Board of Directors - Public Meeting

Wed 02 April 2025, 14:00 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

1 min

13. Declarations of Interest

Information *Mark Jones*

Verbal item

13.1. Register of directors' interests

Information *Mark Jones*

13.1. Directors DoIs - Apr 2025.pdf (3 pages)

1 min

14. Minutes of the previous meeting

Approval *Mark Jones*

14. Minutes_Board of Directors - Public meeting_050225.pdf (9 pages)

2 min

15. Action Log

Discussion *Mark Jones*

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

5 min

16. Research Story

Information

10 min

17. Chair's report and stakeholder update

Information *Mark Jones*

17.1. Charitable Funds update

Information *Kevin Parker-Evans*

17.1. Board of Directors Charitable Funds April 25.pdf (9 pages)

10 min

18. Chief Executive's report

Information *Mary Fleming*

18. CEO Board Report_Apr 2025_FINAL.pdf (5 pages)

15 min

19. Integrated performance report

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

19. Board of Directors IPR M11 2425 FINAL.pdf (4 pages)
19a. M11 2425 Integrated Performance Report FINAL.pdf (17 pages)

19.1. Better Lives Programme update

19.1. WWL Board - System Priorities Update - 02 April 2025.pdf (22 pages)

15 min

20. Board Assurance Framework

Information *Steven Parsons*

20. BAF Report Board April 2025 final.pdf (31 pages)

30 min

21. Committee chairs' reports

Information *Non Executive Directors*

21.1. Quality and Safety

Information *Francine Thorpe*

21.1. AAA.QS - March 2025.pdf (2 pages)

21.2. Finance and Performance

Information *Julie Gill*

Report to follow due to close proximity to the meeting.

21.3. People Committee

Information *Mark Wilkinson*

21.3. AAA - People Committee - Feb 2025.pdf (2 pages)

21.4. Audit Committee

Information *Simon Holden*

21.4. AAA - Audit Committee - 20 Feb 2025.pdf (2 pages)

21.5. Research Committee

Information *Clare Austin*

21.5. AAA - Research - Mar 2025.pdf (2 pages)

10 min

22. Finance Report

Information *Tabitha Gardner*

22. Trust Finance Report 24-25 February Month 11 Board.pdf (16 pages)
22. Trust Finance Report February 2025.pdf (2 pages)

10 min

23. Partnerships report

Information *Richard Mundon*

23. Trust Board - Partnerships Report April 2025 FINAL (no highlights).pdf (7 pages)

10 min

24. 7-day services report

Information *Sanjay Arya*

24. Seven Day Services Audit 2024-25.pdf (11 pages)

3 min

25. Reflections on equality, diversity and inclusion

Discussion *Mark Jones*

Consent Agenda

0 min

26. Risk appetite statement FY 2025/26

Approval *Steve Parsons*

26. Risk Appetite 25-26 v3.pdf (19 pages)

0 min

27. Use of the Common Seal

Information

27. Use of the common seal.pdf (5 pages)

0 min

28. Gender pay gap report

Information

28. Gender Pay report for board.pdf (10 pages)

0 min

29. Modern Slavery and Human Trafficking statement

Approval

29. Modern slavery statement 2025-2026.pdf (4 pages)

0 min

30. Maternity Dashboard Reports

Approval

30. Maternity Dashboard report February 25.pdf (10 pages)
30a. Maternity Dashboard - Feb 25.pdf (3 pages)
30b. Neonatal Dashboard - Feb 25.pdf (3 pages)

0 min

31. Audit Committee annual report

Information

00 Audit Committee annual board report and cover sheet.pdf (7 pages)

0 min

32. Date, time and venue of the next meeting

Information

04 June 2025, 1.15pm, Trust Headquarters

Agenda item: 14.1

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

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

NON-EXECUTIVE DIRECTORS	
Name	**Declared interests**
AUSTIN, Claire	Employed by Edge Hill University as Pro-Vice-Chancellor and Dean of the Faculty of Health and Social Care and medicine Son works for NR Barton Ltf (CHRN: 11530910) as a Trainee Auditor
BRADLEY, Rhona	Trustee, Addiction Dependency Solutions charity Governor, Learning Training Employment (LTE) Group Non-Executive Director, Home Group Housing Association Spouse is The Rt Hon Lord Bradley of Withington
GILL, Julie	Nil declaration
HOLDEN, Simon	Chairman of Governors, Pear Tree Academy School Director, Simon Holden Associates Limited (CRN: 09546681) Non-Executive Director, LocatED Property Ltd (No: 10385637)
JONES, Mark	Nil declaration
LOBLEY, Lynne	Nil declaration
MOORE, Mary	Director and shareholder, Scenario Health Ltd (CRN: 13066776) Non-Executive Director, Stockport NHS Foundation Trust
WILKINSON, Mark	Employed by NHS Cheshire and Merseyside as Cheshire East Place Director

	Non-Executive Director and Vice Chair, Bolton At Home Ltd Non-Executive Director, Mastercall Healthcare Governor, Edge Hill University Director and shareholder, Fairway Consulting Services Ltd (CRN: 13767002) Wife employed by Lancashire County Council public health department Son works for Mersey and West Lancs NHS FT
THORPE, Francine	Independent Chair, Salford Safeguarding Adults Board

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

PARKER-EVANS, Kevin	Spouse is Head of Safeguarding and Designated Adult safeguarding nurse for NHS Greater Manchester (Stockport Locality) Honorary Senior Clinical Lecturer at Edge Hill University
PARSONS, Steven	Self employed as a Football Referee Shareholder, BT Group Shareholder, Lloyds Bank Group Shareholder, Fuller, Smith and Turner PLC (family shares, arises from previous employment) Member, Nationwide Building Society Member, Newcastle Building Society (through merger with Manchester Building Society) Member, Co-Op Group Committee member, East Cheshire Harriers and Tameside Athletics Club Member, Campaign for Real Ale

Board of Directors - Public meeting

Wed 05 February 2025, 13:30 - 16:15

Room 16, Floor 3, Wigan Life Centre (South)

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Sanjay Arya (Medical Director), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Sarah Brennan (Chief Operating Officer), Mary Fleming (Chief Executive), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Richard Mundon (Deputy Chief Executive), Mary Moore (Non-Executive Director), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Kevin Parker-Evans (Chief Nurse), Simon Holden (Non-Executive Director), Steve Parsons (Director of Corporate Governance), Juliette Tait (Chief People Officer)

Absent: Aydin Djemal (Development Non-Executive Director), Francine Thorpe (Non-Executive Director)

Presenters

Shatha Attarbashi (Obstetrics and Genealogical Consultant, Present at: 26), Natalie Garforth (Present at: 26), Selina Morgan (Freedom to Speak Up Guardian, Present at: 27), Cathy Stanford (Divisional Director for Maternity and Neonates, Present at: 26)

In attendance

Nina Guymer (Head of COrporate Governance and Deputy Company Secretary (Minutes)), Hameeda Khan-Davey (Development Non-Executive Director), Member of the public (1), Member of the public (2), Member of the public (3)

Meeting minutes

14. Declarations of Interest

Information

Mark Jones

The table of declarations was noted. No further declarations were made.

14.1. Register of directors' interests

Information

Mark Jones

14.1. Directors DoIs - Feb 2025.pdf

15. Minutes of the previous meeting

Approval

Mark Jones

The Board **APPROVED** the minutes of its last meeting noting them to be a true and accurate record.

15. Minutes_Board of Directors - Public Meeting _041224.pdf

16. Action Log

Discussion

Mark Jones

16. Public Board Action Log 2024.pdf

16.1. University Teaching Hospitals update

Information

Richard Mundon

The Deputy Chief Executive had been asked to provide an update on the current position with shared posts and deferred to the Medical Director who reminded the Board that the University Hospital Association (UHA) requires trusts to have a minimum number of 6% (or 13) of the consultant workforce with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. The guidance does not clarify whether the individuals may have a different profession (such as a nursing background) and therefore the UHA are being asked to consider this as a way forward, particularly as it supports the direction of travel of the wider NHS towards alternative workforce models. The application will be submitted on 27 March 2025. He clarified that after this it is likely to be a few weeks before the status is confirmed. He agreed to report back on this at the next meeting.

ACTION: S Arya

Prof C Austin announced that Edge Hill University have now attained medical school status, noting that at least 50% of the students in the first co-hort are from a wider demographic background.

17. Patient Story

Information

Kevin Parker-Evans

A patient story was shared which highlighted failure at several levels to discharge a patient with his medication, instead meaning that he had stayed in a hospital bed for longer than necessary at a time when a critical incident had been declared.

It was noted that the ward and team involved would be engaged with and encouraged to share the story with and colleagues.

18. Chair's report and stakeholder update

Information

Mark Jones

The Chair begun by expressing thanks on behalf of outgoing Lead Governor Andrew Haworth, to the Board, the executive support and corporate affairs teams. He went on to congratulate Prof S Arya on his recent award of an OBE for services to Black and Minority Ethnic Doctors and Healthcare in North-West.

He reported upon recent discussions around ensuring that items reported at the public board meetings are appropriately aligned and positioned on the agenda, hence the integrated performance report being moved towards the start of the agenda. Further, the assurance committees' workplans would be reviewed to ensure that all areas requiring focus are addressed at the appropriate time and by the right set of people.

He then shared a update on his contact with external stakeholders since the last meeting.

