addition to having a healthy and number of hospital volunteers, we have introduced a Lived Experience Volunteers and partners who are beginning to provide essential inputs into our ✓ Developing a culture among our teams which gives patients the power – again, the introduction of Martha's Rule has helped in giving patients, relatives and carers more opportunity to identify deterioration ✓ Support patients to manage their own care, particularly making use of digital approaches (e.g. patient initiated follow ups, digital apps, self-booking) ✓ Clear, accurate patient communication ✓ Review our estates through the eyes of our patients and residents ✓ Develop a deeper understanding of patient experience by making it easier for them to provide feedback –e.g. provide digitally enabled feedback via QR codes

Objective:	**To promote early detection and intervention, preventing avoidable ill-health.**
Where we are at the end of 2025/26	✓ Redesigning community services across Wigan around the needs of communities and reducing duplication (working in partnership with primary care, social care, mental health, voluntary sector, WWL community services) by using the Better Lives Programmes of work to truly achieve a system approach to supporting our community

	✓ Focus on prevention, with specialties using data and working with primary care to support identification of inequality in outcomes and opportunities to intervene earlier ✓ Alignment of health promotion opportunities within our services

Performance against the relevant indicators and performance thresholds set out in NHS England's Oversight Framework

The following indicators are set out in NHS England's Oversight Framework. *Please note Summary Hospital-level Mortality Indicator (SHMI) and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.*

Key

(green)	Performing on or above target
(amber)	Performing below trajectory; robust recovery plan required
(red)	Failed target or significant risk of failure
↑	Improved position
↓	Worsening position
↔	Steady position

Indicator	2023/24		2024/25		2025/26
Infection Control					
Clostridium difficile (C. *difficile*)	56 Threshold= 0	↑	76 Threshold = 0	↑	77
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	0	↓	1	↔	1

C.difficile:

In 2025/26 each case underwent a detailed review to ascertain any lapses in care. Irrespective of this, comprehensive action plans were drawn up to address any learning that resulted from these investigations and progress is monitored at the Infection Prevention Control Group. There were 21 'Lapses in Care' identified; the most common reason was related to samples being taken later than they should have been, followed by inappropriate use of antibiotics. Actions are ongoing to remind staff of the importance of timely sampling and the Consultant Microbiologists and Antibiotic Pharmacist continue to promote and monitor antibiotic use.

MRSA Bacteraemia:

There was one cases logged as attributable to the Trust in 2025/26.

Data Source: National Health Protection Agency data collection, as governed by standard national definitions.

Indicator	2023/24		2024/25		2025/26
Never Events					
Number of Incidents Reported as Never Events (Threshold= 0)	5	↔	5	↓	2

In 2025/26 we saw 2 incidents that were classified as 'never events' under the national framework definitions. The first incident related to a wrong site nephrostomy and the second surrounded a wrong site carpel tunnel procedure. Whilst there first incident clearly aligned to the national framework, the second was not so clear, however, the Trust has taken the decision to report it as such to show it's openness an honesty. Both incidents noted human factors and one reformatting issue in relation to the CT performed. Action plans for both have been completed and evidence on the implementation tested.

Data Source: Datix Risk Management System. 'Never Events' are governed by standard national definitions.

Accident and Emergency (ED)	**2023/24**		**2024/25**		**2025/26**
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	68.92%	↑	70.61%	↑	71.88%

Significant work has been undertaken in 2025/26 to ensure that the Trust performs to the standard and we are pleased that we have been identified as the most improved Trust in the Greater Manchester Area for our A&E performance

Data Source: Management Systems Services (MSS), as governed by national standard definitions.

Cancer Waits	**2023/24**		**2024/25**		**2025/26**
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	93.86%	↓* ↓**	85.56%	↓	81.66%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	87.37%	↓*	84.07%	↓	78.03%

WWL's overall performance for all standards related to the 62-day cancer waiting times in 2025/26 have been affected throughout the year by a number of factors within different services, however in certain specialties such as colorectal, there has been good performance. A number of specialties have seen capacity challenges and we continue to work with our GP colleagues to ensure that appropriate referrals are being made.

All breaches have a harm review and if any harm has been identified to have occurred, an incident is raised to investigate this further. No harms have been identified within the breaches.

We continue to collaborate with our partners across Greater Manchester to improve patient pathways and deliver the best possible outcomes for our patients.

Data Source: NHS Digital, as governed by standard national definitions.

Complaints, Patient Advice and Liaison Service and the Parliamentary & Health Service Ombudsman

Patient Relations and Patient Advice and Liaison Service (PALS) are dedicated to enhancing the patient, carer and relative's experience. We welcome complaints and concerns to ensure that continuous improvement to our services takes place and to improve experience through lessons learned.

The Patient Relations and PALS Team has continued their proactive role dealing with concerns and all other contacts; providing information, guidance and advice, appointment and admission queries, legal and access to records requests; many of which had the potential to becoming a formal complaint. The department continues to work closely with the Divisions to promote a positive patient experience and to actively encourage a swift response to concerns which may be received by letter, e-mail, telephone or visitor to PALS, providing resolution in real time.

All complaints and concerns are discussed at our weekly Learning from Patient Safety Events Group which was established in January 2024 in line with our launch of the Patient Safety Incident Response Framework. These have corporate and divisional representation from medical, nursing, midwifery and allied health professionals and gives an opportunity to review any complaint received with the more complex and serious complaints highlighted. Where appropriate, certain complaints may be escalated for further investigation via the Patient Safety Incident Response process. These meetings also provide the opportunity to triangulate information with incidents, possible claims or HM Coroner Inquests.

Statistical information in respect of complaints and concerns is collected and monitored to identify trends. We continue to share statistical information from formal complaints nationally (KO41a) within quarterly reports to a variety of groups and the Quality & Safey Committee. This includes information on the Subject of Complaint, the Services Area (in-patient; out-patient; ED and Maternity), amongst other information for each individual site under our responsibility.

We understand that every concern or complaint is an opportunity to learn and make improvements for our future patients, their relatives and carers. We also recognise that handling complaints and concerns effectively matters for people who use our services and explanations and apologies, if required, are provided. Feedback of any nature are welcomed to learn and reflect on how we work and to make the appropriate improvements. The table overleaf outlines actions taken, and lessons learned from a sample of complaints received. These learning points are not just shared with the service concerned but with the wider Trust in order that we may improve the experience of patients, relatives and members of the public who interact with our services.

Complaints Theme and Brief Summary	Actions Taken and Lessons Learned
Values and Behaviours: Patient attended department and states is exempt from wearing face mask. Unhappy with attitude of staff member who insisted they wear one. Generally found the staff member rude and disrespectful.	Staff member was not fully aware of the guidelines for mask wearing. Individual feedback to staff member involved in relation to the current guidelines for patients who are exempt from wearing a mask. Staff member involved to undertake customer care course, with support from manager
Communication: Family, friends and relatives could not get through on the telephone to ward(s) and area(s) to obtain an update on their loved one. Lack of communication to	The Patient Relations Team implemented an email messaging service – messages and pictures are emailed into the department, these are picked up by the team, printed off and delivered to the ward(s) and area(s). The team also requested the Trust to pay for Patient Line to use

families regarding the care and treatment provided to patients in hospital.	for all our patients, and for a period of time patients received Freeview TV and free outgoing calls, with incoming calls a significantly reduced cost
Patient Care: Complainant unhappy with care and treatment from the district nurses and lack of supplies that were available for the patient.	Division of community have established an End-of-Life Lead Nurse who is working on a number of initiatives to improve the quality of the patient/carer experience. Training is being undertaken for all staff regarding the IPOC and an end-of-life register is now in place within each team.
Clinical Treatment: Patient has concerns regarding treatment, diagnosis, and discharge he received in department after attending due to having a fall. Patient re-admitted due to injuries being missed at previous attendance and has further concerns raised regarding his care, treatment, medication and discharge	Shared learning with all clinical divisions with emphasis on the importance of the secondary survey in all patients experiencing trauma including those with normal CT imaging, particularly in cases where there is a normal reported CT scan. Process for receiving 3rd party discrepancy reports to be identified and to be discussed at WWL discrepancy meetings. CT trauma images to be reviewed with multi-planar reformats (MPRs) to increase the detection rate of abnormalities visualised in the coronal and sagittal orientation.

Improvement Plans as a result of complaints referred to the Parliamentary Health Service Ombudsman

The role of the Parliamentary and Health Service Ombudsman (PHSO) is to provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS England, have not acted properly or fairly or have provided a poor service.

The aim of the PHSO is to provide an independent, high quality complaint handling service that rights individual wrongs, drives improvement in the public service and informs public policy.

During 2025/26 the PHSO requested information regarding 7 complaints. Some of these relate to historical complaints as there has been a backlog of processing cases by the PHSO. On receipt of every outcome from the PHSO results in an action plan that is monitored within the Division

Part 3.2 Quality Initiatives

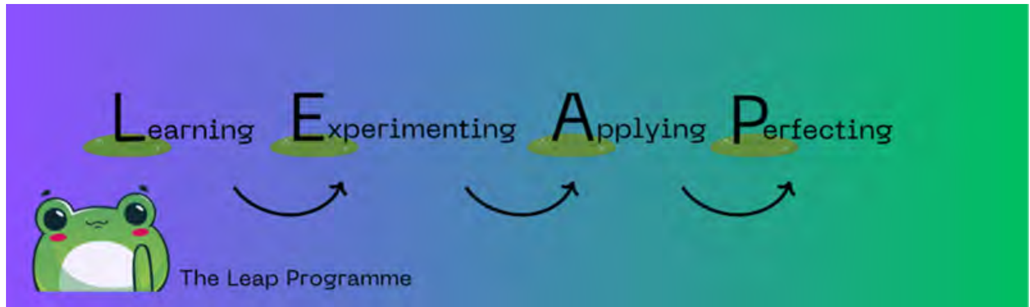
The Trust has a robust cycle of continuous improvement and we built and launched an electronic management tool within our electronic Audit management system, AMaT that has allowed those undertaking continuous improvement projects to manage their work, as well as having a better overview of the programmes underway**.**

Continuous improvement at WWL

Over the last year, Continuous Improvement (CI) at WWL has focused on **building improvement capability**, **strengthening learning from patient safety incidents**, and **aligning improvement activity to Trust priorities** – supporting safer care, better outcomes and a more empowered workforce.

🚀 Building Improvement Capability: The LEAP Programme

A major milestone this year was the **launch of the LEAP improvement capability programme (November 2025)**, replacing the previous continuous improvement offer with a clearer, more inclusive pathway.



What we delivered

- A **multi level programme**:
  - **Level 1 - LEARN** and **Level 2 - Experiment**: online, interactive modules accessible to all staff
  - **Level 3 - APPLY**: face-to-face sessions focused on practical improvement delivery
  - **Level 4**- **PERFECT**: active delivery of improvement projects
- This provides a **clear progression route** that supports staff from first exposure to CI through to leading improvement work.

Why this matters

- Continuous improvement capability is no longer limited to a small cohort — it is now **embedded, scalable and accessible**.
- Teams are better equipped to lead change locally, rather than relying on central support.
- A consistent language and methodology for improvement across the Trust.
- The programme directly supports Trust priorities around **quality, safety and productivity**.

✅ **Reason to celebrate:** WWL now has its own, sustainable improvement capability model aligned to national best practice.

🎤 Creating Momentum: CI Conference and Roadshows

To support the LEAP launch and build energy around improvement, we delivered a **Trust-wide conference and roadshow programme**.

Highlights

- Successful online conference, showcasing improvement in action and signalling strong organisational commitment.
- Roadshows across services, bringing improvement closer to frontline teams.
- External presentations to enable new ideas as well as internal speakers spreading learning and improvements to a wider audience.

Impact

- Raised awareness and visibility of Continuous Improvement.

- Reinforced the message that **improvement is everyone's business**.
- Created opportunities for teams to connect, share learning and feel recognised.

☑ **Reason to celebrate:** Improvement moved from something "done to teams" to something **owned by teams**.

🔗 Alignment to Trust Priorities

Across all activity, Continuous Improvement has been deliberately aligned to what matters most for WWL:

- **Patient safety and quality**
- **Staff capability and engagement**
- **System learning and reliability**

CI is increasingly seen as an **enabler of Trust strategy**, not a standalone function.

☑ **Reason to celebrate:** Improvement is becoming part of "how we do things here", not an add-on.

🛣 What's Next: Embedding and Maturing Improvement

Building on the foundations laid over the last 12 months, the next phase of Continuous Improvement at WWL will focus on **greater system grip, assurance and sustainability**, particularly through **Board-level improvement oversight** and the development of a **Quality Management System (QMS)**.

📌 Board-level Improvement and Oversight

- Strengthening how improvement, learning and risk are **visible and assured at Board level**.
- Supporting clearer **lines of sight** from frontline learning (including PSIRF) through to strategic priorities and decision-making.
- Enabling the Board to have confidence not just in knowledge of issues, but in the **effectiveness of improvement actions** taken to address them.
-

Impact we are aiming for

- Improved strategic grip on quality and safety.
- Better prioritisation of improvement work.
- Stronger organisational learning and accountability.

⚙ Developing a Quality Management System (QMS)

- Designing and implementing a **coherent QMS** that brings together:
  - Improvement capability (LEAP)
  - Patient safety and PSIRF learning
  - Quality governance and assurance
- Moving from isolated improvement activity towards a **joined-up, repeatable system** for managing quality and improvement.
- Supporting consistency, clarity and sustainability across services.

Impact we are aiming for

- A shared understanding of how quality is planned, monitored and improved.
- Reduced duplication and greater alignment between teams.
- Improvement becoming part of everyday business, not additional work.

Conclusion

This Quality Account for 2025/26 reflects our continued dedication to delivering high-quality, patient-centred care. Over the past year, we have made significant strides in enhancing our services, embedding the new Patient Safety Incident Response Framework, and improving the quality of our responses to patient feedback and complaints. These efforts are a testament to the commitment and professionalism of our staff across all sites.

As we look ahead to 2026/27, our focus remains on continuous improvement, with clear priorities including the further integration of patient safety initiatives, strengthening our workforce culture, and progressing our ambition to become a university teaching organisation. We are proud to serve the people of Wrightington, Wigan, Leigh, and beyond, and we remain committed to transparency, accountability, and excellence in everything we do.

We welcome feedback from our patients, staff, and partners, and we look forward to working collaboratively

Appendix 1 – National Clinical Audits

Count	Programme / work stream	Provider organisation	Eligible to Participate	Participated
1	Breast and Cosmetic Implant Registry	NHS Digital	YES	NO
2	Case Mix Programme	Intensive Care National Audit & Research Centre	YES	YES
3	Child Health Clinical Outcome Review Programme 1 - Testicular Torsion	National Confidential Enquiry into Patient Outcome and Death	YES	YES
	Child Health Clinical Outcome Review Programme 1 - Transition from child to adult health services	National Confidential Enquiry into Patient Outcome and Death	YES	YES
4	Cleft Registry and Audit Network Database	Royal College of Surgeons - Clinical Effectiveness Unit	NO	N/A
5	Elective Surgery (National PROMs Programme)	NHS Digital	YES	YES
Emergency Medicine QIPS: Workstream				
6	Assessing cognitive impairment in older People	Royal College of Emergency Medicine	YES	NO
	Infection Preventions & Control		YES	NO
	Mental Health self-harm		YES	NO
	Pain in Children		YES	NO
7	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	YES	YES
Falls and Fragility Fracture Audit Programme Workstream				
8	Fracture Liaison Service Database	Royal College of Physicians	YES	YES
	National Audit of Inpatient Falls		YES	YES

	National Hip Fracture Database		YES	YES
Gastro-intestinal Cancer Programme Workstream				
9	National Bowel Cancer Audit	NHS Digital	YES	YES
	National oesphago-gastric cancer		YES	YES
10	Inflammatory Bowel Disease Audit	IBD Registry	YES	NO
11	LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	NHS England and NHS Improvement	YES	YES
Maternal and Newborn Infant Clinical Outcome Review Programme				
12	Maternal mortality surveillance and confidential enquiry. (confidential enquiry includes morbidity data)	University of Oxford / MBRRACE-UK collaborative	YES	YES
	Perinatal confidential enquiries		YES	YES
	Perinatal mortality surveillance		YES	YES
13	Medical and Surgical Clinical Outcome Review Programme 1 - Community Acquired Pneumonia	National Confidential Enquiry into Patient Outcome and Death	YES	YES
	Medical and Surgical Clinical Outcome Review Programme Endometriosis		YES	YES
	Medical and Surgical Clinical Outcome Review Programme 1 - End of Life Care		YES	YES
14	Mental Health Clinical Outcome Review Programme	University of Manchester / NCISH	NO	N/A
15	Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	The British Association of Urological Surgeons	YES	YES

National Adult Diabetes Audit Workstream				
16	National Diabetes Core Audit	NHS Digital	YES	YES
	National Pregnancy in Diabetes Audit		YES	YES
	National Diabetes Footcare Audit		YES	YES
	National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms		YES	YES
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme Workstream				
17	Paediatric Asthma Secondary Care	Royal College of Physicians	YES	YES
	Adult Asthma Secondary Care		YES	YES
	Chronic Obstructive Pulmonary Disease Secondary Care		YES	YES
	Pulmonary Rehabilitation-Organisational and Clinical Audit		YES	YES
18	National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	YES	YES
19	National Audit of Cardiac Rehabilitation	University of York	YES	YES
20	National Audit of Cardiovascular Disease Prevention	NHS Benchmarking Network	NO	N/A
21	National Audit of Care at the End of Life	NHS Benchmarking Network	YES	YES
22	National Audit of Dementia	Royal College of Psychiatrists	YES	YES
23	National Audit of Pulmonary Hypertension	NHS Digital	NO	N/A
24	National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	NO	N/A

25	National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK	YES	YES
National Cardiac Audit Programme Workstream				
26	National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	YES	YES
	Myocardial Ischaemia National Audit Project		YES	YES
	National Adult Cardiac Surgery Audit		NO	N/A
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)		YES	YES
	National Heart Failure Audit		YES	YES
	National Congenital Heart Disease		NO	N/A
27	National Child Mortality Database	University of Bristol	NO	N/A
28	National Clinical Audit of Psychosis	Royal College of Psychiatrists	NO	N/A
29	National Early Inflammatory Arthritis Audit	British Society of Rheumatology	YES	YES
30	National Emergency Laparotomy Audit	Royal College of Anaesthetists	YES	YES
31	National Joint Registry	Healthcare Quality Improvement Partnership	YES	YES
32	National Lung Cancer Audit	Royal College of Surgeons of England	YES	YES
33	National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	YES	YES
34	National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	YES	YES

35	National Ophthalmology Database Audit	The Royal College of Ophthalmologists	YES	YES
36	National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	YES	YES
37	National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative	YES	YES
38	National Prostate Cancer Audit	Royal College of Surgeons	YES	YES
39	National Vascular Registry	Royal College of Surgeons	YES	YES
40	Neurosurgical National Audit Programme	The Society of British Neurological Surgeons	NO	N/A
41	Out-of-Hospital Cardiac Arrest Outcomes Registry	University of Warwick	NO	N/A
42	Paediatric Intensive Care Audit	University of Leeds / University of Leicester	NO	N/A
43	Perioperative Quality Improvement Programme	Royal College of Anaesthetists	YES	YES
Prescribing Observatory for Mental Health Workstream				
44	Improving the quality of valproate prescribing in adult mental health services	Royal College of Psychiatrists	NO	N/A
	The use of melatonin.		NO	N/A
Renal Audits: Workstream				
45	National Acute Kidney Injury Audit	UK Kidney Association	NO	N/A
	UK Renal Registry Chronic Kidney Disease Audit		NO	N/A
Respiratory Audits: Workstream				
46	Adult Respiratory Support Audit	British Thoracic Society	YES	YES
	Smoking Cessation Audit- Maternity and Mental Health Services		YES	NO

				(Currently on Hold by Provider)
47	Sentinel Stroke National Audit Programme	King's College London	YES	YES
48	Serious Hazards of Transfusion National Hemovigilance Scheme	Serious Hazards of Transfusion	YES	YES
49	Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	YES	YES
50	Trauma Audit & Research Network	The Trauma Audit & Research Network	YES	YES
51	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	YES	YES
52	UK Parkinson's Audit	Parkinson's UK	YES	YES

Participation in NCEPOD Studies (National Confidential Enquires into Patient Outcomes & Death)

Study Title	Eligible to Participate	Participated
Dysphagia in Parkinson's Disease	YES	YES
In Hospital Management of Out of Hospital Cardiac Arrests	YES	YES
Physical Healthcare in mental health hospitals	YES	YES
Transition from child to adult health services	YES	YES
Epilepsy	YES	YES
Crohn's Disease	YES	YES
Community Acquired Pneumonia	YES	YES

Annex A: Statement of Directors' Responsibilities in respect of the Quality Report

The Directors of Wrightington, Wigan and Leigh NHS Foundation Trust ("WWL") are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations and subsequent amendments to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that the NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2025 to March 2026
  - Papers relating to Quality reported to the Board over the period April 2025 to March 2026
  - Feedback from commissioners
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The 2025 national patient survey
  - The 2025 national staff survey
  - CQC inspection reports published during the financial year 2025/26
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

30 June 2026 *Chairman*

30 June 2026 *Chief Executive*

Annex B: How to provide feedback on the account

Feedback on the content of this report and suggestions for the content of future reports can be provided by calling the Trust Freephone Number 0800 073 1477 or by emailing: foundationstrust@wwl.nhs.uk

Agenda item: [17]

Title of report:	WWL's NHSE statement on information on health inequalities
Presented to:	Board of Directors
On:	17th June 2026
Presented by:	Richard Mundon, Deputy Chief Executive
Prepared by:	Annie Lowe, Consultant in Public Health, Michelle Cooper, Principal Data Analyst, Joan Brookes, Specialist Data Analyst, DAA
Contact details:	BI PerformanceReport@wwl.nhs.uk Annie.lowe@wwl.nhs.uk

Executive summary

This report outlines the Trust's response to NHS England's updated statutory requirements to collect, analyse and publish disaggregated data on health inequalities within the annual report. It includes:

- An overview of Wigan's health needs
- Analysis of inequalities in access, experience and outcomes in elective and urgent and emergency care
- Progress in improving data quality and reporting
- Key actions taken and next steps

Analysis of data from 2023–2025 shows consistent patterns of inequality by age and deprivation across WWL services. Patients in the most deprived areas continue to wait longer for elective treatment, have DNA rates twice as high as those in the least deprived areas, and are almost four times more likely to be frequent A&E attenders. Children and young people remain more likely to wait longer for elective care, while older adults experience higher A&E attendance, frequent attendance and readmission rates. This report will be incorporated into the Trust's Annual Report.

Link to strategy and corporate objectives

This work directly supports the Trust's commitment to reducing inequalities and improving the quality of care for all patients. It aligns with the following corporate objectives:

- CO1 – to improve the quality of care for our patients and residents
- CO2 – to ensure that our residents and patients have the best possible experience of our care
- CO3 – to promote early detection and intervention, preventing avoidable ill-health
- CO4 – make WWL a great place to work and ensure that our staff feel valued
- CO6 – Drive improvements in our overall performance, placing patients at the centre of everything we do. Take our opportunities to be outstanding.
- CO8 – to further strengthen existing partnerships and develop new ones to complement and support our NHS services and research activities.

Risks associated with this report and proposed mitigations

Failure to act on health inequalities places the Trust at risk of non-compliance with statutory duties and could contribute to widening inequalities, poorer population health and increased demand on services. The Health Inequalities and Prevention Plan provides a structured approach to mitigate these risks through strengthened governance, senior leadership oversight, improved data quality and usage, and workforce development. Delivery will require engagement from teams across the Trust despite significant operational pressure. To ensure sustainability, health inequalities and prevention must become embedded within everyday practice, supported by shared ownership and incremental changes to business-as-usual processes.

Financial implications

Addressing health inequalities and preventing illness can improve productivity, reduce avoidable demand and generate long-term efficiencies. There is no immediate financial requirement to deliver the plan, although future investment may be needed. The Trust will prioritise low-cost, high-impact actions and seek external funding for interventions where appropriate. Opportunity costs associated with staff time will need to be recognised.

Legal implications

As a Foundation Trust, WWL is legally required to consider the impact of its decisions on health inequalities and service quality under the Triple Aim duty (Health and Care Act 2022). The Trust must also publish an annual health inequalities statement under section 13SA of the NHS Act 2006, demonstrating how data has been used to identify and address inequalities. NHS England's *Statement on Information on Health Inequalities* sets out statutory expectations for how Trusts should evidence this work. Publication of this report within the Annual Report, alongside delivery of the Health Inequalities and Prevention Plan, will ensure compliance with these requirements.

People implications

The report is focused on health inequalities experienced by WWL patients. We recognise that there will be implications for staff who live in the borough.

Equality, diversity and inclusion implications

This work aims to reduce unfair differences in access, experience and outcomes by improving data quality and reporting. There are clear synergies with the EDI Strategy Group, and close collaboration will be essential to ensure alignment and maximise impact.

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

- The report has been presented to ETM and at the Board's Workshop.

Recommendation(s)

- The board is asked to receive and approve the Statement on Information on Health Inequalities for inclusion in the Annual Report.

HEALTH INEQUALITIES STATEMENT

Health inequalities are unfair, unjust and avoidable differences in health between groups. They arise from unequal access to healthy living conditions, healthcare and the support people receive. In December 2025, the Trust launched its Health Inequalities and Prevention Plan, which aims to create lasting change where preventing illness and health inequalities becomes part of our everyday practice, to improve the health of our population. A key part of this approach is using high-quality data and insight to inform action on health inequalities through both operational and strategic decision-making.

This report sets out our organisational response to NHS England's updated *Statement on Information on Health Inequalities*. The national guidance outlines the statutory requirements for NHS bodies to collect, analyse and publish robust, disaggregated data to understand and address inequalities in access, experience and outcomes. In line with the Core20PLUS5 approach and the wider ambitions of the 10-Year Health Plan, this report describes how we will embed these requirements into our local systems, strengthen data quality, and ensure that insights on health inequalities meaningfully shape our planning, commissioning and service delivery.

The report includes:

- An overview of Wigan borough's health needs
- Understanding healthcare access, experience and outcomes
- Improving data quality, collection and analysis
- Using information on health inequalities — areas of progress and next steps

Understanding Wigan's health needs

Approximately 77% of the Trust's catchment population live in the Wigan Borough[1], which is home to 330,000 people. The population is growing and ageing: between 2011 and 2021 the number of residents increased by 11,472, and the 70–79 age groups grew by over 40%, making this the fastest-growing older population in Greater Manchester. The borough remains predominantly White British (95%), though ethnic diversity is increasing, with notable growth in Asian, Black and mixed ethnic groups over the past decade.

Health inequalities remain one of the most significant challenges. Wigan is the 78th most deprived local authority in England, and 28.5% of residents live in neighbourhoods among the 20% most deprived nationally. These inequalities translate into stark differences in health outcomes: life expectancy varies by 8.1 years for men and 9.1 years for women between the most and least deprived areas, driven largely by higher rates of circulatory disease, cancers and respiratory conditions in more deprived communities.

Overall health outcomes in the borough are worse than the England average. Residents live shorter lives and spend more years in poor health, with healthy life expectancy around 58 years for both men and women. The leading causes of death mirror national trends - dementia, lung cancer, pneumonia and heart disease - but premature mortality is strongly patterned by deprivation. Key preventable risks such as smoking, alcohol-related harm, physical inactivity and obesity continue to contribute significantly to poor health, with 74.6% of adults living with overweight or obesity and high rates of falls among older adults.

[1] Microsoft Power BI

Children and young people also experience poorer outcomes than national averages, including higher levels of dental decay and elevated rates of overweight and obesity in early years, alongside persistent inequalities in child poverty and early development[2].

Understanding healthcare access, experience and outcomes

To help us identify unwarranted variation in access, experience and outcomes across different population groups, this section focuses on inequalities within core performance measures that align with our operational priorities. The analysis concentrates on:

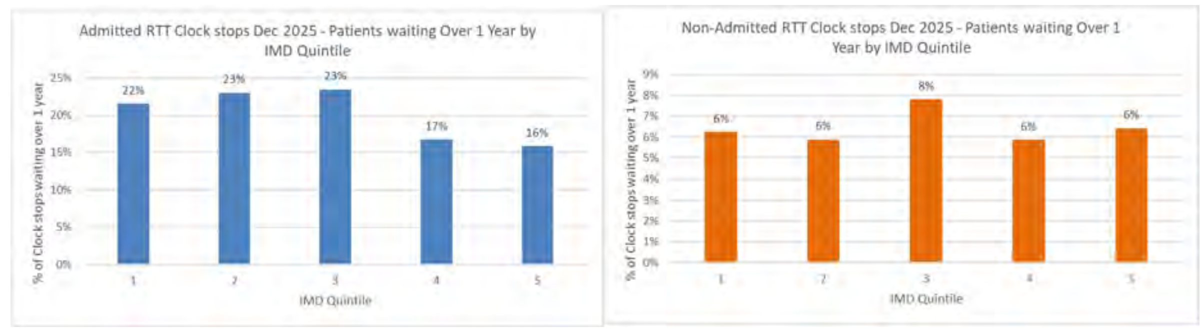
- **Elective care:** waiting lists and outpatient DNAs
- **Urgent and emergency care:** A&E frequent attenders, average length of stay and readmissions
- **In hospital mortality**
- **Index of Disparity**

In 2023, three health inequalities insight reports were produced for the Trust, highlighting variation in waiting lists, occurrences of patients failing to attend appointments (DNAs), A&E attendances and emergency admissions. By using the same metrics, we have been able track trends annually. This paper therefore compares performance for April - December 2025 with 2024/25, 2023/24 and 2022/23.

All data has been disaggregated by age, sex, and Index of Multiple Deprivation (IMD), and where possible ethnicity, to identify unwarranted variation linked to protected characteristics and deprivation. These characteristics are now embedded within on-demand reporting, enabling more consistent and systematic monitoring of inequalities.

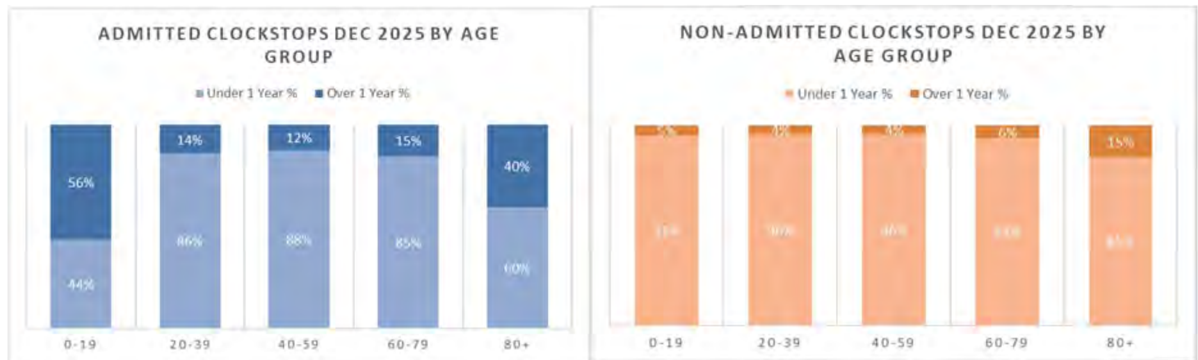
Waiting Lists

- As of December 2025, the proportion of patients in the more deprived, and median deprived areas who wait over 1 year for admitted care remains higher than the percentage in the least deprived areas.
- Patients waiting over 1 year for outpatient treatment across all of the quintiles ranges from 5.9%-6.4%, except for quintile 3, with 7.8% of patients.

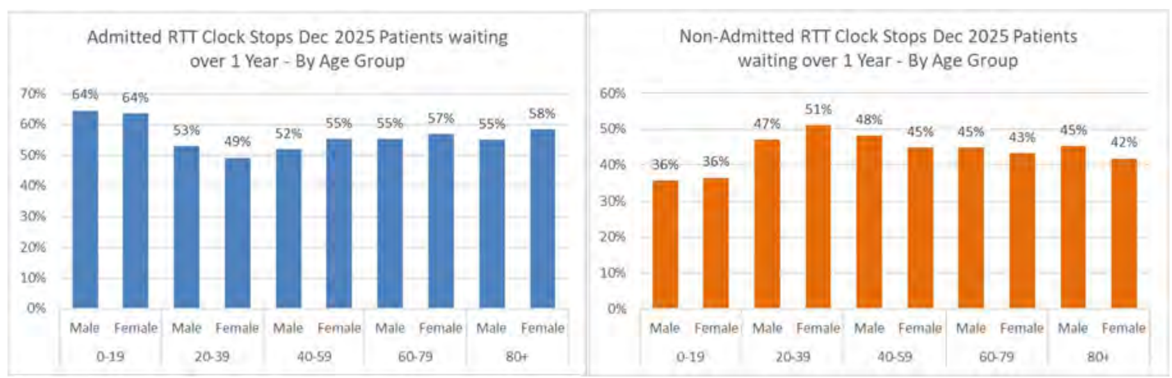


- Children remain more likely to wait over 1 year for admitted treatment, 56%, with 40% of patients aged over 80 years waiting over 1 year, compared with 12-15% for remaining patients. 15% of patients aged over 80 wait over 1 year for outpatient treatment compared to 4-6% for other patients.

[2] Wigan Borough Joint Strategic Needs Assessment Population Health Summary



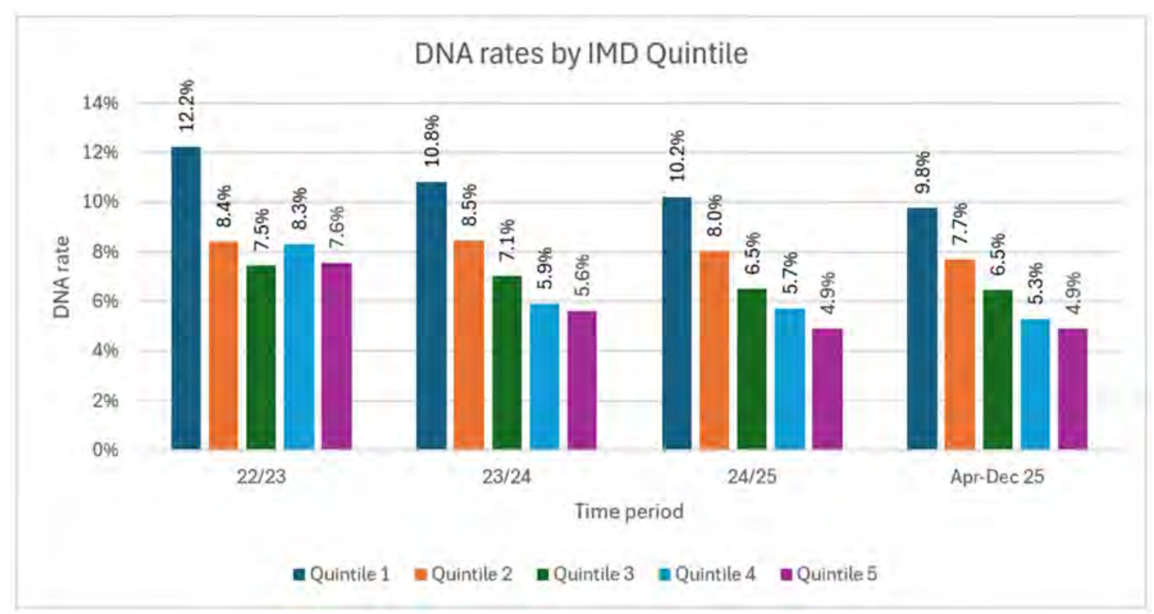
- The latest waiting list position, as at December 2025, shows a higher proportion of patients aged 0-19 who waited over 1 year for admitted care.



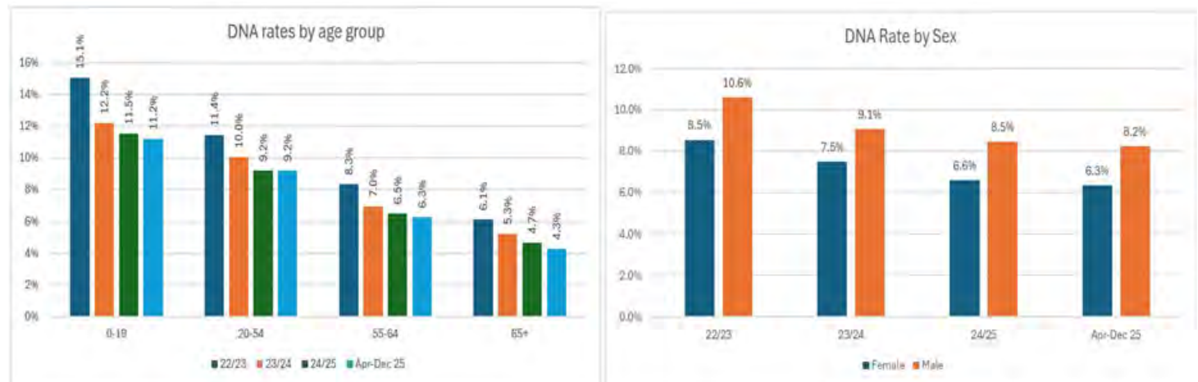
- Disaggregation of patients waiting over 1 year by ethnic group was conducted, but due to small numbers it was not possible to draw any conclusions.