19. Chief Executive's report

Information

Mary Fleming

The Chief Executive presented the report which had been shared prior to the meeting.

In addition to the updates included within the report, she wished to thank the Chief Finance Officer for supporting the achievement of surgical hub accreditation and the move of significant theatre activity to the Wrightington site. The Medical Director expressed thanks to the consultant team who have embraced the move of this number of theatre lists to the Wrightington site.

She also thanked the Chief People Officer for her support to reduce the pay bill in a strategic and safe way, ultimately helping to spend the Wigan pound in a better way.

Lady R Bradley noted that significant challenges remain, appreciating the importance in bringing staff along on the journey and asked how it will be ensured that staff are well briefed in an honest way which provides the right balance of information and support.

The Director of Communications and Stakeholder Engagement advised that there are two main monthly touch points, being 'All Staff Team Brief' and 'Leaders' Forum' as well as other communications such as vlogs and updates, which are intentionally executive led. She also highlighted the need to talk about contentious issues more widely as a Trust, such as escalating areas within the urgent care facility, as staff speak about these kinds of things amongst themselves and this can result in a lack of clarity or negative feelings around a lack of information.

The Chief People Officer added that WWL have a strong relationship with staff side and trade union colleagues, this transparency supports a collaborative approach to making changes or decisions which impact staff.

Following a query raised about WWL's position on social media, in particular in relation to the platform 'X'. the Director of Communications and Stakeholder Engagement noted that this is a watching brief, for WWL currently this is a very positive space but she appreciated that in terms of the NHS as a whole, there have been challenges and that GM will take a joint decision on whether 'X' will continue to be utilised.

The Chief Executive noted how positive social media can be and emphasised that the Trust can utilise it to share very real messages for public support - such as A&E being full.

The Board noted the update.

19. CEO Board Report_Feb 2025_Final.pdf

20. Integrated performance report

Information

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

The Director of Strategy & Planning summarised the report and comments were invited from lead executives in each area.

Mr S Holden noted that virtual wards are at 50% capacity versus a target of 80% but yet escalation remains high. He therefore asked when and how efforts to increase virtual care and reduce occupancy will step up.

The Chief Operating Officer noted a move to a new digital platform which will support more patients to be virtually cared for and a review of how virtual wards can be used in combination with other elements of care would be occurring shortly. Staff are in place to screen cases daily to identify those suitable for virtual care but she acknowledged that this can and should be expanded at pace.

21. Board of Directors M9 2425 IPR.pdf
21a. Board of Directors IPR_M9_2425.pdf

21. Committee chairs' reports

Information

Non Executive Directors

The non-executive directors listed presented their respective reports.

21.1. Quality and Safety

Information

Mary Moore

The Medical Director responded to the alert around CO3 regarding adolescent diabetic care to advise that paediatricians have been asked to make contact with youth workers, who are, in turn in contact with the patients concerned. The positive aspect of this being a less 'medical' approach, which may feel less overwhelming for younger people, was noted.

Lady R Bradley noted that the Safeguarding Effectiveness Group recently heard that the collective action of GPs in Wigan means that they are not delivering collective care in terms of safeguarding. She reported that she has prompted the safeguarding representative from the Integrated Care Board to raise this issue, as the locality will need system support to resolve this problem.

A discussion ensued around the difficulties with shared care and that the connectivity between different parts of the overall health system can be very challenging.

22.1. AAA.QS - Jan 2025.pdf

21.2. Finance and Performance

Information

Julie Gill

The report was noted.

22.2. AAA - FP - Jan 2025.pdf

21.3. People Committee

Information

Mark Wilkinson

The Deputy Chief Executive reported on a 35.9% staff take up of the flu vaccines but that this means that WWL are in the middle of the pack in terms of the local system.

Mrs M Moore asked if the Trust monitors those who had not been vaccinated and have been sick returning to work, further, she asked if there has been any correlation between sickness absence reasons and vaccination data.

This has not been done but it was noted that this would be possible and agreed that it could be useful and added to the 'return to work' form.

The Chief People Officer described WWL's new People and Culture Strategy, which focusses on keeping staff well and safe; workforce planning transformation; embedding positive and health cultures through shared values; equality diversity and inclusion. She agreed to circulate this to board members for information.

ACTION: J Tait

It was suggested that the strategy comes to an upcoming workshop or away day.

22.3. AAA People - Dec 2024.pdf

22. Board Assurance Framework

Information

Steven Parsons

The Board considered each of the four objective pillars as set out, noting confidence that there had been no changes since the last meeting.

The Deputy Chief Executive noted that the partnerships pillar and its objectives are owned by the Board rather than its committees. He reccomended that, in light of the £2.3m received for work on LED lighting, which would reduce the Trust's carbon footprint, the risk around the delivery of the net--zero healthcare provider target is reduced.

The Board **AGREED** and were content for him to report this back to the Head of Risk for amendment to the document.

20. BAF Report Board February 2025.pdf

23. CQC review of UEC

Information

Kevin Parker-Evans

The Chief Nurse provided a presentation which summarised recent visits by regulators and partners supporting improvement at WWL. He highlighted several areas of assurance in respect of each and went on to summarise the actions which were set following the visits. He made it clear that the Trust does not accept that corridor care should be normalised but nevertheless, as it is happening, there had been a need to ensure that provisions are available to make those patients more comfortable, such as eye masks to shield them from the corridor lights during the night.

The Chief Operating Officer and Medical Director expressed support for the way forwards set out, noting that WWL has responded to patient needs proactively, through the Lived Experience Group and the 'nurse in charge' hotline.

The Chair asked whether the plan is to bring this soon

In response to a query from the Chair around how fast the

The Chief Operating Officer advised that a directorate is being created for discharge and flow so that the teams concerned report through one management route and have clear leadership.

The Chief Executive made it clear that the Better Lives Programme will not deliver alone and requires input from internal hospital programmes and partners such as the Emergency Care Improvement Support Team (ECIST). She noted that each assurance committee should maintain oversight on areas within its remit.

The Chief People Officer agreed and asked whether there could be an opportunity to enhance and modernise A&E through capital funding, with the Medical Director highlighting that Wigan's A&E is one of the smallest in the region, contrasted with the levels of deprivation and demand on the service.

The Deputy Chief Executive advised that there is likely to be capital funding of this nature and that WWL must be on the front foot in terms of preparing potential bids in readiness.

Mr S Holden noted that the Chief Executive had said that the key metric in considering whether A&E is operating effectively is length of stay and asked what the best way of reporting this is.

The Chief Executive explained that trusts must collect data on all inpatients with a length of stay of one night or longer. This data is split by those who meet the criteria to reside and those who no longer meet the criteria to reside, data is signed off by a senior manager and submitted on a weekly basis.

The report was received and noted.

23. ED Safety Quality & Assurance FEB 25.pdf

24. Safe Nurse Staffing Bi-annual review

Discussion

Kevin Parker-Evans

The Chief Nurse introduced the report noting that it provides an opportunity for him to provide assurance to the Board based on his professional opinion on the staffing position.

Prof C Austin noted that the ratios were set in 2017 and asked if there will be a review of whether these are still appropriate, which the Chief Nurse confirmed.

She further asked whether the unregistered staff category does not include allied health professionals.

The Chief Nurse explained that this is the case due to technical reporting requirements and noted the issue that this creates with the Chief Allied Health Professional undertaking a review of where members of this staff group are working and how.

The Chief People Officer noted that, as well as being a practical approach, using a model of blended professionals will allow better control in terms of managing the uplift of substantive staff

Mr M Wilkinson wished to clarify that whilst the report provides assurance, this is only noted to be in respect of core clinical areas and therefore felt unassured in terms of the escalated areas, which are utilised on a regular basis. He asked which assurance committee should keep this under review.

The Chief Nurse suggested that this would be People Committee and agreed to take this forwards. He explained that the report is required to cover specific areas and does not account for escalated areas. He emphasised the need to consider the report in triangulation with how the rest of the hospital is performing, utilising an alternative workforce or moving staff to cover busier areas, rather than investing in more staff.

ACTION: K Parker Evans

The Board noted the nurse staffing establishments and **APPROVED** the recommendations detailed within the report, noting the recommendation that the transformation work continues with no investment in staffing or increase in headcount to be made at the current time.

It felt assured that the inpatient wards and departments are safely staff without the need for further investment, moving forwards it was clarified that any areas requiring additional investment will progress business cases through the correct governance routes, the position to be detailed through this report, although without a descision on investment being sought.

24. Bi- Annual Nurse Staffing Review September 2024 inc Exec Summary FINAL.pdf

25. Finance report

Information

Tabitha Gardner

The Chief Finance Officer summarised the report which was shared in advance of the meeting, noting that the Trust is optimistic that its plan will be reached at year end.

The Chief Executive queried how likely it is that the risk around clawback of income from several ICB contracts will materialise and asked what is influencing this position.

Following her response that part of this is due to the Leigh Community Diagnostic Centre being underused, the Chair asked how this has happened.

The Deputy Chief Executive advised that this is largely since assumptions were made about the amount of activity which would be given to the Trust through different avenues, including the ICB itself.

The Chief Operating Officer added that WWL are working with the ICB to ensure that surgical hubs are the first patient choice option for regular hip knee hand and hernia operations. Hernias in particular would be handled at the Leigh site.

The Board received and noted the report which had been shared prior to the meeting.