Outpatient DNAs

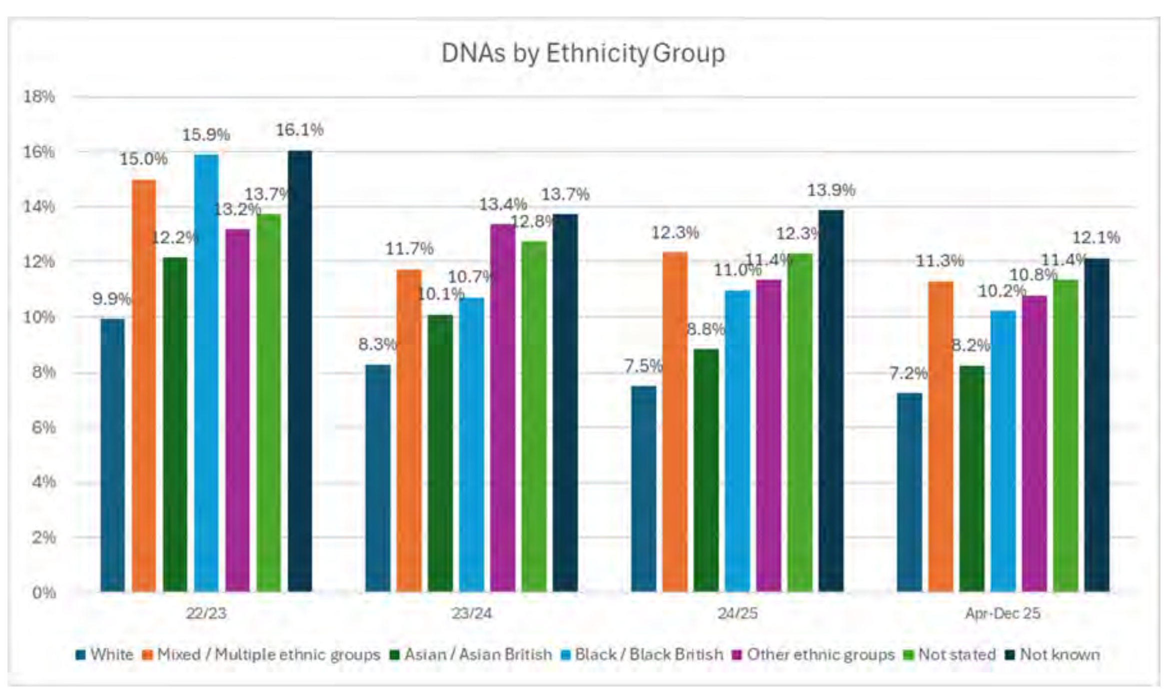
- The overall DNA rate for the Wigan residents at WWL was 7.4% in April - December 2025, this is showing a downward trend (9.4% in 2022/23 to 8.2% in 2023/24, 7.6% in 2024/25).
- Outpatient DNA rates continue to be highest for those living in the most deprived areas, as deprivation reduces so does the DNA rate.
- Between April - December 2025, the DNA rate for patient's resident in quintile 1 (20% most deprived areas) was twice as high as for those residents in quintile 5 (20% least deprived areas).
- This is consistent with previous years showing a persistent inequality.



- There has been a year-on-year reduction in DNA rates across all age groups, and by sex. The highest levels remaining amongst the younger age groups, specifically those aged 0 to 19 and males aged 20 to 54 years. As age increases, the rate of DNA continues to reduce across all time periods analysed.
- DNA rates remain consistently higher in males, particularly those aged 20-54 years, with the latest DNA rate being 15.28%.

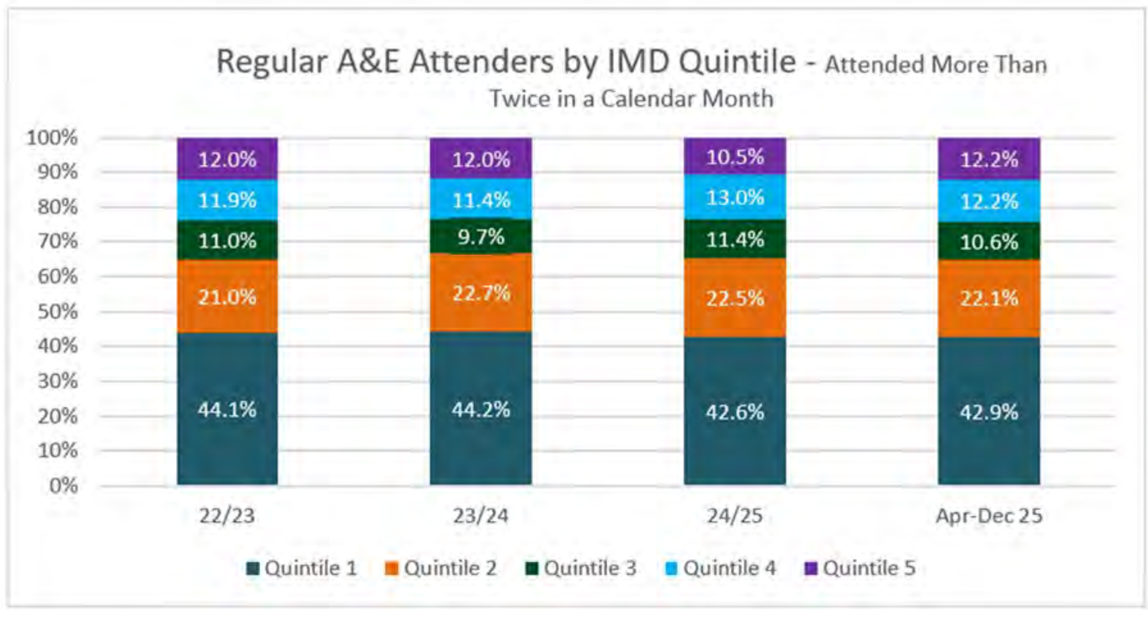


- DNA rates have reduced over time across all ethnicity groups; however, the chart demonstrates a persistent inequality gradient, with some groups consistently experiencing higher non-attendance than others. In every year shown, patients recorded as “Not known” and those in “Mixed / Multiple ethnic groups” have the highest DNA rates, while the “White” group has the lowest. Although the gap between groups has narrowed by April - December 2025, these differences remain, indicating that improvements have been unevenly realised. The continued prominence of the “not known” category also highlights a data quality inequality, where incomplete ethnicity recording may both mask true disparities and reflect lower engagement with services.

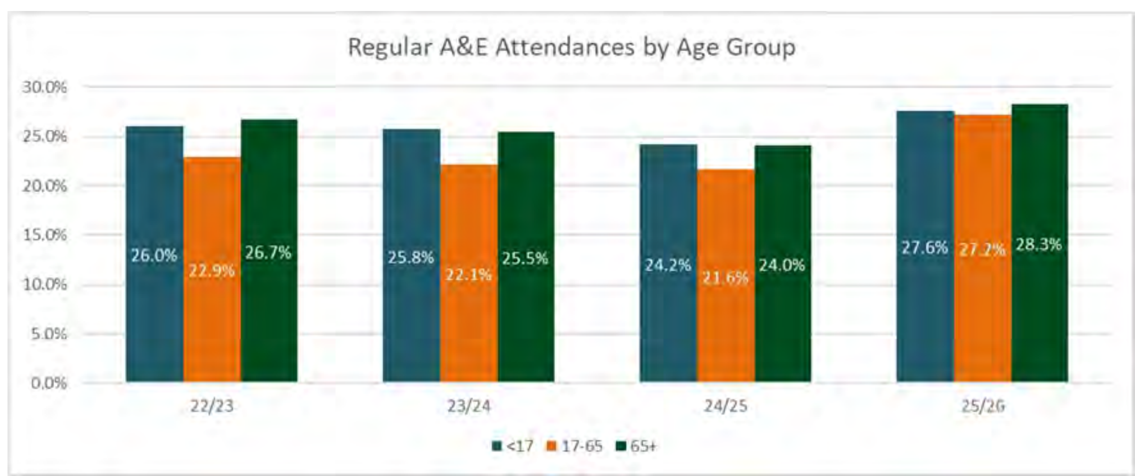


A&E Frequent attenders

- Patients living in the most deprived areas were found more likely to be an A&E regular attender. Reviewing the data for patients who attend more than twice in a calendar month, the most deprived quintile equated to between 42.6% and 44.2% for the time periods analysed, compared to the least deprived quintile ranging from 10.5% - 12.2%.
- This is consistent with the findings from previous years.



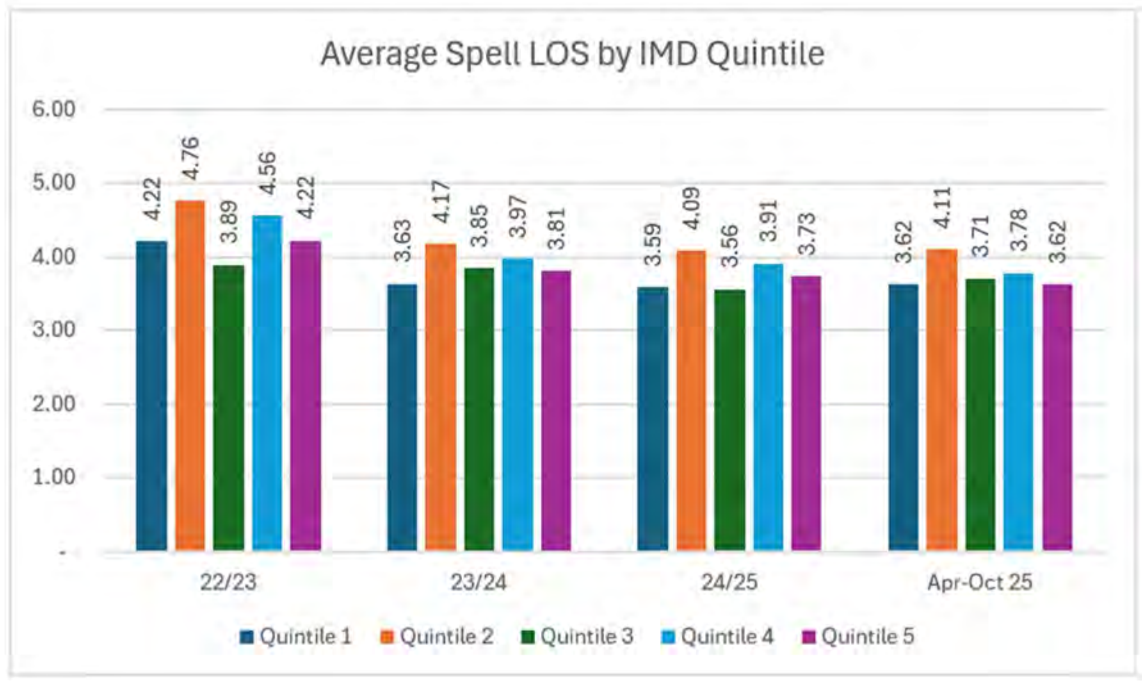
- A&E reattendance rates over the 4 years are highest amongst older age groups, closely followed by those in the <17 category.
- In terms of regular A&E attendance rate, there is a dip across all age groups in 2024/25 followed by a marked increase in 2025/26 across all age groups, indicating a broad rise rather than pressure within a particular age cohort.



- Across all time periods, the White ethnic group makes up the clear majority of regular A&E attenders, accounting for around 86–89% of attendances. All other ethnic groups individually represent small proportions, generally 1–3% each, including Asian / Asian British, Black / Black British, Mixed / Multiple ethnic groups, and Other ethnic groups. This reflects the ethnic make-up of the local population, and it is difficult to draw further conclusions due to small numbers.

Average length of stay

- The average length of stay shows a general downward trend across all quintiles over time.
- Average length of stay is a similar when comparing quintile 1 (most deprived) to quintile 5 (least deprived), whilst quintile 2 consistently shows the highest length of stay. It is unclear why we observe this trend, and it may warrant further investigation.

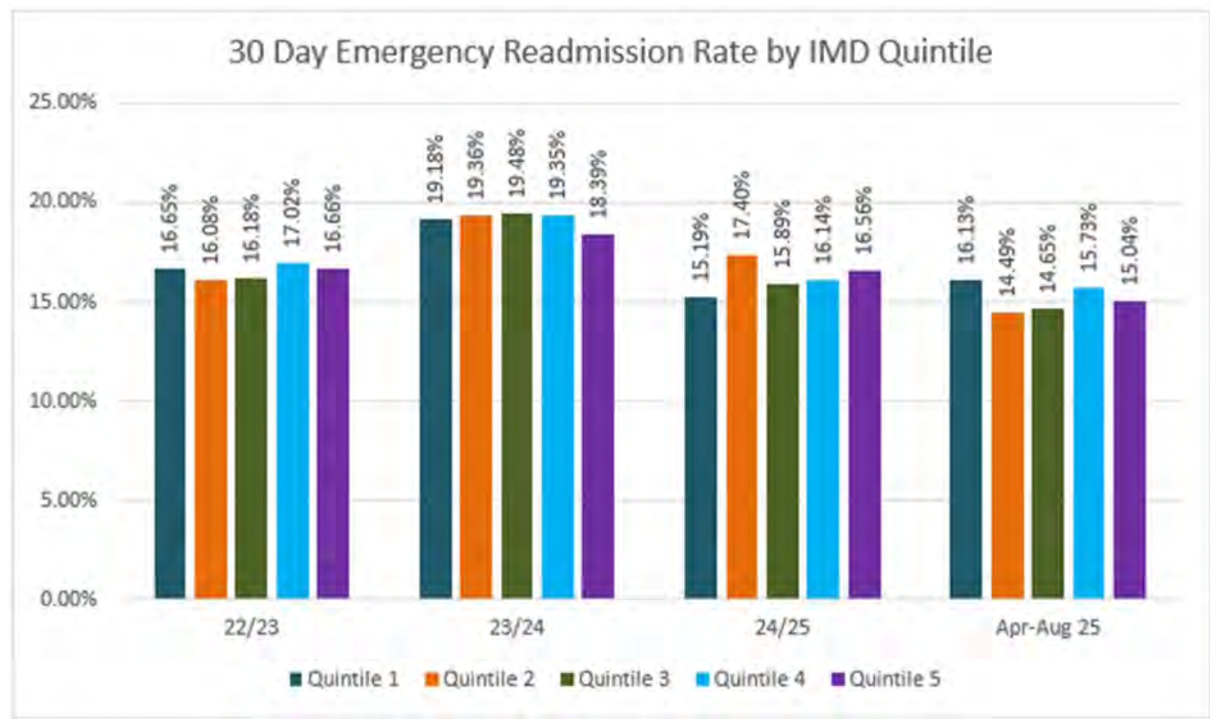


Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

Readmissions

- There is no consistent pattern to show that more or less deprived patients are more likely to be readmitted within 30 days.
- During April - August 2025, the lowest rate was in quintile 2, 14.49% and the highest rate in quintile 1, with 16.13%. However, this is inconsistent with previous years, meaning that the

significance is unclear - during 2022/23 and 2023/24 there was little variation in 30-day readmission rate between the quintiles. During 2024/25 quintile 1 had the lowest level of 30-day readmission rate at 15.19% and quintile 2 saw the highest rate at 17.4%.

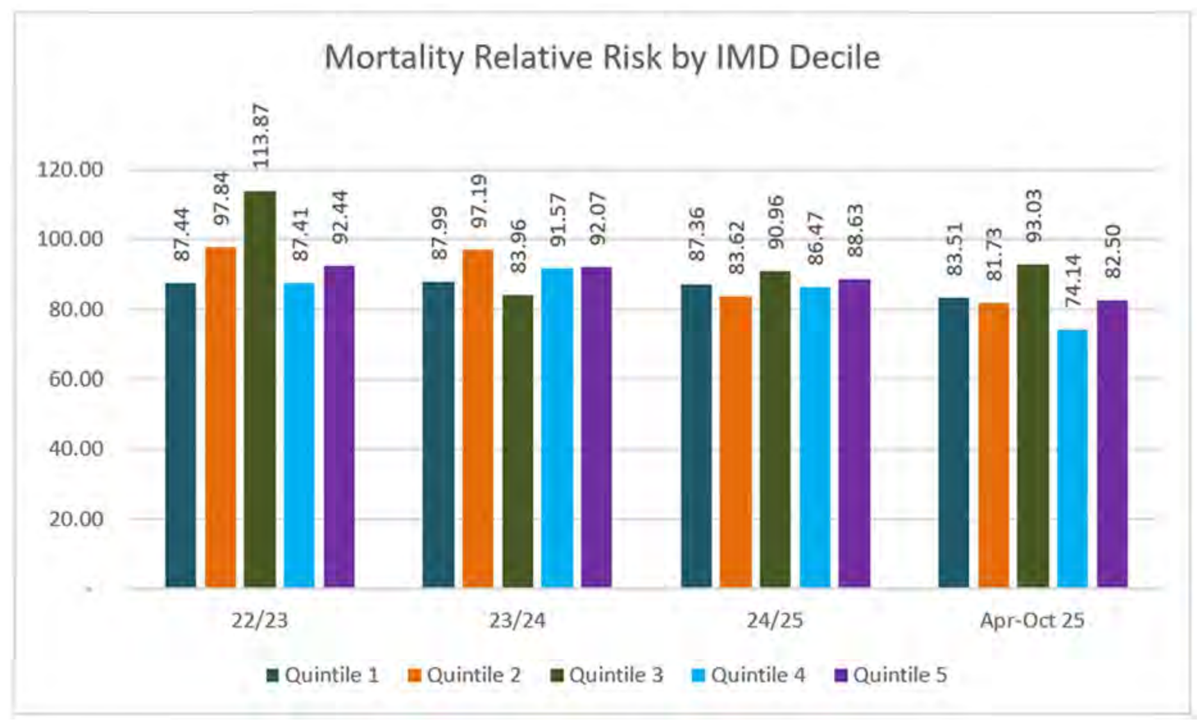


Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- As age increases, the rate of readmission also increases. During 2022/23 19.65% of patients aged 75 years and above were readmitted into hospital within 30 days of discharge; the figure for 2023/24 was 21.24%, for 2024/25 was 20.73% and for April - August 2025 was 21.11%.

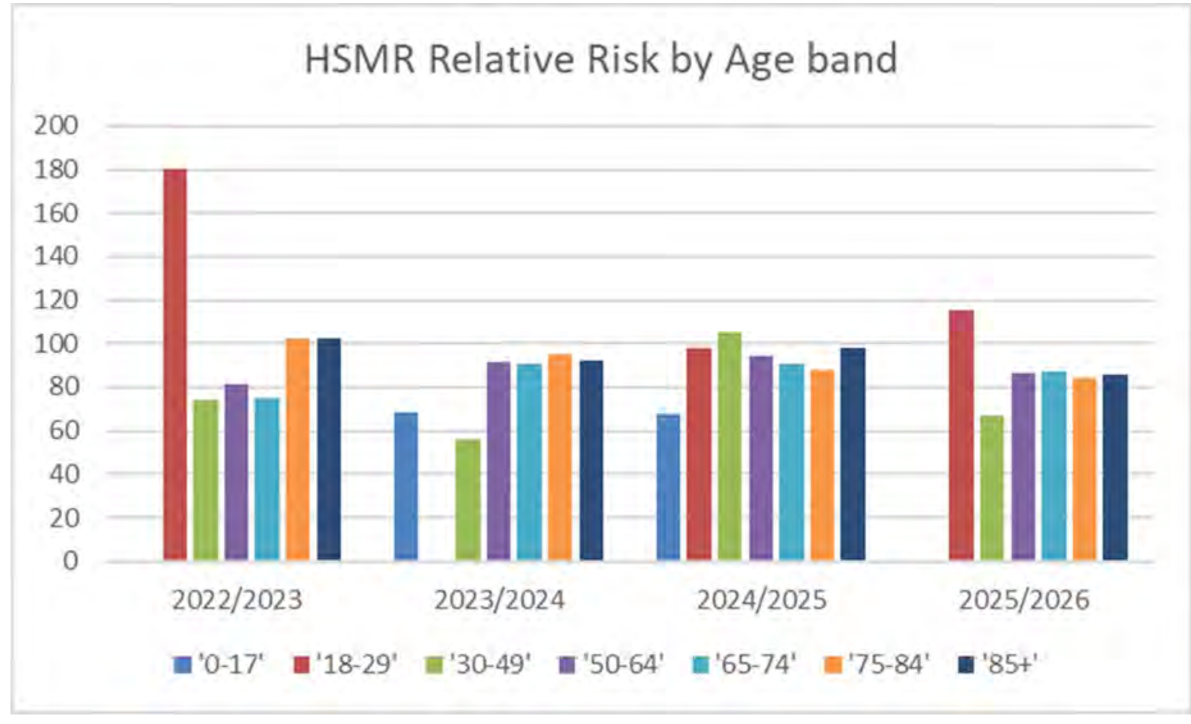
In hospital mortality

- In hospital mortality relative risk has been calculated using 'Dr Foster Limited' methodology. Dr Foster's Hospital Standardised Mortality Ratio (HSMR) Relative Risk is a statistical measure used to compare the number of observed in-hospital deaths within a trust or specialty to the number of deaths that would be *expected* based on national benchmarks. The national benchmark position compares relative risk to 100; below this number is a more favourable comparison.
- In 2022/23, quintile 3 is above the threshold, at 113.87. Whilst for 3 of the 4 time periods, quintile 3 is the highest reported relative risk, this has been below 100 since 2023/24, suggesting that deaths are within what is expected.
- There are no notable inequalities by deprivation.



Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- HSMR Mortality Relative Risk is calculated for individual patients and rates are reported within or outside of expected ranges. Although some levels are above the national 100 benchmark, all levels are within expected ranges, with the 18-29 age banding having 1-2 deaths per year. The majority of relative risk relating to in hospital standardised mortality ratios have reduced across all age bands.



HSMR Relative Risk by age group	2022/2023	2023/2024	2024/2025	Apr-Nov 25
'0-17'	0.00	68.18	67.44	0.00
'18-29'	180.34	0.00	98.28	115.17
'30-49'	74.14	56.25	105.20	66.78
'50-64'	81.75	91.24	94.18	86.79
'65-74'	75.10	90.65	90.92	86.83
'75-84'	102.45	95.28	87.96	84.55
'85+'	102.61	92.47	97.79	85.93

Source: Dr Foster Limited on-line portal. Accessed 12/2/26.

- The relative risk for both sexes converge over time, latest figures females 83.5, males 86.5, both significantly under the 100 national benchmark.

Index of Disparity

The Index of Disparity (IoD) is a summary measure used to quantify relative inequality across multiple groups for a given indicator. The table below gives a breakdown of the inequality measures for the metrics included in this paper. It is calculated by measuring the disparity between different groups from the average. The groups used in calculating the IoD are: Age, Gender, Deprivation Quintile and Ethnicity.

To illustrate how the index of disparity works take the following example:

If 5 people have an average of 10 sweets in a bag the disparity would be how far away from 10 sweets each person actually had. If all 5 people had 10 sweets each, then disparity would be 0. If some people had much higher or lower than 10 sweets the bigger the disparity would be.

Metric Name	Age	Gender	IMD Quintile	Ethnicity	Total IoD
DNA Rate	0.34	0.14	0.22	0.12	0.21
Average Length of Stay	0.38	0.03	0.04	0.2	0.16
RTT - 52+ Week Waiters (Rate)	0.48	0.05	0.08	0.42	0.26
Hospital Standardised Mortality Ratio (HSMR)	0.1	0.18	0.04	0.24	0.12
30 Day Readmissions	0.31	0.08	0.04	0.23	0.16
A&E Frequent Attenders	0.01	0.01	0.03	0.42	0.12

In summary:

- This approach is new to the Trust and represents an innovative way of working that is not yet routinely used within the NHS. It is being trialled as part of the NHS commitment to addressing health inequalities. As this work is still at an early stage, the results should be interpreted with caution while we continue to develop our understanding of its usability and limitations.
- The analysis suggests higher levels of overall inequality in DNA rates and waits over 52 weeks.

- There is variation by age across DNA rates, average length of stay, waiting times and readmissions.
- Deprivation (IMD quintile) appears to be a less consistent driver of inequality across the selected metrics, except for DNA rates, where the gradient remains strong.
- Ethnicity appears to influence waiting times, HSMR, readmissions and A&E frequent attenders suggesting potential inequalities. However, these findings should be interpreted with caution due to small sample sizes and incomplete ethnicity recording.

To strengthen our ability to identify and act on inequalities, the Index of Disparity will be introduced into key metrics within the Trust's integrated performance report, with opportunities to extend its use across other strategic and operational reporting. Using a single, comparable measure will support prioritisation, enable monitoring of progress over time, and raise the visibility of inequalities within routine reporting to drive discussion and action.

Improving data quality, collection and analysis

Accurate, comprehensive and consistently recorded data is essential for identifying health inequalities and taking effective action. Incomplete or inconsistent data limits our ability to understand whether services are meeting the needs of all population groups.

Ethnicity
For this report, it has not been possible to present all metrics disaggregated by ethnicity due to small sample sizes, which would risk presenting misleading conclusions. This reflects both the demographic profile of Wigan Borough, where 95% of residents identify as White British, and incomplete ethnicity recording across Trust services. A high proportion of patients continue to have 'unknown' or 'not recorded' ethnicity, highlighting the need for improvement.

Ethnicity recording rates for April - December 2025 are shown in the table below. The proportion of patient records with valid ethnic group codes exceeds the national averages reported in NHSE's Ethnicity Recording Improvement Plan. It is positive that no records contain a blank or null ethnicity field. However, there remains room for improvement in the use of 'not stated' and 'not known' codes, which appear to be used more frequently in outpatient data.

Core measures for A&E attendances / DNAs / inpatient admissions April - December 2025			
Core measures	A&E attendances	DNA (Outpatient)	Inpatient admissions
Percentage of records with blank or null codes for ethnicity	0.0%	0.0%	0.0%
Percentage of records with residual ethnic codes including – not stated, not known	1.6%	9.1%	2.9%
Percentage of patient records with a valid, non-residual ethnicity code in data sets	98.4%	90.9%	97.1%

In 2024, our data, analytics and assurance (DAA) team reviewed ethnicity recording across inpatient, outpatient and emergency care contacts. The review identified inconsistent recording practices,

variation in data completeness between services, and the absence of a standard operating procedure. Since then, system change recommendation to mandate ethnicity recording on the Leigh Urgent Treatment Centre has been implemented and has resulted in improving completion from 78% to 86%. In addition, protected characteristic fields are now embedded within core Qlik applications, and the DAA team continues to apply a health inequalities lens where data allows. Continued work to further standardise ethnicity recording across our services will help strengthen data quality and consistency.

Although local analysis is challenging, national evidence and local deep dives, such as the review of inequalities in endoscopy care in 2024, confirm that racial inequalities do exist. Work is underway to address this, including the development of the Trust's Anti-Racism Strategy, improvements to equality impact assessments, and actions to strengthen data quality as set out in the Health Inequalities and Prevention Plan and ethnicity data review.

Community Paediatrics
Long waiting times in community paediatrics were evident during April - September 2023 and April - September 2024, with around two-thirds of patients waiting over one year. During April - September 2024, 62% of patients waiting more than one year for an ENT admission were children. Due to data quality issues, it has not been possible to review this information for 2025. This has been identified as a risk, and work is planned to address the data quality concerns while improvements continue through the clinical cervices redesign transformation programme in community paediatrics.

Areas of Progress

During 2025/26, the Trust has strengthened its approach to health inequalities by embedding an equity lens more systematically into planning, governance and operational delivery. The Health Inequalities and Prevention Plan was finalised and implementation has begun, setting a clear strategic direction and establishing six priority areas: strengthening governance, improving data quality, developing an empowered workforce, addressing inequalities in access, experience and outcomes, advancing neighbourhood and population health, and embedding prevention in practice. A new Health Inequalities and Prevention Steering Group will oversee delivery, and the integration of health inequalities considerations across board subgroups will support action and provide challenge across all areas of activity.

Health inequalities reporting
Where possible, data within on-demand reporting is disaggregated by age, sex, ethnicity and IMD, to enable more consistent and systematic monitoring of inequalities. Work is underway to incorporate the Index of Disparity into the integrated performance report, enabling the board to routinely identify and act on inequalities. Further analytical work has strengthened understanding of variation within specific pathways. An alcohol and inequalities report (March 2025) identified a strong correlation between deprivation and alcohol-related harm, with the most deprived deciles accounting for the majority of alcohol-related A&E attendances and admissions. A specific piece of work is underway to understand inequalities in access to cardiology investigations.

Developing an empowered workforce
This year, progress includes staff education and awareness sessions, expansion of training opportunities, and the appointment of a joint Consultant in Public Health, with Wigan Council, and a WWL-based youth worker. This approach supports the development of a confident workforce equipped to recognise and act on health inequalities.

Addressing inequalities in access, experience and outcomes
Targeted work has begun to improve health literacy, including redesigning outpatient communications, alongside specific service-level projects such as those within speech and language therapy. In relation to DNAs, the text reminder service, which was implemented following the development of a DNA predictor, was extended to two reminders for all appointments, leading to a further reduction in DNA rates. However, inequalities persist, and the Trust is exploring additional targeted action.

Working in partnership to advance neighbourhood and population health
A neighbourhood-focused approach has been initiated, beginning with Scholes in Central Wigan, to understand and address inequitable access at community level. The Integrated Delivery Board, co-chaired by the Trust's Chief Executive and Wigan Council's Director of Public Health, continues to drive system-wide action. Joint analyses with Wigan Council have informed targeted respiratory support in high-need areas, and wider neighbourhood health models are being developed through the Healthy Wigan Partnership. WWL services, are scoping and trialling new ways of working, such as 'Work Well' models, supporting people into employment, and community appointment days within musculoskeletal services.

Embedding prevention in practice
Preventative approaches continue to expand, including the trial of opportunistic inpatient flu vaccination to improve uptake among underserved groups. Joint work with Wigan Council seeks to further embed prevention into clinical pathways, with an initial focus on smoking cessation and wider determinants.

Summary and Next Steps

Analysis of elective and urgent and emergency care data shows clear and persistent inequalities across age and deprivation. DNA rates remain twice as high for patients living in the most deprived areas compared with the least deprived, despite an overall downward trend. Younger age groups (0–19) and males aged 20–54 continue to have the highest DNA rates. Inequalities are also evident in urgent and emergency care, with 43% of all A&E frequent attenders coming from the most deprived quintile. And readmission rates increase steadily with age, highlighting the need for targeted support for older adults.

Alongside this, the Trust has made year-on-year progress in strengthening its approach to health inequalities. The Health Inequalities and Prevention Plan provides a clear strategic framework, and through this, work is underway to improve data quality, deepen insight, empower the workforce and embed prevention and neighbourhood-based approaches. The evidence presented reinforces the need to accelerate this work and ensure that health inequalities are consistently addressed across transformation programmes, service design and operational decision-making.

Next Steps
Building on progress to date, the Trust will continue to strengthen its approach to health inequalities in 2026/27 by:

- **Launching the Health Inequalities and Prevention Steering Group** to oversee delivery of the health inequalities and prevention plan, and ensure a coordinated, system-wide approach.

- **Strengthening the use of the NHS England Statement on Information on Health Inequalities**, identifying a core set of metrics aligned to Trust priorities and reviewing these throughout the year to maintain a consistent narrative, and ensure timely action.
- **Introducing the Index of Disparity** within our integrated performance report and other strategic and operational reporting to support routine identification and action on inequalities.
- **Embedding health inequalities and prevention within strategic planning, transformation programmes and core business functions**, ensuring that reducing inequalities is a central priority across all Trust activity.

Agenda item: [18]

Title of report:	NHS Provider Licence - Annual Self-Certification of Compliance (2025/2026)
Presented to:	Board of Directors
On:	17 June 2026
Item purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Interim Director of Corporate Governance
Contact details:	E: julie.dawes@wwl.nhs.uk

Executive summary

1. In previous years, NHS Foundation Trusts were required by NHS England to self-certify annually that they comply with the conditions of the NHS Provider Licence (the Licence). In addition, there was a requirement to publish an annual statement on the Trust website stating that the Trust continued to comply with the Licence conditions. This included explicit signed declarations against a number of conditions. Following the publication of the new NHS Provider Licence in 2023 the Board self-certification process was removed to reduce the administrative burden.

2. Compliance with the Licence is now routinely monitored through the NHS Single Oversight Framework (NOF) segmentation ratings allocated by NHS England. For the relevant period, the Trust was rated segment [4].

3. From a governance perspective, whilst no longer mandatory, it is considered good practice for the Board to continue to annually self-certify. This report sets out the Trust's assessment of compliance with the relevant Licence conditions for the period 2025/26, supported by evidence from internal control systems, Board oversight mechanisms, and independent assurance.

4. For the period under review, the Trust has undertaken an assessment of compliance against the applicable conditions:

- Condition G3 – Fit and Proper Persons
- Condition G5 – Systems for Compliance
- Conditions NHS1 and NHS2 – Availability of Information and Governance
- Condition CoS7 – Availability of Resources.

5. Based on triangulated assurance from internal audit, external audit, Board Assurance Framework (BAF), committee oversight, and statutory reporting (including the Annual Governance Statement), the Trust considers that there is a reasonable and evidence-based basis to confirm compliance with all applicable Provider Licence conditions:

Condition	Narrative	Status
Condition G3	Fit and Proper persons regulations compliance	Compliant
Condition G5	Systems for compliance	Compliant
Conditions NHS1 and NHS2	Publication of statutory documents Maintenance of effective governance arrangements	Compliant
Condition CoS7	Availability of resources	Compliant

Link to strategy and corporate objectives
There are reference links to the organisational strategy.

CQC Key Line of Enquiry
Well-Led. The Trust is required to meet the terms of its Licence and this report proposes the evidence available to support the Board's assessment

Risks associated with this report and proposed mitigations
There are no risks associated with this report.

Financial implications
There are no financial risks associated with this report.

Legal implications
Compliance with the requirement of the NHS Provider Licence, received on authorisation, as revised in 2023.

People implications
There are no people risks associated with this report.

Equality, diversity, and inclusion (EDI) implications
N/A

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 Trust Board is invited to note the content of this report and by doing so:

a) Receive significant **ASSURANCE** that the Trust is compliant with the NHS Provider Licence and confirms its support in terms of the source, robustness, and an appropriate level of independent assurance provided by the assessment process; and

b) To formally **APPROVE** the proposed self-certification for 2025/26 as '*confirmed'* for each of the applicable Provider Licence Conditions as detailed above; and to further **APPROVE** publication of the Board's declaration of compliance on the Trust's website as appropriate.

Board of Directors Meeting – 17 June 2026

NHS PROVIDER LICENCE - ANNUAL SELF-CERTIFICATION OF COMPLIANCE (2025/2026)

1. Introduction

1.1 The NHS provider Licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, with coherence across legislation, policy, and regulatory frameworks.

1.2. Compliance with the Licence is routinely monitored through the NHS Single Oversight Framework (with segmentation ratings allocated by NHS England. For the relevant period, the Trust was rated segment [4].

1.3. The Trust is required to self-certify its compliance with the following conditions after the financial year end (2025/2026):

1.3.1. Condition G3:	Fit and Proper Persons as Governors and Directors
1.3.2. Condition G5:	Systems for Compliance with Provider Licence conditions.
1.3.3. NHS 1 & 2:	Good governance arrangements
1.3.4.Condition CoS:	Provider has reasonable expectation that required resources will be available to deliver the designated services

2. Condition G3 – Fit and Proper Persons requirement.

2.1 Condition G3 states that Trusts must not have in place any person, as a Governor or Director, who is not fit and proper.

2.2 Governors must not be subject to undischarged bankruptcy, a moratorium period of a debt relief order, undischarged arrangements with creditors, or conviction for an imprisonable offence within the preceding five years. [All Governors submit a fit and proper persons declaration on election or appointment and must declare any change in circumstances that occur during their tenure.]

2.3 Directors are subject to similar conditions and additionally must meet the criteria of a fit and proper person under the NHS England Framework for board members. This Framework is incorporated within the recruitment and selection processes for all Board appointments and the Directors' appraisal process, including annual individual self-attestations and other required checks. Compliance is also reported annually to the Audit Committee and Board.

2.4 The Trust's compliance with this requirement has been subject to an Internal Audit (April 2026) which identified as an area of strength the Fit and Proper Person Test Procedure with three areas highlighted for improvement. These are in the process of being actioned and

a revised Fit and Proper Person Test Policy and compliance assurance report is scheduled to by considered by the Board in October 2026.

It is proposed that the Trust confirms its compliance with this requirement.

3. Condition G5 – Systems for compliance with Licence Conditions and related obligations

3.1 Condition G5 requires licensees to take all reasonable precautions against the risk of failure to comply with the Licence conditions, legal requirements, and stipulations of the NHS Constitution, including the establishment, implementation, and regular review of processes and systems to identify and mitigate risk of non-compliance.

3.2 The Trust has a robust compliance framework in place as part of the system of internal controls, to maintain oversight and assurance. This includes reports to Board on the following items:

- 3.2.1. Board Assurance Framework.
- 3.2.2. An Integrated Performance Report, delivering a consolidated summary of critical metrics across quality, safety, people, performance, and finance, further aiding Board Oversight.
- 3.2.3. Regulatory compliance assurance reports to Board Assurance Committees and Board
- 3.2.4. Reservation of Powers, Schemes of Delegation, and Standing Financial Instructions Reviews
- 3.2.5. Board Committee Effectiveness and Terms of Reference Reviews (report to Board delayed until October 2026)
- 3.2.6. Committee Chair assurance reports (AAAs) to the Board detailing risks and issues that required escalation; and
- 3.2.8. Other specific reports on high-risk areas.
- 3.2.9. Trust Risk Register

3.3 The Audit Committee undertakes a regular review of risks to internal controls and reports assurance to the Board.

3.4 The Trust's Internal Auditors (MIAA) undertake several specific risk-based internal controls audits each year. The Head of Internal Audit Opinion for 2024/2025 was 'Substantial *Assurance'* The draft Head of Internal Audit Opinion for 2025/26, provided to the Audit Committee (May 2026 meeting) was the same as the assurance rating of 'substantial' provided to the Trust in the previous year. It is not anticipated this opinion will alter when the final Annual Report is provided to the Audit Committee on 23 June 2026.

3.5 Annual assurance is also provided through the Annual Report and Accounts process.

3.6 Areas of strength include:

- 3.6.1. A mature committee framework, with clear escalation via AAA reports to Board;
- 3.6.2. Sustained improvement in Internal Audit opinion, demonstrating a strengthening control environment.

3.7 Areas for continuing development are:

- 3.7.1. Continued alignment of the Trust Risk Register and Board Assurance Framework against the revised Risk Appetite Statement (April 2026).
- 3.7.2. Further integration and appropriate review of assurance sources.

3.8 It is proposed that the Trust confirms its compliance with this requirement.

4. Good Governance conditions – NHS1 and NHS2

4.1 Condition NHS1 requires Trusts to make available written and electronic copies of its Constitution and most recent annual accounts/report of Auditor and annual report. The Trust does so by publishing those items on its website.

4.2 Condition NHS2 outlines the governance arrangements that the Trust must adhere to, including Board capability, oversight of quality, financial stewardship, and sustainability obligations.

4.3 The Board is required to review annually their systems and processes to ensure good governance. There is no set approach for how NHS England expects this to be evidenced but would normally include a review of the effectiveness of board and committee structures, reporting lines and performance and risk management systems.

4.4 The Board currently has six substantive committees with delegated authority for undertaking statutory duties and/or consideration of key strategic matters and risks, including those required under this Condition, each chaired by a Non-Executive Director.

4.4.1. Audit Committee;
4.4.2. Finance and Performance Committee;
4.4.3. People Committee;
4.4.4. Quality and Safety Committee;
4.4.5 Research Committee;
4.4.6. Remuneration Committee.