25. Board Cover Sheet - Trust Finance Report December 2024.pdf
25a. Trust Finance Report 24-25 December Month 9 Board.pdf

26. Maternity reports

Information

Kevin Parker-Evans

The Divisional Director for Maternity and Neonatal Services and her team joined the meeting, introduced by the Chief Nurse who explained that the papers are presented for approval for the Clinical Negligence Scheme for Trusts (CNST).

She began by advising the an oversight panel has reviewed the evidence for the year with the ICB who were content with the evidence submitted. All 10 safety standards have been met and therefore approval is requested for the Chief Executive to sign the submission form.

Mr S Holden observed that the figures do not quite add up in terms of the births detailed and made a suggestion that figures are reviewed prior to submission.

The Chief Executive congratulated the team for the work to meet the standards.

26.1. CNST Presentation

Cathy Stanford, Shatha Attarbashi, Natalie Garforth

26.1. CNST YEAR 6 Quadrumvirate Presentation Feb 2025 (updated) Substantive.pdf

26.2. Consultant Attendance Audit

The Board received and noted the report.

26.2.Cons attendance to Nov 24.pdf

26.3. Updated Paediatric Tier 1 Action Plan

The Board received and noted the report.

26.3. (4.13) TIER 1 ACTION PLAN DECEMBER 2024 UPDATE.pdf

26.4. Q3 Perinatal Quality Surveillance Report

The Board of Directors reviewed the contents of the paper to provide oversight and assurance that there are effective systems of clinical governance and monitoring of safety for maternity and neonatal services.

26.4. Perinatal Quality Surveillance Q3 24-25 Oct-Dec 24 (For Board).pdf

26.5. PMRT Report

The Board received and noted the report.

26.5. Perinatal Mortality Report 2024 For Board.pdf

26.6. Biannual maternity staffing paper

She noted that the Trust is required to submit the maternity biannual staffing review twice in the each 12 month reporting period and that this is the second of the two papers. WWL had been asked specifically to evidence compliance around provision of one to one care in labour; that they have in place a supernumerary shift coordinator at the start of every shift and their escalation processes should those requirements not be in place.

The Board noted the 25% staffing uplift which had been endorsed by the Quality and Safety Committee but unable to be effected due to the financial position. The Board noted that this will allow for the increased training needs to comply with Saving Babies Lives and The Maternity (and Perinatal) Incentive Fund Year 6/7 training requirements. It noted that the final Ockenden Report also recommends that average sickness levels from the previous 3 years, maternity leave, and annual leave (inclusive of the 'birthday leave' scheme) is calculated within the uplift.

26.6.Biannual Staffing Report December 2024 V3.pdf

27. Freedom to Speak Up Guardian's report

Information

Selina Morgan

The Freedom to Speak up Guardian joined the meeting to summarise the report.

The Chief People Officer felt assured by the report, she noted the high volume of people wishing to remain anonymous and wondered if there may be something to be considered around encouraging staff to feel confident to give their name, which ultimately will help the Trust to target support in response. On reflection there was a concern that this may be a result of the style of leadership. The executive team agreed to consider and report back on this at the next meeting.

ACTION: J Tait

Prof C Austin noted a lack of concerns around patient safety or quality and asked if the Board feel assured that staff are aware that this type of concern can and should be raised through the FTSU route.

The Chief People Officer noted that it can be difficult to make it clear that the service is not just for individual staff concerns, since it is often based within a HR team in particular.

The Guardian advised that leadership and management support sessions would soon be delivered which would be utilised to address both issues. She added that all of the cases reported currently do have an impact ultimately on patient safety.

The Board received and noted the report.

27. FTSU Board Report 21.01.25 v4.pdf

28. Health inequalities update

Information

Richard Mundon

The Deputy Chief Executive summarised the report which was shared in advance of the meeting.

The Chief Executive noted that there has been a reduction in the number of smokers and also incidents of falls lately and noted the need to analyse what has been done to result in these positive outcomes.

A discussion ensued around utilising a workshop to support a discussion around what factors should be monitored in terms of health inequalities and how partnership working can support a reduction in equalities, with a particular focus on safeguarding and paediatric care. It was noted that health inequalities reports are scheduled to be reviewed by the board biannually and that one would be scheduled at an upcoming Board workshop.

28. Health Inequalties Board Paper 2024_25 update.pdf

29. Reflections on equality, diversity and inclusion

Discussion

Mark Jones

The Board felt that it has become much more aware of quality, diversity and inclusion as well as health inequalities related considerations and was pleased to note that Edge Hill University's great work in increasing the number of students from a wider demographic background in it's most recent medical school co-hort.

Consent Agenda

30. Maternity Dashboards

Information

30c. Optimisation Dashboard - Dec 24.pdf
30b. Neonatal Dashboard - Dec 24.pdf
30. Dashboard report December 24.pdf
30a. Maternity Dashboard - Dec 24.pdf
30e. Perinatal Exception Report - Dec 24.pdf
30d. Perinatal Dashboard - Dec 24.pdf

31. Annual Sustainability report 2023/24

Information

The Board **APPROVED** the report.

31. Annual Sustaniability Report - Front Cover.pdf
31a. Annual Sustainabilty Report 24 25.pdf

32. ED&I annual report

Approval

The Board noted the report.

32. EDI front sheet.pdf
32a.EDI Annual Report 2023 - 2024 final.pdf

33. Guardian of Safe Working Hours

Information

The Board noted the report.

33. GOSWH Quarter 3 Oct to Dec 2024.pdf

34. Safeguarding annual report

Approval

The Board noted the report.

34. Safeguarding Annual Report 2023 2024 FINAL.pdf

35. Date, time and venue of the next meeting

Information

02 April 2025, 1.15pm, Trust Headquarters

Action log: February 2025

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Feb 2025	16.1/25	University Teaching Hospitals update	Report back on application progress.	S Arya	2 Apr 2025	
5 Feb 2025	*24/25*	*Safe Nurse Staffing Bi-annual review*	*Provide assurance on the staffing of escalated areas for the People Committee.*	*K Parker Evans*	*Referred to People Committee.*	---
5 Feb 2025	21.3	People Committee AAA	Circulate the People and Culture Strategy to board members.	J Tait	4 Jun 2025	Not yet due.
4 Dec 2024	193.4/24	People Committee AAA	Consider whether anything additional can be done to support Board members to speak up where they have concerns.	J Tait	4 Jun 2025	27/25 saw an additional request for input on how staff can be encouraged to give their name when reporting.
4 Dec 2024	194/24	Workforce Race Equality Standard and Workforce Disability Equality Standard (WRES and WDES)	Consider whether any other Board focussed updates should/could be provider wider than the assurance given to the People Committee.	J Tait	4 Jun 2025	Not yet due.

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board of Directors Charitable Fund Update April 2025

Charitable Funds Operational Steering Group

- First meeting held 11th March 2025
- ToR agreed
- Membership agreed
- Enthusiastic conversations r.e the group and strategic delivery of charity moving forward

Charitable Funds Operational Manager appointed

- Emily Mundon has been appointed as Interim Charitable Fund operational Manager (via NHSP)
- Commence's in post Monday 24th March
- Recruitment of Fixed term post is running in parallel to Emily starting

Fundraising Update- Hoodies

- Go live April 2025
- £5000 Direct Charity Fundraiser
- £4.50 Charity input per garment >200

Fundraising update-OTIS project

- Mobile Calm carts now in situ
- Fundraising for sensory room continues currently c.£12K
- Extremely positive feedback already through neurodiverse network r.e mobile calm carts

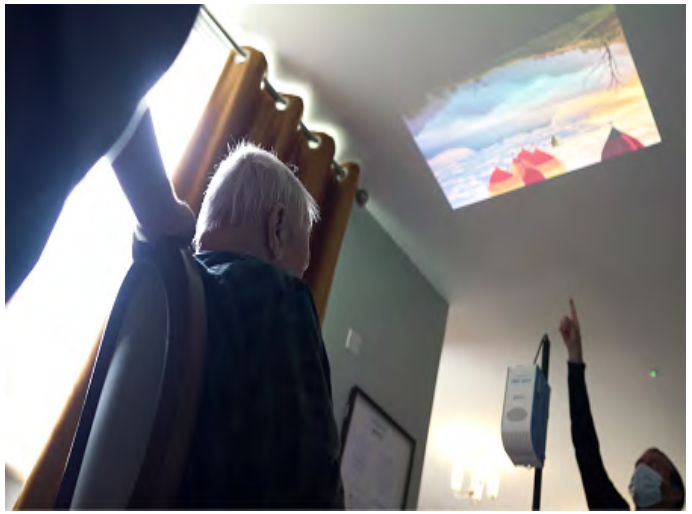
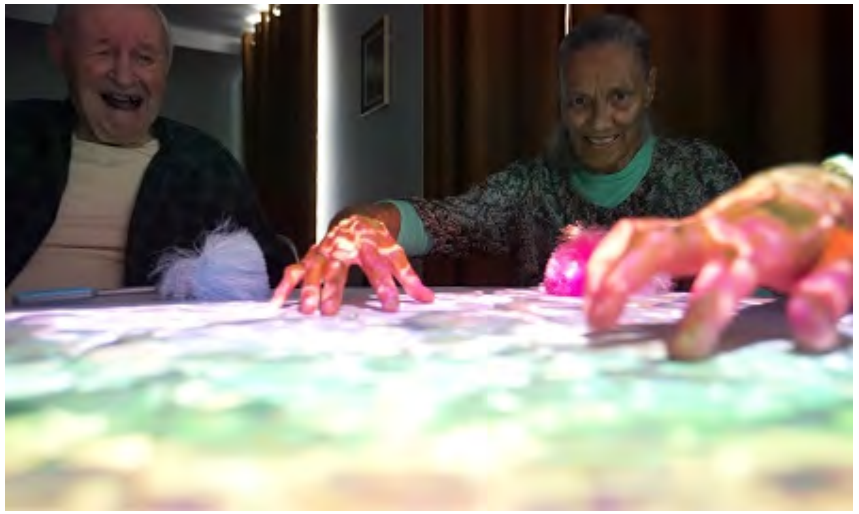
Fundraising update- Orell Ward

- Orell specific fundraising following care of a patient
- Sofology staff (where the patient worked) completed the Silver How challenge in the Lakes
- £3,200 raised from challenge
- £1,000 further donated from Sofology
- 3 recliner chairs donated to the ward
- Total funds raised c.£10K

Successful Applications- Jolly Trolley CAU

- Cost £6,720
- Aims
  - Interactive Diversional therapy
  - Reduction in Hospital Acquired Functional decline
  - Reduction in Enhanced care
  - Reduction in Falls
  - Increase in Cognitive stimulation

Approved Applications- Happiness Programme


- To be led by patient experience team
- To reduce trust wide hospital acquired functional decline ambitions
- Support sundowning
- To work in parallel with Enhanced care review

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Thank you

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	02 April 2025
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
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Executive summary

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

Link to strategy and corporate objectives

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

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

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

Recommendation(s)

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

Improving Patient Waiting Times
Our Urgent and Emergency Care Services continue to experience a pressured position. However, positive steps were made during a March internal sprint initiative, which saw our teams work together to improve performance and increase the number of patients seen within the 4-hour care standard in the Emergency Department (ED) and Urgent Treatment Centres. The month saw some excellent days of performance against the locally agreed standard and reducing the requirement for temporary escalated areas. We are working to embed and sustain this during April, but there are still improvements to make to ensure our patients are treated in a timely manner and long waits are eradicated in a sustained way. Considerable improvements have also been made with WWL's diagnostic performance, going from 17.07% in January to 9.97% waiting over six weeks in February. Regarding our Electives, we continue to work towards being compliant with the 18-week, 52-week, and Urgent and Emergency Care standards in line with the Operational Planning Guidance for 2025/26.

It is crucial we make these improvements for our Wigan Borough residents, working with our system partners to ensure that everyone has fair and equitable access to healthcare and the best possible outcomes for life. This is underpinned by our Better Lives programme of work. This programme continues to develop and progress, with a System Visibility dashboard now in place, enabling joined-up place-based conversations about how we care for our residents from the moment they enter our ED to their discharge from hospital and the onward care they receive from both health and care colleagues to obtain the best possible outcomes and effectively lead a better life. WWL will also be further driving efficiencies and productivity into the new financial year through working closely with primary care to ensure that we maximise the use of advice, guidance, and validation of patients on waiting lists and reduce the number of Did Not Attends (DNAs).

Cleanest Acute Trust
WWL was named as the cleanest Acute Trust in the country for the second year running out of 123 Trusts. Patient-Led Assessments of the Care Environment (PLACE) assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services of a Trust might be enhanced. For 2024, WWL has taken first place nationally, and first place within the North West (NW) for all Acute Trusts. This is a fantastic achievement as over the last seven years, WWL has been consistently placed within the top ten per cent of the country, showing a consistent improvement in the environmental services we provide within our patient care areas. The PLACE assessments took place across all Trust sites including the Royal Albert Edward Infirmary, the Thomas Linacre Centre and six of the community premises owned by WWL.

National Staff Survey 2024
The 2024 National Staff Survey results were published in March 2025. The annual survey is the largest workforce survey in the world and provides invaluable insight into our colleagues' experiences across the NHS. This year, 774,828 NHS staff took part. At WWL, we are committed to providing staff with a safe, engaging, and thriving working environment, and as an organisation, we embrace our Trust value of "Listen and Involve". The results of the survey help us understand how staff feel about working in our organisation, what we're doing well, and what we may need to change or improve. We're pleased to see that we are top in Greater Manchester for the theme 'Morale' and above the sector (acute and community Trusts) for the fourth year running. We have also continued to score the highest in Greater Manchester for 'We are Safe and Healthy'. However, our response rate is not where we need it to be. The response to the survey this time took a slight dip to 35% (37% in 2023). Whilst this equates to over 2500 staff informing us what it is like to work at WWL, this doesn't provide an accurate reflection of the views of the wider workforce. WWL is committed to the delivery of our People and Culture Strategy which already starts to address some of the issues raised, and to gain further insight, the Executive Team will be leading a number of engagement events in Spring, open to all staff, and will also target specific staff groups to ensure we are focussed on what matters most to our colleagues.

Investments and Developments

It was a pleasure to welcome MP for Leigh and Atherton, Ms Jo Platt, to officially open our Theatre Suite Development and the opening of a fourth theatre at Leigh Infirmary in March. This development has enabled the site to become the Trust's main centre for breast surgery, with a new state-of-the-art, ultra-clean theatre and recovery area supporting the existing three theatres on the site. This means patients from the area will have less distance to travel and more options will be available to those needing to attend Leigh Infirmary for surgery.

At the end of March, we opened the brand-new Theatre 12 to patients at Wrightington Hospital, following the opening of Theatre 11 at the site in October last year. Both developments will lead to improved productivity and increase WWL's capacity to reduce waiting lists for patients awaiting orthopaedic surgery. The new theatres and supporting recovery areas further reinforce Wrightington Hospital's Surgical Hub status, establishing WWL as the NW Centre for Orthopaedic excellence, due to our technical expertise and resources. Surgical Hub sites are intended to deliver a high volume of low-complexity procedures, which will be key to tackling long waiting lists. Theatres 11 and 12 have been designed specifically to focus on these kinds of procedures, such as soft tissue knee surgery and low-complexity joint replacements.

In February, friends and family of a much-loved health advocate gathered to celebrate the naming of a new room in his name. WWL's Clinical Research Hub in Ashton-in-Makerfield officially opened the 'Greenwood Room', in recognition of former WWL Governor and Patient Research Advisor, Bill Greenwood OBE, and his service to the Trust. The 'Greenwood Room' is an accessible space to welcome local residents and health and care staff, to talk about, and take part in, research. Bill's contribution to the group and the research field led to WWL researchers wanting to make sure that he be fittingly recognised.

WWL is to be awarded £2,148,000 towards solar panel funding installation across multiple sites from the UK Government and Great British Energy. The healthcare sector can play a vital role in helping the UK adapt to a changing climate and reducing its carbon footprint and WWL recognises the impact of our activities on the health of current and future generations. This funding will certainly help us to create a sustainable future and support us in achieving our Net Zero strategy by 2045. WWL will install 3,235 solar panel modules by April 2026, at all three hospital sites as well as community locations.

Working Towards Financial Sustainability

And finally, NHS finances have continued to be in the headlines over the past few months, and the financial performance for WWL remained challenging as we approached the end of the financial year. However, month 11 showed notable progress, with a material reduction in risk compared to earlier months. Our position improved in both month 10 and 11, delivering an in-month surplus and reducing our year-to-date deficit. I'm pleased to report that divisional Elective Recovery Fund performance has also seen an improvement. The Specialist Services Division met their plan, in value, in month due to the continued effort of the team. The Medicine and Surgery divisions continue to exceed their activity plans. Our year-to-date performance remains below the plan, but ongoing action with the Getting It Right First Time team continues to support activity delivery.

Regarding Cost Improvement Plan (CIP) delivery, we are now delivering in line with plan. Unfortunately, a significant element of this delivery has not been achieved recurrently, impacting our planned financial sustainability and future years CIP requirements. The deficit funding received this year has ensured we haven't required external cash support this far. However, based on our current run rate, external cash support will be necessary in 2025/26. Our underlying financial position has improved from £30m in our Financial Sustainability Plan to a forecast closing 24/25 position of £26m; a £4m improvement. Whilst this is less than our plan set out, it is progress towards our financial sustainability goal.

Looking ahead to 2025/26, the financial challenges are set to continue. The 2025/26 CIP plan is a significant stretch and in excess of anything WWL has delivered previously. The focus will be on our CIP being delivered recurrently with every pound being a reduction on our expenditure run rate and real cash out of the organisation. We have undertaken a robust planning process to ensure the organisation has a challenging but credible plan which has also been reviewed externally at the request of the Regional and Integrated Care Board.

A strong focus on transformation and continued grip and control are essential to our success in 2025/26, whilst continuing to maintain patient safety and high quality of care for our patients.

Title of report:	Month 11 24/25 Integrated Performance Report
Presented to:	Board of Directors Meeting
On:	2nd April 2025
Item purpose:	Information
Presented by:	Deputy Chief Executive
Prepared by:	Principal Data Analyst, Data Analytics and Assurance
Contact details:	BIPerformanceReport@wwl.nhs.uk

Executive summary

The latest update of the Trust's Integrated Performance Report (IPR) for Month 11, which covers the period of February 2025, is presented to the Board of Directors.