4.5 Each Committee will undertake a review of its effectiveness and Terms of Reference during 2025-2026, with the report scheduled to be presented to the Board of Directors (October 2026).

4.6 Each Committee provides regular Assurance Reports (AAAs) that are reviewed by the Board. These reports focus on issues requiring escalation and offer assurance on actions that aim to improve governance.

4.7 The Trust Significant Risk Register is regularly reviewed at relevant Assurance Committees and with effect from August 2026 also at Board of Directors meetings.

4.8 The Board Assurance Framework (BAF) serves as a structured tool to identify and manage strategic risks, helping ensure committees' activities align with the Trust's strategic goals. In Quarter 3 2025/26, the Board Assurance Framework was refreshed to ensure alignment with the Trust's Strategy for 2025-2030.

4.9 Effective clinical governance processes are evidenced through:

4.9.1. Incident management processes and procedures (Patient Safety Incident Response Framework).
4.9.2. Raising concerns processes.
4.9.3. Duty of Candour processes.
4.9.4. Care Quality Commission inspection processes and outcomes.

4.10 The Trust's Annual Report, incorporating the Annual Governance Statement includes commentary on committee performance and any gaps identified in effectiveness, promoting transparency in governance. The Trust's annual report sets out several key areas where

evidence of compliance with regulatory requirements and internal governance standards is presented:

4.10.1. Care Quality Commission (CQC) Compliance:

[The Trust is compliant with CQC registration standards for the period under consideration.]

4.10.2. Workforce compliance:

Regular reporting on workforce metrics, including vacancy rates, staff turnover, and mandatory training completion, is overseen by the People Committee and included in the Integrated Performance Report to Board.

4.10.3. Internal Audit and Governance

The Trust's governance structure includes an annual internal audit plan managed by the Audit Committee. In addition, there is a robust process in place to ensure that any limited assurance reports issued by Internal Audit are routinely escalated to the relevant board committee to ensure the appropriate level of oversight of the implementation of any associated recommendations.

4.10.4. Board Assurance Framework

The Board Assurance Framework provides a structured approach for the Board to monitor and manage risks that could impact the achievement of strategic objectives. This framework is part of the Trust's compliance with NHS Foundation Trust License Condition 4.

4.11 The Trust's plans for achieving net zero carbon emissions are detailed in the Green Plan and relevant sections of the Annual Report, targeting a net-zero footprint by 2040 for emissions under their direct control. The Trust has implemented various initiatives, including infrastructure upgrades, green space initiatives, operational changes, and sustainable waste management.

4.12 Whilst the Trust is on a continuous journey of improvement, it is our assessment that the governance systems are well established and functioning effectively. It is proposed that the Trust confirms its compliance with this requirement.

5. CoS7: Availability of Resources

The Trust must, as a provider designated as providing Commissioner Requested Services, not later than two months from the end of each Financial Year, self-certify as to the availability of the Required Resources for the period of 12 months, in one of the following forms:

(a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

(b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required

Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services."

(c) *"In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".*

5.1. The Trust is required to confirm that it has the required resources to continue to provide those services, management, workforce, financial and facilities and resources. Commissioner Requested Services are services that:

5.2. The evidence to support this self-certification includes:

5.2.1. Going concerns assessment process, considered by the Audit Committee (May 2026).

5.2.2. External Audit Opinion (initial indication presented at the Audit Committee in May 2026), following completion of the interim audit was positive. A full audit report will be presented to the Audit Committee on 23 June 2026.

5.2.3. Trust patient services contracts.

5.2.4. The year to date and the annual financial position as detailed in both the monthly Financial Report and the relevant financial section of the Integrated Performance Report presented to the Finance and Performance Committee and the Board of Directors

5.2.5. Medium-term financial plan (MTFP) submitted to NHS England (March 2026 and the Trust delivered the end of year position agreed with the Greater Manchester Integrated Care System.

5.3. It is proposed that the Trust confirms its compliance with this requirement.

6. Conclusion

The Trust has undertaken a comprehensive and evidence-based assessment of compliance with the NHS Provider Licence.

Across all applicable conditions:

- Governance systems are embedded and operating effectively.
- Assurance is triangulated across multiple independent sources.
- There is a clear trajectory of improvement, particularly in internal control maturity.

While no breaches of licence conditions are identified, the Board should note:

- The importance of sustained focus on governance maturity
- Continued regulatory scrutiny in specific service areas.
- The need to maintain robustness of assurance processes.

The Trust can accordingly self-certify compliance as "CONFIRMED" for all applicable Provider Licence conditions.

7. Recommendation

The Trust Board is invited to note the content of this report and by doing so:

a. Receive significant **ASSURANCE** that the Trust is compliant with the NHS Provider Licence and confirms its support in terms of the source, robustness, and an appropriate level of independent assurance provided by the assessment process; and

b. To formally **APPROVE** the proposed self-certification for 2025/26 as '*confirmed'* for each of the applicable Provider Licence Conditions as detailed above; and to further **APPROVE** publication of the Board's declaration of compliance on the Trust's website as appropriate.

Agenda item: [19]

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Equality Delivery System 2025 Report
Presented to:	People Committee
On:	17th June 2026
Item purpose:	Approval
Presented by:	Tracy Narot, Chief People Officer
Prepared by:	Angelique Hartwig (Head of Staff Experience) and Debbie Jones, EDI Lead (Services)
Contact details:	Angelique.hartwig@wwl.nhs.uk

Executive summary

This paper provides a summary of the assessment outcomes for Equality Delivery System (EDS) 2025, the recommended action for improvement and next steps. The EDS report and proposed actions require Board approval. The attached EDS report will be published on the Trust website, noting draft status until the final submission at Board. EDS implementation by NHS Providers is mandatory in the NHS Standard Contract.

The Committee should note the following ratings:-

Overall rating: Developing **Score 17** (five points off 'Achieving')

Domain 1	Commissioned or provided services	9 out of a possible 12 Middle score of the three services included	Achieving
Domain 2	Workforce health and wellbeing	4 out of a possible 12	Developing
Domain 3	Workforce health and wellbeing	4 out of a possible 12	Developing

The scores indicate that there is inconsistent evidence for how our organisation currently meets the Public Sector Equality Duty of fair and inclusive practices for our staff and patients from all protected characteristics. The recommended actions focus strongly on strengthening collective accountability of our senior leadership to meet equality standards for our staff as well as within our patient services. The delivery of the recommended action plan at the back of the EDS report will be regularly monitored and overseen by the EDI Strategy Group.

Link to strategy and corporate objectives
EDS delivery links with the Equality, Diversity and Inclusion Strategy (2022 – 2026) and WWL's 2030 Strategy.

Risks associated with this report and proposed mitigations
There are some limitations in progressing improvement actions due to EDI being a shared responsibility across the team, which can impact capacity and the pace of delivery.

Responsibility for Domain 1 sits with the EDI Patient Services Lead (0.6 WTE), based within the Patient Experience and Engagement Team. This role does not have additional dedicated resource to support delivery or the planning of stakeholder engagement activity. For Domains 2 and 3, EDI is recognised as a shared responsibility across the People Services Team, with activity embedded within a range of roles rather than led by a single dedicated post. While this approach supports collective ownership, the absence of a coordinating lead means that the pace of mobilising, embedding, and driving forward improvement actions may be slower.

To mitigate this, improvement actions will continue to be distributed across relevant team members, with strategic oversight and coordination provided by the Associate Director of OD and Inclusion.

Legal implications
All NHS organisations are required to meet the Public Sector Equality Duty which supports the Equality Act 2010. The EDS is designed to encourage the collection of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010 and to set their equality objectives.

Whilst the implementation of EDS is monitored by NHS England and Care Quality Commission, the Equality and Human Rights Commission (EHRC) is the primary external regulator for monitoring compliance with the Equality Act 2010, including the PSED.

People implications
Improvements to metrics identified as targets will have positive impact on the experience of staff from protected groups and those living with a disability and long-term condition.

Equality, diversity and inclusion implications
The EDS is one of the key NHS EDI improvement frameworks to support NHS organisations in collecting robust evidence on how their practices and services meet the Equality Act. Positive scores in the EDS would indicate that we are ensuring that all colleagues and patients or services users from any protected characteristics have a positive and fair experience at WWL.

Which other groups have reviewed this report prior to its submission to the committee/board?
EDI Strategy Group – 18th May 2026

Recommendation(s):
The Board is asked to note the content of the EDS report and approve the publication of the report on our organisational website.

Report

The EDS is an accountable improvement tool for NHS organisations in England – in active conversations with patients, public, staff, staff networks and trade unions – to review and develop their services, workforces and leadership. It is driven by evidence and insight. Delivery of EDS by NHS Providers forms part of the NHS Standard Contract.

The EDS is commissioned by NHS England with support from the NHS Equality and Diversity Council (EDC).

The EDS comprises eleven outcomes spread across three domains, which are:

1. Commissioned or provided services
2. Workforce health and well-being
3. Inclusive leadership.

The outcomes are evaluated, scored and rated using available evidence and insight. It is the ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

Evidence collection 2025

Domain 1:
As required, three patient services were identified for review during 2025/26:

- COPD Service, RAEI
- Community Chronic Fatigue Service
- Mortuary Service, RAEI

A separate evidence pack was compiled for each service across all 9 protected characteristics for the following 4 outcomes:

1A: Patients have required levels of access to the service
1B: Individual patients health needs are met
1C: When patients use the service, they are free from harm
1D: Patients report positive experiences of the service

Compilation of evidence packs largely utilised already existing data and reports. Service leads provided specific input on their service. Evidence was then published on the Trust website.

Engagement with patients and public was undertaken from 26/11/25 until 26/01/26. The engagement approach agreed to be implemented this year, included:

- On-line survey and evidence published on Trust website (alternative formats provided). Service users and local community encouraged to review and give feedback.

- E-mail sent to Staff; Volunteers; Governors / Patient Experience and Engagement Group Members; Wigan Borough EDI Group; and other Local Groups inviting them to review evidence and give feedback. Articles included in Trust News / social media.

- Presented to Lived Experience Partners at December 2025 Meeting, encouraging them to review evidence and give feedback.

- Undertaking ‘Real Time’ Patient Experience Surveys on COPD and at COPD Support Group on 26/11/25

- Reviewing Mortuary OWLL Assessment Report undertaken in September 2025

Only one of the service scores can be included in the final EDS Assessment. Following NHS England Guidance, the middle score out of the three services reviewed for Domain 1 has been added together to provide the overall score for all domains.

Domain 2 and 3:

Domain 2 examines how effectively the organisation supports the health, safety, wellbeing and overall experience of its workforce. The evidence for Domain 2 was collated from stakeholders who deliver staff health and wellbeing services or provide independent support for staff, including Occupational Health, Psychological Services, Steps4Wellness, Freedom to Speak Up Guardian and HR.

For Domain 3, evidence was gathered from the Board and Assurance papers. The evidence was summarised and any supportive documents attached for the scoring exercise. Details of our evidence and performance on each outcome are detailed in the appended full EDS Reporting template.

As in previous years, we used the detailed scorecard provided by NHS England to score the domain outcomes. For the scoring exercise of Domain 2, we invited staff networks, Staff side representatives, Chaplaincy and Staff Experience representatives to a scoring meeting at which the evidence and supportive documentation was discussed. Every participant submitted their individual scores for each domain outcome which were averaged. For Domain 3, we invited the Staff Side Leads to provide an independent scoring for each outcome.

Assessment results

The outcome of each domain and an overall rating is as follows.

- **Overall rating:** Developing (**Score 17** – five points off 'Achieving')

Domain 1	Commissioned or provided services	9 out of a possible 12 Middle score of the three services included	Achieving
Domain 2	Workforce health and wellbeing	4 out of a possible 12	Developing
Domain 3	Workforce health and wellbeing	4 out of a possible 12	Developing

Please see score card below to see where our scores fit on a scale.

The full report has been attached to this summary report.

Score card	
Each Outcome	**Overall – adding all outcome scores in all domains**
Undeveloped activity – organisations score out of 0 for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – organisations score out of 1 for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Achieving activity – organisations score out of 2 for each outcome	Those who score **between 22 and 30,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – organisations score out of 3 for each outcome	Those who score **31 or more,** adding all outcome scores in all domains, are rated **Excelling**

Summary/Recommended actions

Domain 1

The Committee can take assurance that two out of three reviewed services (COPD, Community Chronic fatigue) scored highly in the EDS assessment, indicating fair and inclusive services for our patients and service users. The Patient Experience Team will continue to support the Mortuary Service in meeting accessibility standards which will lead to a more positive experience for patients and relatives.

As three different patient services are identified every year for inclusion in our EDS Assessment submission, it is difficult to measure year-on-year score comparisons, like we can for Domain 2 and 3. Each service has their own specific improvement recommendation proposals. It is also to be noted that only one of the services can be included in the final EDS Assessment.

The EDS process has highlighted that for us to achieve more equitable standards of our patient services, we require insights from people with lived experience and more engagement from stakeholders from all protected characteristics. It can be challenging to obtain feedback that covers all protected characteristics, especially when responses are low. We will continue to work in partnership with staff, patients and our lived experience partners. For staff, this means continuing to raise awareness of initiatives and engaging with protected groups to ensure that all staff feel valued, respected and able to progress through the organisation. It also means the opportunity to share and build on areas of good practice whilst addressing areas for development. For patients and carers, this means being able to access our services, receive care and support and be treated with respect and dignity.

There is an opportunity here to expand our lived experience partnership by recruiting more members across all 9 protected characteristics. We recognise that people in our community have different needs and qualities. Understanding the diversity and needs of our local population can help us to plan and deliver services better. We will continue to engage with our communities to better understand their needs based on their protected characteristics. We recognise the importance of equality monitoring. Data enables us to identify if any patients with a protected characteristic are facing any barriers to healthcare.

There is a need to continue to: -

- Closely monitor patient feedback methodologies to measure improvement work going forward.
- Continue to work with Divisional Service Leads to educate them about the requirements of the EDS and the importance of equality and diversity monitoring.
- Continue to strengthen divisional accountability for conducting Equality Impact Assessments for service provisions and continuing to ensure reasonable adjustments are considered and adhered to.

Service specific actions are assigned to the service leads and progress updates reported to the Divisional PEEG. The service actions will be monitored and recommended corporate actions will be implemented by the Corporate Patient Experience & Engagement Group (PEEG) and overseen by the EDI Strategy Group.

Domain 2

The Committee can take partial assurance that staff health and wellbeing services are meeting the Public Sector Equality Duty (PSED) requirements. Outcome scores for Domain 2 have largely remained consistent with last year, with one outcome recommended for down scoring.

Stakeholders acknowledged that the Trust has a comprehensive range of wellbeing, psychological support, and occupational health services set out in policy. However, there were mixed views regarding the practical availability, accessibility, and consistency of these services. Concerns were raised that current arrangements are not adequately protecting staff from abuse or harassment - particularly patient-on-staff racism and inappropriate staff-on-staff behaviours. Whilst work is underway to develop supporting policies, it will take some time for these to embed and for us to see improvements in this space and see a reduction in negative staff experiences.

Data reviewed shows no positive movement in key indicators related to morale, retention, or staff advocacy, and therefore associated scores have remained unchanged.

For Outcome 2C (Wellbeing Support Offer), stakeholders unanimously recommended a reduction in scoring to Developing activity (previously Achieving in 2024). This reflects recent changes to the wellbeing support model and concerns about service capacity and sustainability. The Freedom to Speak Up service remains well established. Stakeholders highlighted uncertainty around the future of psychological support provision and whether it will meet organisational demand.

It is important to note that there have been recent improvements to the wellbeing support offer and in order to develop a more sustainable solution the Trust has introduced a new Employee Assistance Programme (EAP) which launched in March this year. The EAP provides a broader range of support services for staff, and initial insights into utilisation have been positive, with staff accessing the service within the first week of launch. While this is encouraging, stakeholders emphasised that further evaluation of impact, accessibility, and alignment with staff needs will be critical.

Overall, the findings highlight the need for sustained wellbeing provision, clearer escalation pathways, strengthened anti-abuse frameworks, and improved organisational accountability to ensure staff feel safe, supported, and valued at work.

The stakeholders proposed improvement actions which could increase the scoring for Domain 2 next year, including:

- Launch and implement new Wellbeing Policy
- Clarification and communication of alternative routes for accessing psychological support which will meet staff needs
- Finalise and implement anti-racism and zero-tolerance policies to strengthen organisational processes to protect staff from racism, discrimination and violence from all sources
- Create better oversight of abusive incidents and trauma-informed post-incident support for staff
- Consider investment in equality specialist role/expertise in the organisation to support EDI activities

The recommended actions will be implemented by relevant People Services task and finish groups, including the Sickness Absence Working Group chaired by the Deputy Chief People Officer and the Disability Confident working group which is led by the Associate Director of OD and Inclusion and forms part of the core EDI workstreams overseen by the EDI Strategy Group. The working groups aim to take tangible actions to reduce sickness absence and improve the health and wellbeing of our staff with disabilities and long-term health conditions. All progress updates are regularly reported to the EDI Strategy Group.

Domain 3

The Committee can take partial assurance that the scores for Domain 3 Inclusive Leadership have seen some improvement since last year. Outcome 3A on the Board's commitment and understanding of equality and health inequalities has upgraded from "underdeveloped activity" to "achieving activity". The new Chair has clearly articulated a stronger organisational ambition to work in partnership across the wider system to tackle health inequalities and health inequalities are now recognised as a core Board priority, signalling a step change in strategic focus and leadership accountability. There is clear ownership at executive level for the health equity agenda and investment in specialist role to support the delivery of the Health Inequalities and Prevention Plan. However, stakeholders have noted that there are no plans to invest in dedicated EDI specialist resource, which they felt would further demonstrate that EDI is central to business activities.

For the other outcomes, the stakeholders have recommended the scores remain at "Developing activity". They noted the robust governance structure for EDI and set up of a dedicated steering group and workstreams. There are still gaps ensuring consistent high quality Equality Impact Assessments take place across the organisation, and demonstration of improvements in equality data reporting (i.e., Gender Pay Gap, Workforce Race and Disability Equality Standards).

The assessment of inclusive leadership Domain 3 has identified continued areas of improvement to make EDI core business, including:

- Implementation of Health Inequalities and Prevention Plan
- Consider investment in EDI specialist resource to support the implementation of EDI strategic objectives
- Improved oversight and consistent approach to Equality Impact Assessments
- Measurable improvements against EDI objectives as part of our EDI national reporting requirements.

The implementation of the above actions will be key to improving EDS in 2026 and improving the experience of WWL's staff and patients. The Committee can be assured that the new People and Culture Strategy launched in May 2025 has a clear strategic focus on inclusion and making tangible improvements regarding our EDI Strategy. The CPO will work closely with the CEO to review the scope and direction of the EDI Strategy Group going forward to ensure that the EDI agenda is collectively owned by senior leadership at WWL and that progress against EDI objectives at Trust and divisional level will be monitored through the strategy group.

The Board is asked to note the content of the EDS report and approve the publication of the report on our organisational website.

Assurance on EDS 2025 will be given through regular updates to the EDI Strategy Group and further to People Committee.

Classification: Official

Publication approval reference: PAR1262

NHS Equality Delivery System 2025

EDS Reporting Template

Draft subject to Board Approval

Version 1, 17 March 2026

Contents

Equality Delivery System for the NHS.. 2

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		Wrightington, Wigan and Leigh NHS Teaching Hospitals Foundation Trust	Organisation Board Sponsor/Lead		
			Chief People Officer: Tracey Narot Chief Nursing Officer: Kevin Parker-Evans		
Name of Integrated Care System		Greater Manchester			

EDS Lead	Angelique Hartwig and Debbie Jones		At what level has this been completed?	
				*List organisations
EDS engagement date(s)	**Domain 1:** 26th November 2025 until 26th January 2026 **Domain 2:** 28th January 2026 **Domain 3:**10th February 2026		Individual organisation	Yes
			Partnership* (two or more organisations)	
			Integrated Care System-wide*	

Date completed	March 2026	Month and year published	TBC
Date authorised		Revision date	

Completed actions from previous year	
Action/activity	**Related equality objectives**
EDS 2024/25 service stakeholder feedback reports shared with Divisions and Patient Experience and Engagement Group	**Domain 1**
Implement patient improvement initiatives to improve the overall patient experience in emergency care. EDS Stakeholder Feedback Report for Emergency Department shared with Divisional Leads. Feedback incorporated within Emergency Care improvement plans, devised from CQC Patient Experience Feedback Survey undertaken during 2024.	**Domain 1**
To continue to raise dementia awareness for staff on Orrell Ward. Staff awareness of dementia raised on Orrell Ward. Aligned with the delivery of the new Fundamentals of Care Strategy launched February 2025. As part of the 12 month delivery plan, a patient experience focus was launched in April 2025. Drop-in training sessions for staff on Orrell Ward were also delivered by the Trust's Admiral Nurses.	**Domain 1**
To continue to closely monitor patient feedback methodologies to measure improvement work going forward. EDS progress and patient feedback reports (FFT) reported at Patient Experience and Engagement Meetings.	**Domain 1**
To encourage more engagement from patients from all protected characteristics to gain further insights from people with lived experience Continuing to recruit additional members to join WWL's Lived Experience Partnership.	**Domain 1**
To strengthen divisional accountability for conducting Equality Impact Assessments for service provisions. Ensure reasonable adjustments are considered and adhered to. During 2025/26 a Reasonable Adjustment Working Group was established to review WWL's approach to providing reasonable adjustments for service users, incorporating the requirements of the NHS England's	**Domain 1**

Reasonable Adjustments Digital Flag Information Standard (and Accessible Information Standard). Membership includes Lived Experience Partners and RNIB Representation. It was agreed that current IT challenges with recording and alerting patient needs / reasonable adjustments cannot be used as a reason for not asking patients about their needs. Ophthalmology and Breast Screening Services will be piloting this new approach from 30th March 2026 for 3 months. Best practice can then be rolled out to other areas within the Trust.	
Signpost to local and national resources and support pathways for each of the mentioned conditions e.g. obesity, diabetes, asthma, COPD. Resources on health conditions have been added to the intranet, further guidance and learning events are under development	**Domain 2**
Provide clear guidance on workplace adjustments and upskill leaders in supporting their staff in receiving appropriate adjustments Wellness at Work resources have been launched including workplace adjustment guidance for staff and managers; WWL has been successful with funding bid organised by Charities Together and will employ Wellbeing Adjustment Advisor to support our staff with long-term health condition	**Domain 2**
Review current HR practices and consistency of disciplinary action under conduct policy Have begun to review our formal processes as part of a Avoiding Harm workstream which will focus on preventative action, streamlining investigation process, person-centred and compassionate principles and training for all parties involved	**Domain 2**
Review response to incidents protect staff against patient racism, discrimination and violence As part of Anti-Racism Framework, we have developed a draft anti-racism and red-card/yellow-card policy to provide staff with confidence in escalating incidents of racial abuse, harassment or discrimination. The policies are going through internal approval processes.	**Domain 2**
Implement NW BAME Assembly Anti Racist Framework.	**Domain 2**

WWL has been awarded Bronze recognition of the North West BAME Assembly Anti-Racist Framework.	
Establish Sickness Absence Task and Finish Group to provide more timely support for staff at risk or currently off sick. A Sickness Improvement Group was established in early 2025 which is chaired by Deputy Chief People Officer. The group has developed an improvement plan to reduce sickness absence across the Trust which includes improving data quality, reducing length of absence, improving wellbeing and raising the profile and accountability around wellbeing.	**Domain 2**
Continue to strengthen our services for staff and workstreams on compassionate and inclusive culture to improve staff experience. New leadership development programme 'We Lead' has been launched in April 2025 to empower leaders to develop compassionate leadership skills and foster positive team culture	**Domain 2**
Leadership and implementation of the Health Inequality agenda Consultant of Public Health has been employed to lead on the organisation's health inequalities and prevention plan and an action plan has been drafted to support the implementation of the agenda.	**Domain 3**

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below	
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Three patient services were identified for review during 2025/26.

- **COPD Service, Royal Albert Edward Infirmary**
- **Community Chronic Fatigue Service**
- **Mortuary Service, Royal Albert Edward Infirmary**

A separate evidence pack was compiled for each service identified and published on the trust's website. Compilation of evidence packs largely utilised already existing data and reports. Service leads provided specific input on their service.

Existing data and reports included:

- Patient Surveys (local & national)
- Patient feedback / Lived experience
- The Friends and Family Test (FFT results)
- Serious incidents, never events and complaints
- Examples of reasonable adjustments made
- Policies and Procedures / Interpreting and Translation information

Engagement with patients and public was undertaken from 26/11/25 until 26/01/26. The engagement approach agreed to be implemented this year, included:

- On-line survey and evidence published on Trust website (alternative formats provided). Service users and local community encouraged to review and give feedback.

- E-mail sent to Staff; Volunteers; Governors / Patient Experience and Engagement Group Members; Wigan Borough EDI Group; and other Local Groups inviting them to review evidence and give feedback. Articles included in Trust News / social media.

- Presented to Lived Experience Partners at December 2025 Meeting encouraging them to review evidence and give feedback.

- Undertaking ‘Real Time’ Patient Experience Surveys on COPD and at COPD Support Group on 26/11/25

- Reviewing Mortuary OWLL (Observe, Watch, Listen and Learn) Assessment Report undertaken in September 2025

As advised by NHS England guidance, the middle score out of the three services for Domain 1 will be added together to provide the overall score.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**See Appendix 1** • **COPD Service**, Royal Albert Edward Infirmary • **Community Chronic Fatigue Service** • **Mortuary Service**, Royal Albert Edward Infirmary	3 2 1	COPD Service Lead Chronic Fatigue Service Lead Mortuary Service Lead EDI Service Lead
	1B: Individual patients (service users) health needs are met	**See Appendix 1** • **COPD Service**, Royal Albert Edward Infirmary • **Community Chronic Fatigue Service** • **Mortuary Service**, Royal Albert Edward Infirmary	3 2 2	COPD Service Lead Chronic Fatigue Service Lead Mortuary Service Lead EDI Service Lead
	1C: When patients (service users) use the service, they are free from harm	**See Appendix 1** • **COPD Service**, Royal Albert Edward Infirmary • **Community Chronic Fatigue Service** • **Mortuary Service**, Royal Albert Edward Infirmary	3 3 2	COPD Service Lead Chronic Fatigue Service Lead Mortuary Service Lead EDI Service Lead

	1D: Patients (service users) report positive experiences of the service	**See Appendix 1** • **COPD Service**, Royal Albert Edward Infirmary • **Community Chronic Fatigue Service** • **Mortuary Service**, Royal Albert Edward Infirmary	3 2 0	COPD Service Lead Chronic Fatigue Service Lead Mortuary Service Lead EDI Service Lead
Domain 1: Commissioned or provided services overall rating (As advised by NHS England guidance, the middle score out of the three services for Domain 1 has been used for the overall score rating).			**9**	Community Chronic Fatigue Service

Domain 2: Workforce health and well-being

Introduction: The health of our workforce is critical, and NHS organisations are best placed to support healthy living and lifestyles. The EDS recognises that our staff are also our patients, who belong to various community groups; the very same community groups that we serve. WWL is encouraged to monitor the health of our workforce, support self-care and build health literacy among staff.

Evidence was collated and scored in collaboration with stakeholder groups (staff side, Chaplaincy, diversity staff networks).

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Detailed list of evidence for Domain 2 can be found in Appendix 2. The Trust screens all new staff for a range of health conditions during the initial Occupational Health and Health and Safety risk assessment process. Staff are offered direct support for specific health conditions if referred to OH (including conditions such as obesity, diabetes, asthma, and COPD and mental health conditions) The Trust provides comprehensive support services to support staff's health, including wellbeing services, safeguarding and chaplaincy services Data is reviewed routinely, however limited access to data on specific health conditions or breakdown by protected characteristics Key updates for this outcome: A new Wellbeing Policy has been developed in response to staff feedback gathered through surveys and focus groups, replacing the existing Attendance Management Policy. This updated policy moves away from a punitive, reactive approach to sickness management and instead focuses on proactive wellbeing support A Sickness Improvement Group was established in early 2025 which is chaired by Deputy Chief People Officer. The group has developed an improvement plan to reduce sickness absence across the Trust which includes improving data quality, reducing length of absence, improving wellbeing and raising the profile and accountability around wellbeing.	1	Staff Experience

		WWL has launched a refreshed flexible working policy and guidance to support keeping staff in work. Staff are encouraged to discuss flexible working options at induction or anytime after that. New Wellness at Work resources have been launched including workplace adjustment guidance and wellness at work plan to support staff in having regular wellbeing conversations about their health, how to support them in work and what adjustments can be made to stay well in work. WWL has secured grant funding via NHS Charities Together to employ a Wellbeing Adjustment Advisor role for 12 months which will provide additional support to staff to agree adjustments and support their wellbeing at work. Stakeholders felt the organisation has policies and services on paper, but implementation is inconsistent and in some areas rapidly deteriorating. Overall, the group recommended no improvement in score (remain at 1, Developing). To improve the EDS rating for this Domain, the organisation will need to: • Launch of Wellbeing Policy and full implementation of new processes to support attendance • Continuation of psychological support for staff following changes to wellbeing service provision from Apri 2026 • Further strengthening of data (including ESR) to ensure equitable support • Provide more timely/proactive support for staff who are at risk of going off or are currently off sick		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	The main evidence of the prevalence of bullying, harassment and abuse was considered using the following sources of: • NHS England Workforce Race Equality Standard (WRES) • NHS England Workforce Disability Equality Standard (WDES) • Datix • Freedom to Speak Up report • Safeguarding Report • Fair experience at work report Our data sources suggest a reduction in violence/abuse cases involving patient on staff; however National Staff Survey data suggests that bullying and harassment from staff has worsened. The Freedom to Speak Up Annual Report indicates that about a quarter of referrals relate to incivilities, bullying and discrimination. Updates to this Outcomes: Yellow and Red Card Policy: A draft policy has been developed to support escalation of incidents involving patients/public who are violent and or abusive (Yellow and Red Card Policy) The main purpose of this policy is to provide staff with effective to de-escalate any unacceptable violent/nuisance and disturbance behaviour or, should de-escalation prove unsuccessful, to invoke Yellow or Red Card to sanction patients/public showing inappropriate/unacceptable behaviour/ abuse. A new Violence Prevention Strategy is currently being developed and a Violence and Aggression Working group has been established in December 2025. This group will help to ensure we take a multi-disciplinary approach and triangulate our data and insights to ensure	1	People Services

		our processes are appropriate, timely and will provide duty of care for those involved in incidents. WWL has been working towards the North West Anti-Racist BAME Assembly Bronze accreditation and has committed to an anti-racist strategy and policies to protect our staff and patients from racial abuse and discrimination. WWL has also signed the NHS Sexual Safety Charter and has launched a new Sexual Misconduct Policy which aims to support staff who have experienced any sexual unwanted behaviour by other staff and provides new reporting process for staff to raise concern about sexual misconduct. Stakeholders felt the organisation makes attempts, but policies do not go far enough, are inconsistently applied, and staff do not feel protected. Overall, the group recommended no improvement in score (remain at Developing). To improve the EDS rating for this Domain, the organisation will need to: • Launch Yellow/Red Card policy and monitor its effectiveness • Strengthen Conduct Policy to demonstrate zero-tolerance of racism • Strengthen support for staff following incidents • Continue work to build compassionate workplace culture		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	WWL provides a comprehensive range of support and advice services to assist staff for those who have suffered stress, bullying, harassment or abuse, including Safeguarding Team, HR, staff wellbeing and psychological support services, Trauma Risk Assessment, self-service Steps4Wellness toolkit, trade union, Freedom to Speak Up Guardian, and staff networks. Both Staff Side and Freedom to Speak Up Guardian act independently and impartially to support staff. The evidence from the services highlighted that the accessibility of them could be improved to provide timely support to staff. Stakeholders felt that support offer is going to be reduced due to ongoing organisational redesign. Available services may not be able to provide timely response or support. The group recommended to decrease the score to 1 – Developing Activity To improve the EDS rating for this Domain, the organisation will need to: • Assure that alternative wellbeing/psychological support provision will meet staff needs • Continue to build Freedom to Speak Up Guardian service and use feedback mechanisms to implement improvements	1	People Services

	2D: Staff recommend the organisation as a place to work and receive treatment	This Domain 2D question relies on evidence from the NHS Staff Survey 2024. The grading guidance has indicated, WWL's staff recommending WWL as a place to work would need to be above 70% to enable a score greater than 1 to be awarded. Staff recommending organisation as a place to work: Trust overall average 59.13% (vs 63.3% in 2023) NHS sector average 61% BME Staff 63.4% (vs. 71.6% in 2024) Staff with long-term health conditions 51% Staff recommending organisation as a place to receive treatment: Trust overall average = 58.7% (vs 62.5% in 2023) NHS sector Average = 61.5% BME staff = 66.9% (vs 70.1% in 2023) Staff with long lasting health conditions and illness = 52.6% National Staff Data, WRES and WDES data is being collected annually and compared to support EDI strategy and People and Culture Strategy. Annual action plans are developed to improve staff experience and address key indicators of inequity.	1	People Services
Domain 2: Workforce health and well-being overall rating			**4**	

Domain 3: Inclusive leadership

Evidence was collated and presented to stakeholder groups (staff side & a neighbouring NHS Trust). Each outcome was scored out of 3 and a mean score was taken.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Please see Appendix 2 for the detailed evidence provided. The Trust Board has shown a commitment to the anti-racism agenda by becoming a signatory to the GM anti racism framework and having achieved the Bronze recognition of the North West Black Asian Minority Ethnic Assembly Anti-Racist Framework. The new Chair has articulated ambition to strengthen partnership working within the system to address health inequalities and make this a key priority for the Board. The Board has an appointed Health Inequalities Lead (Deputy Chief Executive) and employed a consultant for public health to lead on the creation and implementation of the organisation's Health Inequalities and Prevention Plan which is aligned with the Progress with Unity framework. The first phase of the action plan has six priorities which focus on building the infrastructure	2	Board

		needed to support a shift to creating the conditions for health inequalities and prevention activity to thrive Although the organisation has seen an improvement in prioritising EDI as core business activity over the past year, there is currently no further investment planned for EDI resource to support the EDI strategy. The raters recognise the steps taken to make EDI a priority for the organisation and recommend a score of 2 – Achieving activity. To improve the rating for Outcome 3A, the organisation would need to: • Consider further investment in EDI resource to demonstrate commitment to EDI agenda and accelerate implementation of EDI strategy • Implement the Health Inequalities Improvement Plan to meet the NHS EDI improvement plan and NHS contract requirements		

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	A random sample of WWL's 2023/24 minutes/agendas/papers were examined for evidence to score against the 3B outcome. Progress against EDI strategy is overseen by the EDI Strategy Group which is chaired by the Chief Executive. The Corporate report and business case templates have been amended to give consideration as to the impact on equality, diversity or inclusion at WWL. ED&I reflections are discussed at all assurance committees. Equality Impact assessments are in place for policies and some projects and have recently been built into the business case cycle. However, there are still inconsistencies in assessments being completed for services and there is still no central monitoring mechanism in place. The raters recommended no improvement in score (remain at Developing). To improve the rating	1	Corporate

		for Outcome 3B, the organisation would need to: • Build consistency in conducting Equality Impact Assessments for all policies and projects and ensure that this is monitored • Strengthen divisional accountability for developing EDI related objectives in their business plans		

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	The introduction of the EDI Strategy Group and associated workstreams has strengthened the governance around EDI and allowed for the implementation of EDI related action plans to be regularly monitored. Some workstreams have taken key action to improve staff experience, such as supporting our global majority colleagues at WWL and supporting our staff with long-term health conditions. WWL has appointed a Health Inequality lead and employed a Consultant for Public Health to create and implement the Health Inequalities and Prevention plan. However, the organisation has not yet been able to demonstrate measurable progress towards reducing health inequalities. WRES, WDES, Gender Pay Gap reporting, and EDS continue to be reported to Board for assurance purposes. Despite strengthening the governance structure for EDI, there is limited evidence demonstrating	1	Board

		measurable progress against EDI reporting frameworks. The raters recommended no change in score (remain at Developing). To improve the rating for Outcome 3C, the organisation would need to: • Demonstrate progress against health inequalities improvement plan • Demonstrate measurable progress of action plans associated with EDI reporting frameworks (including WRES, WDES, Gender Pay Gap and NHE EDI Improvement Plan)		
Domain 3: Inclusive leadership overall rating			**4**	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Phil Powell, Joanne Matthews	**Independent Evaluator(s)/Peer Reviewer(s):**

EDS Organisation Rating (overall rating): 17 (Developing)

Organisation name(s): **Wrightington, Wigan and Leigh NHS Teaching Hospitals Foundation Trust**

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Head of Staff Experience, Angelique Hartwig EDI Lead (Service): Debbie Jones	2025/26
EDS Sponsor	**Authorisation date**
Interim Chief People Officer: Emma Newton Chief Nursing Officer: Kevin Parker-Evans	

TO BE NOTED: FOR DOMAIN 1 ACTIONS FROM 2025/26 REVIEW RELATE TO ALL OUTCOMES (not individual outcomes)

Domain	Outcome	Objective	Action	Completion date

Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service 1B: Individual patients (service users) health needs are met 1C: When patients (service users) use the service, they are free from harm 1D: Patients (service users) report positive experiences of the service	**Each service will progress the actions from their EDS work.** **To continue to closely monitor patient feedback methodologies to measure improvement work going forward.**	EDS2025/26 Service Stakeholder Feedback Reports to be shared with Divisions and Patient Experience and Engagement Group Implementation of Family and Friends Test (FFT) Cards in COPD to enable continuous real-time patient experience feedback. To review feedback monthly and record any further improvements made. Mortuary Service to review appropriate patient feedback methodologies which can be used to collate and monitor patient relative feedback to measure improvement work going forward (Comments Cards in waiting area) Community Chronic Fatigue Service to monitor patient feedback from the Greater Manchester Patient Satisfaction Survey for Myalgic Encephalomyelitis / Chronic Fatigue Syndrome / Long Covid Services, to measure improvement work going forward. To continue to monitor patient feedback from the Friends and Family Test (FFT) Cards and Service Feedback Patient Information.	April 2026 April 2026 July 2026 May 2026

Domain	Outcome	Objective	Action	Completion date
		More EDS engagement from local community from all protected characteristics to gain insights from people with lived experience.	To continue to recruit Lived experience Partners from all 9 protected characteristics. Embed more targeted engagement across all 9 protected characteristics within EDS engagement plans.	Jan 2027

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source 2D: Staff recommend the organisation as a place to work and receive treatment	• Implementation of new policy, guidance and training to ensure timely support for staff who are at risk of going off or are currently off sick • Provide adequate support for staff with mental health conditions • Improve the support available for staff experiencing bullying, harassment and violence from any source.	• Launch of Wellbeing Policy and full implementation of new processes to support attendance • Embed alternative wellbeing/psychological support provision which meets staff needs following changes to wellbeing service provision from April 2026 • Strengthen processes to address and learn from incidents of abuse, harassment or discrimination and provide support for staff (Yellow/Red Card policy; Avoiding Harm programme) • Continue to build Freedom to Speak Up Guardian service and use feedback mechanisms to implement improvements	May 2026 May 2026 Q1 2026 Ongoing

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Meeting legal and contractual EDI and Health Inequalities requirements Improve the quality of health inequalities and equality impact assessments Strengthen the investment in EDI and making EDI core business Sharpening the focus of the monitoring of the implementation of actions and their impact	• Implement the Health Inequalities Improvement Plan to meet the NHS EDI improvement plan and NHS contract requirements • Review options to further invest in EDI resources to accelerate implementation of EDI agenda • Strengthen divisional accountability for developing EDI related objectives in their business plans • Build consistency in conducting Equality Impact Assessments for all policies and projects and ensure that this is monitored • Demonstrate measurable progress of action plans associated with EDI reporting	March 2027 Ongoing May 2026 September 2026 Financial year 26/27

			frameworks (including WRES, WDES, Gender Pay Gap and NHE EDI Improvement plan)	

Appendix 1

Domain 1 Service Evidence and Stakeholder Feedback Reports:

Appendix 2

Domain 2 Evidence:

Domain 3 Evidence:

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Chronic Fatigue

Equality Delivery System (EDS) 2025/26
Domain 1: Stakeholder Feedback

Introduction

Every year, as part of the requirements of the Equality Delivery System (EDS), all NHS Trusts have to review the equality and inclusion work undertaken in three of their patient services and provide evidence across all 9 protected characteristics, against the following four outcomes.

1A: Patients (service users) have required levels of access to the service

1B: Individual patients (service user's) health needs are met

1C: When patients (service users) use the service, they are free from harm

1D: Patients (service users) report positive experiences of the service

Outcomes are then evaluated, scored and rated using available evidence and insight through engagement with patients and public.

The three patient services identified for review this year (2025/26) were:

- COPD Service, Royal Albert Edward Infirmary
- **Community Chronic Fatigue Service**
- Mortuary Service, Royal Albert Edward Infirmary

This report summarises the stakeholder feedback obtained for Community Chronic Fatigue Service.

Method

Evidence was reviewed and collated across all 9 protected characteristics for the outcomes stated above. An evidence pack was produced and published on the Trust website. **See Appendix 1**

Engagement with patients and public was undertaken from 26/11/25 until 26/01/26. The engagement approach agreed to be implemented this year, included:

- On-line survey and evidence published on Trust website (alternative formats provided). Service users and local community encouraged to review and give feedback.

- E-mail sent to Staff; Volunteers; Governors / Patient Experience and Engagement Group Members; Wigan Borough EDI Group; and other Local Groups inviting them to review evidence and give feedback. Articles included in Trust News / social media.

- Presented to Lived Experience Partners at December 2025 Meeting encouraging them to review evidence and give feedback.

Acknowledgments

Wrightington, Wigan and Leigh NHS Teaching Hospitals Foundation Trust would like to thank everyone who chose to take part in this review.

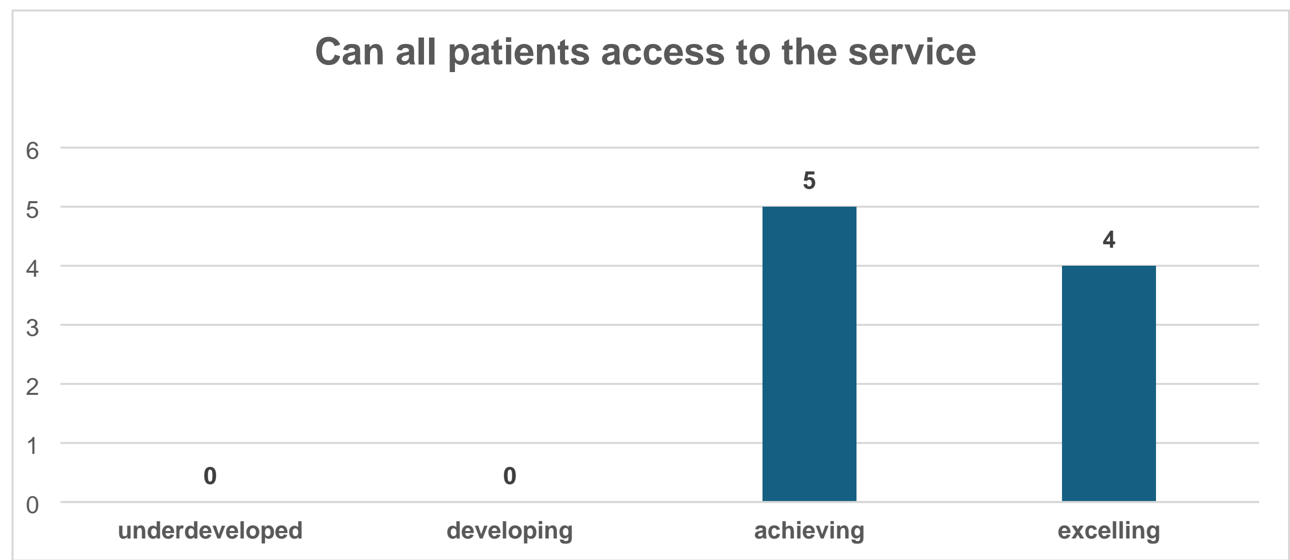
Results

The results on the following pages show the feedback and scores received from:

Total Number of Participants	On-Line Survey	EDS Score Form (via E-mail)	Real-time Patient Experience Survey
9	8	1	0

Scores and Feedback

Question 1



Overall, Mode Score: Achieving

Patient Comments (WWL Response to questions raised included)

Excelling
Patients across all groups have equal access to the service and at present the service has representations across all groups.

Evidence and feedback from service users.

Excellent feedback from patients. Looks like everything is in place to allow good access.

Achieving
There appears enough put in place but would like more information on it to give a better score.

There is a comprehensive list of areas that support patients.

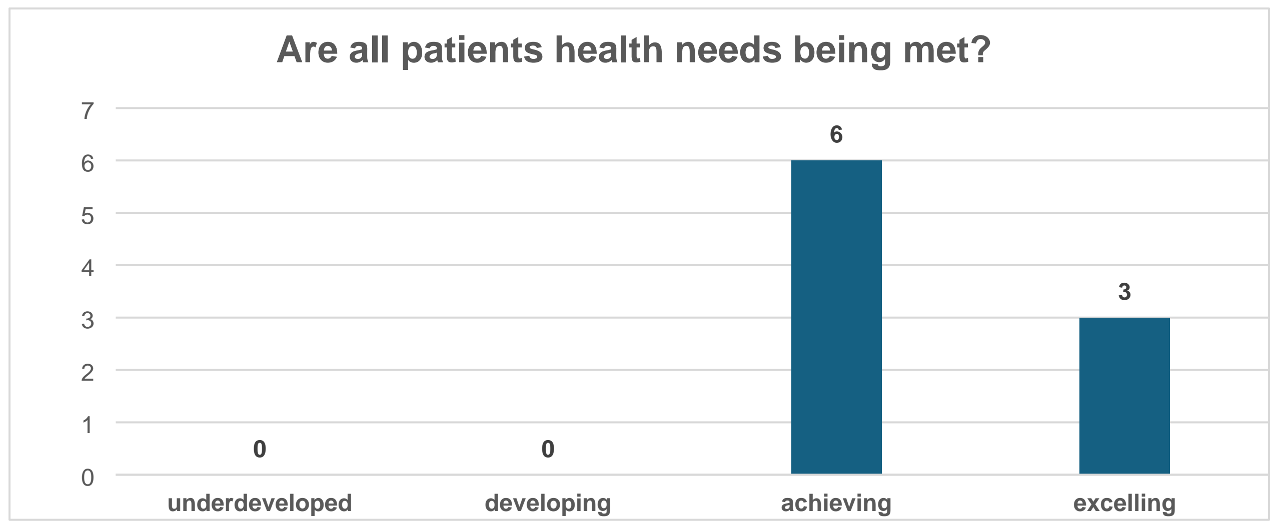
Substantial evidence given.

Not clear how patients are actually referred to the service, so cannot be sure that all patients WHO NEED TO access it can ACTUALLY do so, especially as there is a mandatory 4 months wait before referral.

WWL Response: Patients initially must be referred by the GP as medical reasons need to be ruled out first. Once they are diagnosed a patient can access the service as a patient initiated follow up within 12 months once their care episode has ended. With regard to the 4 month wait, the service is implementing Introduction Group Sessions which will reduce the 4 months wait significantly. One to one sessions will still be offered if a patient prefers this.

Then groups will be offered depending on what patients require, such as pacing, fatigue, neurodivergence, young person's group, mindfulness, interpersonal relationships, stress tolerance (anxiety management) sleep and working and benefits. This will significantly reduce the waits

Question 2



Overall Mode Score: Achieving

Patient Comments (WWL Response to questions raised included)

Excelling
They provide individual care plans tailored to each service user.

Evidence and feedback from service users.

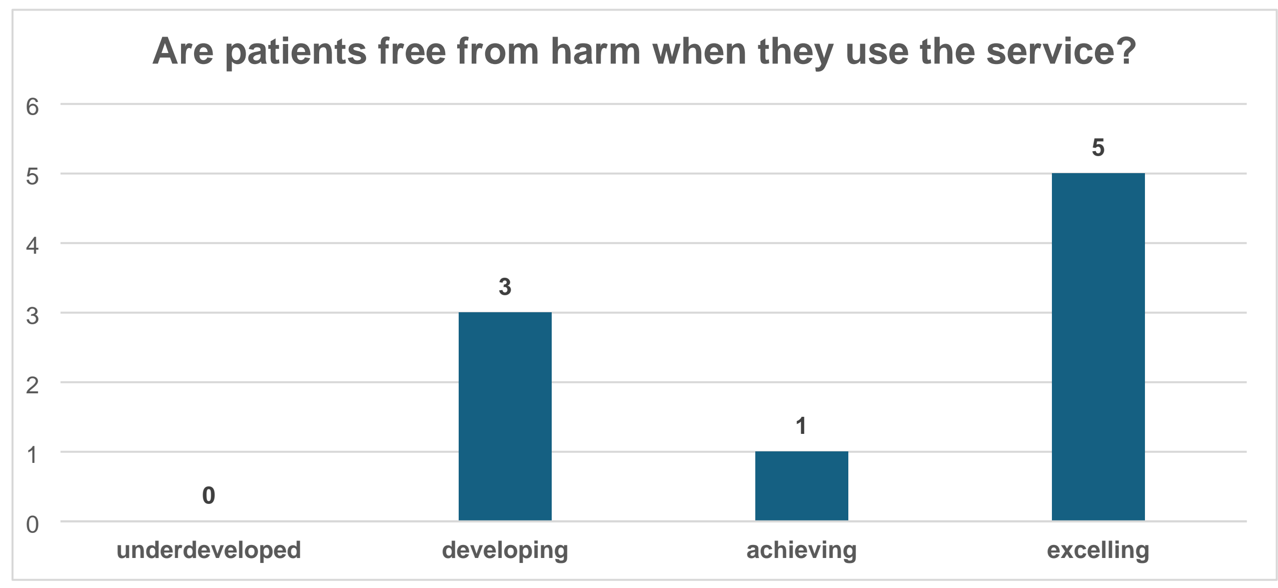
I would think so from the patients' comments.

Achieving
It would appear so from the information given.

Based on the provided information.

The 4 month wait for referral may compromise some patient's views that their health needs are being met by the service. (See WWL Response to Question 1)

Question 3



Overall, Mode Score: Excelling

Patient Comments (WWL Response to questions raised included)

Excelling
As someone who uses this service, and has done for the last 9 years, I have always felt safe using the service.

Evidence and feedback from service users.

Great comments received. Everything seems to be in place to create a security for the patient.

The evidence provided shows that every effort has been made to meet the criteria.

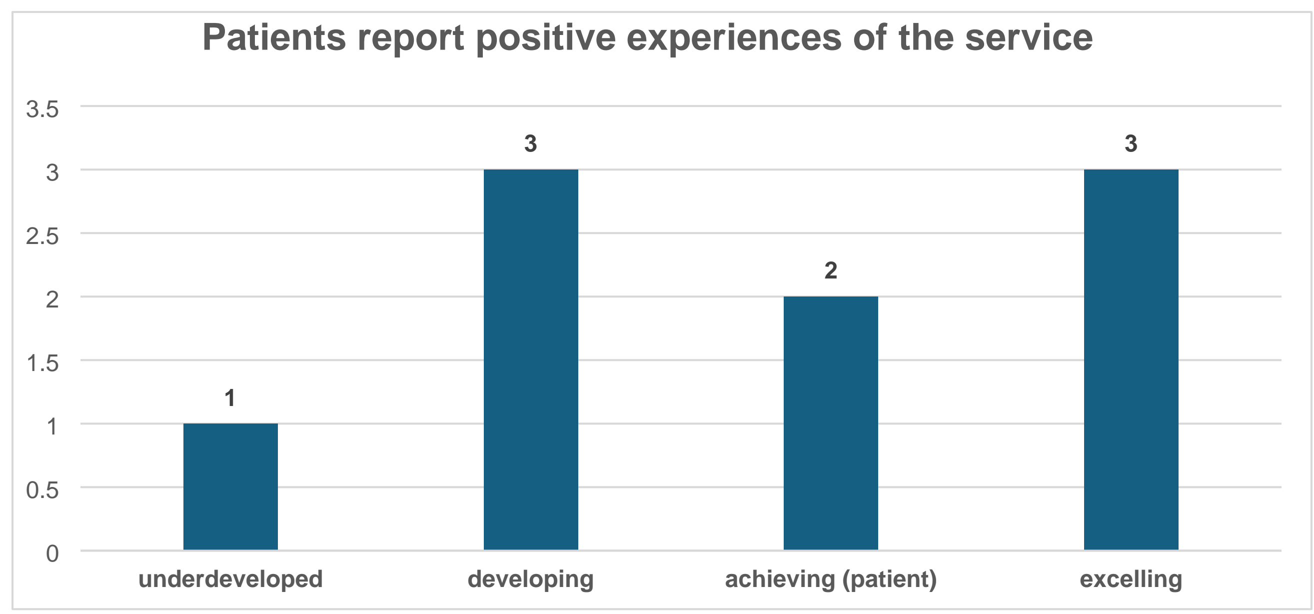
Achieving
Is there a quiet space available for neurodivergent patients? Are they able to have longer appointment times, if needed?

WWL Response: The service will be providing separate introduction sessions for neurodivergent patients, including smaller groups or one to one sessions.
There is a quiet area in Golborne for all our patients away from the main waiting area.

Developing
Not enough evidence to give a better score.

There is no evidence presented demonstrating typical interventions/support, although reference is made to the various safe guarding elements that are followed.

Question 4



Overall Mode Score: Achieving

Patient Comments

Excelling
Patient Story!

Evidence and feedback from service users.

Patient comments clearly show positive experiences.

Achieving
The only downside is the waiting time for appointments. This cannot be helped by the team though as I feel they could do with more staff which is a trust wide funding issue rather than the service fault. They manage extremely well in difficult overwhelming circumstances.

Developing
I can see that a survey is currently being conducted for patient feedback.

There are limited positive responses of patients, there are no negative issues highlighted and how these were responded to.

More patient feedback needed.

Underdeveloped
No relevant relative/carer feedback provided.

Question 5

What reasonable adjustments would you want us to make for future hospital appointments

No comments recorded.

Conclusion

Based on the feedback provided, **Community Chronic Fatigue Service scored overall 9 points** for Domain 1: Commissioned / Provided Services. Scores allocated shown below

Outcome		Overall 'Mode' Score	
1A	Patients have required levels of access to the service	2	Achieving
1B	When patients use the service, they are free from harm	3	Excelling
1C	Individual patients health needs are met	2	Achieving
1D	Patients report positive experiences of the service	2	Achieving

Suggestions for improvement (EDS)

- More engagement from public from all protected characteristics to gain insights from people with lived experience.

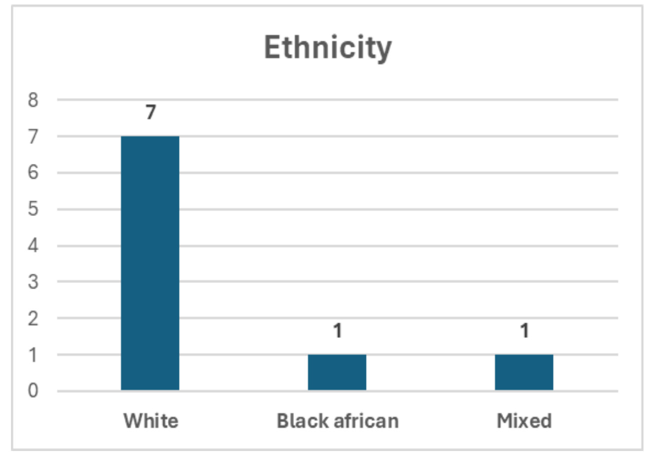
Suggestions for improvement – Chronic Fatigue Service

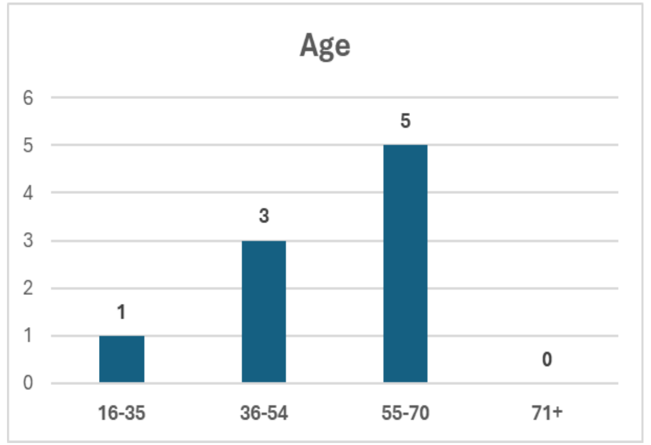
- Service Leads to share EDS 2025/26 Domain 1 Service Stakeholder Feedback Reports with Divisions via Divisional DQEG Meeting on 12th March 2026.

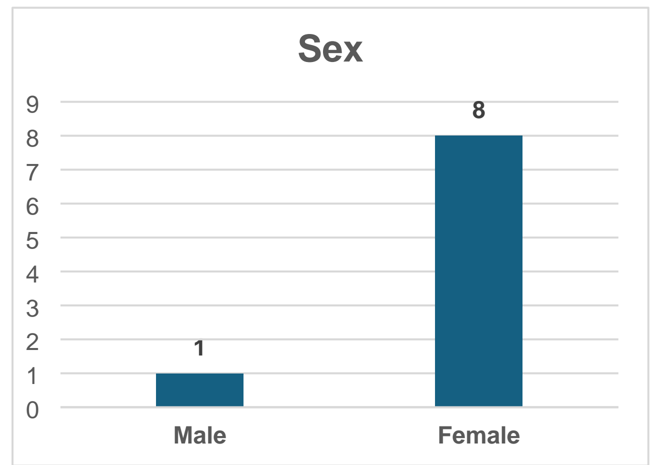
- To monitor patient feedback from the Greater Manchester Patient Satisfaction Survey for Myalgic Encephalomyelitis / Chronic Fatigue Syndrome / Long Covid Services, to measure improvement work going forward.

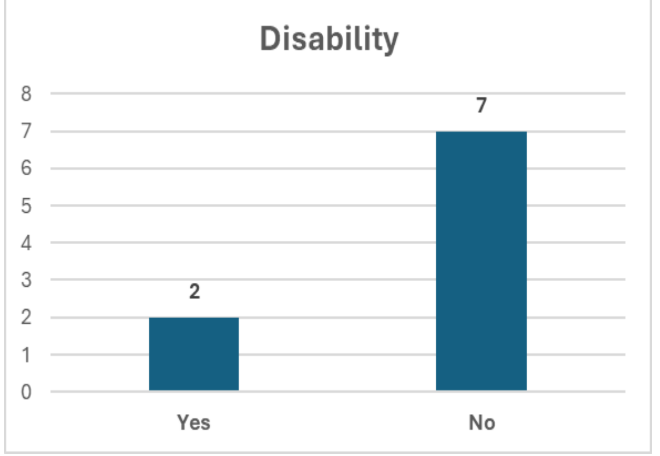
- To continue to monitor patient feedback from the Friends and Family Test (FFT) Cards and Service Feedback Patient Information.

Stakeholder Equality monitoring data

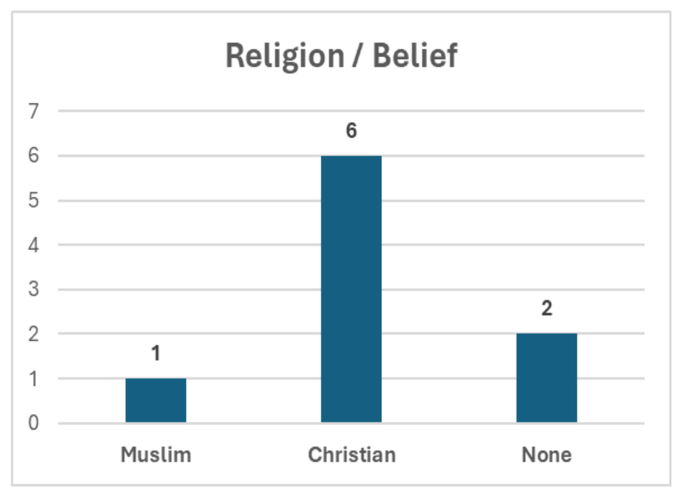


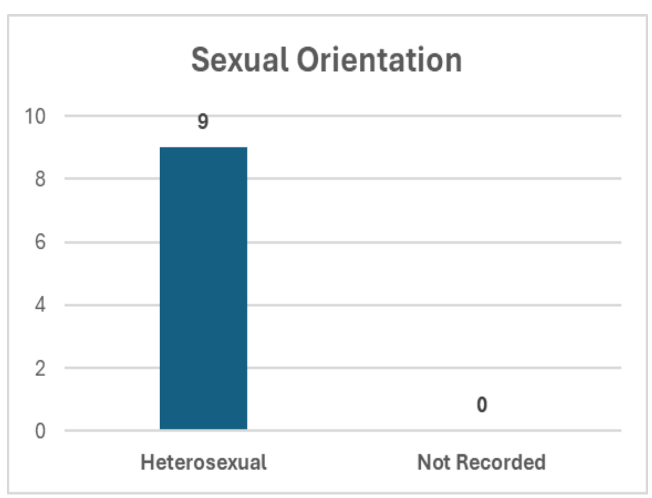






1 Physical / 1 Not Stated





Appendix 1

Myalgic Encephalomyelitis/ Chronic Fatigue Syndrome / Long Covid Team Community Division - Equality Engagement

The Equality Delivery System (EDS) is a framework which was created by the Department of Health to help NHS Organisations to make improvements on equality, diversity and inclusion. To improve the services they provide for their local communities, consider health inequalities in their /local area and provide better working environments free of discrimination.

WWL want you, our service users and local community to have a say on our equality and inclusion work for ME/CFS/LC/Long Covid Team We want to:

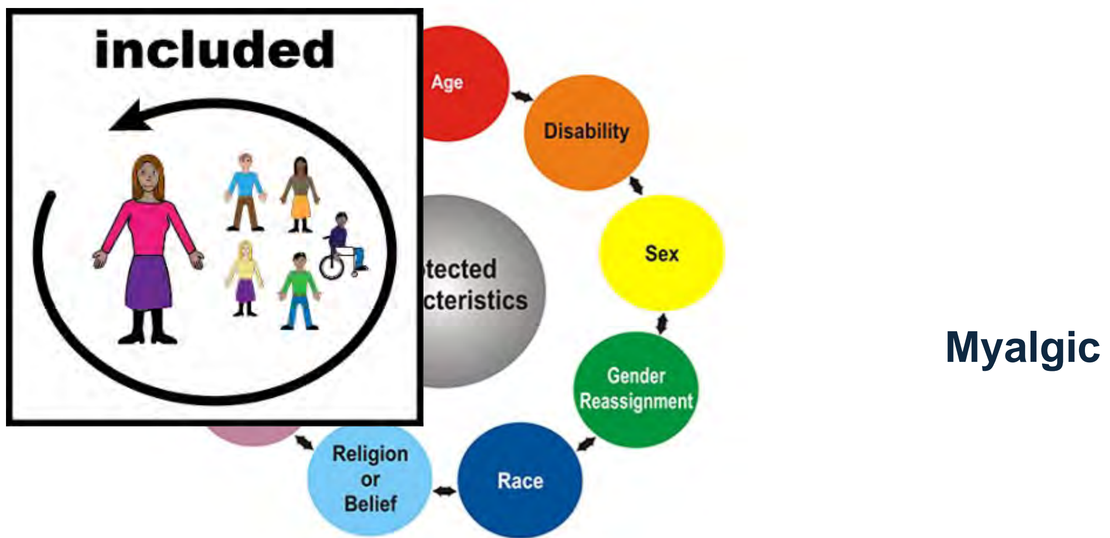
- **Show you what we currently provide and what we are working on**
- **Ask you "are we getting it right for everyone / people from all protected characteristics?"**
- **Tell us how well you think we are doing - Score us on the following questions**
- **Help us decide what we need to do next**

Can all patients (who need to) access the service?

When patients use the service, do they feel safe? (free from harm)

Are individual patient's health needs being met? (receiving good care)

Are patients reporting positive experiences?



Myalgic Encephalomyelitis(ME) / Chronic Fatigue Syndrome (CFS) / Long Covid Team Community Division

The ME / CFS / Long Covid Specialist Multi-disciplinary Team are based in the Community Division of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.

Referrals are accepted for presenting symptoms of fatigue.as per NICE guidance lasting for a duration of 4 months, worsening after periods of exertion and unrelieved by rest with other medical causes ruled out.

The team which includes a Rehabilitation Medicine Consultant, Physiotherapists, Occupational therapists and admin, are based at Golborne clinic. They provide initial diagnosis followed by therapeutic intervention in the form of one to one and/or group support. They offer clinic appointments, telephone appointments, home visits and virtual appointments via Attend Anywhere in accordance with patient need.

Golborne Clinic

Evidence 1: Can all patients (who need to) access to the service?	
Protected Characteristic	**Evidence on how each group can access this service**
Sex (Male / Female)	Single sex toilets available at Golborne Clinic Patients have equality of opportunity to access the service in relation to health irrespective of whether they are male, female, single, divorced, separated, living together or married.
Transgender / Gender Re-assignment	Guidance available for staff on supporting trans and non-binary patients. The ME/CFS/LC Team provide equal opportunity in relation to health care for individuals irrespective of whether they are male or female, trans or 'whether they identify with the gender they were assigned at birth'. The team understands and the maintains confidentiality about an individual's trans identity / history.
Age **(18 years+)**	The service is for adults over 18 years.

	Children would be referred to Paediatrics – The service does accept transitional patients at the request of the referring clinician /GP if deemed appropriate.
Race or Ethnicity	Access to interpreter and translation services. We have full access to interpreter and translation services for patient's relatives/carers from different ethnicities who do not speak English as their first language. WWL provides access to the following interpreter and translation services: • Face to Face and telephone interpreters • British Sign Language Interpreter (face to face and video remote on demand
Disability: Hearing Impairment	Access to British Sign Language Interpreters (face to face and video remote) Portable hearing loop available in Golborne clinic and microphones at reception to enable staff and patients to hear each other due to the screens.
Disability: Visual Impairment	Information / correspondence can be provided in braille, large print, audio on request. Provision of additional support available. (recorded within individual notes on system one)
Physical Disability	Toilet provisions which accommodate disabled patients are available in Golborne clinic. Access to the clinic – clinic is on one floor and has designated parking facilities for disabled patients. Golborne clinic was chosen as a central location in the borough for ease of access for patients. Staff undertook a review of the waiting area and create their own space for patients to facilitate patient needs due to the nature of ME/CFS/LC.
Learning Disability	Access to Learning Disability Team and carer support available. Patient information can be obtained in easy read format / large print.
Mental Health Need	The service provides an in-depth triage process in which accommodations for any mental health need can be discussed before accessing the service e.g. virtual assessments, home visits, named clinicians and availability of chaperone. One to one or group session are offered based on individual needs. We always endeavour to promote links with Local Mental Health services and complete joint working with the counselling and talking therapies service.
Sexual Orientation	The ME/CFS/LC Service recognises and respects individual's sexuality and the right of maintenance of confidentiality about an individual's sexuality, this is recorded on system one if the patient consents to share this information.
Religion / Belief (please specify)	Access to interpreter and translation services. ME/CFS/LC Service recognises and respects individual's religion and beliefs and this is recorded on system one if the patient consents to share this information.
Marriage & Civil Partnership	The ME/CFS/LC Team provide equal opportunity in relation to health care for individuals irrespective of whether they are single, divorced, separated, living together or married or in a civil partnership. This is recorded on system one if the patient consents to share this information.

Pregnancy & Maternity	The ME/CFS/LC Team provides equality of opportunity in relation to health care for women irrespective of whether they are pregnant or on maternity leave or breast feeding. Golborne Clinic provides baby changing facilities.
Carer Status	Access to Wigan Council's Carer Support Team. The team will provide flexibility of appointment times to accommodate carer responsibility. This is recorded on system one if the patient consents to share this information.

Patients across all groups have equal access to the service and at present the service has representations across all groups.

Evidence 2: Are all individual Patients health needs being met? (having needs met in a way that works for them)
Patients report they feel listened to and understood which underpins a feeling of safety. The service ensures all possible procedures are put in place at all times.
Personalised Individual Care Plans **All patients have a personalised individual care plan**. If a need/adjustment in relation to a patient's protected characteristic is required, then this is considered when the patient is admitted onto the caseload. All needs / care plans are reviewed at each patient contact.
Weekly MDT meeting

Staff meet weekly to discuss individual patients who require more complex intervention and have access to a regional Tier 4 pathway in Salford for clinicians to present very complex patients with access to a range of specialist consultants.

Equality Impact Assessment

An Equality Impact Assessment is undertaken on ME/CFS/LC every 3 years. Last Assessment undertaken July 2025. We use this assessment to identify potential impacts, both positive and negative across all 9 protected characteristics, and look at how we could avoid disadvantages or further improve the delivery of our services.

To view a copy of our equality impact assessment please e-mail EDI@wwl.nhs.uk

Evidence 3: Are patients free from harm when they use the service? (feel safe / there are procedures in place to ensure safety)

The service ensures all possible procedures are put in place at all times to ensure patient feel safe and free from harm.

Trust Risk Management Policy

All serious incidents / complaints are investigated, and lessons learnt embedded within Trust practice.

All staff within the ME/CFS/LC Team have a role in identifying risk and patients are protected from harm.

Personalised Individual Care Plans

All patients have a personalised individual care plan.

If a need/adjustment in relation to a patient's protected characteristic is required, then this is considered when the patient is admitted onto the ME/CFS/LC caseload

Links with Safeguarding Team

Staff have completed safeguarding training and are aware of how to access WWL and council safeguarding teams

Links with Independent Domestic violence Advisor (IDVA) Nurses

ME/CFS/LC Team members have received awareness training on domestic violence and know how to refer to IDVA Nurses.

Evidence: Patients report positive experiences of the service

Patient feedback

The Trust collects and obtains feedback from patients through its PALS processes and patient surveys which are reported to the Trust Board of Directors

A GM wide patient satisfaction survey for ME/CFS/LC services is currently part of the ongoing ICB review of services and under development.

FFT Results

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services, should have the opportunity to provide feedback on their experience.

The FFT asks people about their experience of services they have used and offers a range of responses.

No family friendly results available at present but below are some recent patient compliments:

Patients report positive experiences around patient care but are often disappointed by the waiting time to receive the treatment.

Sample of some of the positive feedback received:

Transgender patient:
I feel I have been treated very well by the service. The clinic environment feels safe for me, all members of staff at reception and from the clinic are kind and friendly. I also appreciate the comfortable seats in the waiting area, and the water and tissues available in the clinic room.

Patient requiring an interpreter:
I think the service is very good. They organise telephone interpreters in my language for every visit and give me extra time for my appointment to help me. They understand my culture and the problems I have had. I am very happy with this service.

Patient:
Thank you so much. Your emails are such a huge comfort. To know you are there to ask and receive advice. So much appreciated.

Patient:
Thank you so much for the letters they are brilliant what a star.

A Patient's Story: My Recovery Journey

I became ill with long Covid early on in the pandemic, at a time in my life when I was under huge physical and mental demand. I had a toddler and a small child, there was no childcare available, I was expected to home school my 5 year old, I was still breastfeeding and being woken in the night, my work was necessary to the functioning of the NHS, my husband was a front line worker. There was no place or space to rest and convalesce, and no help from the NHS. When I look back I see how I had pushed myself for years to function at a high level, putting everything and everyone else before my own needs.

After 7 months of spending almost all of my time alone in bed with long covid, on Christmas Day, listening to my children downstairs playing and celebrating whilst I lay in bed exhausted, door closed and curtains drawn, I broke down. And expending all that emotional energy cost me so much that I relapsed, a relapse that took me two years to pull myself out of.
During that time I became bedbound, being wheeled to the toilet and eating food just a few minutes at a time whilst lying down, sometimes being spoon fed. My mind was foggy, I couldn't engage my brain for more than few minutes at a time before it shut down.

For the next 18 months I was up and down. I had severe anxiety and every single symptom and noise made me ruminate and panic. I woke up every day in the early hours with fear literally

raging up and down my body, I would stay in freeze mode, still as a statue, too scared to move, staring at the wall trying not to think, waiting for my husband to wake was absolute torment, and as soon as he woke I would say the same thing every day ' I cant take this anymore, I'm so desperate for it to stop, but there is no way out.' I became severely depressed. I objectively believed I was no more worthy than a broken toy and that I needed to be thrown in the bin. I gave the illness a personality, saw it as an evil force to be feared. I have never experienced such emotional torment, I felt oppressed. There were some improvements, but the emotional energy being spent meant that overall I was spiralling down. I felt as though the walls were closing in on me. I believed I would never get better, only worse until there was nothing left of me, and that terrified me. I could see it, and recognise what was happening to me, but I was so unable to control my symptoms, emotions and energy that I couldn't stop it from happening.

For 18 months I didn't get a wash of any kind, except for my hands once a day. I changed my pyjamas once a month and needed help to dress, I gave up on underwear. My hair became so matted I cut it off – it took me a week to cut it all off, one cut a day, exhausted by lifting my arms more than once. My husband encouraged me to wash but I declined – he offered to lift me into the bath or shower – he didn't understand that even with help I would expend energy, that I couldn't tolerate temperature change, that I didn't want to expose my wasted body. I didn't have the energy to explain these things – I just said 'no'. I was judged for my lack of hygiene, it made me feel ashamed, but they had no understanding of how energy intensive personal hygiene is, and how scary it is to spend energy, knowing that unbearable consequences could follow.

I had a bed, and a box next to the bed with a few belongings, and that was pretty much my life. The hardest thing was being removed from my children's lives, not knowing them anymore, not caring for them despite the instinctive knowing that I should be, lying in bed whilst their birthday parties went on downstairs, needing my husband to interpret my toddlers sentences and hand gestures for me - a unique toddler language that I should have known as if it were my own. We had just minutes together twice a day – once in the morning and once at bedtime and all my waking hours I would be looking forward to this. But sometimes they could take me or leave me, I wasn't their favourite person anymore, and this really hurt. Outside of these planned times, when I had no energy, they might come running into my room to tell me something or just to be with me, and within minutes would exhaust me physically and cognitively – and so I began to fear them. I couldn't bear to reject them and so I engaged with them and so my symptoms worsened. If I did reject them the sadness that comes with that was also exhausting – there was no way out of it. So I began hiding in the walk-in-wardrobe – lying down in there with a pillow and blanket. I asked my husband to put a lock on the door, and only once I was inside with the door locked did I feel truly safe from the world. We told the children that I was at the doctors where they had a special resting bed that would make me better. I hid in the wardrobe for just over a year and a half. My children would come to look for me regularly shouting 'mummy are you home yet?', but I could breathe freely knowing they couldn't 'hurt' me and I wouldn't have to reject them.

When I started to improve, in the evenings when my energy was typically at its highest, my husband would lift me out of the wardrobe and put me into bed, my children would come running to me as soon as they heard and we would have four precious minutes together, then five, then six, then more. All day I would hold that at the forefront of my mind, knowing that if I rested and rested something good would come. One day they made a picture for me and my husband stuck it on the ceiling in my bedroom for me to look at whilst I lay down, this gave them such joy that within a matter of weeks my bedroom walls were full of their pictures. And in every family picture they made I was there with them, not lying down but standing up just as I should have been.

People around me tried to help but their version of helping was unhelpful. My mum in particular was very hard on me, saying 'just get yourself moving' and 'I know you're in a dark place but you have to start trying, if not for yourself then for your children - they need you and so do I'. It felt like emotional blackmail, maybe that's harsh. She would direct her anger and frustration at me, as if I was bad, and then I would feel guilty, ashamed, anxious. She would come to me crying saying 'this is killing me', and I would feel so sad for her, but also angry at her for making me feel

worse. I would say 'I can't cope with your emotions as well as my own, you need to find someone else to talk to', but she ignored this, I think she thought if I could see how hard it was for her I would 'get myself moving' and get better. My husband would try to encourage me by saying things like 'you just need to stop caring' and 'it's all in your head, just take that extra step'. Not being understood or believed is incredibly draining and miserable and ultimately perpetuated my symptoms. I cut my mum off, hiding under the covers whenever I heard her footsteps on the stairs. I WAS trying, trying my absolute best, but ultimately, I just didn't know how to help myself, nor did I have any energy to figure it out. I was judged, disbelieved, talked about in earshot – it only worsened the isolation and anxiety. I think disbelieving my reality was their coping strategy and I forgive them. Despite their negativity, without their support I never would have had a chance at getting better either.