During Month 11 operational pressures remained heightened within the Trust, despite improved performance around our 4hr waits, the number of patients remaining in the Emergency Department (ED) longer than 12 hours is high, resulting in the congestion and overcrowding of the ED. In order to decompress the Emergency Department there has been the continued requirement to maintain the opening of escalation capacity, resulting in continued escalation temporary staffing spend. The cost of escalation showed a decrease in Month 11 compared to the previous month but is still high and represents a risk to delivery in 25/26. The lower level of escalation spend in Month 11 is likely to be associated with fill rates and not direct spend. The Better Lives programme aims to support the work to improve this position and continues at pace.

There has been an increase in the Grade 3 and 4 Hospital acquired Pressure Ulcers which has triggered a Trust wide After-Action review, the review will determine any links to the length of stay that patients are staying within the Emergency Department prior to being admitted to assessment Units. Whilst there was a slight decrease in the number of falls in Month 11, three of those falls resulted in moderate or above harm. The team continue to work hard in relation to the complaints process with Month 11 seeing a compliance of 73%, there is a direct correlation with the number of complaints received and the Trusts operational pressures. There was a 112% increase in plaudits in Month 11 and an increase in the number of complaints resolved informally.

Month 11 mortality metrics are good. The Summary Hospital-level Mortality Index (SHMI) continues to show a sustained improvement and Hospital Standardised Mortality Ratio (HSMR) remains below target. More up to date analysis through the Healthcare Evaluation Dat system

supports this improving trend and collaboration with Advancing Quality Alliance (AQuA) provides insight into further areas for improvement. There were no “never events” in February.

Month 11 encouragingly saw Trauma & Orthopaedics hit their plan on value with a general overperformance on value for Elective Recovery Fund (ERF). We are working with the Integrated Care Board (ICB) to agree an outturn position. Revenue was in surplus, and this represented an improvement on previous months. We are on plan to deliver our planned £800k deficit in 24/25. Our Cost Improvement Programme (CIP) is due to deliver in total with previous underperformance recovered. Recurrent CIP is not delivering to planned levels, and this is reflected in our 25/26 financial challenge. Grip and control processes remain in place. The cash balance was higher at £18.8m in Month 11 and is above plan mainly due to timing differences between receipt and payment of invoices. However, the £8.9m control total funding has now been received, and the cash requirement for 25/26 is under review. The level of run rate and cash releasing CIP delivery will be critical to this.

In month 11 we are still predicting some breaches against the 65 and 78 week wait targets. Patient choice is a significant factor in this. The position is dynamic as we continue to scrutinise and focus on long waiters to improve the year end position. For 65 weeks, there are only two areas with capacity breaches – these being in dermatology and gynaecology. We are declaring zero 104-week breaches, however due to the misapplication of watch and wait 'W' codes, there is some residual risk. Work is being undertaken to minimise this impact. The original investigation into the usage of these codes in December identified a total of 7,310 potential Referral to Treatment (RTT) pathways, spanning back to 2018, that may have been incorrectly administered and required validation. Of these, 2995 could have been 104+ week waiters. So, reaching this position represents a significant achievement and the removal of the “W” code as an option, reports that flag potential misapplication of codes and routine data quality meetings provides assurance that this issue will not recur. Work is still continuing to improve the position regarding the percentage of patients waiting less than six weeks for diagnostics, particularly for Non-obstetric Ultrasound (NOUS). This is showing an improving position, and progress continues with the mutual aid project.

The Month 11 improvement in 4-hour A&E waits at 67.8% looks to be sustained into the March Sprint and the increased focus on ED transformation has had a significant impact in reducing corridor care. We have committed to a standard of 71% in March. Bed occupancy is below target at 95%, but this is primarily a result of a reclassification of our General and Acute (G&A) bed base, rather than any reduction in pressure across our acute site.

Our people metrics show sustained improvement on the whole. Sickness levels decreased in Month 11 but are still not within our agreed minimum standard of 5.5%, which continues to be driven by operational pressures. Vacancy rates are also presenting above our accepted tolerance of 5%, but when compared with other organisations are low as a result of stringent vacancy controls, particularly among our nursing and midwifery cohort of staff. Turnover reports consistently below the standard of 8.5%, reflecting the ongoing work to implement good employment practices, including our new flexible working policy. Executives will be holding “listen and involve” engagement sessions with staff to understand how we can go even further to improve staff experience and sustain the reduced turnover. The performance on appraisals is the subject of renewed focus through divisional assurance meetings.

83.82 whole time equivalents (WTE) have been transacted year to date as at Month 11 compared with the plan of 158.75 WTE, a gap of 74.93 WTE (47%). At month 11 there is an unidentified gap for the year end of 54.02 WTE which will be mitigated in year through over delivery of the Mutually Agreed Resignation Scheme (MARS), which will be transacted in Month 12.

Link to strategy and corporate objectives

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

Risks associated with this report and proposed mitigations

There are no risks currently associated with the report.

Financial implications

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

Legal implications

None currently identified.

People implications

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

Equality, diversity and inclusion implications

None currently identified.

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

Executive Team Meeting 19.03.25 and 26.3.25.

Recommendation(s)

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

Report

Please see the enclosed M11 IPR report.

Appendices

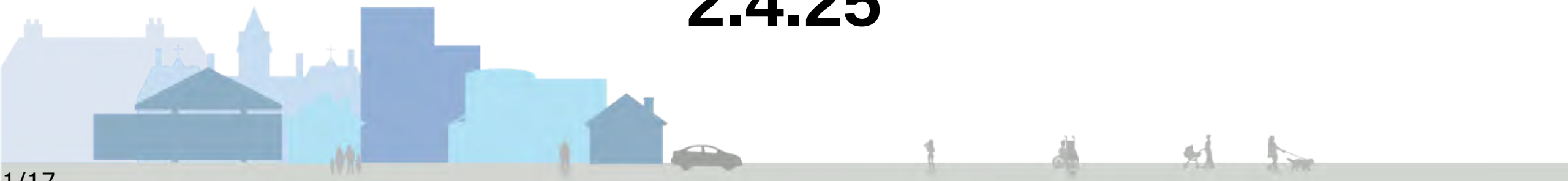
None.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M11 24/25 Integrated Performance Report

Board of Directors Meeting

2.4.25



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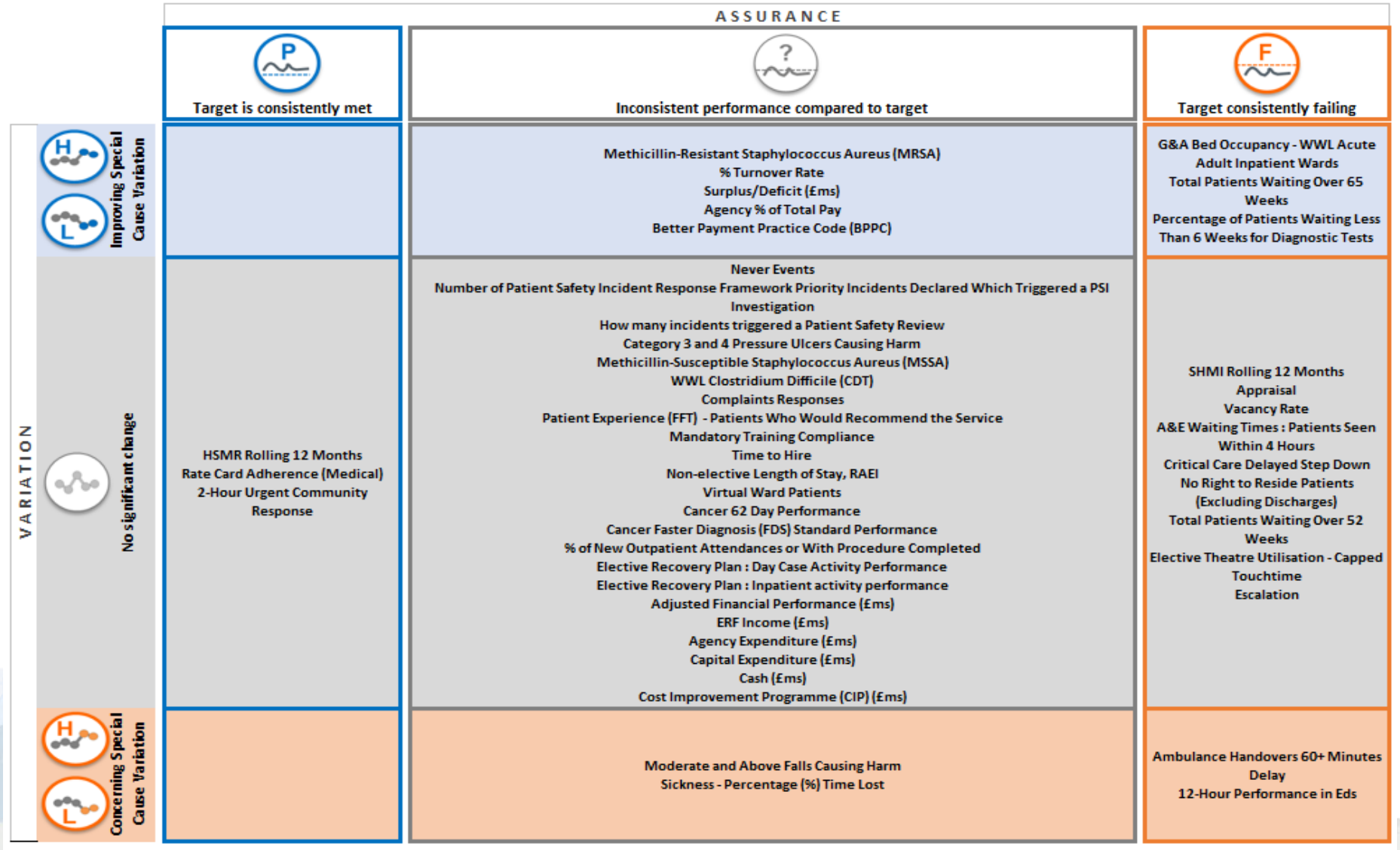
Trust Matrix : M11 February 25