During this time I leaned on my husband for literally everything, as did the children, and he suffered because of it. But he kept going, kept feeding me, caring for the children, speaking on my behalf, working, sitting with me whenever he had a chance. My mother in law cleaned the house, did all the family organising, and she believed in me. She was the only one who ever said to me 'this is not your fault, you didn't ask to be ill or want to be ill, but you'll get better.' My mum helped a lot with the children and the cooking, and still does.

We did try to find emotional support but because I could not engage in conversation well it was hard to find. I also paid privately to work with a psychiatrist and tried many medications, and the side effects and disappointments were hard to bear. It took a year and a half of trying medications to finally settle on a combination and dosage that helped my mood. And around the same time, after around 2years of being ill, an Occupational Therapist at the Chronic Fatigue Service Clinic did a course of DBT with me via email, I had enough energy to read 1 page a week, and bit by bit I implemented the techniques and saw improvements.

A few months later I started an online course named 'ANS Rewire'. After another six months or so the course had had such an effect on me that I was able to do timeline therapy with the Chronic Fatigue Service Clinic. I do believe it was a combination of these four things that propelled me forward on my healing journey. And this makes me firmly advocate for online support, in the form of a course, as well as some specialised help, would help those with severe symptoms to be able to recover, one sentence or one minute at a time, until the techniques become habits and their energy snowballs to a point where they can engage in face to face help.

In the initial stages of the illness when I searched the internet for help, the overwhelm was incredible. There are so many differing theories, so much money that one could spend seeking a cure, and so much hopeless and helpless information. Another reason for the need to have an NHS badged online course, to avoid the overwhelm and expense that comes with seeking help.

For a long time I believed that when I got better I would go and find my toddler and six year old and give them big hugs and take them out for a walk with the pram. But the pram and those children were long gone. But still I believed I would somehow go back in time. I had to grieve for my children and come to a place of acceptance. It was a difficult journey made possible by spending increasing amounts of time with my children at the age they are. I sometimes feel like I have four children – the two little girls that I lost and the two bigger girls that replaced them. But this feeling comes to me less and less over time as I heal. When I look at photos of them taken during the years I spent in bed I become disoriented – I don't recognise their faces, clothes or shoes, I don't know what age they were, it makes me panic. I avoid doing it, for now.
I did not deserve to be ill and my children did not deserve to lose so much of me.

I still cannot lay my head flat, vertigo was my worst symptom and is still my biggest fear. I avoid closing the bedroom door in the day or getting under the covers in the daytime. I still have stubborn trauma symptoms relating to the illness and I am working on these all the time.

I’ve had to change many things such as tackling perfectionism, people pleasing, low self esteem, but also to finally tackle longstanding trauma issues and anxiety disorders. The more I work on my emotional health, mindfulness, brain rewiring, routines and habits, the better I become.

I’m now making up for lost time with my children and working on being able to work again. I even know now that I can fully recover. I also know now what the most important things are to me – the things I started to add back into my life when I was able to function again such as brushing my teeth twice a day and reading to my children. And things I will never ever add back in such as excessive cleaning, excessive checking, worrying about things outside of my control, perfectionism. When you lose your physical and cognitive functioning and have to rebuild your life from scratch you get to prioritise and rebuild it in the best possible way. I’m not glad I’m ill, but I’m not sorry either – I could never have the perspective nor be the person I am today without it. I love my life and myself more than I ever have. Severely affected people are an emergency, even though we aren’t seen that way, we are, and there is a way for us to get better.

COPD

Equality Delivery System (EDS) 2025/26
Domain 1: Stakeholder Feedback

Introduction

Every year, as part of the requirements of the Equality Delivery System (EDS), all NHS Trusts have to review the equality and inclusion work undertaken in three of their patient services and provide evidence across all 9 protected characteristics, against the following four outcomes.

1A: Patients (service users) have required levels of access to the service

1B: Individual patients (service user's) health needs are met

1C: When patients (service users) use the service, they are free from harm

1D: Patients (service users) report positive experiences of the service

Outcomes are then evaluated, scored and rated using available evidence and insight through engagement with patients and public.

The three patient services identified for review this year (2025/26) were:

- **COPD Service, Royal Abert Edward Infirmary**
- Community Chronic Fatigue Service
- Mortuary Service, Royal Abert Edward Infirmary

This report summarises the stakeholder feedback obtained for COPD at the Royal Albert Edward Infirmary.

Method

Evidence was reviewed and collated across all 9 protected characteristics for the outcomes stated above. An evidence pack was produced and published on the Trust website. **See Appendix 1**

Engagement with patients and public was undertaken from 26/11/25 until 26/01/26. The engagement approach agreed to be implemented this year, included:

- On-line survey and evidence published on Trust website (alternative formats provided). Service users and local community encouraged to review and give feedback.
- E-mail sent to Staff; Volunteers; Governors / Patient Experience and Engagement Group Members; Wigan Borough EDI Group; and other Local Groups inviting them to review evidence and give feedback. Articles included in Trust News / social media.
- Presented to Lived Experience Partners at December 2025 Meeting encouraging them to review evidence and give feedback.
- Undertaking 'Real Time' Patient Experience Surveys on COPD and at COPD Support Group on 26/11/25

Acknowledgments

Wrightington, Wigan and Leigh NHS Teaching Hospitals Foundation Trust would like to thank everyone who chose to take part in this review.

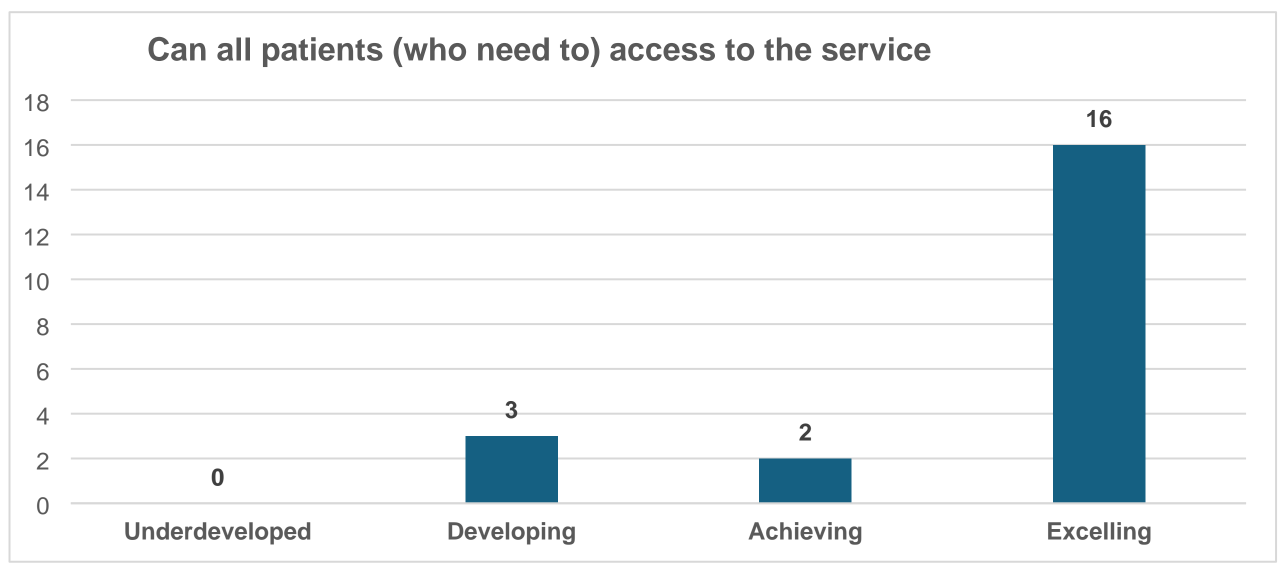
Results

The results on the following pages show the feedback and scores received from:

Total Number of Participants	On-Line Survey	EDS Score Form (via E-mail)	Real-time Patient Experience Survey
21	8	1	12

Scores and Feedback

Question 1



Overall, Mode Score: Excelling

Patient Comments (WWL Response to questions raised included)

Excelling
So obvious from patient feedback, what has been put in place by the staff and staff training.

Evidence and feedback show that all protected characteristics are addressed.

Reading the information provided, I feel it is quite comprehensive to allow access to the service.

Achieving
Alot of evidence given.

Just a suggestion - an online support group may be beneficial for patients who have difficulty travelling to places, in addition to the face-face support group at Leigh. Also, just a thought - are all patients able to travel to Leigh? Where do our COPD patients live?

WWL response: Support Group was previously held in Hindley (between Wigan and Leigh) unfortunately that room became unavailable. The room in Leigh is provided free of charge as the service has no budget for this group. Patients do attend from Leigh, Wigan and Warrington. There is ample parking and the room is easily accessible, which is important due to the symptoms of COPD.

The service is unable to provide an On-Line Support Group due to time constraints and WIFI access. The group is a drop-in interactive session, which would not be appropriate for remote access. The group is run on the ‘goodwill of the team and is not affiliated to the British Lung Foundation.

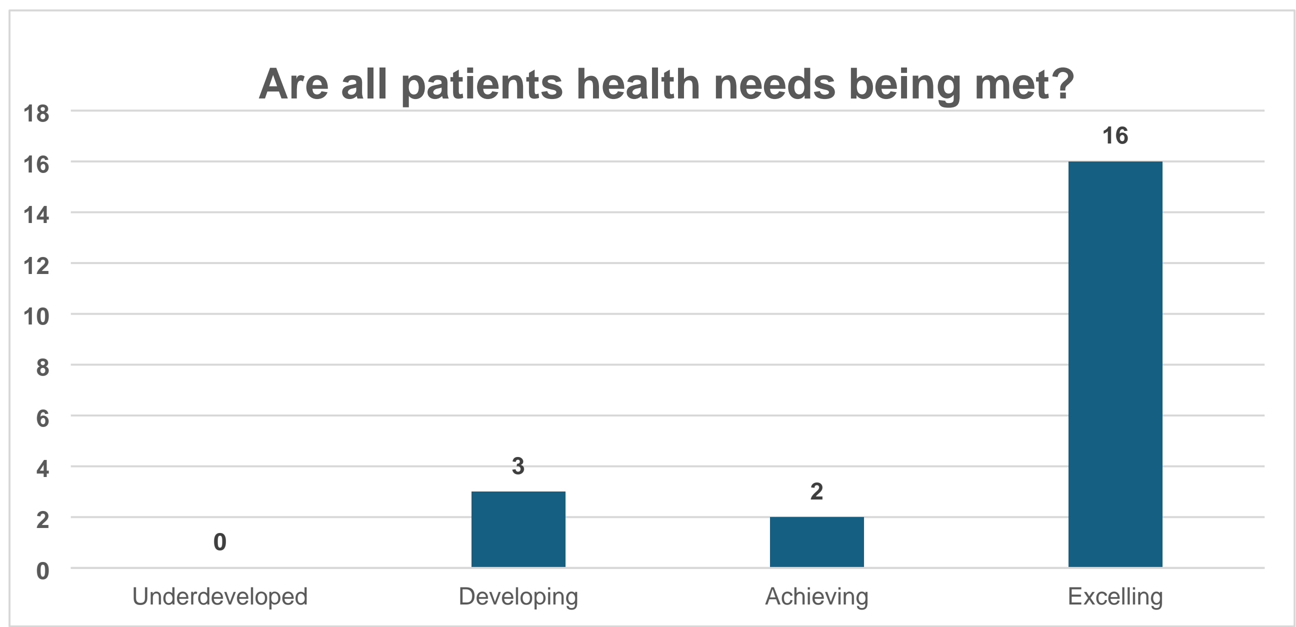
Developing
Was difficult to access the service initially but once registered it has been very productive and supportive.

The service works well for patients already identified with COPD.

It has not been made clear how patients are referred to these services, so there is no evidence that ALL patients WHO NEED TO are able to access.

WWL response: The service recently sent updated information flyers about the service and support group to all Wigan and Leigh GPs and the Pulmonary Rehabilitation Group. The service provides a one stop, same day assessment service for confirmed COPD patients.

Question 2



Overall Mode Score: Excelling

Patient Comments

Excelling
Received exceptional care.

Extensive evidence from what has been put in place.

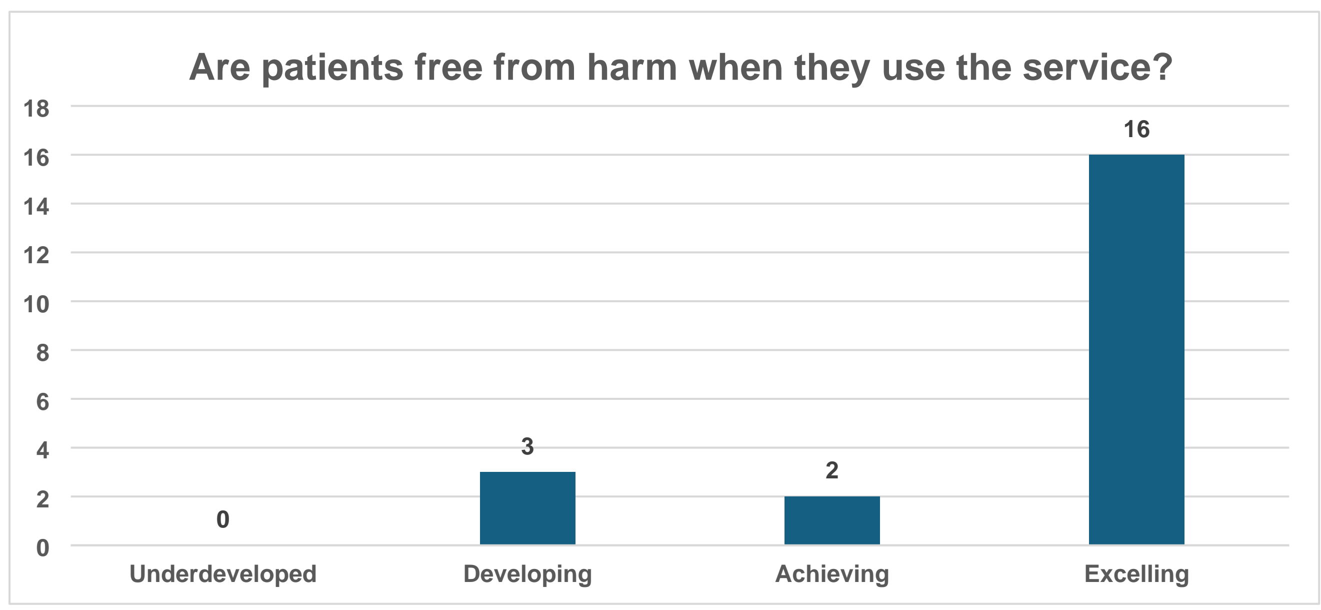
Evidence and feedback show that all protected characteristics are addressed.

Everything seems to be in place. Great comments from satisfied patients.

Developing
From the Evidence Survey: "31 patients participated in this survey". This is a very small number of respondents considering the number of patients experiencing this problem.

The limited feedback from a very small user group provides evidence that they felt free from harm, however the lack of feedback from other user groups (i.e. non-white British service users, SEND service users, patient carers etc) is reflected in the scoring.

Question 3



Overall, Mode Score: Excelling

Patient Comments

Excelling
Patient feedback and staff assurance.

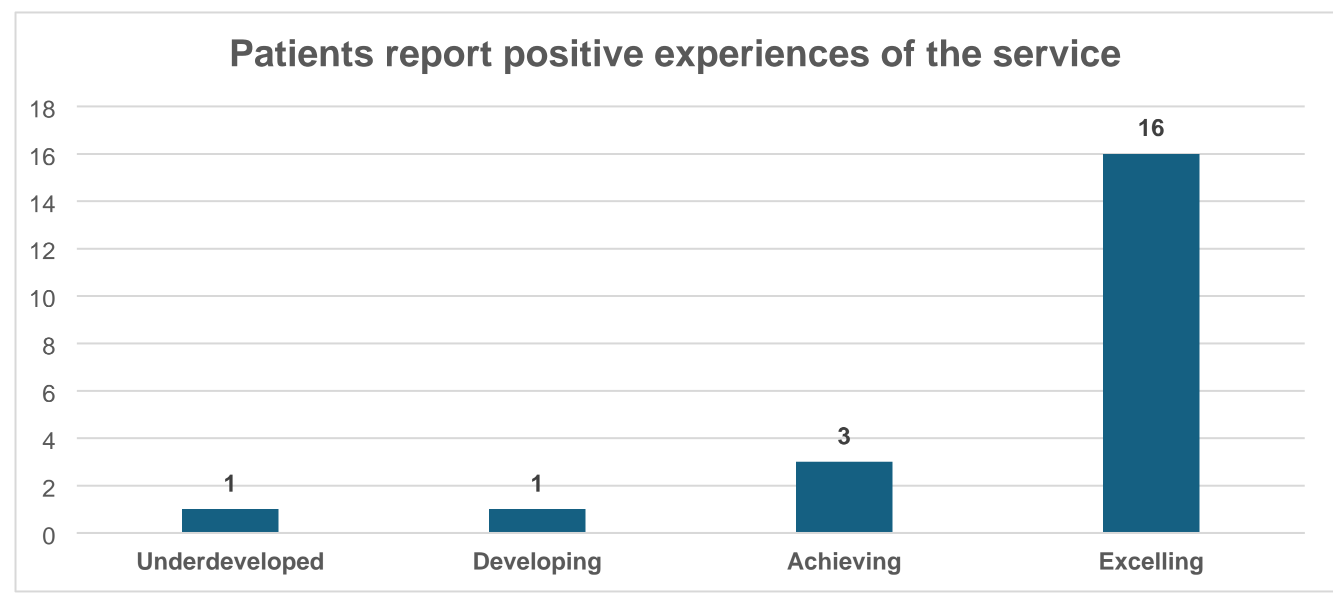
Evidence and feedback show that all protected characteristics are addressed.

Lots of personal comments showing they were happy with the service.

Developing
Evidence is in place demonstrating compliance procedures, but there is no anecdotal support where this has been met in real terms.

The limited feedback from a very small user group provides evidence that they felt free from harm, however the lack of feedback from other user groups (i.e. non-white British service users, SEND service users, patient carers etc) is reflected in the scoring

Question 4



Overall Mode Score: Excelling

Patient Comments

Excelling
Excellent service all friendly and obliging. Everything explained to perfection. Could not fault service.

Service has been brilliant!

Did not know about the service until attended the Pulmonary Rehab Course. I will be using the service the next time I have an infection.

Makes people more knowledgeable about condition. They are helpful on different topics.

No formal complaints.

Evidence and feedback show that all protected characteristics are addressed.

Excellent feedback from patients.

Achieving
Initial access to the service is far too difficult particularly when families are struggling to cope.

Patient feedback.

Evidence and feedback show that all protected characteristics are addressed.

Developing
From the Evidence Survey: "31 patients participated in this survey". This is a very small number of respondents considering the number of patients experiencing this problem.

Underdeveloped
No relevant relative/carer feedback provided.

Question 5

What reasonable adjustments would you want us to make for future hospital appointments?

Perfect - Cannot get any better!

Longer support in the community. The initial 2 weeks is not necessarily adequate.

Nothing!

Nothing! Found everything ok!

Some form of emergency access at weekends.

Conclusion

Based on the feedback provided, **COPD scored overall 12 points** for Domain 1: Commissioned / Provided Services. Scores allocated shown below:

Outcome		Overall 'Mode' Score	
1A	Patients have required levels of access to the service	3	Excelling
1B	Individual patients health needs are met	3	Excelling
1C	When patients use the service, they are free from harm	3	Excelling
1D	Patients report positive experiences of the service	3	Excelling

Suggestions for improvement (EDS)

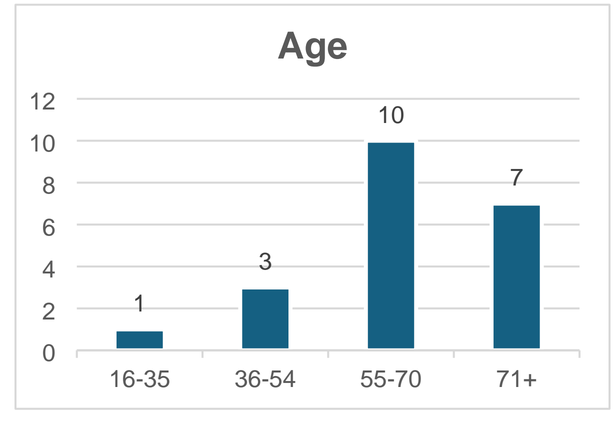
- More engagement from public from all protected characteristics to gain insights from people with lived experience.

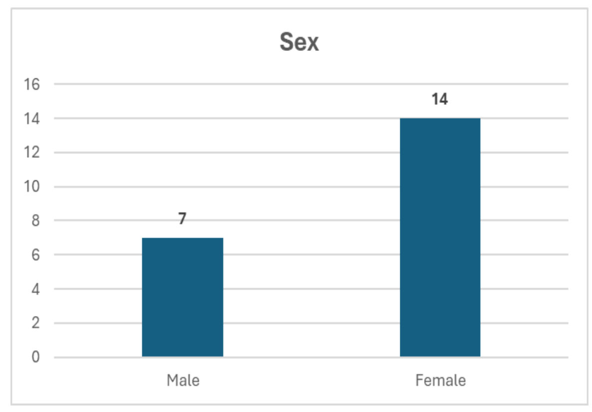
- Service Lead to share EDS 2025/26 Domain 1 Service Stakeholder Feedback Reports with Divisions (via Divisional PEEG).

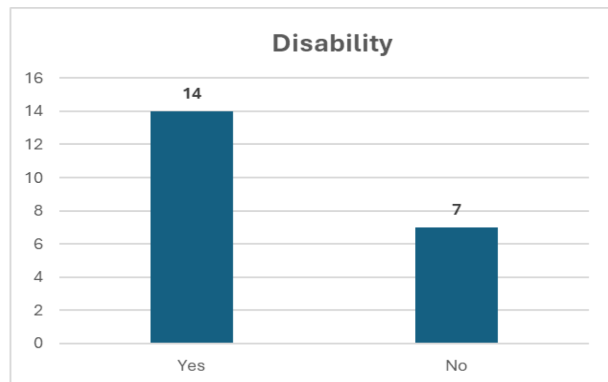
Suggestions for improvement – COPD

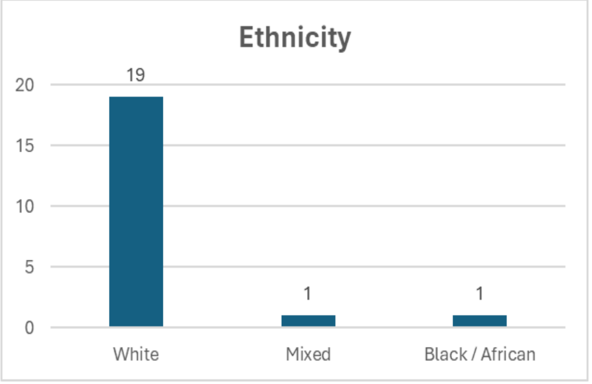
- To implement Family and Friends Test (FFT) Cards in COPD to enable continuous real-time patient experience feedback. To review feedback monthly and record any further improvements made.

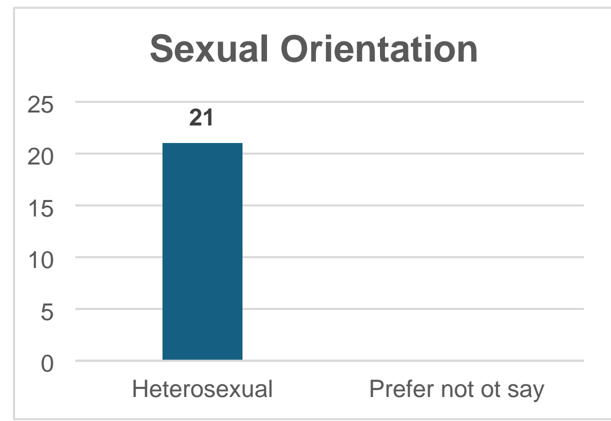
Stakeholder Equality monitoring data

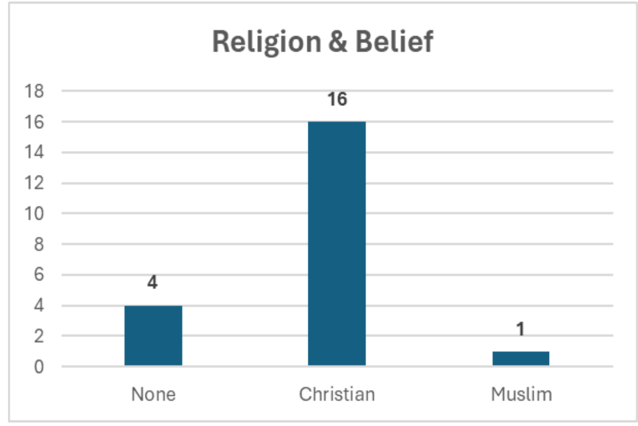


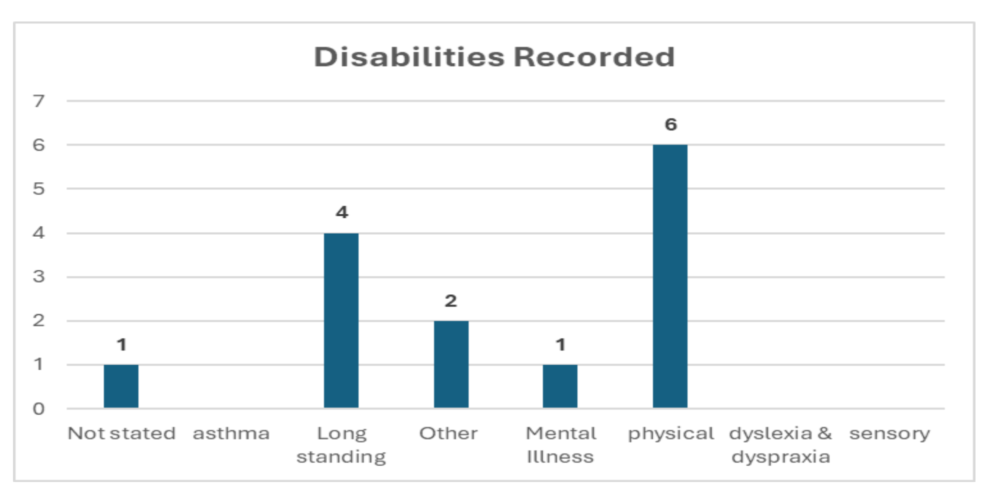












Equality Diversity & Inclusion — Everyone is Unique

Appendix 1

COPD, Royal Albert Edward Infirmary - Equality Engagement

The Equality Delivery System (EDS) is a framework which was created by the Department of Health to help NHS Organisations to make improvements on equality, diversity and inclusion. To improve the services they provide for their local communities, consider health inequalities in their local area and provide better working environments free of discrimination.

WWL want you, our service users and local community to have a say on our equality and inclusion work for COPD Unit. We want to:

- **Show you what we currently provide and what we are working on**
- **Ask you "are we getting it right for everyone / people from all protected characteristics?"**
- **Tell us how well you think we are doing - Score us on the following questions**
- **Help us decide what we need to do next**

Can all patients (who need to) access the service?

When patients use the service, do they feel safe? (free from harm)

Are individual patient's health needs being met? (receiving good care)

Are patients reporting positive experiences?

Included

Chronic Obstructive Pulmonary Disease (COPD) Unit Royal Albert Edward infirmary –

We provide a one stop, same day assessment service for confirmed COPD patients who are experiencing an exacerbation.

The assessment may include blood tests, chest xray, ECG, Spirometry or a combination of these.

After assessment you may be offered a 2 week monitoring period of home visits and telephone call. A 6 week clinic may also be offered.

The service also offers COPD Specialist Nurse Led Clinics and Consultant Clinics.

We also provide a full Oxygen Assessment Service

We offer a COPD/Oxygen Support Group monthly off site at Tesco Leigh (Last Wednesday of month)

Evidence 1: Can all patients (who need to) access to the service?	
Protected Characteristic	**Evidence on how each group can access this service**
Sex *(Biological)* (Male / Female)	**Unisex toilets available.** **Curtains to separate male and female patients.**
Transgender / Gender Re-assignment	**Unisex toilets available.** **Curtains to separate male and female patients.** **Staff ask patients for their preferred pronouns** **Guidance available for staff on supporting trans and non-binary patients.**
Age (18 years+)	**COPD is an adult disease (normally affecting patients over 35 years of age.**
Race or Ethnicity	**Access to interpreter and translation services.** We have full access to interpreter and translation services for patient's parents/relatives/carers from different ethnicities who do not speak English as their first language. WWL provides access to the following interpreter and translation services: • Face to Face and telephone interpreters • British Sign Language Interpreter (face to face and video remote on demand) **Special dietary requirements catered for on the Unit if required** (would liaise with Kitchen Staff). **Access to Chaplaincy and Spiritual Care Team. Prayer Room available in site.**
Disability: Hearing Impairment	**Disability considered as part of risk assessments / care plans for Oxygen and COPD (recorded in notes) / Provision of additional support available** **Access to British Sign Language Interpreters** (face to face and video remote) **Written instructions can be provided if required.**

	Unit can be quite noisy at times, so patient can be moved into a quieter area if required (chapel / office) **Carers encouraged to accompany patient when attending unit.**
Disability: Visual Impairment	**Disability considered as part of risk assessments / care plans for Oxygen and COPD (recorded in notes) / Provision of additional support available** **Information / correspondence can be provided in braille, large print, audio on request.** **Carers encouraged to accompany patient when attending unit.**
Physical Disability	**Disability considered as part of risk assessments / care plans for Oxygen and COPD (recorded in notes) / Provision of additional support available** **Toilet and bathroom provisions accommodate disabled patients.** **Provisions in place to accommodate patients who are physically disabled.** Including adaptive chair spaces to accommodate wheelchairs and mobility scooters. **Access to bariatric services** **Provision of additional support available** (recorded within individual care plan).
Learning Disability	**Disability considered as part of risk assessments / care plans for Oxygen and COPD (recorded in notes) / Provision of additional support available** **Carers encouraged and welcomed to accompany patient.** **Access to Learning Disability Team.** **Patient information can be obtained in easy read format / large print**. **All staff have attended Oliver McGowen Training.** **Pre- screen appointments can be provided if required to facilitate a quieter environment.** **Access to ear defenders if required.**
Mental Health Need	**Carers welcomed during patients stay. Provision of additional support available.** **Access to RAID Team.** **Access to Talking Services.** **Access to Addiction Services.** **Access to Chaplaincy and Spiritual Care Team** (close working relationship)

	Staff in Unit from varied backgrounds (have extensive knowledge / previous experience of mental health needs). Not restricted to time constraints – can adapt length of patient's assessment, dependant to their individual needs. This is explained at the beginning of the patient's assessment, to help alleviate any anxieties and fears.
Sexual Orientation	**Unit Ward actively promotes LGBTQIA+ Events** (including Wigan Pride – Annual Event) **Staff ask patients for their preferred pronouns** **Unit Staff have an awareness of Equality, Diversity and Inclusion and are respectful of everyone.**
Religion / Belief (please specify)	**Access to Chaplaincy and Spiritual Care Team. Prayer Room available in site. Staff aware of prayer times.** **Access to interpreter and translation services.** **Special dietary requirements catered for if required.** **Curtains to separate male and female patients / maintain privacy. Religion / Faith recorded in notes and factored within care plan.**
Marriage & Civil Partnership	**Ward actively promotes EDI Events** (including LGBTQIA+) – Display Board on Unit promoting monthly EDI events / celebrations,
Pregnancy & Maternity	**Individualised Care Plans –** to date the Unit has never had to care for a pregnant patient (this could be due to the COPD / Oxygen patients being of an older age range). **Breast Feeding Room and baby Changing facilities available on site.**
Carer Status	**Access to Wigan Council's Carer Support Team and Community Link Workers.** **COPD Support Group** – Open to patients and carers as and when they would like to attend. Based in Tescos, Leigh. Meetings held monthly.

Evidence 2: Are all individual Patients health needs being met?
(having needs met in a way that works for them)

Personalised Individual Care Plans

All patients have a personalised individual care plan.

If a need/adjustment in relation to a patient's protected characteristic is required, then this is considered when the patient is cared for on the COPD Unit.

For Example:

- Learning Disability Team asked to support patient with learning disability during assessment.
- One patient when becomes tired, uses sign language – For clinical discussions, video remote and face to face BSL interpreters is then used. Two members of staff have learned basic British Sign Language for social interaction purposes. This was appreciated by the patient and has helped develop confidence and trust in the service.
- Patient's religion / faith recorded in notes and factored in to care plan.

Equality Impact Assessment

An Equality Impact Assessment is undertaken on COPD every 3 years. Last Assessment undertaken June 2024. We use this assessment to identify potential impacts, both positive and negative across all 9 protected characteristics, and look at how we could avoid disadvantage or further improve the delivery of our services.

To view a copy of our equality impact assessment please e-mail EDI@wwl.nhs.uk

Evidence 3: Are patients free from harm when they use the service? (feel safe / there are procedures in place to ensure safety)

Trust Risk Management Policy

It is Trust Policy for all serious incidents / complaints to be investigated, and lessons learnt embedded within Trust practice.

All staff working in the COPD Department have a role in identifying risk and ensuring children and adults are protected from harm.

Personalised Individual Care Plans

All patients have a personalised individual care plan.

If a need/adjustment in relation to a patient's protected characteristic is required, then this is considered when the patient is cared for on the COPD Unit.

Lessons Learned from Incidents embedded within everyday activity

Received feedback from a patient recently, advising that he felt safe discussing his sexual orientation, which he has never discussed previously in a healthcare setting for fear of receiving poor care.

Evidence: Patients report positive experiences of the service

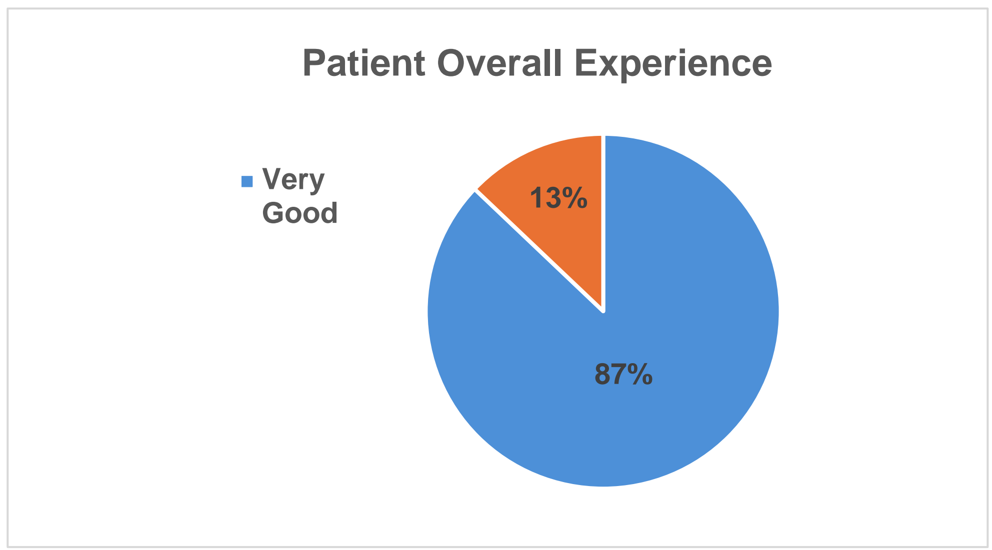
Patient feedback

The Trust collects and obtains feedback from patients through its PALS processes and patient surveys which are reported to the Trust Board of Directors

No formal complaints in relation to COPD have been received.

During October 2025 a Patient Experience Survey was undertaken in the COPD Department.

31 patients participated in this survey. Feedback showed that patients are reporting positive experiences when using the COPD Service. Results shown below:



All patients who participated in the survey, reported a 'very good' and 'good' experience.

The reasons why these scores were given are listed below:

COPD is amazing. Always a phone call away for advice and always able to come to COPD for a full assessment. Feel reassured with my mum.

All staff lovely. Very helpful!

They are brilliant

Excellent staff. Given lots of time to discuss.

Excellent staff, communication and service

Friendly staff. No waiting

Nurses always helpful and look after patients - delays due to consultant delay

Staff very attentive and helped alleviate my anxieties, ensured comfortable during stay

Very professional staff, knowledgeable & friendly / well informed of every procedure
Friendly staff - could not do enough
Staff lovely

Helpful staff and friendly

Friendly staff. Drinks and food offered. Relatives welcome. Plenty time to talk
staff attentive and helpful

Excellent staff. Very informative and extremely helpful. COPD had reduced my time spent sitting in A&E awaiting treatment. Exceptional service. Staff always pleasant, patient and helpful.

Made to feel comfortable. All staff pleasant and explained everything well

Thorough explanations about condition. Friendly supportive staff. Informed about steps for the future. Very professional approach.

Attentive and polite staff. Explain everything / Marvelous team! Friendly and efficient staff

Friendly staff attitude. Good treatment. No waiting to be seen. Great staff!