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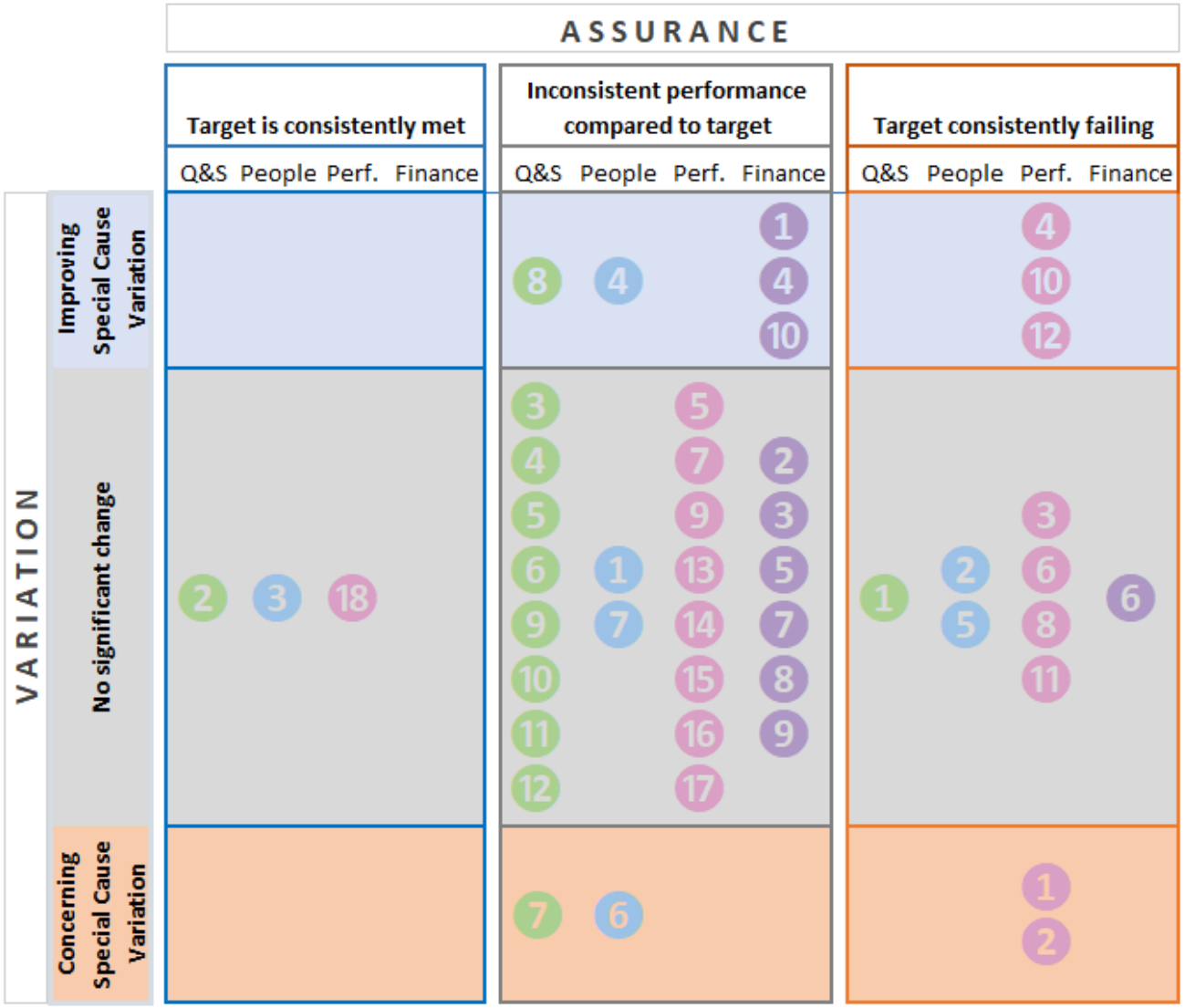

Quality & Safety KPIs

1. SHMI Rolling 12 Months
2. HSMR Rolling 12 months
3. Never Events
4. Number of Patient Safety Incident Response Framework priority incidents declared which triggered a Patient Safety Incident Investigation
5. How many incidents triggered a Patient Safety Review
6. Category 3 and 4 Pressure Ulcers causing harm
7. Moderate and Above Falls causing harm
8. Methicillin-Resistant Staphylococcus Aureus (MRSA)
9. Methicillin-Susceptible Staphylococcus Aureus (MSSA)
10. WWL Clostridium Difficile (CDT)
11. Complaints Responses
12. Patient Experience (FFT) - Patients who would recommend the service

People KPIs

1. Mandatory training compliance
2. Appraisal
3. Rate card adherence (Medical)
4. % Turnover Rate
5. Vacancy rate
6. Sickness - %age time lost
7. Time to hire

Performance KPIs

1. Ambulance handovers 60+ minutes delay
2. 12-hour performance in EDs
3. A&E waiting times : patients seen within 4 hours
4. G&A Bed Occupancy - Acute Adult Inpatient Wards, WWL
5. Non-elective Length of Stay, RAEI
6. Critical Care Delayed step down
7. Virtual ward patients
8. No Criteria to Reside Patients (excluding Discharges)
9. Cancer 62 day performance
10. Total patients waiting over 65 weeks
11. Total patients waiting over 52 weeks
12. Percentage of patients waiting less than 6 weeks for diagnostic tests
13. Cancer faster diagnosis (FDS) standard performance
14. % of new outpatient attendances or with procedure completed
15. Elective Theatre Utilisation
16. Elective Recovery Plan : Day case activity performance
17. Elective Recovery Plan : Inpatient activity performance
18. 2-hour urgent community response

Finance KPIs

1. Surplus /Deficit (£ms)
2. Adjusted Financial Performance (£ms)
3. ERF Income (£ms)
4. Agency % of Total Pay
5. Agency Expenditure (£ms)
6. Escalation (£ms)
7. Capital Expenditure (£ms)
8. Cash (£ms)
9. Cost Improvement Programme (CIP) (£ms)
10. Better Payment Practice Code (BPPC)

Trust Holistic Narrative : M11 February 25

During Month 11 operational pressures remained heightened within the Trust, despite there being an improved performance around our 4hr waits, the number of patients remaining in the Emergency Department (ED) longer than 12 hours is high, resulting in the congestion and overcrowding of the ED. In order to decompress the Emergency Department there has been the continued requirement to maintain the opening of escalation capacity, resulting in continued escalation temporary staffing spend. The cost of escalation showed a decrease in Month 11 compared to the previous month but is still high and represents a risk to delivery in 25/26. The lower level of escalation spend in Month 11 is likely to be associated with fill rates and not direct spend. The Better Lives programme aims to support the work to improve this position and continues at pace.

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Quality & Safety Overview: M11 February 25

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	SHMI Rolling 12 Months	Oct 24	105.05	100		F	105.03	103.82	106.23
2	HSMR Rolling 12 months	Dec 24	92.64	100		P	91.52	89.39	93.64
3	Never Events	Feb 25	0	0		?	0	0	2
4	Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation	Feb 25	0	4		?	3	0	9
5	How many incidents triggered a Patient Safety Review	Feb 25	22	33		?	29	0	56
6	Category 3 and 4 Pressure Ulcers causing harm	Feb 25	4	0		?	2	0	6
7	Moderate and Above Falls causing harm	Feb 25	3	1	H	?	2	0	5
8	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Feb 25	0	0		?	0	0	0
9	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Feb 25	0	0		?	1	0	6
10	WWL Clostridium Difficile (CDT)	Feb 25	6	5		?	6	0	18
11	Complaints Responses	Feb 25	73.2%	90%		?	65.0%	39.1%	91.0%
12	Patient Experience (FFT) - Patients who would recommend the service	Feb 25	87.4%	86.7%		?	87.1%	80.6%	93.6%

Summary icons key:

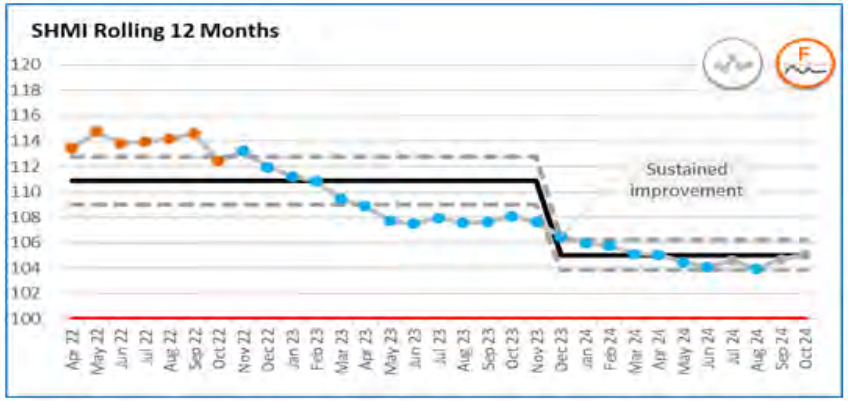
Quality & Safety Narrative: M11 February 25

SHMI / HSMR
The Trust most up to date SHMI from Oct 2024 is 105.05 which is still well within the 'funnel plot' for expected range. As a comparison to GM Peers, SHMI values range from 94.11 to 118.30, with WWL having a proportionately lower bed base. HSMR remains strong for WWL at 92.64, with GM comparisons ranging from 85.12 to 120.83.