Friendly and professional staff. Made to feel at ease. Everything explained clearly

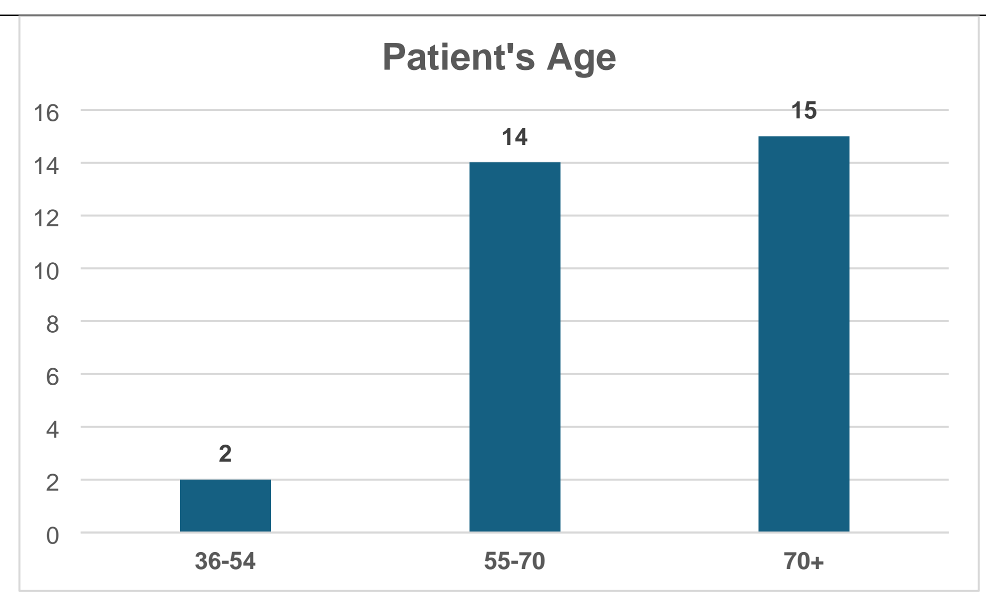
Always treated well
Very efficient

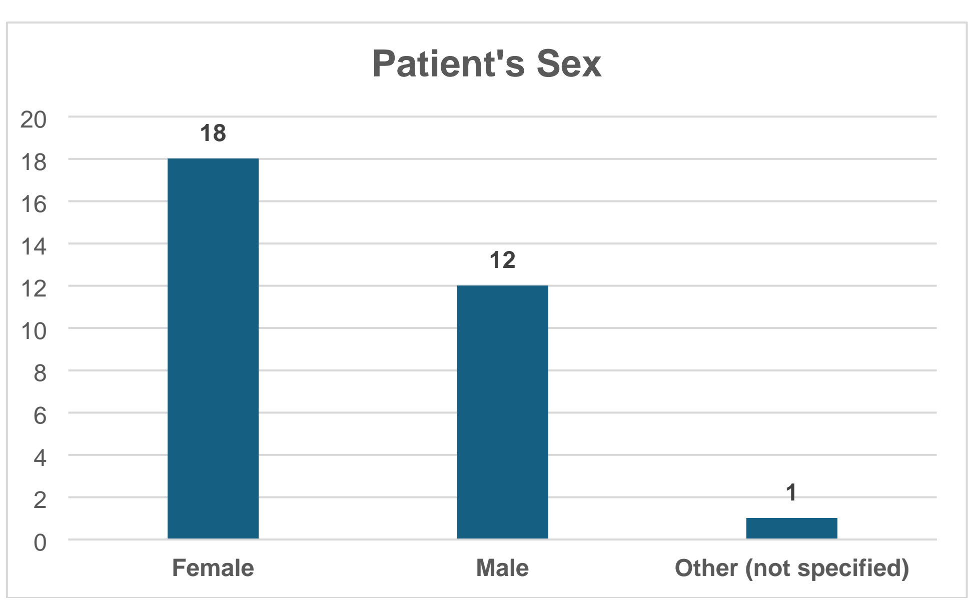
Staff extremely efficient, friendly & knowledgeable
Very happy with service. Staff lovely!

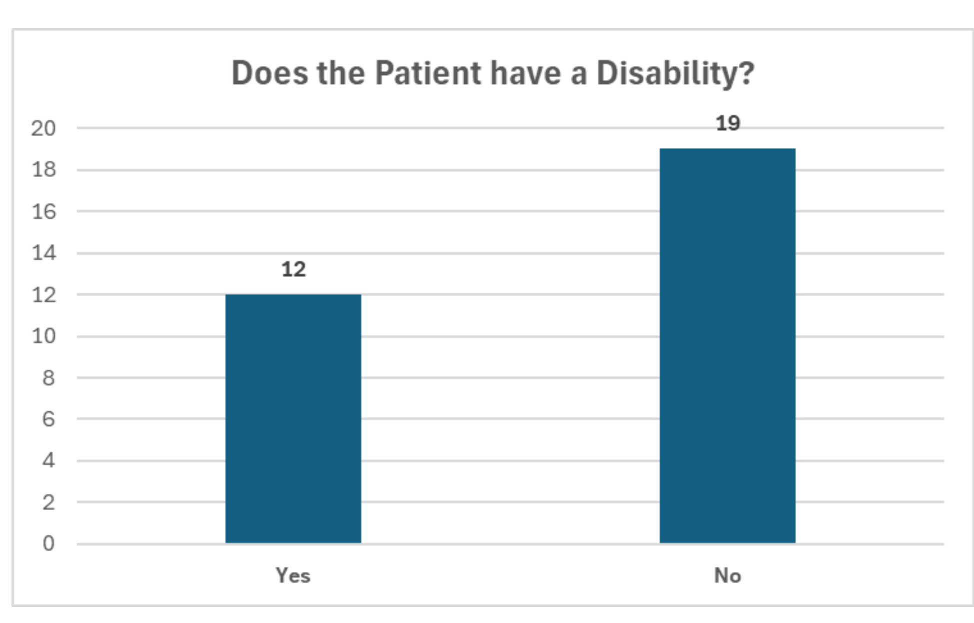
When Patients were asked how they could make their experience better

No patients recommended any improvements – All were happy with the service provided.

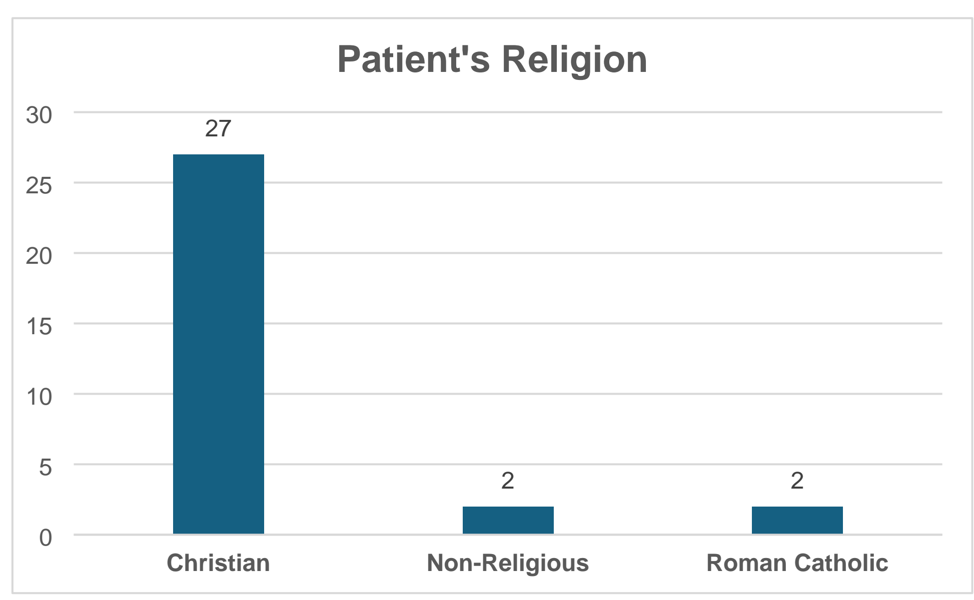
Patient Demographics:


Patient's Age
16
14
12
10
8
6
4
2
0
2
14
15
36-54
55-70
70+


Patient's Sex
20
18
16
14
12
10
8
6
4
2
0
18
12
1
Female
Male
Other (not specified)


Does the Patient have a Disability?
20
18
16
14
12
10
8
6
4
2
0
12
19
Yes
No

Longstanding Illness	5
Sensory	1
Physical	5
Mental Health	1



Ethnicity

All patients who participated in survey were of British White Ethnicity

Sexual Orientation

All patients who participated in survey declared that their sexual orientation was Heterosexual

Mortuary

Equality Delivery System (EDS) 2025/26
Domain 1: Stakeholder Feedback

Introduction

Every year, as part of the requirements of the Equality Delivery System (EDS), all NHS Trusts have to review the equality and inclusion work undertaken in three of their patient services and provide evidence across all 9 protected characteristics, against the following four outcomes.

1A: Patients (service users) have required levels of access to the service

1B: Individual patients (service user's) health needs are met

1C: When patients (service users) use the service, they are free from harm

1D: Patients (service users) report positive experiences of the service

Outcomes are then evaluated, scored and rated using available evidence and insight through engagement with patients and public.

The three patient services identified for review this year (2025/26) were:

- COPD Service, Royal Albert Edward infirmary
- Community Chronic Fatigue Service
- **Mortuary Service, Royal Albert Edward infirmary**

This report summarises the stakeholder feedback obtained for the Mortuary Service at Royal Albert Edward Infirmary.

Method

Evidence was reviewed and collated across all 9 protected characteristics for the outcomes stated above. An evidence pack was produced and published on the Trust website. **See Appendix 1**

Engagement with patients and public was undertaken from 26/11/25 until 26/01/26. The engagement approach agreed to be implemented this year, included:

- On-line survey and evidence published on Trust website (alternative formats provided). Service users and local community encouraged to review and give feedback.
- E-mail sent to Staff; Volunteers; Governors / Patient Experience and Engagement Group Members; Wigan Borough EDI Group; and other Local Groups inviting them to review evidence and give feedback. Articles included in Trust News / social media.
- Presented to Lived Experience Partners at December 2025 Meeting encouraging them to review evidence and give feedback.
- Mortuary OWLL (Observe, Watch, Listen & learn) Assessment undertaken September 2025

Acknowledgments

Wrightington, Wigan and Leigh NHS Teaching Hospitals Foundation Trust would like to thank everyone who chose to take part in this review.

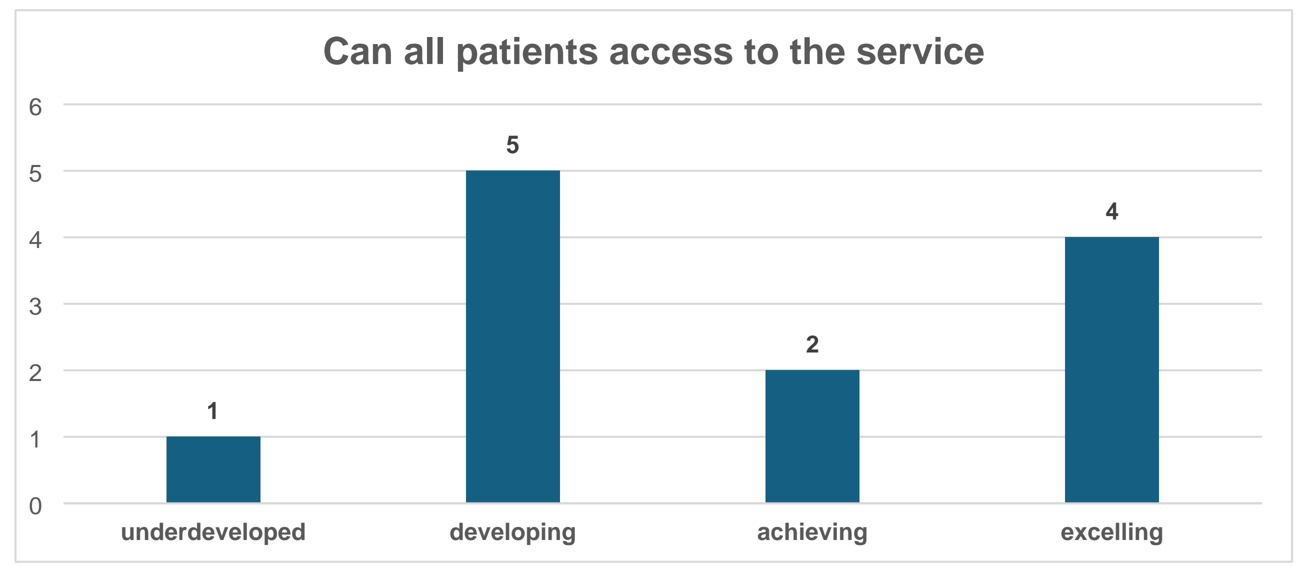
Results

The results on the following pages show the feedback and scores received from:

Total Number of Participants	On-Line Survey	EDS Score Form (via E-mail)	OWLL Assessment
12	10	1	1

Scores and Feedback

Question 1



Overall, Mode Score: Developing

Comments

Excelling
Compelling evidence, no complaints and team are constant in their diligence.

This is clearly identified in the procedures set out.

Achieving
This is a difficult service area to assess, and agreed procedures are followed.

Developing

No wheelchair access / Ramp to access the building which will obviously stop some people from accessing the building.

I understand that the location of the Mortuary is on a very steep hill and there is no parking, making access difficult for wheelchair users and others with physical disabilities.

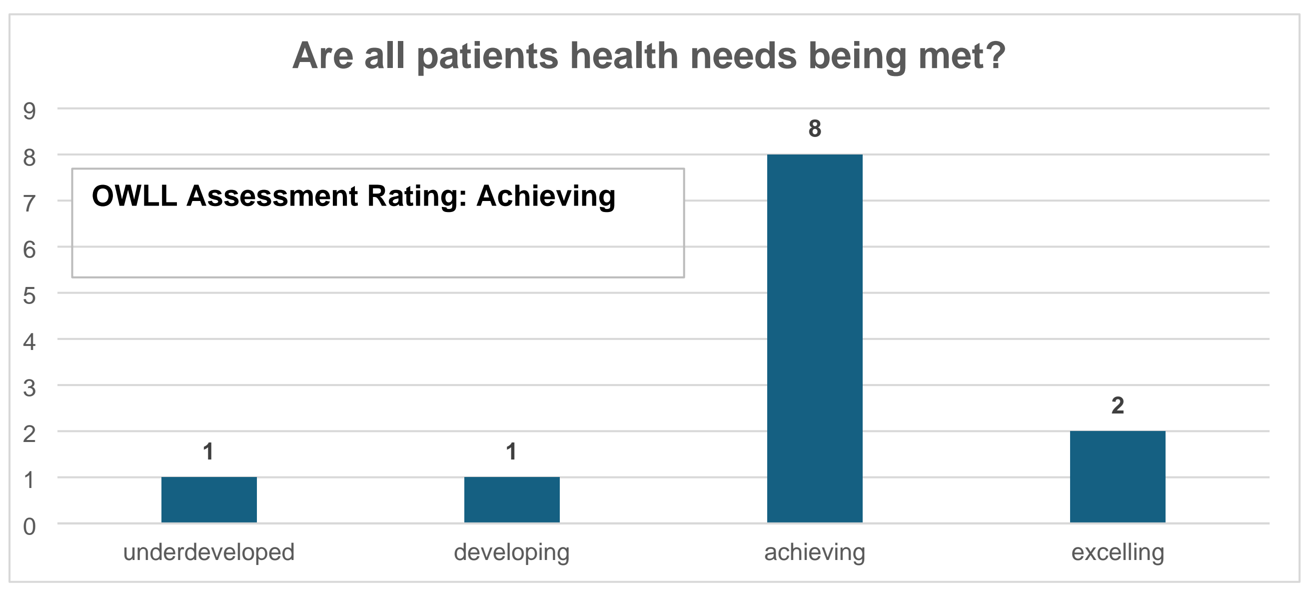
Disability access needs to be improved for carers and families.

Patients pass away at all times of the day/night and the service is only accessible during normal day time working hours. (**WWL Feedback**: An On-Call Service is provided out of hours)

No suitable wheelchair access / No dedicated parking facilities.

Underdeveloped
Wheelchair access is not up to standard due to the location.

Question 2



Overall Mode Score: Achieving

Comments

Excelling
Again, no complaints to the contrary.

The evidence shows that every effort has been made to meet the criteria, within the confines of what is available to the Mortuary Team.

Achieving
Limited space in the Mortuary.

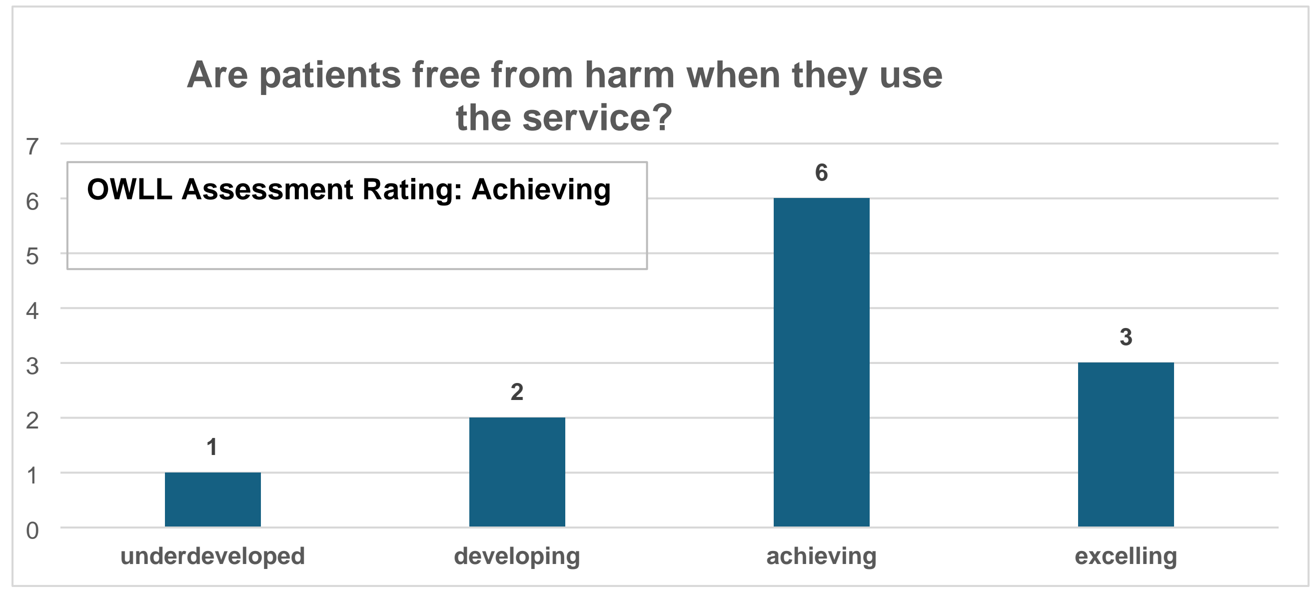
Says that it has been agreed that parents of a child death say their goodbyes in the A&E Department. Does not say who made this agreement and is it in the best interest/wishes of all parents.

This is not really relevant. The relatives are in trauma and need support with emotions, this is not part of the remit.

It would appear so from what the trust offers.

Underdeveloped
Due to the emotional experiences of the service, no feedback is available. But the wheelchair access is not up to standard due to the location.

Question 3



Overall, Mode Score: Achieving

Comments

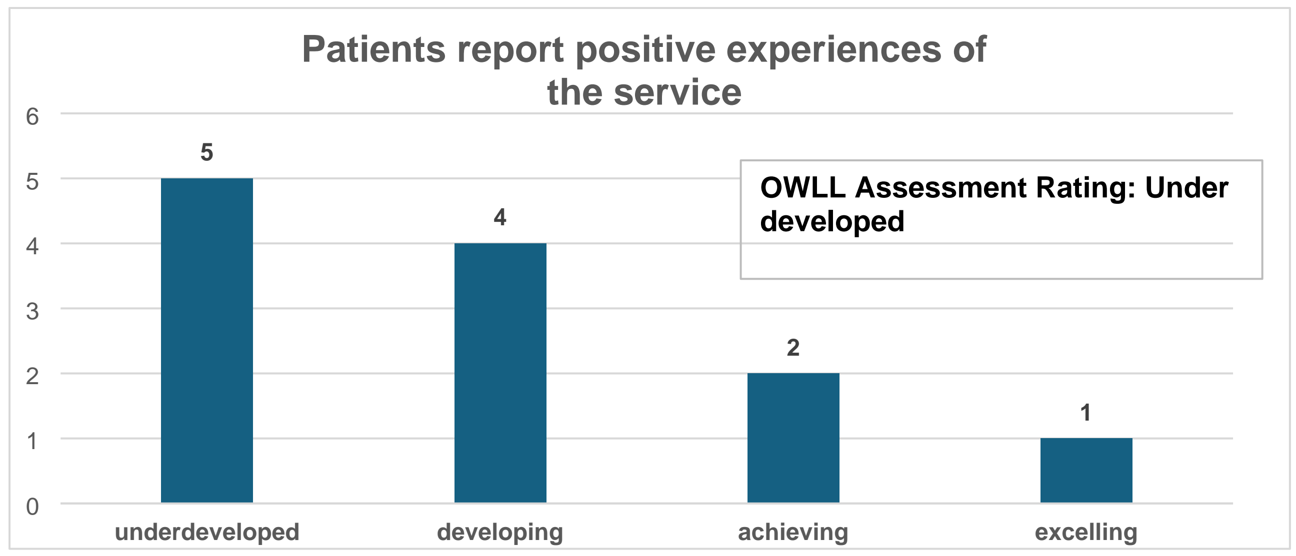
Excelling
No incidents to argue otherwise.

The evidence shows that every effort has been made to meet the criteria within the confines of what is available to the Mortuary Team.

Achieving
From the information given.

Developing
It is obvious that clear responses cannot be received from surveys, due to the sensitivity of this service.

Question 4



Overall Mode Score: Underdeveloped

Comments

Excelling
Again, evidence of families giving thanks.

Achieving
I would say yes. I could not see any negative comments, although appreciate it is a sensitive task to achieve a full survey from a survey. I can see this is being looked into.

Developing
Evidence provided.

I understand that the service is looking for ways in which to obtain feedback from service users in a sensitive way, taking into account that this is a difficult and upsetting time for relatives.

The department has made reference to this and would like to evolve a sensitive way of assessment.

Underdeveloped
Difficult to get feedback due to nature of the circumstances but as no formal complaints/concerns apparent then presume positive experiences but no evidence to that effect.

Due to the emotional experiences of the service, no feedback is available.

No carer or family feedback presented in evidence.

No relevant relative/carer feedback provided.

Question 5

What reasonable adjustments would you want us to make for future hospital appointments

No comments provided.

Conclusion

Based on the feedback provided, **the Mortuary Service scored overall 5 points** for Domain 1: Commissioned / Provided Services. Scores allocated shown below:

Outcome		Overall 'Mode' Score	
1A	Patients have required levels of access to the service	1	Developing
1B	When patients use the service, they are free from harm	2	Achieving
1C	Individual patients health needs are met	2	Achieving
1D	Patients report positive experiences of the service	0	Underdeveloped

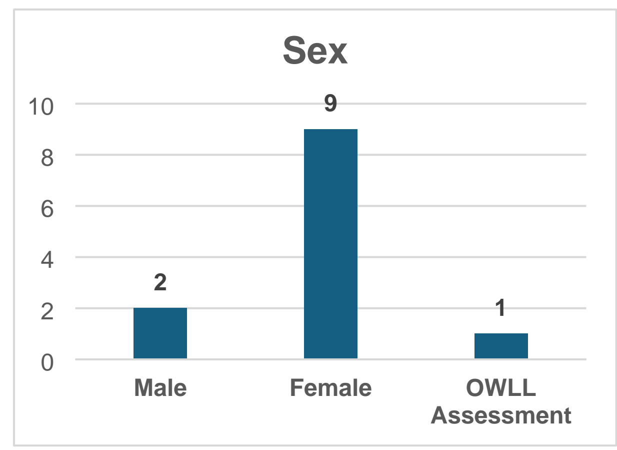
Suggestions for improvement (EDS)

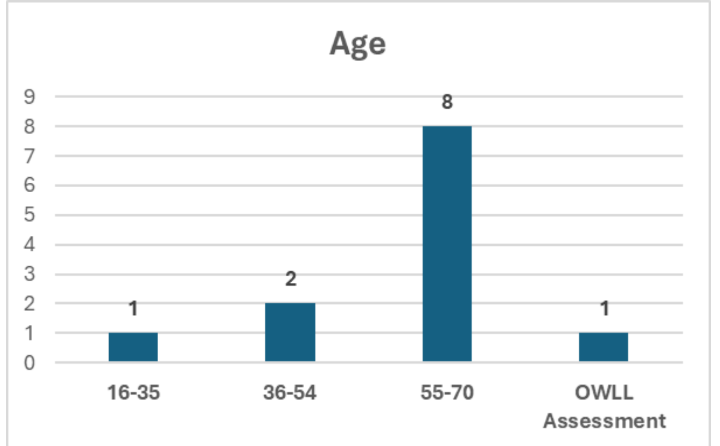
- More engagement from public from all protected characteristics to gain insights from people with lived experience.
- Service Lead to share EDS 2025/26 Domain 1 Service Stakeholder Feedback Reports within Division.

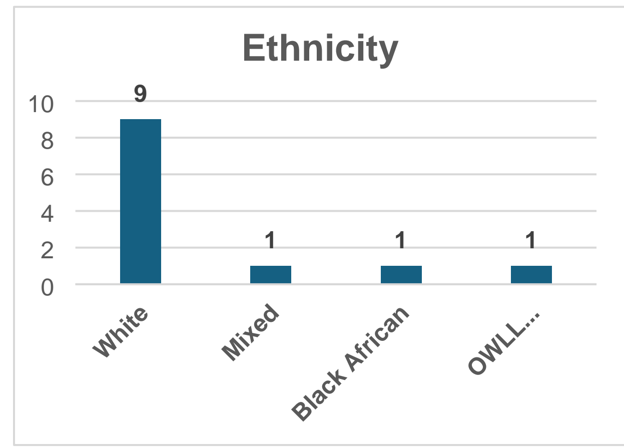
Suggestions for improvement – Mortuary Service

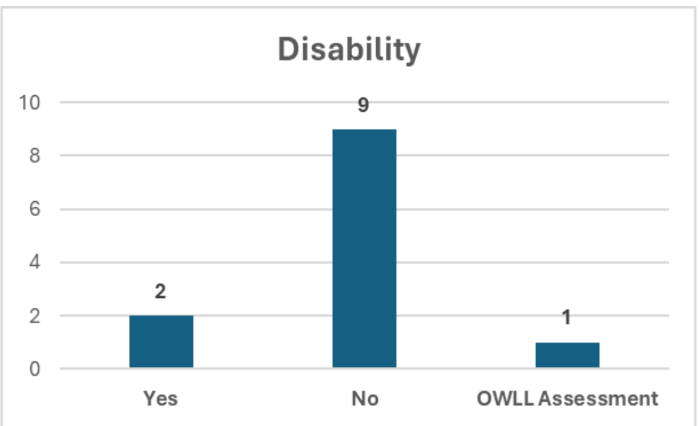
- EDS Stakeholder Feedback to be incorporated within OWLL Assessment Department Action Plan.
- To review appropriate patient feedback methodologies which can be used to collate and monitor patient feedback to measure improvement work going forward (comment Cards in waiting area).

Stakeholder Equality monitoring data

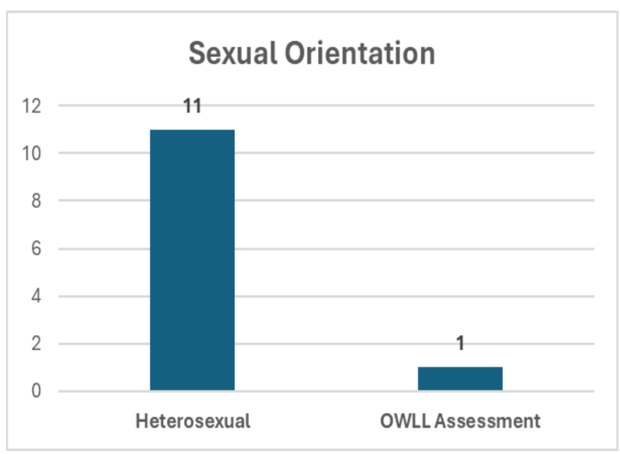


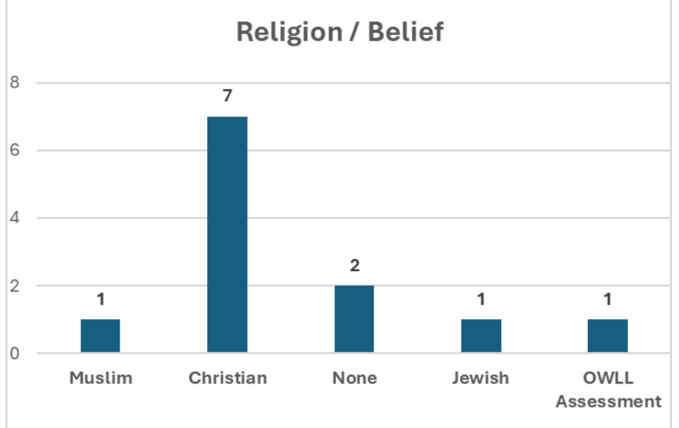






1 Physical / 1 Not Stated





Appendix 1

Mortuary, Royal Albert Edward Infirmary – Equality Engagement

The Equality Delivery System (EDS) is a framework which was created by the Department of Health to help NHS Organisations to make improvements on equality, diversity and inclusion. To improve the services they provide for their local communities, consider health inequalities in their local area and provide better working environments free of discrimination.

WWL want you, our service users and local community to have a say on our equality and inclusion work for Orrell Ward. We want to:

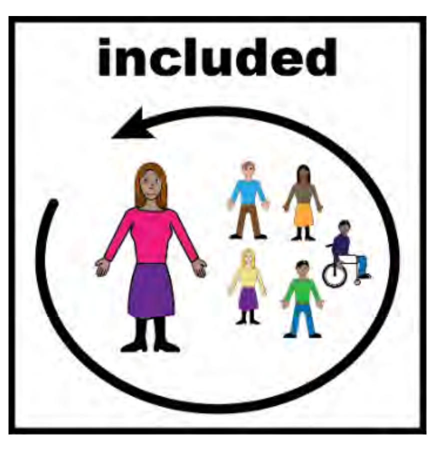
- **Show you what we currently provide and what we are working on**
- **Ask you "are we getting it right for everyone / people from all protected characteristics?"**
- **Tell us how well you think we are doing - Score us on the following questions**
- **Help us decide what we need to do next**

Can all patients (who need to) access the service?

When patients use the service, do they feel safe? (free from harm)

Are individual patient's health needs being met? (receiving good care)

Are patients reporting positive experiences?



Mortuary Service - Royal Albert Edward infirmary

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, provides a comprehensive mortuary service that includes the receipt and temporary storage of bodies for both the hospital and local community. Post-mortem examinations are undertaken on behalf of the HM Coroner for Greater Manchester West and the service accommodates visiting relatives.

The mortuary service is regulated by the Human Tissue Authority and ensures that deceased patients are properly cared for and that their families receive respectful and sensitive treatment. The service also includes the return of deceased persons' personal possessions to their relatives and the handling of deaths occurring in hospital settings.

The mortuary at Royal Abert Edward Infirmary is in an individual building situated to the rear and left of the hospital and has one very simple room (not a Chapel of Rest); this is used for both viewings and identifications - it provides private surroundings for immediate next of kin only who were unable to be present at the time of death. Viewings are arranged by appointment with next of kin only, by contacting the Mortuary Service direct. Friends and distant relatives are encouraged to see their relative / friend to pay their last respects at the funeral Director's Chapel of Rest. Deceased patients are cared for by a small team of 5 members of staff working in the mortuary.

It is a small facility and during busy periods deceased patients may be moved to Leigh Infirmary Mortuary, where there is the same care provided by the team, until the chosen funeral director is able to transfer in to their care.

Mortuary Staff Statement

"We do our best; the patient must always come first. We are a small team, only 5 of us work here. Last winter there were 190 patients in the mortuary it was difficult. We provide the same care to the patients as the nurses do on the wards"

Evidence 1: Can all patients access to the service?	
Protected Characteristic	**Evidence on how each group can access this service**
Sex *(assigned at birth)* Male / Female	Unisex single toilet facilities available for patient's relatives. Non-clinical, private viewing area and separate private waiting area. Access to Bereavement Liaison Nurse. Viewing times are arranged by appointment only – Private viewings.
Gender Re-assignment (Transgender / Non-Binary / Gender Fluid)	Unisex single toilet available for patient's relatives. Guidance available for staff on supporting trans and non-binary community. Non-clinical, private viewing area and separate private waiting area. Access to Bereavement Liaison Nurse. Viewing times are arranged by appointment only – Private viewings.
Age **(18 years+)**	The mortuary provides a comprehensive mortuary service for deceased patients of all ages (babies, children and adults).
Race or Ethnicity	Access to interpreter and translation services is available for patient's parents/relatives/next of kin from different ethnicities who do not speak English as their first language. WWL provides access to the following interpreter and translation services: • Face to Face and telephone interpreters • British Sign Language Interpreter (face to face) • Information can be made available in other languages on request. Relatives can use the Viewing Room for body washing rituals if required for cultural reasons. An out-of-hours on-call service is available which facilitates the release of faith deaths if required. Access to Hospital Chaplaincy Team and Bereavement Support Nurse. Access to Hospital Chapel.

Disability:	Access to disabled toilet facilities for patient's relatives. Access to British Sign Language Interpreters if required (pre-booked) for viewings. E-mail can be used to communicate with hearing impaired relatives. Information can be made available in audio, large print and braille on request Guide dogs are allowed to accompany relatives. There is ramped entrance to the mortuary (but the pathway to the mortuary is on a very steep hill, making it possibly difficult for families and wheelchair users. The mortuary is a small building and can be restrictive for wheelchair users) There is no parking available directly near the mortuary. Bariatric fridge facilities are available at Leigh if required. All staff have attended Oliver McGowen Training
Sexual Orientation	Staff ensure that deceased patients are properly cared for and that their families receive respectful and sensitive treatment. Staff have an awareness of Equality, Diversity and Inclusion and are respectful of everyone.
Religion / Belief (please specify)	Religious needs of the deceased patient are taken into consideration and met. Religion / Faith recorded in notes and factored within deceased patient's care plan. The Mortuary Team are culturally sensitive to all religions and work in partnership with undertakers of different religious groups. Relatives can use the Viewing Room for body washing rituals if required. An out-of-hours on-call service is available which facilitates the release of faith deaths if required. Access to Chaplaincy and Spiritual Care Team. Prayer Room available on site. Access to interpreter and translation services.
Marriage & Civil Partnership	Civil Partnership now recognised within registration system of death.
Pregnancy & Maternity	Bereavement Specialist Nurse available Bereavement Midwife available to support families through these difficult times. Private viewing room available (moses baskets for babies) Patient Information Leaflets available (Guidance and Support for Relatives of the Bereaved) Breast Feeding Room and baby Changing facilities available on site for relatives

Evidence 2: Are all individual Patients health needs being met?
(having needs met in a way that works for them)

Patient Care Plans

Staff ensure that deceased patients are properly cared for and that their families receive respectful and sensitive treatment.

Religious needs of the deceased patient are taken into consideration and met. Religion / Faith recorded in notes and factored within deceased patient's care plan.

If a need/adjustment in relation to a patient's protected characteristic is required, then this is considered

For Example:

- We are able to facilitate ritual washings if requested.
- We have a non-faith viewing room which is big enough to position the patient as required for any faith death i.e. facing mecca.

Equality Impact Assessment

An Equality Impact Assessment is undertaken on the Mortuary Service every 3 years. Last Assessment undertaken December 2024. We use this assessment to identify potential impacts, both positive and negative across all 9 protected characteristics, and look at how we could avoid disadvantage or further improve the delivery of our services.

To view a copy of our equality impact assessment please e-mail EDI@wwl.nhs.uk

Evidence 3: Are patients free from harm when they use the service? (feel safe / there are procedures in place to ensure safety)

Trust Risk Management Policy

It is Trust Policy that all serious incidents / complaints are investigated, and lessons learnt embedded within Trust practice.

All staff working in the Mortuary have a role in identifying risk and ensuring patients and relatives are protected from harm.

Patient Care Plans

Staff ensure that deceased patients are properly cared for and that their families receive respectful and sensitive treatment.

Lessons Learned from Incidents embedded within everyday activity

Parents are welcomed to the mortuary with their child if escorting. Staff need to be notified so that they can be prepared.

For parents who have experienced a child death in the Emergency Department, it has been agreed that parents are encouraged to say goodbyes in Accident and Emergency due to the length of time they are there. The mortuary staff can come and meet parents if the death happens in hours.

Evidence: Patients report positive experiences of the service

Patient / Relative feedback

The Trust collects and obtains feedback from patients through its PALS processes and patient surveys which are reported to the Trust Board of Directors

It is very rare for feedback to be given from relatives using the Mortuary Service due to the emotions families are going through at the time.

Relative Experience Surveys

Mortuary Staff do not routinely collect feedback from patient's relatives about their experience. This is a particularly stressful and emotional time for them.

This is an area the department however would like to engage with / look at how feedback could be obtained in the future.

Equality Delivery System – Domain 2
Staff Health and Wellbeing

Domain 2 Evidence

Domain	EDS Scoring Evidence	Supporting narrative	Supportive Data
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	The organisation monitors the health of all staff. The organisation supports all staff to actively manage their conditions via various methods.	Sickness absence data and declared disabilities are being recorded centrally by HR and are part of the Workforce Dashboard which is updated monthly. Occupational Health provides core services such as work health assessments, rehabilitation, health surveillance. They also support with risk management around sharp injuries psychological stress, infectious diseases and vaccinations. Managers can refer staff into OH for specialist medical advice if they feel their work/role is impacting on their ability to undertake their role/having an adverse effect on their health. Steps4Wellness Team runs regular health checks to staff and support with referral to GP, Staff Physio service, Staff Psychological Support and other support services	Sickness absence data and declaration of disabilities (contacted Sarah) Steps4Wellness and Staff Psychological Support Team offer
	Direct support to help staff manage obesity, diabetes, asthma, and COPD, and mental health conditions	Staff are offered support by OH to manage obesity, diabetes, asthma, COPD and mental health conditions: This is done opportunistically during routine appointments. Referral data from Q1-Q3 2025 suggests that 28% of referrals related to mental health conditions, no referrals were made for conditions such as obseity or COPD and that less than 1% of referrals related to diabetes. There is currently no route to identify and contact staff who have these health conditions as they cannot be recorded as disability categories on ESR. Support may be offered if staff report off sick due to issues arising from these health conditions or, alternatively, if referred to OH. Staff Psychological Support offer to respond to individual needs regarding mental health and neurodiversity Steps4Wellness Team collaborates with subject matter experts (e.g. Diabetes Team) to raise awareness about health conditions. New Wellness at Work Resource Suite has been launched, including a new wellness at work handbook which signposts to support offer for specific health conditions. EDI monitoring data not available for staff wellbeing and psychological support services.	OH data Wellness at Work resources

	The Trust provides psychological and wellbeing services to support staff with mental health conditions and wellbeing.	Comprehensive staff wellbeing and staff psychological support offer, including health promotion, individual and team based wellbeing support, individual therapeutic interventions in addition to range of group-based interventions Chaplaincy and Spiritual Care Team are available to provide pastoral, emotional, spiritual, and religious support. Safeguarding team offer support regarding domestic abuse or sexual safety issues for all staff and have a high proportion of referrals coming from staff who have accessed mental health support.	Steps4Wellness and Staff Psychological Support Team offer see above S4W Toolkit
	The organisation promotes and provides innovative initiatives for work-life balance, healthy lifestyles, encourages and provides opportunity to exercise. The organisation signposts to national and VSCE support. The organisation uses data to support their workforce in making healthy lifestyle choices.	WWL has launched a refreshed flexible working policy and guidance to support keeping staff in work. Staff are encouraged to discuss flexible working options at induction or anytime after that. S4W Team runs comprehensive wellness offer such as regular health checks, organises health promotion events and encourages exercise through trust-wide engagement initiatives. The team uses the NHS Health and Wellbeing Framework and staff network feedback to further enhance their health and wellbeing offer and make it more accessible for those from underrepresented groups . New Wellness at Work resources have been launched including workplace adjustment guidance and wellness at work plan to support staff in having regular wellbeing conversations about their health, how to support them in work and what adjustments can be made to stay well in work. WWL has secured grant funding via NHS Charities Together to employ a Wellbeing Adjustment Advisor role for 12 months which will provide additional support to staff to agree adjustments and support their wellbeing at work.	Flexible Working Policy Steps4Wellness and Staff Psychological Support Team offer see above S4W Toolkit Wellness at work resources
	The organisation uses sickness and absence data to support staff to self-manage long term conditions and to reduce negative impacts of the working environment. The organisation actively works to increase health literacy within its workforce.	A new Wellbeing Policy has been developed in response to staff feedback gathered through surveys and focus groups, replacing the existing Attendance Management Policy. This updated policy moves away from a punitive, reactive approach to sickness management and instead focuses on proactive wellbeing support—helping colleagues stay well at work and enabling a quicker, supported return when absence is unavoidable. The policy includes clear escalation routes, guidance on how to support staff with health needs in work and sets clear expectations around responsibilities for looking after our own and others wellbeing. A Sickness Improvement Group was established in early 2025 which includes Staff Side Chair, Occupational Health, the Trust Wellbeing Lead and other members of the People Services and is chaired by Deputy Chief People Officer. The group has	Reducing Absence Action Plan EDI monitoring data not available for staff wellbeing and psychological support services which impedes ability to analyse accessibility of services by

		developed an improvement plan to reduce sickness absence across the Trust which includes improving data quality, reducing length of absence, improving wellbeing and raising the profile and accountability around wellbeing. Some of the completed actions include: • Draft of Wellbeing Policy completed and currently being ratified through Partnership Forum • Wellbeing at work resources launched • Reducing the use of the "unknown" absence recording category to improve data quality • Introduction of secondary absence recording code to improve data quality • Wellbeing resources for staff updated on the intranet and re-circulated to • Managers • Promotion campaign for staff physio offer completed Managers and HR both get monthly information in regards to absence and the reasons recorded for this. ESR data is being used to support with sickness absence however has currently a 6 week delay. Additionally, there is currently no central recording of workplace adjustment needs or actions which limits data insights into how well staff are supported with long-term health conditions. Managers and their divisional HR reps will discuss what internal support is available and signpost staff during dedicated well-being/sickness absence meetings to support a return to work or if absence continues OH, Staff wellbeing and Staff Physio services are signposted to those who are on sickness absence. To increase health literacy, psychoeducation and self-help resources are provided via group sessions or intranet resources as well as to intervention groups and clients of the psychological support team Avenues via eRoster to support more live absence data is being explored with relevant HR teams (75% of workforce on eRoster). Automatic signposting to internal services is also being explored.	protected characteristics

Domain	EDS Scoring Evidence	Supporting narrative	Supportive Data	Score
Domain 2: Workforce health and wellbeing				
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	The organisation has a zero-tolerance policy for verbal and physical abuse towards staff. The organisation penalises staff who abuse, harass or bully other members of staff and takes action to address and prevent bullying behaviour and closed cultures, recognising the link between staff and patient experience	**Yellow and Red Card Policy:** We have developed a policy on managing patients/public who are violent and or abusive (Yellow and Red Card Policy) which clearly articulates that all staff should be free from racist discrimination, harassment, bullying or victimisation and that violent or abuse behaviour will not be tolerated and decisive action will be taken to protect staff, patients and visitors (see excerpt from Yellow and Red Card Policy in the evidence pack on page 14). The main purpose of this policy is to provide staff with effective arrangements, which will in the first instance, seek to de-escalate any unacceptable violent/nuisance and disturbance behaviour and thereby reduce the risk of injury to all concerned. In the second instance, should de-escalation prove unsuccessful, this policy explains the circumstances in which staff can invoke a Yellow or Red Card to sanction patients/public showing inappropriate/unacceptable behaviour/ abuse, up to and including the sanction of excluding patients/public who present an unacceptable risk. The policy is currently in draft and going through internal approval processes. In the **Violence and Aggression policy** wording, we clearly communicate that we do not condone, nor tolerate any aggressive, abusive or violent behaviour towards our employees from any source and that we take decisive action to protect staff, patients and visitors, which can include immediate removal or arrest, issuing informal or formal warnings, or exclusion of a patient from treatment other than immediate emergency care. The SOP outlines the reporting procedure via Datix and stakeholder involvement to make informed decision regarding any actions against the person who has displayed abusive, violent behaviour as well as the support options for the individuals involved. A new Violence Prevention Strategy is currently being developed and a Violence and Aggression Working group being established by December 2025 and will consist of stakeholders from Estates and Facilities, Security, Health and Safety, HR, L&D, and Trade Union Rep. This group will help to ensure we take a multi-disciplinary approach and triangulate our data and insights to ensure our processes are appropriate, timely and will provide duty of care for those involved in incidents. The Dignity at Work policy refers to the Equality Act and employees' right to work in a safe environment free from risk of bullying, discrimination, harassment, or abuse for any reason including any protected characteristics people may have.	HR policies and processes in place relating to Dignity at Work and Conduct V&A policy Sexual Misconduct Policy Draft Yellow and Red Card policy	

		Any concerns regarding bullying or abuse which are formally raised with HR are recorded on HR tracker which lists all cases and approvals linked to conduct. Any behaviour that falls under conduct can be considered using our internal decision tree which defines level of tolerance for specific breaches of conduct, such as physical abuse or assault, discriminatory language or behaviour and information breaches. WWL has worked towards gaining the NorthWest Anti-Racist BAME Assembly Bronze accrediation and has committed to an anti-racist strategy and policies to protect our staff and patients from racial abuse and discrimination. WWL has also signed the NHS Sexual Safety Charter and has launched a new Sexual Misconduct Policy which aims to support staff who have experienced any sexual unwanted behaviour by other staff and provides new reporting process for staff to raise concern about sexual misconduct		
	The organisation provides appropriate support to staff and where appropriate signposts staff to VSCE organisations who provide support for those who have suffered verbal and physical abuse.	WWL provides a comprehensive range of support and advice services to assist staff for those who have suffered stress, bullying, harassment or abuse, including Safeguarding Team, HR, staff wellbeing and psychological support services, self-service Steps4Wellness toolkit, trade union, Freedom to Speak Up Guardian, and staff networks. However, there is currently no process for signposting to available support offer when staff report incidents of abuse via Datix and it depends on the investigating manager to provide support options. Proactive signposting of support could be improved by embedding this into the reporting process, e.g. when incidents from patients are raised via Datix, so that staff will be aware of their options for support Where a complaint is raised under the auspices of a HR policy then managers are asked to initiate a personalised communication and support framework for the employees involved which would include both the alleged victim and alleged perpetrator. HPMA has called on member trusts to implement recommended actions to reduce avoidable harm during investigations and we are currently working up an action plan to review our HR policies and processes and make investigations a more person-centred, compassionate process. Further work as part of anti-racist and civility and respect programmes have led to developments of a draft Civility Response Framework to support informal resolution as a positive route to resolve incidents of incivility before they progress to incidents of a more serious nature. In addition to the framework, the	Civility Response Framework	

		organisation is planning on reviewing its current policies around conduct to reduce avoidable harm during investigations		
	The organisations can provide evidence that percentages for bullying and harassment are decreasing year on year for any staff group were there are higher than average incidents.	*National Staff Survey 2024* suggests that percentage for bullying and harassment from colleagues or managers has worsened since 2023 but is comparable to NSS 2022. Percentage of staff experiencing harassment, bullying or abuse is worse for those from multi-ethnic backgrounds or those who have a long-term health condition; particularly high from bullying from staff towards BME colleagues (32%) and from colleagues towards those with a long-term health conditions (23%) *Domestic violence report* shows that 65 staff referred to Safeguarding team for support in 23-24. Majority of referrals relate to emotional abuse and coercion, followed by physical abuse; all female reporting with no data on BME background available *Violence and aggression* incidents towards staff reported via Datix have reduced from 493 to 342 year on year, with majority being patient on staff incidents (335). Staff-on-staff violence or abuse was rare. Currently, we are still unable to include a breakdown of data by prptected characteristics. The latest Freedom to Speak Up Guardian report Q2 2025 suggests that about a quarter of referrals related to attitudes and behaviours, i.e. concerns abot peer and managerial conduct, which indicates that incivility continues to be a common themes that gets reported to FTSUG. For the majority of FTSUG cases, individuals do not disclose their protected characteristics and thus there is not sufficient data to find pattern of themes related to harassment on the grounds of protected characteristics.	WRES Indicators 5&6 / WDES Metric 4A Datix report Safeguarding Team DA referral data	

	The organisations use evidence from people's experiences to inform action and change and influence other system partners to do so	HR regularly produces a Fair Experience at Work reports for People Committee which provides data an learning from Executive Scrutiny Panel and Employee Relations Review Panels regarding the fair treatment of staff throughout conduct related HR processes. The data for 2024 shows, that there have been more conduct cases than in 2023 and 2022 combined. An increase in Dignity at Work cases indicates that staff feel able to raise concerns as well as a rise in reported number of incidents of inappropriate behaviours, inclusive of bullying or act os incivility. Themes around team relationship issues and leadership are common and are addressed through the People and Culture Strategy to improve organisational culture of civility. The reports highlight a disproportionate amount of staff from BME background entering disciplinary processes compared to white staff. Majority of conduct cases relate to Information Governance breaches. HR have developed effective links with safeguarding leads including HIDVAs (Hospital Independent Domestic Violence Advocate) and joint discussions and actions are determined when a referral is made either internally or externally in regards to an incident involving a member of our workforce. HR and safeguarding also agree workforce policies in partnership that are associated to domestic violence, allegations linked to safeguarding and also the new national policy framework, which has triggered local policy development linked to sexual misconduct. Relationships with Health and Safety are less established but if a case was referred to HR that had a health and safety aspect then advice and exchange of information would commence with appropriate team members.	Fair experience at work reports EDI strategy group TOR	

Domain	EDS Scoring Evidence	Supporting narrative	Supportive Data	Score
Domain 2: Workforce health and wellbeing				
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	The organisation supports union representatives to be independent and impartial. Freedom to Speak Up guardians are embedded. Relevant staff networks are staff led, funded and provided protected time to support and guide staff who have suffered abuse, harassment, bullying and physical violence from any source.	Whilst the union maintains impartiality, HR and Union representatives aim to work in partnership and foster good working relationships. The Freedom to Speak Up Guardian service is well established, operate independently, impartially, and objectively, whilst working in partnership with individuals and groups throughout WWL Trust, including the senior leadership team. They seek guidance and support from and, where appropriate, escalate matters to, bodies outside the organisation. have developed a network of Freedom to Speak Up Champions recruited via an EoI (Expression of Interest) form. FTSU Champions, thank, support and signpost, they do not handle cases. FTSU Champions always adhere to confidentiality and help the FTSU Guardian to promote the awareness and importance of a positive Speak Up and Listen Up culture. They are trained appropriately and have completed an approved training programme. Three communities of inclusion staff networks are well established, have protected time and have received guidance on signposting to appropriate support service. Staff networks are being supported in increasing membership and engagement of staff with network forum activities by Staff Experience team.		
	Relevant staff networks are engaged, and equality impact assessments are applied when amending or creating policy and procedures for reporting abuse, harassment, bullying and physical violence.	Staff networks are invited to the EDI Strategy Group and involved in EDI workstreams regarding staff experience and have been asked for feedback for current/prposed changes to guidance and policies		
	Support is provided for staff outside of their line management structure. The organisation monitors, and acts upon, data surrounding staff abuse, harassment, bullying and physical violence.	WWL provides a comprehensive range of support and advice services to assist staff for those who have suffered stress, bullying, harassment or abuse, including Safeguarding Team, HR, staff wellbeing and psychological support services, self-service Steps4Wellness toolkit, trade union, Freedom to Speak Up Guardian, and staff networks A Civility Response Framework is currently being developed to support staff in exploring all options of support and resolution and enabling them to reach informal resolution where appropriate and avoid unnecessary further harm through formal processes.	See evidence for 2B Civility Response framework draft	

Domain	EDS Scoring Evidence	Supporting narrative	Supportive Data	Score
Domain 2: Workforce health and wellbeing				
Outcome 2D: Staff recommend the organisation as a place to work and receive treatment	WWL's staff recommending WWL as a place to work/ to receive treatment: % of staff who live locally to services provided by the organisation do/would choose to use those services % of staff who live locally are happy and regularly recommend the organisation as a place to work. % of staff who live locally to services provided by the organisation would recommend them to family and friends.	National Staff Survey 2024 Recommendation of organisation as a place to work: Trust overall average 59.13% (vs 63.3% in 2023) NHS sector average 61% BME Staff 63.4% (vs. 71.6% in 2024) Staff with long-term health conditions 51% Recommendation of organisation as a place to receive treatment: Trust overall average = 58.7% (vs 62.5% in 2023) NHS sectorAverage = 61.5% BME staff = 66.9% (vs 70.1% in 2023) Staff with long lasting health conditions and illness = 52.6%	National Staff Survey	
	The organisation uses sickness and absence data to retain staff, with a staff retention plan in place. The organisation uses data from end of employment exit interviews to make improvements.	National Staff Survey data suggests that about 29% of staff think about leaving the organisation in the next 12 months. Compared to organisation average, staff with a long-term health condition are more likely to think about leaving than other staff (35.7%). Workforce retention is one of the four projects under the Sustainable Workforce Transformation Scheme and relies on turnover and exit interview data to support action plans to improve retention. Separate strategic sickness absence group has been established to improve data accuracy and timeliness to enable proactive health and wellbeing support. Exit interview themes are regularly shared with HR and OD to support improvements. If concerns are raised during interview, they may be escalated to HR or senio leaders in respective teams.	National Staff Survey data on intention to leave Exit interview process and data available (reports to be generated from February 2025 onwards)	
	The organisation collates and compares the experiences of BAME, LGBT+ and Disabled staff against other staff members, and acts upon the data. The	National Staff Data, WRES and WDES data is being collected annually and compared to support EDI strategy and People and Culture Strategy. Annual action plans are developed to improve staff experience and address key indicators of inequity. We have an established EDI Strategy Group which oversees the implementation of the EDI Strategy via dedicated workstreams,	NSS data use; EDI strategy group workstreams; Focus groups with staff	

	organisation works with partner organisations to better the experiences of all staff.	such as Anti-Racist and Civility workstream and Disability Confident Workstream. There is currently no national reporting requirements around LGTQIA+ data and no a ssociated workstreams that lead on actions related to improving the experience for our colleagues from this community. Our Depute Chief Executive leads the anchor institution steering group to work with our local partners in the Wigan Borough to improve health inequalities and the experience at work for people in our community. Improving routes into employment at WWL is a key part of the strategy, particularly for those with disabilities or long-term health conditions. We run Sector-based work academy programmes for unemployed people which provide placement opportunities and subsequent recruitment into roles at WWL	networks on their experience	
	WWL's staff recommending WWL as a place to work/ to receive treatment: % of staff who live locally to services provided by the organisation do/would choose to use those services % of staff who live locally are happy and regularly recommend the organisation as a place to work. % of staff who live locally to services provided by the organisation would recommend them to family and friends.	National Staff Survey 2023 Recommendation of organisation as a place to work: Trust overall average 63.34% (2% improvement) NHS sector average 61.2% Recommendation of organisation as a place to receive treatment: Trust overall average = 62.47% NHS sectorAverage = 88.82% BME staff = 70.06% (improved by 4%) Staff with long lasting health conditions and illness = 51.13% (decreased by 4%) Gay or Lesbian staff = 53.06% (improved by 6%)	National Staff Survey	

Equality Delivery System – Domain 3
Staff Health and Wellbeing

Domain 3 Evidence

Domain	EDS Scoring Evidence	Supporting narrative	Supportive Data
Outcome 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Both equality and health inequalities are standing agenda items in all board and committee meetings.	The Corporate report template has now been amended to ask colleagues to give consideration as to how their report may impact equality, diversity or inclusion at WWL. ED&I reflections are discussed at all Board of Directors, Council of Governors, and Assurance Committees	
	Board members and senior leaders meet frequently with staff networks. Staff networks have more than one senior sponsor.	Each staff network has had an Executive sponsors who attends staff network forum events regularly. Going forward, each network will have two Exec champions to broaden the advocacy for and visibility of the networks	
	Board members and senior leaders sponsor religious, cultural or local events and/or celebrations. Board members and senior leaders enable underserved voices to be heard Board members hold services to account, allocate resources, and raise issues relating to equality and health inequalities on a regular basis.	Board members and senior leaders acknowledge religious, cultural or local events and/or celebrations. More evidence from Board needed to demonstrate strong engagement with diversity celebration events. The Chair supports and continues to proote the Boards-anti-racism statement, explicitly recognising that racism manifests in multiple forms and reaffirming the Trust's commitment to zero tolerance of discrimination.	Exec evidence

	Board members implement the Leadership Framework for Health Inequalities Improvement. Board members and senior leaders demonstrate commitment to health inequalities, equality, diversity and/or inclusion. Board members and senior leaders actively communicate with staff and/or system partners about health inequalities, equality, diversity and inclusion.	The Chair has attended Health and Wellbeing Board in December 2025 to influence the borough's strategic priorities and has articulated clear ambition to strengthen partnership working within the system to address health inequalities. They continue to position health inequalities as a central organising principle, explicitly linking the Trust's anti-racist stance to its responsibilities as an anchor institution, including its influence through employment, procurement, education and partnership working across the system. The Board has an appointed Health Inequalities Lead (Deputy Chief Executive) who leads on the Anchor Institution Steering Group which is focussed on place-based partnership working and improving health inequalities in the Wigan Borough. A consultant for public health has been employed to supported the creation and implementation of the organisation's Health Inequalities and Prevention Plan which is aligned with the Progress with Unity framework. The first phase of the action plan has six priorities which focus on building the infrastructure needed to support a shift to creating the conditions for health inequalities and prevention activity to thrive. The Chair, Chief Executive, and each Executive Director will hold responsibility for overseeing the delivery of specific actions within the Health Inequalities and Prevention Action Plan. A dedicated Health Inequalities and Prevention Group will be established to drive effective oversight and implementation. The group will set the strategic direction, monitor progress, and provide assurance that health equity and prevention are embedded across the Trust's operations and aligned with statutory duties and system-wide priorities. The group will also serve as a central forum for coordination, learning and collaboration. The group will be chaired by the deputy Chief Executive and provide reports to the Quality and Safety Committee, EDI strategy group and Wider Leadership Team Meetings.	
Outcome 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Both equality and health inequalities are standing agenda items and discussed in board and committee meetings.	The Corporate report template has now been amended to ask colleagues to give consideration as to how their report may impact equality, diversity or inclusion at WWL. ED&I reflections are discussed at all assurance committees and moving forwards, it was suggested that related comments are included in the advise section of the associated AAA (alert, advise, assure) reports.	

	Equality and health inequalities impact assessments are completed for all projects and policies and are signed off at the appropriate level where required. Staff risk assessments, specific to those with protected characteristics, are completed and monitored	Equality Impact assessments are in place for policies and some projects and has recently been build into the business case cycle. However, there is currently no central monitoring mechanism in place and no current training offer to support with Equality Impact Assessments. Information on EIAs including guidance and flow charts are available from the intranet. Staff risk assessments are being completed if applicable, however, data cannot be monitored centrally.	Health Inequalities and Prevention Plan
	Required actions and interventions are measured and monitored. The WRES, WDES and/or NHS Oversight and Assessment Framework are used to develop approaches and build strategies.	The EDI strategy has been informed by the key EDI reporting frameworks as well as our staff voice through the usual engagement channels (National Staff Survey, National Quarterly Pulse Survey, Staff Networks, Listening Events). The strategic direction and priorities are annually reviewed based on newest data insights on staff and patient experiences. Actions plans are developed for all key EDI related reporting requirements, such as WRES, WDES, Gender Pay Gap, Equality Delivery System as well as our internal EDI strategy; Action plans are signed off by Board and their implementation monitored via the EDI Strategy Group which is chaired by Chief Executive.	Board paper bundle
	Equality and health inequalities are reflected in the organisational business plans to help shape work to address needs	The main areas in which we meet EDI via planning is through a focus on the following areas… • Our business plans need to support delivery of our strategic ambitions, one of which is personalised care for patients, which means delivering culturally sensitive and inclusive care • Access to services: ensuring equitable access to care regardless of age, disability, ethnicity, etc • Supporting targeted national initiatives to reducing inequalities: for example, through the expansion of endoscopy services and to support people to make an informed choice about participating in bowel cancer screening • We would expect divisional business plans also to include objectives in relation to supporting our staff, including the promotion of a workforce that reflects the diversity of the communities we serve, as well as supporting staff to ensure they are equipped to deliver inclusive care	EIA information, toolkit and flow charts

Domain	EDS Scoring Evidence	Supporting narrative	Supportive data
Outcome 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Board members, system and senior leaders ensure the implementation and monitoring of the relevant below tools: WRES (including Model Employer), WDES, NHS Oversight and Assessment Framework, Impact Assessments, Gender Pay Gap reporting, staff risk assessments (for each relevant protected characteristic), SOM, end of employment exit interviews, PCREF (Mental Health), EDS 2022, Accessible Information Standard	The Trust has embedded robust EDI governance structures to ensure consistent monitoring and accountability. Impact is tracked through a multi-layered approach that includes the EDI Strategy Group, chaired by the CEO, which meets every two months. At each meeting, a detailed highlight report is submitted and reviewed, summarising progress against EDI objectives, risks, and mitigations. A summary of these reports is then shared with the People Committee twice a year, providing assurance on delivery and identifying areas for improvement. EDI initiatives are explicitly included in Board papers and assurance committee updates, ensuring that executive leadership maintains visibility and ownership of the outcomes. Reflective practice at Board meetings is linked to measurable actions, which are logged and monitored through governance processes.	EDI Strategy Group TOR Board Assurance Framework
	Interventions for unmet goals and objectives are present for the relevant below tools. Board members, system and senior leaders actively support those experiencing the menopause within the working environment. Organisations work with system partners to refocus work, to meet unmet need and demonstrates change	There are seven established EDI workstreams to address key themes of inequity for both our staff and our patients. All workstreams have action plans in place and provide regular highlight reports to the EDI Strategy group. Some workstreams have demonstrated steady progress with their action plans including those to support and improve the experience of our Global Majority colleagues and those with long-term health conditions as well as improving patient experience. Further evidence is needed to demonstrate clear progress with regards to Gender Pay Gap, inclusive recruitment and health inequalities. Board members support interventions for those experiencing menopause, particularly the Director of Communications and Chief People Officer are advocating for our internal educational and peer support offer around menopause.	EDI Strategy Group updates
	Those holding roles at AFC Band 7 and above are reflective of the population served	There are still inequalities in representation at senior leadership level as supported by WRES and Gender Pay Gap data, including underrepresentation of BME staff at Band 7 and above in clinical roles, higher percentage of male senior leaders in the highest income quartile compared to female leaders (particularly in medical and dental workforce) and low declaration of disabilities at senior leadership level.	WRES, WDES reports, Gender Pay Gap report

	Organisations are able to show year on year improvement using Gender Pay Gap reporting, WRES and WDES. Board members, system and senior leaders monitor the implementation and impact of actions required and raised by the below tools	WRES: Most indicators have stayed the same. There has been a slight deterioration in staff reporting incidents of discrimination from manager or other colleagues over the last 12 months (24-25) from 21% to 24%; There was also a deterioration in likelihood of entering a formal disciplinary proceedings; WDES: Majority of indicators have not changed significantly; Slight improvement of disability declaration rate from 4.2% to 5.1%; slight deterioration in likelihood of entering formal capability process; Slight improvement in equity relating to likelihood of being appointed from shortlisting as a disabled applicant; Gender Pay Gap: No significant improvements have been demonstrated to close the Gender Pay Gap.	WRES, WDES reports, Gender Pay Gap report

Agenda item: [21.1]

Title of report:	Maternity Dashboard and Optimisation Report
Presented to:	Board of Directors
On:	17th June 2026
Item purpose:	Information
Presented by:	Kevin Parker-Evans (Chief Nursing Officer and DIPC)
Prepared by:	Gemma Weinberg (Digital Midwife)
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations.

The April dashboard has highlighted that there are some areas for increased observation.

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

Financial implications

N/A

Legal implications

N/A

People implications

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

Equality, diversity, and inclusion implications

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

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

None

Recommendation(s)

The board are asked to note the April 2026 dashboard and overview of indicators as outlined below.

Report

April 2026 Exception report - Maternity
Summary

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

- There were 52 validated midwifery red flags reported in April.
- We are now validating red flag figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. However, they only relate to Delivery suite There is a separate red flag report which investigates the red flags in more detail.
- The shift coordinator was able to remain supernumerary for all shifts in April.
- 1:1 care is validated at 100% in April.
- There were 5 Maternity complaints received in April, and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

PSII Commissioned Incidents

There were no PSII Commissioned incidents reported in April.

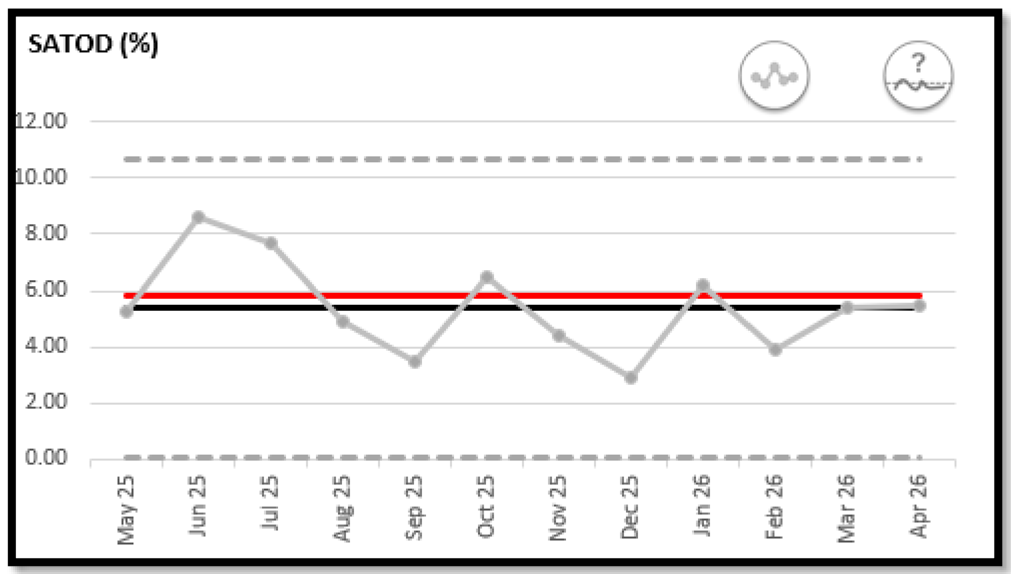
StEIS reported incidents

There was one StEIS reported incident in April. This was an incident where a baby was born with poor cord gases and was transferred to Bolton for cooling.

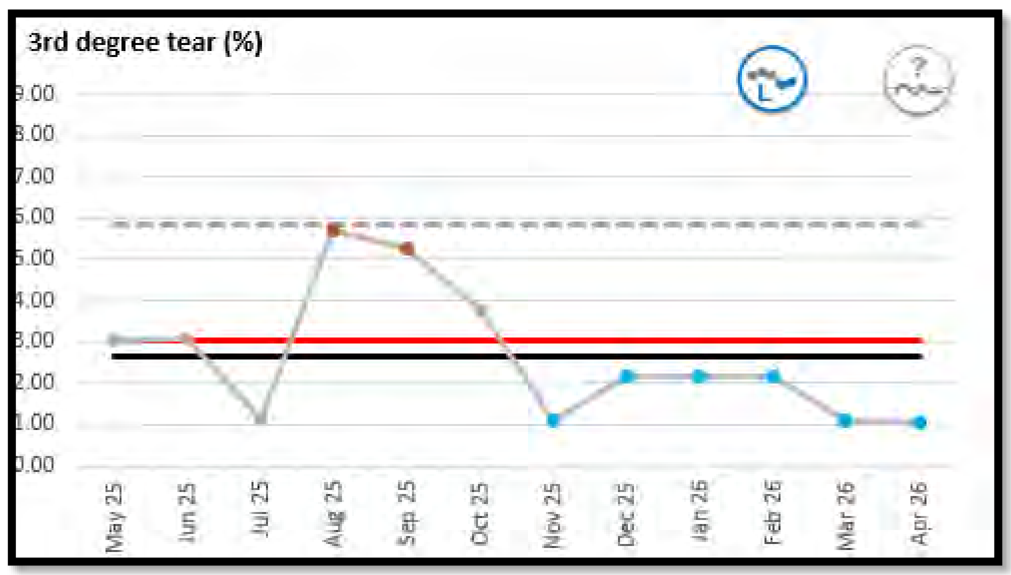
Green

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

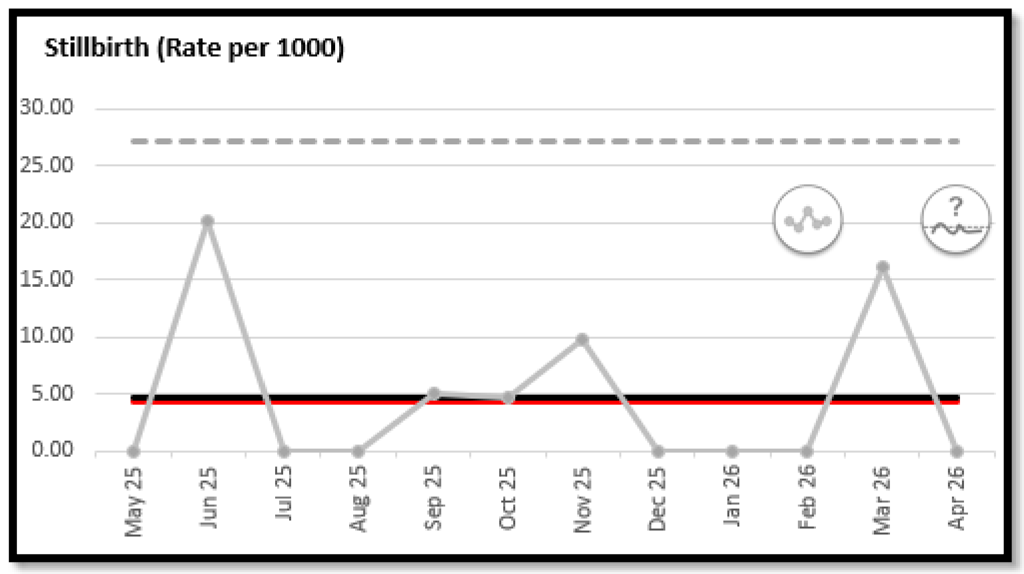
Smoking at the time of Delivery (SATOD) (%).
December saw the lowest SATOD figure ever at WWL and this figure has remained green for several months. Work continues to promote and encourage smoking cessation throughout pregnancy. Changes have been made by the smokefree pregnancy team where contact is established earlier in pregnancy. The below SPC chart shows our % SATOD rates in comparison to the 2025 average from GM (red line).



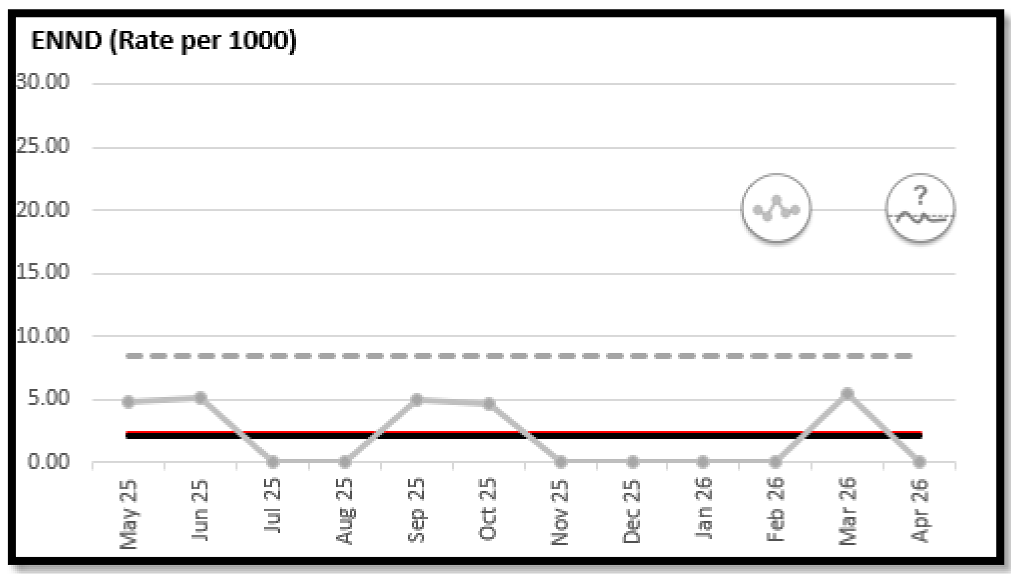
3rd / 4th degree tear (%).
The figure is recorded as a percentage of vaginal births. There was 1 woman who had a 3rd degree tear in April. The below SPC chart shows how we compare to the 2025 GM average for this metric (red line) and is showing a downward trend for this metric. An OASI working group is continuing to look at this metric and at ways to improve it. Several QI projects are in place to support the ongoing work to reduce perineal injury. The PPHS specialist Midwife is in post and working to reduce the incidence.



Number of stillbirths (rate per 1000).
This figure is recorded as a rate per 1000. There were 0 stillbirths in April. The below SPC chart shows how WWL compare with the 2025 average from GM (red line).

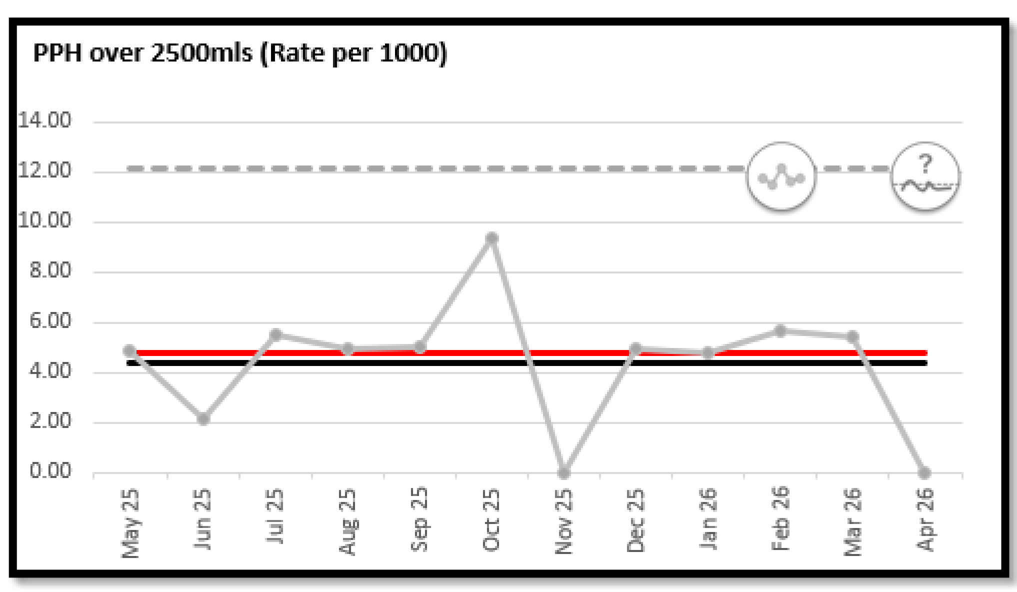


Number of Neonatal Deaths (rate per 1000).
The figure is recorded as a rate per 1000. There were 0 ENND in April. The below SPC chart shows how WWL compare with the 2025 GM average (red line).



Skin to skin contact (%)
Work continues to improve this metric with antenatal education and Midwifery training. The infant feeding team have been asked to attend the pregnancy circles which are commencing in Hindley and Tyldesley. It is hoped that reaching out to women regarding skin-to-skin contact will help to improve this metric.

PPH over 2500mls (rate per 1000).
There were 0 women who had a PPH of over 2500mls in April. The below SPC chart shows how WWL compare with the 2025 GM average (red line). The figures for this metric are recorded as rate per 1000.



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

Supernumerary shift coordinator at start of shift (%)
There was a shift coordinator at the start of shifts for all shifts in April.

Supernumerary Shift Coordinator
This had been red for several months, due to significantly increased activity and acuity on the unit. But April sees 100% of shifts having a supernumerary shift coordinator throughout the shift. As requested on safety champions this will be triangulated with sickness data etc to look at possible issues by the inpatient team.