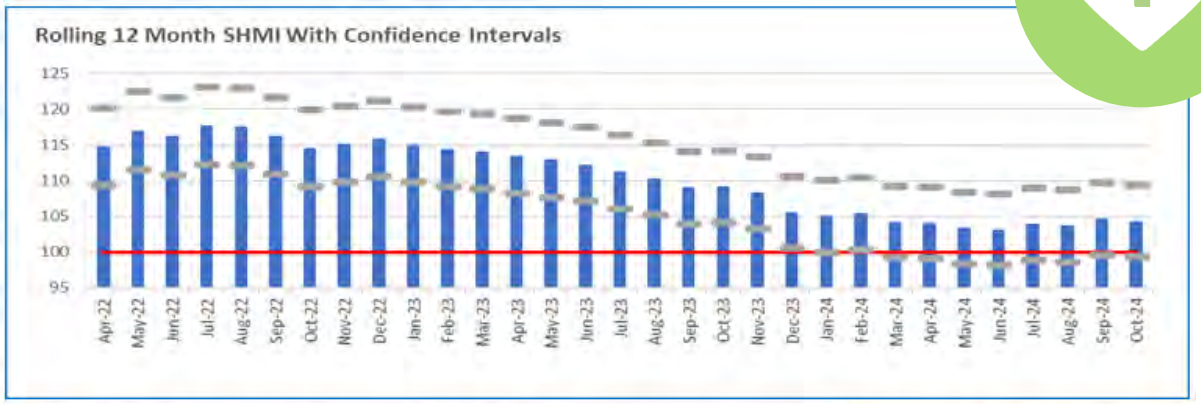
Incidents
In month 11 (February 2025), the Trust did not escalate any incidents as a PSII. However, in line with the Patient Safety Incident Response Framework (PSIRF), 22 additional Patient Safety Reviews (PSRs) were commissioned. The main themes identified from these reviews were related to the management of deteriorating patients and diagnostic delays. Deteriorating patients remain one of our highest reported incident categories. To support ongoing improvement efforts, the Deteriorating Patient Group continues its work, with a focus on strengthening early recognition and response strategies. A multi-professional learning event scheduled for 26 March has been arranged, which will be facilitated by the Medical Director. This event aims to enhance shared learning and drive improvements in patient safety across the organisation.

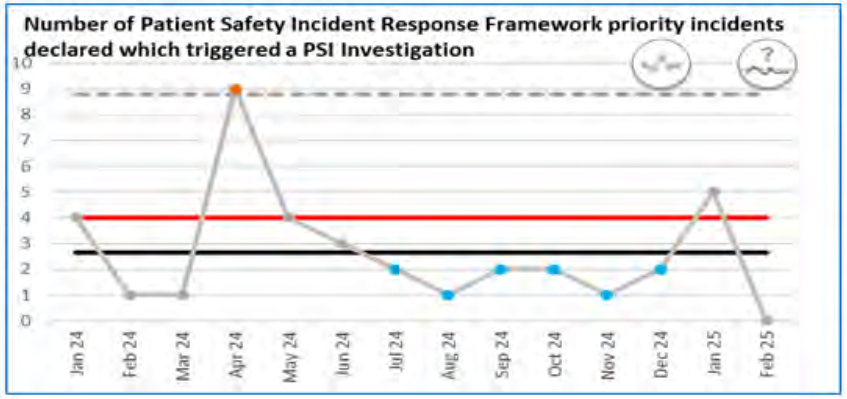
Complaints
The Trust saw an increase in complaints responses up to 74%. Whilst not at the level we have aspired for, this is an increase in recent months. Complaints fortnight meetings continue with the Executive Chief Nurse and Divisional Directors of Nursing to provide support and scrutiny.

Quality & Safety Insight Report: M11 February 25

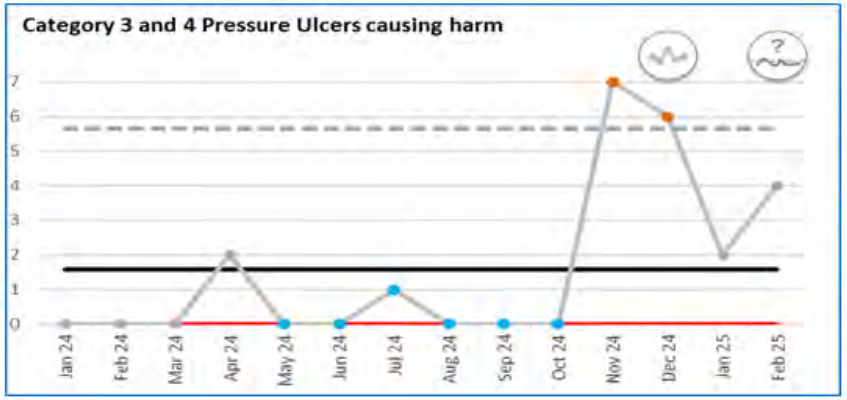


Sep-24
105.05
Variance Type
Common cause variation
Target
100
Target achievement
Metric is constantly failing the target





Jan-25
2
Variance Type
Common cause variation
Target
0
Target achievement
Inconsistent performance compared to target



Feb-25
4
Variance Type
Concerning special cause variation point
Target
0
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
SHMI Monthly and quarterly mortality review groups continue to review any areas of SHMI that are alerting and seek assurances that these are being managed appropriately. **Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI investigation:** There were 0 PSIs commissioned, but in line with PSIRF and our local priorities 22 PSRs were undertaken. **Category 3 and 4 Pressure Ulcers Causing Harm** There continues to be a spike in pressure ulcers; these are being reviewed via usual processes with any themes and trends being investigated.	**SHMI** Continue improvement plans to ensure that patients are appropriately managed Work with system partners to ensure appropriate discharge placements for patients **Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI investigation:** Themes identified were in relation to deteriorating patients and diagnostic delays with learning informing the improvement work being undertaken by the respective groups. **Category 3 and 4 Pressure Ulcers Causing Harm** Following completion of the Action Reviews, an over arching action plan has been developed. In addition, a thematic review has been commissioned to look at any recurring themes for incident where lapse in care has been identified for the past 12 months.	**SHMI** SHMI is currently within national expected range 'funnel plot' and has been so for many months. Both SHMI and HSMR are continuing to fall and are now better than some other similar sized GM Trusts **Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI investigation:** Quarterly monitoring of local priorities relating to these themes inform the Learning from Experience group. **Category 3 and 4 Pressure Ulcers Causing Harm** The improvement plan and outputs from the thematic review will be monitored via Harm Free Care group and Learning from Experience Group.

Our People Overview : M11 February 25

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Mandatory training compliance	Feb 25	94.9%	95%		?	94.9%	94.1%	95.8%
2	Appraisal	Feb 25	81.0%	90%		F	82.0%	80.8%	83.2%
3	Rate card adherence (Medical)	Feb 25	99.8%	80%		P	97.5%	93.9%	101.0%
4	% Turnover Rate	Feb 25	8.4%	8.5%	L	?	8.8%	8.5%	9.1%
5	Vacancy rate	Feb 25	5.3%	5%		F	6.1%	5.1%	7.1%
6	Sickness - %age time lost	Feb 25	5.7%	5%	H	?	5.4%	4.7%	6.2%
7	Time to hire	Feb 25	59.0	65		?	58.1	48.9	67.4

Summary icons key:

Our People Narrative : M11 February 25

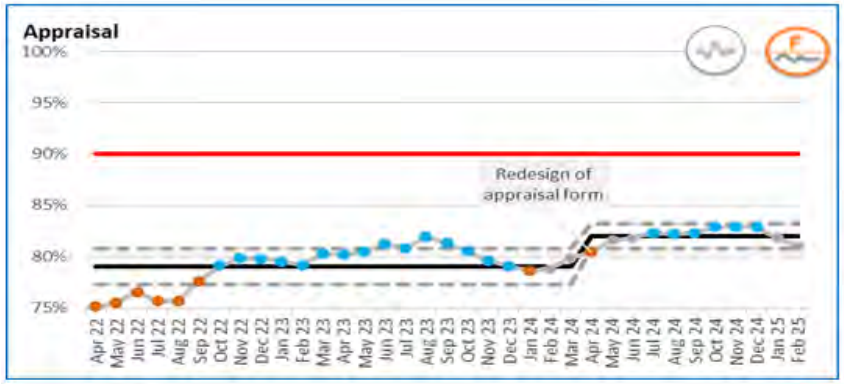
Appraisals – at 81% appraisal completion continues to remain below the Trust target of 90%. Divisions are continuing with efforts to improve compliance, which is monitored monthly through Divisional Assurance meetings. The appraisal process is due to be redesigned to embed the new Trust behaviours and values, and to make the process more useful for staff. Appraisals have been a key area of improvement identified in the 2024 National Staff Survey,and further work will be undertaken to address the feedback received.