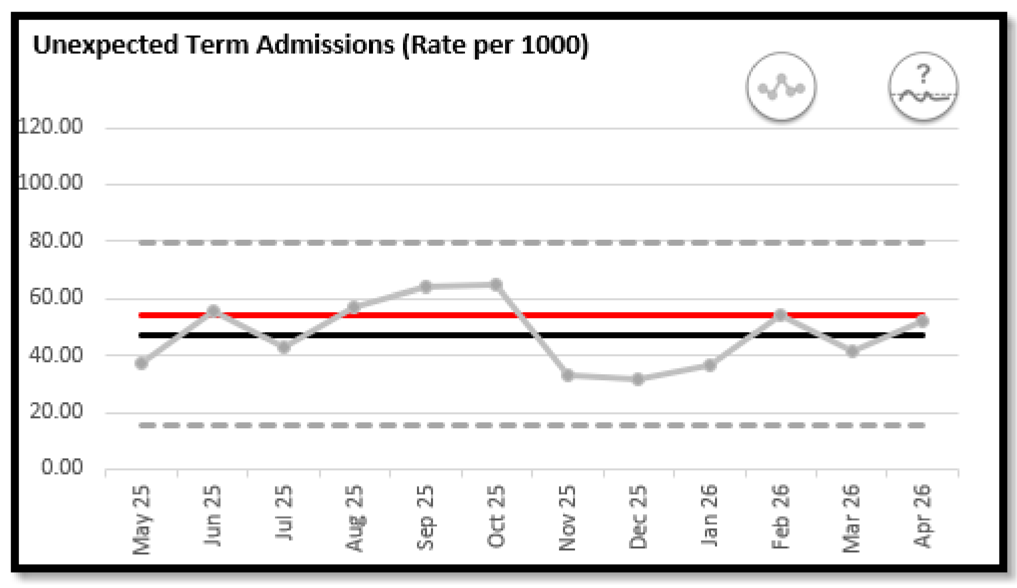
Amber

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

Women readmitted within 28 days of Delivery (rate per 1000).
There were 5 maternal readmissions to the obstetric unit in April. No omissions in care were noted. These admissions were for:

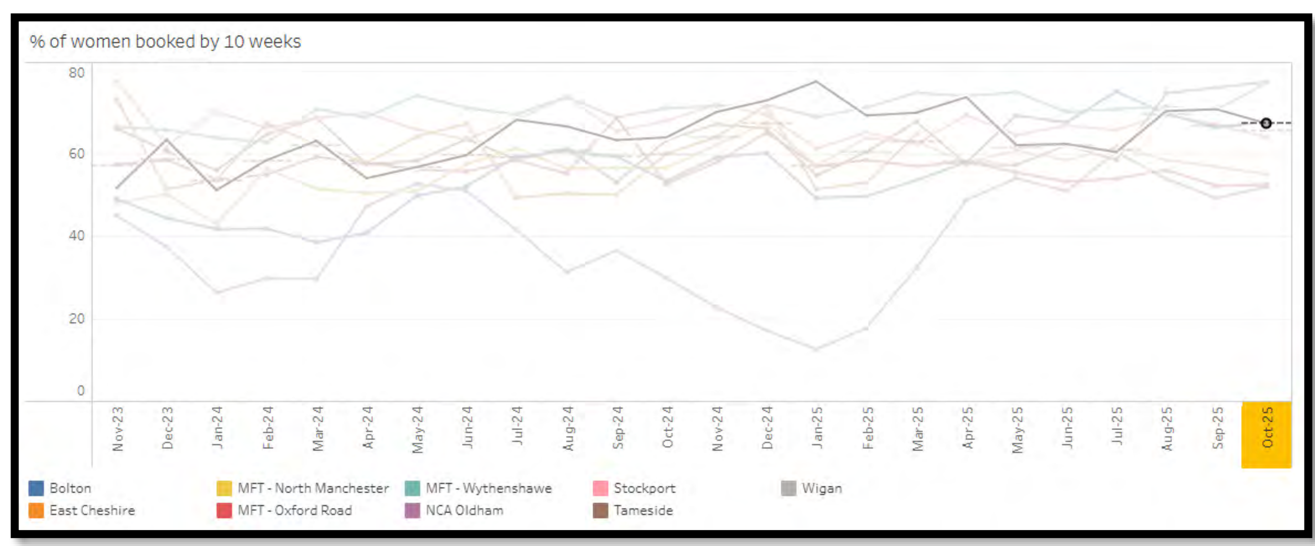
- Secondary PPH
- Raised BP
- Mental health issues
- Chest / calf pain
- Headache

Term admissions to NNU (rate per 1000).
This figure is recorded as rate per 1000 and equates to 9 babies in April. This metric had been seeing a downward trend. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate and to try to improve the figures in this metric. The below is an SPC chart showing our rates in comparison to the 2025 GM average (red line).



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

Booked by 9+6
The aim is to work towards booking all women before 10 weeks of pregnancy. There was a drop in this metric in April, but this is likely due to the significant increase in bookings in March causing delay. The chart below shows how WWL is performing in relation to GM. As this is not currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart. However, WWL are performing well in comparison to other providers within the region.



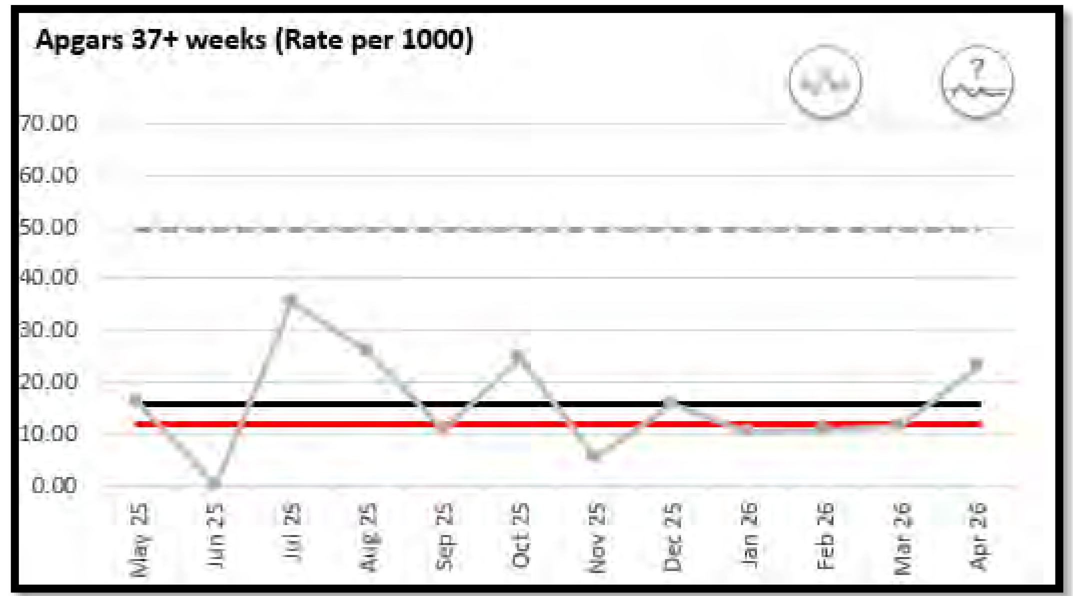
Category 1 Caesarean Sections with no Delay in Decision to Delivery interval (%).
Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and delivery. The figures pulled from Euroking for April show that 2 out of 11 women had an interval of more than 30 minutes. The times where there was a delay ranged from 32 to 54 minutes. This metric is continuing to be reviewed with a deep dive audit by the doctors. The initial results of this audit indicated discrepancies between the written notes and what is recorded on

Euroking. It was therefore agreed in Safety Champions that this audit should be ongoing for a while for increased assurance.

Category 2 Caesarean Sections with no Delay in Decision to Delivery interval (%).
Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and delivery. In April (according to Euroking records) there were 4 women out of 26 who had an interval time of more than 75 mins. The times where there was a delay ranged from 79 minutes to 170 minutes. This metric is continuing to be reviewed with a deep dive audit by the doctors. The initial results of this audit indicated discrepancies between the written notes and what is recorded on Euroking. It was therefore agreed in Safety Champions that this audit should be ongoing for a while for increased assurance

<u>Red</u>

All infants with Apgar's less than 7 (rate per 1000).
The rate per 1000 in April equates to 4 babies. A downward trend had been beginning to show for this metric. The below SPC chart shows how our figures compare to the 2025 GM average (red line).

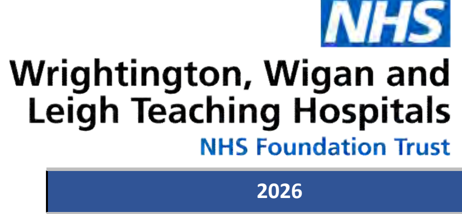


<u>Conclusion</u>

Normal variation and fluctuations are noted with the figures this month and positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green and amber indicators but do show some red areas which will be observed going forward. Persistently amber areas will also be closely observed for patterns. The maternity dashboard continues to be reviewed quarterly by GM and the Maternity Dashboard steering group.

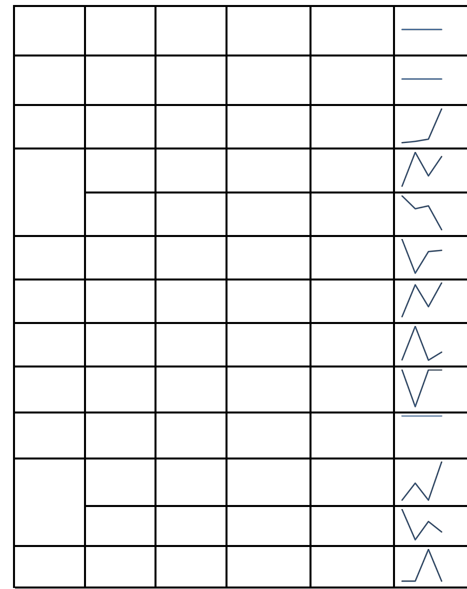
Safety Dashboard 2026

Maternity



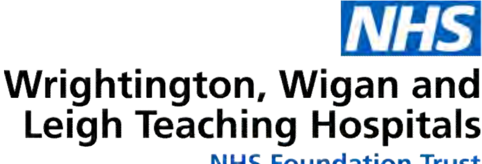
		Goal	Red Flag	Measure	2026 Jan	Feb	Mar	Apr	May	Jun	2026 Q1	Q2	Q3	Q4	YTD	Trend
Activity	Bookings (Total bookings)				225	220	274	235								
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)	Above 80%	Below 50%													
	Registerable births				210	178	186	183								
	NVD (as % of total births)				38.10%	45.51%	39.25%	43.17%								
	Instrumental deliveries (as % of total births)				5.71%	6.74%	9.14%	9.29%								
	Total number of Caesarean Sections (all categories – as % of total births)				56.19%	47.19%	50.54%	46.99%								
	Number successful VBAC				2	3	2	2								
	% of Category 1 Caesarean Sections with no Delay in decision to delivery (over 30 minutes) – as % total cat 1 CS				80.00%	80.00%	70.58%									
	% of Category 2 Caesarean Sections with no Delay in decision to delivery (over 75 minutes) – as % total cat 2 CS				69.20%	76.92%	78.12%									
	Number of Caesarean Section at Full Dilatation				8	1	6	2								
	% total births CS at full dilatation	1 or below	2 or above		3.80%		3.22%									
	IOL (as % of all women delivered – excluding pre labour SROM)	Under 35.9%	Above 40%		35.71%	30.90%										
Maternal Morbidity																
	Of which 4th degree tears (number)				0	0	0	0								
	PPH 1000 - 2500 mls (Rate per 1000)	100 or below	112 or above		130.43		97.83	125.68								
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6		4.76	5.62	5.38									
		Under 25	Above 35			28.09	27.20	28.20								
dity and Mortality							10.75									
	Stillbirths (excluding MTOP as rate per 1000)															
	Number of stillbirths (excluding MTOP)				0	0	1	0								
		Under 1	Above 1.77				5.37									

Neonatal Morbi	Early neonatal deaths (excluding MTOP as rate per 1000)				0.00	0.00	0.00	0.00		
	Number of Early Neonatal Deaths (excluding MTOP)				0	0	0	0		
	-	Under 15	Above 21					23.10		
	-	Under 48	Above 60		36.27					
Public Health	% women smoking at time of booking (as % of total bookings)				8.89%	7.27%	7.66%	4.68%		
	-	Under 8.5%	Above 10%							
		Above 75%	Under 65%		70.95%	83.71%	75.00%	84.50%		
		Above 58%	Under 50%							
Workforce	-		Under 100%			98.80%				
	Percentage of shifts where shift Co-ordinator is able to remain supernumerary		Under 100%		96.77%	98.20%	96.77%			
	Sickness (as % of overall staffing) – report quarterly				7.57%	3.67%	6.01%	4.69%		
	HIE 2 &3 > 37 weeks (rate per 1000)			GM average 2023 0.555/1000	0	0	1	0		



Safety Dashboard 2026

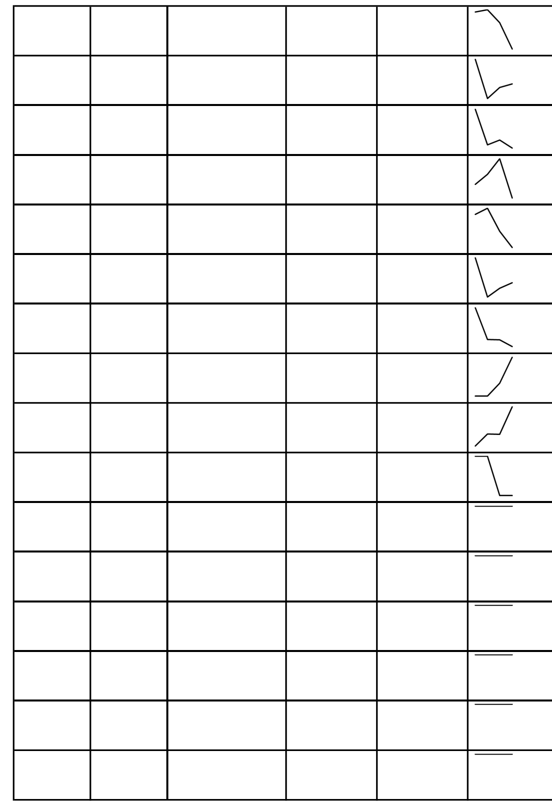
Neonatal



					2026							2025					
		Goal	Red Flag	Measure	Jan	Feb	Mar	Apr	May	Jun	Jul	Q1	Q2	Q3	Q4	YTD	Trend
Safety	% of Shifts Staffed to BAPM	100.00%	< 90%	Badger	81%	95%	95%	100%									
Safety	% of Shifts with Supernumeary Shift Leader	100.00%	< 50%	Badger	80.65%	96%	95%	100%									
Safety	Unit Closed Due to Capacity	0	≥ 1	Datix	1	0	0	0									
Safety	Unit Closed Due to BAPM/Staffing	0	≥ 1	Datix	0	0	0	0									
Admissions	Number of Births from Maternity			Maternity Data	210	178	186	183									
Admissions	Admissions Under 27 Weeks to NNU	0	≥ 1	Badger	0	0	0	0									
Admissions	Total Admissions to Neonatal Unit			Badger	18	18	22	17									
Admissions	Total TC Admissions			Badger	16	15	10	17									
Admissions	Number of unexpected Term Admissions to NNU			Badger	7	9	12	9									
Admissions	Unexpected Term Admissions to NNU *(as % of Births > 37 Weeks Gestation)*	>6%	≤ 4.5%	Maternity/Badger	3.33%	5.06%	6.45%	4.92%									
AP	Mothers Eligible for AN Steroids (*< 34 Weeks*)			NNAP/ NWNODN	1	1	3	0									
AP	% of Mothers Who Received Full Course of Antenatal Steroids	≥ 93%	< 89%	NNAP/ NWNODN	100.00%	0.00%	100.00%	N/A									
AP	Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*)			NNAP/ NWNODN	1	1	1	0									
AP	% of Mothers Receiving Antenatal $MgSO_4$	≥ 85%	< 73%	NNAP/ NWNODN	100.00%	100.00%	100.00%	N/A									
AP	Babies Eligible for Delayed Cord Clamping (< 34 Weeks)			NNAP/ NWNODN	1	1	3	0									
AP	Babies Received Delayed Cord Clamping >1min	≥ 85%	< 73%	NNAP/ NWNODN	100.00%	0.00%	100.00%	N/A									
AP	Babies Eligible for Temperature on Admission (*< 34 Weeks*)			NNAP/ NWNODN	1	1	3	0									
AP	% of Babies With Temperature Within First Hour of Admission (*< 34 Weeks*)			NNAP/ NWNODN	100%	100.00%	100.00%	N/A									
AP	% of Babies With Temperature on Admission of 36.5°C – 37.5°C (*< 34 Weeks*)			NNAP/ NWNODN	100%	100.00%	100.00%	100.00%									

NN	Babies Eligible for Senior Review			NNAP/ NWNODN	18	18	20	16			
	% of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	100.00%	100.00	100.00	100.00			
	% of Ward Rounds Where Parents Present			NNAP/ NWNODN	74.60%	72.70%	77.90%	80.90%			
	Eligible Babies Reciving Retinopathy Screening (*ROP*) (< 31 Weeks or <1501g)			NNAP/ NWNODN	7	0	1	4			
	% of Eligible Babies Receiving Retinopathy Screening (*ROP*) (< 31 Weeks or <1501g)			NNAP/ NWNODN	100.00%	100.00%	100.00%	100.00%			
	Babies With Central Line Blood Infections			NNAP/ NWNODN	0	0	0	0			
	% of Babies With Central Line Blood Infections			NNAP/ NWNODN	0.00%	0.00%	0.00%	0.00%			
	Babies Eligible for Follow-Up At 2 Years			NNAP/ NWNODN	2	5	0	0			
	% of Babies Receiving Follow-Up At 2 Years			NNAP/ NWNODN	50.00%	80.00%	100.00%	100.00%			
Incidents	Number of Incidents Reported			Datix	12	11	17	18			
	Number of Network Exception Reports	0	≥ 1	NWNODN	0	1	0	3			
	Number of Concise Investigations	0	≥ 1	Datix	0	0	1	1			
	Number of StEIS Reported Incidents	0	≥ 1	Datix	0	0	0	0			
	Number of Complaints	< 2	≥ 2	Datix	0	0	0	0			
	Number of Letters of Claim Received	0	≥ 1	Datix	0	0	0	0			
Breastfeeding	% of Babies Receiving Human Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	60.00%	47.60%	42.10%	57.90%			
	Number of Babies Eligible to Receive Breast Milk in the First Two Days of Life (< *34 Weeks*)			NNAP/ NWNODN	1	1	3	0			
	% of Babies < 34 Weeks Receiving Breast Milk in First Two Days of Life			NNAP/ NWNODN	100.00%	100.00%	100.00%	N/A			
	Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14			NNAP/ NWNODN	3	1	1	3			
	% of Babies < 34 Weeks Receiving Breast Milk at Day 14			NNAP/ NWNODN	100.00%	100.00%	0.00%	100.00%			
	Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge			NNAP/ NWNODN	9	4	2	6			
	% of Babies < 34 Weeks Receiving Breast Milk at Discharge			NNAP/ NWNODN	55.60%	75.00%	50.00%	50.00%			
	Care Days IC (*HRG1*)			Badger	9	12	20	3			
	Care Days HD (*HRG2*)			Badger	91	92	61	31			

Activity	Combined Care Days IC, HD (HRG1, HRG2)	>83	<42	Badger	100	104	81	34			
	Care Days SC (*HRG3, HRG4, HRG5, and code9*)			Badger	254	100	143	157			
	Total Care Days			Badger	354	204	224	191			
	Cot Capacity IC %			Badger	29.03%	42.86%	64.52%	10.00%			
	Cot Capacity HD %			Badger	97.85%	109.52%	65.59%	34.44%			
	Cot Capacity SC %			Badger	81.94%	35.71%	46.13%	52.33%			
	Overall Cot Capacity %			Badger	81.57%	52.04%	51.61%	45.48%			
	TC Care Days			Badger	58	58	64	76			
	TC Cot Capacity %			Badger	46.77%	51.79%	51.61%	63.33%			
Training	NLS Accrediated	≥ 70%	< 70%	WWL	97.40%	97.40%	94.90%	94.90%			
	NLS In-House	≥ 90%	< 90%	WWL	97.60%	97.60%	97.60%	97.60%			
	Qualified In Speciality of Intensive Neonates	≥ 70%	< 70%	WWL	93.00%	93.00%	93.00%	93.00%			
	Foundation In Neonates	≥ 70%	< 70%	WWL	97.70%	97.70%	97.70%	97.70%			
	Family Intergrated Care	≥ 85%	< 85%	WWL	100.00%	100.00%	100.00%	100.00%			
	Unicef BFI	100%	< 80%	WWL	100.00%	100.00%	100.00%	100.00%			
	Perinatal Mental Health	≥ 80%	< 80%	HEE	100.00%	100.00%	100.00%	100.00%			



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BIRTHRATE PLUS® ASSOCIATES LIMITED

MIDWIFERY WORKFORCE REPORT

Wrightington, Wigan and Leigh NHS Foundation Trust

February 2026

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Section 1 Executive Summary

Overview

This report evaluates midwifery staffing needs for the maternity unit at Wrightington, Wigan and Leigh and its associated community, using the Birthrate Plus® framework. It includes activity data, casemix analysis, staffing requirements, and comparisons with current funded establishments.

Key Findings

Intrapartum Activity

The annual activity period used was 2024/2025. Annual births increased from 2600 in 2023 to 2966 in 2026, with 152 being from out of area. Casemix acuity has risen, with a shift from lower-risk Categories I–III to higher-risk Categories IV–V, driven by factors like diabetes, mental health, high BMI, and increased induction and operative deliveries. Additional intrapartum activity includes antenatal cases needing 1:1 care, postnatal readmissions, escorted transfers, and non-viable pregnancies.

Ward & Clinic Activity

The maternity ward manages antenatal cases and postnatal activity, including 24 ward attenders, 62 readmissions, and 500 extra care babies

Outpatient clinics include midwife booking, obstetric clinics, specialist midwife clinics, fetal medicine clinics and vaccination clinics.

Community Activity covers home births, imported care, safeguarding cases, and attrition due to pregnancy loss or relocation. Caseloading teams run alongside the traditional community model.

Workforce Analysis

Birthrate Plus® recommended clinical staffing: 142.86WTE.

Current funded clinical staffing: 136.95WTE. Deficit: 5.91WTE.

Specialist & Management Roles: 19.60WTE specialist midwives, with 6.70WTE contributing to clinical care. 7.00WTE senior midwifery managers. Non-clinical staffing has a positive variance of 2.76WTE.

Total Workforce Gap

Total recommended (clinical + specialist + management): 160.00WTE. Current funded total: 156.85 WTE. Overall deficit: 3.15WTE.

Skill Mix current model uses a 92.5/7.5 split between registered staff and maternity support workers (MSWs).

Methodology Birthrate Plus® calculates staffing based on casemix categories I–V, reflecting complexity and dependency levels. It aligns with NICE guidance and is endorsed by RCM and RCOG. Allowances are made for leave, travel, and management roles. (See Appendix 1)

Section 2. Discussion of Annual Activity Data and Casemix

The midwifery workforce report is for maternity services in Wrightington, Wigan and Leigh (WWL) and the local community served by WWL.

The current allowance of 20.0% has been calculated for registered staff and maternity support workers to cover annual leave, sickness and study leave; with 15.0% community travel included in the staffing figures.

Intrapartum

The annual births are 2966 as shown in Table 1. The 2023 report was based on 2600 births so an annual increase of 366. There are 152 women from out of area who birth in WWL and receive their community care locally.
There are 490 women who are cared for in the antenatal, intrapartum and postnatal periods by the case loading teams.

Table 1: Annual Activity

	Annual Total 2025	Annual Total 2023
Delivery Suite	2430	2574
Home	46	26
Caseload births	490	0
Total Births	**2966**	**2600**

The casemix has a major impact on the midwifery establishment especially for intrapartum care as the additional time applied to Categories III to V results in an increase from the one midwife to one woman ratio for Categories I and II, with additional weighting for categories III-V. Category V = 1.4 midwives per women; category IV =1.3 Midwives per women, and category III = 1.2 midwives per women.(*Appendix 2*)

The 2023 report was based on a casemix from May, July and October 2022 which reflected the acuity of women and babies for this time period. Thus, the decision was to calculate midwifery staffing with casemix from a more recent sample of births felt to be representative.

A 3 months' sample for January, March and April 2025 was obtained from the maternity EPR by the midwifery team and additional scrutiny provided by the Birthrate Plus® consultant (Table 2).

Table 2 shows Delivery Suite casemix used in the 2023 and 2026 reports.

Table 2: WWL Casemix

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
Delivery Suite 2025	1.0	2.0	13.0	33.0	51.0
Delivery Suite 2022	*1.6*	*10.2*	*20.1*	*33.8*	*34.3*

Table 2 shows there has been a significant increase in the acuity of women with 84% of women being in the 2 higher categories. The 2022 delivery suite casemix shows the % in Categories I to III was 31.9% and has reduced to 16.0%. The reduction results in the increase in IV and V and as before, the highest % is in Category V. Factors impacting upon the casemix include more co-morbidities such as diabetes, mental health, high BMI, increased induction rates usually in line with national clinical guidance, increase in operative deliveries, neonatal factors are some of the contributing reasons.

Table 3 shows the additional activity in the delivery suite.

Table 3: Additional Intrapartum Activity

	Annual Total
Antenatal cases needing 1 to 1 care	591
Postnatal readmissions	69
Medical Inductions of labour	1941
Escorted transfers OUT	28
Non-viable pregnancies	18

Medical Inductions of Labour are carried out on Delivery Suite.

Triage sees mainly unscheduled activity, with 6125 episodes per annum. The staffing provides 2 Midwives throughout the 24 hours and 7 days a week. This includes staffing a telephone helpline during the day.

Wards

Table 4 shows the annual activity on the mixed Antenatal and Postnatal Maternity Ward.

Table 4: Maternity Wards Activity

	Annual Total
Antenatal admissions	291
Postnatal women	2430
P/N readmissions	62
Postnatal ward attenders	24
Extra care babies	500
Frenotomies	265
NIPEs by midwives	585

The babies requiring transitional care are included in maternity ward activity and staffing.

Outpatients

The Outpatients' profile is unique to each maternity service.

Table 5 shows the clinics currently facilitated clinics or in the short-term planning stage.

Table 5: Outpatient Clinic Activity

Current clinics	Planned clinics
Midwife booking clinics	Pelvic Health clinic
Obstetric clinics	Birth after LSCS – Birth thoughts
Specialist MW clinics	
Fetal Medicine clinics	
Vaccination clinics	

Table 6 provides a summary of the community population receiving maternity care.

Table 6: Community Activity

	Annual Total
Home births	46
Community cases (own births less exports)	1788
Imports – AN and PN care	556
Caseload Teams	490
Total Community Cases	2880
Attrition Cases *(pregnancy loss or move out of area)*	400
Significant Safeguarding cases	221

This shows community activity for the annual activity period in the hospital site. Some women receive antenatal or postnatal care locally but birth elsewhere and these are the 'Imports'. Workforce establishments are adjusted accordingly for this activity.

The attrition cases in each unit reflect the woman who book with the community teams, but then either move out of area or who have an early pregnancy loss.

Safeguarding numbers in each unit represent the women who require additional care and time due to the increase requirements associated with safeguarding complexities.

Section 3: Discussion of Workforce Results

The Birthrate Plus® staffing in Table 7 is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care. It is inclusive of 20.0% uplift to cover annual leave, sickness absence and mandatory training. It also includes day to day management by ward and department managers; community team leaders and coordination of intrapartum services are included in the clinical establishments.

Table 7: Breakdown of Birthrate Plus® Clinical Staffing

Wrightington, Wigan and Leigh NHS Trust	
Intrapartum Services	46.05wte RMs
Triage and Advice Line	10.75wte RMs
Maternity Ward antenatal & postnatal inc TCU	31.31wte RMs, and PN MSWs
Outpatient Services	11.24wte RMs
Day Unit	1.79wte RMs
Total for Hospital	101.14wte RMs and PN MSWs
Community WTE	
Community (Home births, antenatal and/or postnatal care, attrition and safeguarding)	27.72wte RMs and PN MSWs
Caseload teams	14.00 RMs and PN MSWs
Total Clinical WTE	**142.86wte RMs and PN MSWs**

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.

At the request of the Director of Midwifery Bleep holders are included in the clinical calculation providing clinical oversight and support within their role. They will be responsible for managing the flow and activity within the unit, including overnight and at weekends.

Clinical Specialist Midwives

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.

Current Clinical Funded Bands 3 – 7

Comparisons are made with the current funded establishment as per table 8 below and includes any vacant posts not currently allocated to clinical areas.

Table 8: Current Funded Establishment

RMs Bands 5 – 7	Specialist Midwives contribution	PN MSWs	Current Total Clinical wte
119.99wte	6.70wte	10.26wte	136.95wte

Comparison of Clinical Staffing

Table 9: 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

Table 9 indicates the clinical staffing has a deficit of 5.91wte 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.

Non-Clinical Midwifery Roles

The total clinical establishment as produced from Birthrate Plus® is 142.86wte and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services. (See Appendix 4)

Applying 12% to the Birthrate Plus® clinical wte provides additional staff of 17.14wte for the above roles with it being a local decision as to which posts are required and appropriate hours allocated (Table 10).

Table 10: Comparison of Additional Specialist and Management wte

Current funded wte	Birthrate Plus wte	WTE Variance
19.90wte	17.14wte	2.76wte

Table 10 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.

Summary of Workforce

Table 11: Total Clinical, Specialist and Management wte

Current Funded Clinical, Specialist, Management wte	Birthrate Plus wte	WTE Variance
156.85wte	160.00wte	-3.15wte

Note that the total current and Birthrate Plus® establishments do include the Band 3 contribution in postnatal services on the maternity ward, in the community and the caseload teams.
1.28WTE scanning midwives are not included in the clinical contribution as they provide Ultrasonography services only and do not carry out any clinical antenatal assessments as part of their role.

The results in Table 11 indicate the funded baseline establishment has an overall deficit of 3.15wte in the Total establishment when combining all roles.

In addition to the midwifery staffing with the adjustment for postnatal support staff, there is a need to have additional support staff working on delivery suite, maternity ward, triage, outpatient clinics and the caseload teams. To calculate the requirement for these support staff, professional judgement by the senior leadership team of the numbers per shift is used rather than a clinical dependency method.

Table 12: Current Additional Support Staff Roles

Additional roles	**Place of work**
Band 3 MSWs – 4.06wte	Antenatal clinics
Band 3 MSWs – 6.18wte	Triage
Band 3 MSWs – 5.38wte	Delivery suite
Band 3 MSWs – 3.45wte	Maternity ward
Band 3 MSWs – 1.00wte	Caseload teams

Professional Judgement

At the request of the Director of midwifery, the staffing is calculated with 25.0 % uplift as shown in table 14 below to accommodate the increased training requirements for all midwives.

Table 13: Recommended Staffing with 25.0% Uplift

	Clinical WTE	Additional WTE	Total WTE
20.0%	142.86wte	17.14wte	160.00wte
25.0%	149.68wte	17.96wte	167.64wte

Applying 25.0% uplift increases the total establishment by 7.64wte to 167.64wte and compared with the current WTE of 156.85wte the total shortfall is 10.79wte.

Appendix 1. Birthrate Plus®: The Methodology and Factors Affecting Maternity Services

Birthrate Plus® is a workforce planning framework used in UK maternity services since 1988, with periodic updates in line with national maternity policy and guidance. It calculates the total midwifery time required to care for women, based on the minimum standard of providing one-to-one midwifery care throughout established labour.

The Birthrate methodology aligns with the NICE safe staffing guideline for maternity settings and is endorsed by both the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG). The RCM recommends Birthrate Plus® as the only recognised national tool for systematically assessing midwifery staffing needs. While birth outcomes depend on more than staffing levels alone, applying a validated, widely used tool is essential to ensure safe staffing and one-to-one intrapartum care (NICE 1.1.3).

Birthrate Plus has been applied across a wide range of maternity settings—from small stand-alone community units with around 10 births per year to large regional centres with over 8,000. It accommodates different models of care, including traditional, community-based, and continuity teams, while adjusting for local factors such as population demographics, socio-economic needs, rurality, neonatal service provision, and policy changes.

At service level, Birthrate Plus® produces a case mix based on clinical indicators of maternal and infant wellbeing during labour and delivery. Indicators are weighted to reflect the complexity of care and deviations from normal labour, generating five categories (see Appendix 2). Additional categories apply to women admitted for reasons other than labour. Midwife hours per category are then calculated, incorporating national one-to-one standards and additional time for higher-complexity cases (Categories III–V).

Workforce assessments also account for antenatal and postnatal inpatient and outpatient care, community services, and births in local or neighbouring hospitals. Establishment figures are based on agreed care standards, specialist needs, management roles, and the contribution of qualified support staff. Staffing recommendations cover 24/7 provision, including allowances for annual, sick and study leave, as well as travel in community care.

Factors Affecting Maternity Services

The governance agenda—including evidence-based guidelines, monitoring, audits, and training programmes—impacts midwifery requirements. Birthrate Plus® allows for these resources to be factored into workforce planning.

Shifts in service delivery also affect workload. For example:

- **Alongside midwife units**: Women often have shorter postnatal stays, increasing the complexity of cases managed on postnatal wards, including transitional care and safeguarding needs.
- **Postnatal care**: Short stays require intensive midwifery support to prepare women for discharge and reduce risks such as postnatal depression or breastfeeding difficulties.
- **Community-based care**: With more low-risk care delivered in the community, midwives and support staff are seeing women in clinic rather than at home. Reduced antenatal admissions and shorter postnatal stays increase community activity, and midwives now frequently conduct Newborn and Infant Physical Examinations (NIPEs). Due to social complexities and higher acuity being seen nationally this further impacts the community midwifery workforce.
- **Cross-border activity**: Some women receive antenatal or postnatal care locally but give birth elsewhere ("imported" cases), while others deliver locally but live outside the area ("exported" cases). Workforce establishments are adjusted accordingly.
- **Early booking**: NICE guidance recommends booking by 10 weeks' gestation, requiring earlier midwifery input. However, pregnancy loss may mean the number of antenatal women exceeds the number of postnatal women.

Workforce planning also depends on local decision-making. Senior midwifery managers determine skill mix using professional judgement, knowledge of local services, also Birthrate Plus® workforce recommendations. Specialist midwives' contribution to both clinical and non-clinical roles, are accounted for within the workforce assessment.

Appendix 2. Method for Classifying Birthrate Plus® Categories

Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.

Appendix 3. National Reports

Document	Link to website
Mat Neo SIP	https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/
PCLP	https://www.england.nhs.uk/culture/culture-leadership-programme/
National Bereavement Pathway	https://www.nbcpathway.org.uk/nbcp-standards/
MIS	https://resolution.nhs.uk/wp-content/uploads/2025/04/MIS-Year-7-guidance.pdf
Pelvic Health Programme	https://www.england.nhs.uk/publication/service-specification-perinatal-pelvic-health-services/
Birth Trauma Report	https://www.theo-clarke.org.uk/sites/www.theo-clarke.org.uk/files/2024-05/Birth%20Trauma%20Inquiry%20Report%20for%20Publication_May13_2024.pdf
NMC	https://www.nmc.org.uk/globalassets/sitedocuments/independent-reviews/2024/nmc-independent-culture-review-july-2024.pdf
CQC National Review	full_book_national-review-maternity-services-england-2022-2024-1727260088.pdf
MBRRACE	https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2024/MBRRACE-UK_Maternal_FULL_Compiled_Report_2024_V1.1.pdf

Appendix 4. Frequently Employed Specialist and Senior Leadership Roles

Specialist Midwife Roles
Perinatal Mental Health
Professional Midwifery Advocate
Screening
Practice Development
Consultant Midwife
Digital Midwife / IT
Risk and Governance Midwife
Recruitment and Retention Midwife
Diabetes
Preterm Labour
Bereavement Midwife
Infant Feeding Midwife
Multiple Pregnancy- Twin Pregnancy
Fetal Monitoring
Public Health
Safeguarding
Education Lead
Patient Safety
Saving babies Lives
Audit Lead

Senior Leadership Roles
Director of Midwifery
Deputy Director of Midwifery
Head of Midwifery
Deputy Head of Midwifery
Inpatient Matron
Outpatient Matron
Community Matron
Intrapartum Matron

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Use of the common seal during FY2025/26
Presented to:	Board of Directors
On:	17 June 2026
Purpose:	Information
Presented by:	Consent agenda
Prepared by:	Head of Corporate Governance
Contact details:	E: Nina.Guymer@wwl.nhs.uk

Executive summary

This report outlines the occasions on which the foundation trust's common seal has been applied during the financial year 2025/26.

Link to strategy

There is no link to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with the content of this report.

Financial implications

There are no financial implications arising from this report.

Legal implications

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

People implications

There are no people implications arising from this report.

Wider implications

There are no wider implications to highlight.

Equality, diversity and inclusion implications

There are no ED&I or health inequalities implications

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

None

Recommendation(s)

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

1. BACKGROUND

1.1. All foundation trusts are required to have a common seal.[1] The constitution of Wrightington, Wigan and Leigh Teaching Hospitals NHS FT provides that the seal shall only be affixed under the authority of the Board of Directors and that attestation by any two directors shall be deemed to be affixing the seal under the board's authority.[2]

1.2. A seal must be applied in order for the foundation trust to execute documents as a deed. Certain types of document are not legally binding unless they are executed by deed; the most common being those that deal with transfers of land, some leases or tenancies, mortgages, powers of attorney and certain business agreements. It can also sometimes be beneficial to execute other documents as a deed rather than as a simple contract because the time limit for bringing a claim under a deed is double the time limit for a simple contract (12 years as opposed to 6 years).

1.3. The board has reserved to itself responsibility for reviewing the use of the common seal, and this report is presented in order to satisfy that requirement.

2. USE OF THE COMMON SEAL

2.1. Since the last report to the board, the common seal of Wrightington, Wigan and Leigh Teaching Hospitals NHS FT has been applied on 10 occasions, as shown in the table below:

Seal №	Date seal applied	Description of document	Use attested by:
67.	2 Apr 2025	Renewal of underlease for Pemberton Health Centre	1. M Wilkinson 2. R Mundon
68.	2 Apr 2025	Rent review for unit 7 Martland Point	1. M Wilkinson 2. R Mundon
69.	2 Apr 2025	Renewal of underlease for Leigh Health Centre	1. M Wilkinson 2. R Mundon
70.	18 Jun 2025	Renewal of lease for the ground floor of Wigan Investment Centre	1. T Gardner 2. F Thorpe
71.	9 Jul 2025	Renewal of underlease for Atherton Health Centre	1. A Miller 2. F Thorpe
72.	10 Jul 2025	Lease for electricity substation site on Freckleton Street	1. T Gardner 2. R Mundon
73.	18 Sep 2025	Underlease for part of Claire House Health Centre	1. M Fleming 2. S Brennan
74.	4 Dec 2025	10 collateral warranties pertaining to the construction of a multi-story car park on Freckleton Street	1. S Arya 2. J Tait

[1] Sch.7, para.29(1) National Health Service Act 2006

[2] Section 22.2

Seal №	Date seal applied	Description of document	Use attested by:
75.	17 Dec 2025	Documents relating to the multi-story car park on Freckleton Street: • Second deed of variation • Deed of covenant • Operator underlease x2 • Building structure underlease • Revisionary underlease • Licence for alterations x2	1. R Mundon 2. S Brennan
76.	4 Feb 2026	Deed of covenant for 6 Dobson Close, Wrightington	1. C Austin 2. F Thorpe

2.2. All occasions on which the common seal is applied are recorded in a register which is held by the Director of Corporate Governance. This is available for inspection by directors on request.

3. RECOMMENDATIONS

3.1. The Board is recommended to note the occasions on which the common seal has been applied during financial year 2025/26.