Turnover – at 8.4% turnover remains below the Trust target of 8.5% for the fourth month and continues to represent a special cause improving variation. Reasons for leaving are consistent with previous months, with relocation, work/life balance, retirement and promotion being amongst the main reasons for staff leaving the Trust. Actions and strategies to reduce turnover are continuing, with the new Flexible Working Policy and campaign due to launch in April, along with a new leadership development programme due to commence in April. Staff Survey data has been shared with divisions, and along with the development of divisional action plans, a series of Executive Led 'Listen and Involve' engagement sessions with staff will take place across the Trust during April, to hear from staff how we can work together to improve their experience at WWL.

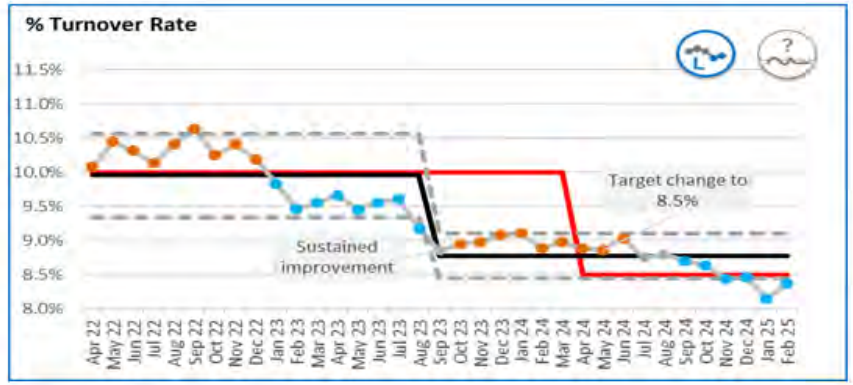
Vacancy – at 5.3% the vacancy rate continues to remain above the Trust target of 5%. Stringent vacancy control processes remain in place, although recruitment is continuing for clinical roles, with successful recruitment undertaken for Additional Clinical roles and appointments to Medical vacancies.

Sickness – The in-month sickness absence rate reduced in February to 5.7%, above the target of 5%, continuing to represent a special cause concerning variation. Both long and short term absence reduced in February, although long term absence continues to represent the greatest proportion of absence at (3.1%). The main reasons for absence remain consistent with previous months - anxiety/stress/depression (28%) coughs/cold/flu (12%), MSK (11%). A thematic review of feedback gathered as part of a review of the development of a new Wellbeing Policy has been undertaken, and the new policy is currently being drafted. The Sickness Absence Task and Finish Group is undertaking a number of actions to support a reduction in absence. Reviews on all long term sickness cases continue to be undertaken to ensure individuals are well supported.

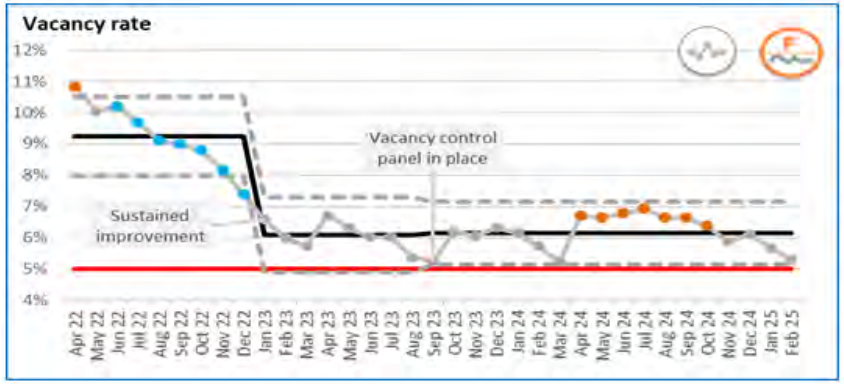
Our People Insight Report : M11 February 25



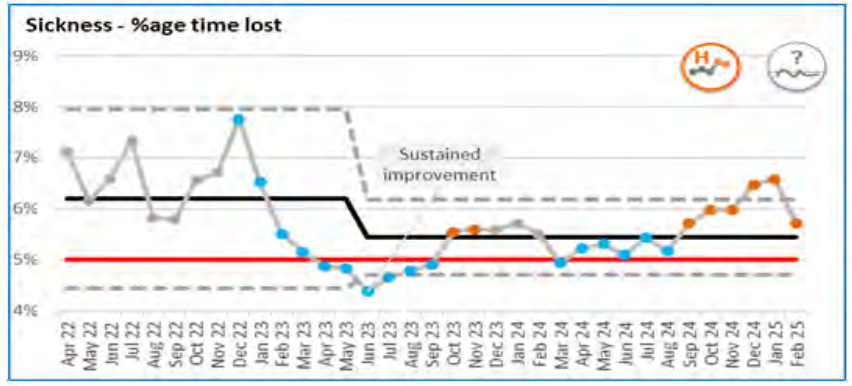
Feb-25
81%
Variance Type
Common cause variation
Target
90%
Target achievement
Metric is constantly failing the target



Feb-25
8.4%
Variance Type
Special cause improving variation
Target
8.5%
Target achievement
Inconsistent performance compared to target



Feb-25
5.3%
Variance Type
Common cause variation
Target
5%
Target achievement
Metric is constantly failing the target



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

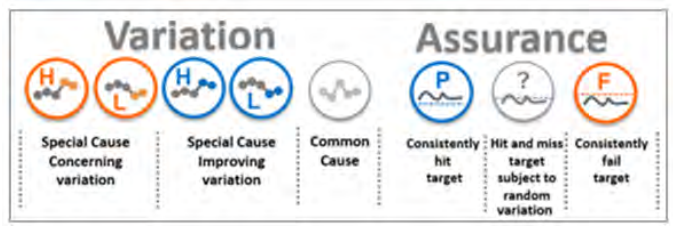
Summary:	Actions:	Assurance:
1. Appraisal rates remain below the target rate of 90%, and has not achieved the target at any point over the last 3 years 2. Turnover continues to remain below the target of 8.5% 3. Vacancy rate remains above the Trust target, although is falling due to recruitment to key vacancies and low turnover 4. Sickness absence rates continue to remain above the Trust target of 5%, although reductions in short and long term absence were noted	1. Continued monitoring of appraisal completion rates through monthly Divisional Assurance Meetings. Redesign of appraisals to incorporate Trust values and behaviours 2. Ongoing actions continuing to support retention, including launch of new Trust behaviours. Analysis of staff survey feedback to inform local action plans 3. Continued vacancy controls remain in place. Recruitment to patient facing roles ongoing 4. Action plan under development to support reduction in absence, new Wellbeing Policy being drafted	1. Data containing outstanding appraisals sent to divisions on a monthly basis. Oversight of completion percentage through Divisional Assurances Meetings and People Committee 2. Oversight and analysis of turnover rates through Workforce Metrics reports via Divisional Assurance Meetings, Wider Leadership Team Meeting and People Committee 3. Oversight of vacancy rates through Workforce Metrics reports via Divisional Assurance Meetings, Wider Leadership Team Meeting, People Committee and Finance Improvement Group 4. Oversight also via Divisional Assurance Meetings, Wider Leadership Team Meeting and People Committee, along with Sickness Absence T&F Group

Our Performance Overview : M11 February 25

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Ambulance handovers 60+ minutes delay	Feb 25	391	0	H	F	273	51	495
2	12-hour performance in EDs	Feb 25	17.8%	10%	H	F	17.2%	14.5%	20.0%
3	A&E waiting times : patients seen within 4 hours	Feb 25	67.8%	76%		F	69.2%	65.6%	72.8%
4	G&A Bed Occupancy - WWL Acute Adult Inpatient Wards*	Feb 25	95.0%	96%	L	F	99.3%	98.2%	100.4%
5	Non-elective Length of Stay, RAEI	Feb 25	4.16	4.68		?	4.07	3.46	4.69
6	Critical Care Delayed step down	Feb 25	15	0		F	18	2	33
7	Virtual Ward Occupancy	Feb 25	79.6%	80%		?	71.2%	46.6%	95.9%
8	No Right to Reside Patients (excluding Discharges)	Feb 25	115	50		F	93	65	121
9	Cancer 62 day performance	Jan 25	76.6%	70%		?	78.4%	67.2%	89.5%
10	Total patients waiting over 65 weeks	Feb 25	166	0	L	F	270	44	496
11	Total patients waiting over 52 weeks	Feb 25	1837	238		F	2241	1745	2736
12	Percentage of patients waiting less than 6 weeks for diagnostic tests	Feb 25	90.0%	95%	H	F	80.6%	76.3%	85.0%
13	Cancer faster diagnosis (FDS) standard performance	Jan 25	78.7%	77%		?	81.2%	75.0%	87.4%
14	% of new outpatient attendances or with procedure completed	Feb 25	46.5%	46%		?	45.1%	42.7%	47.4%
15	Elective Theatre Utilisation - Capped touchtime	Feb 25	81.3%	85%		F	81.5%	79.1%	83.9%
16	Elective Recovery Plan : Day case activity performance	Feb 25	100.4%	100%		?	97.1%	84.3%	110.0%
17	Elective Recovery Plan : Inpatient activity performance	Feb 25	103.3%	100%		?	104.5%	81.3%	127.6%
18	2-hour urgent community response	Feb 25	88.3%	70%		P	86.2%	77.8%	94.7%

* Please note this metric changed from G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI to G&A Bed Occupancy - WWL Acute Adult Inpatient Wards from 18/12/24

Summary icons key:



Our Performance Narrative : M11 February 25

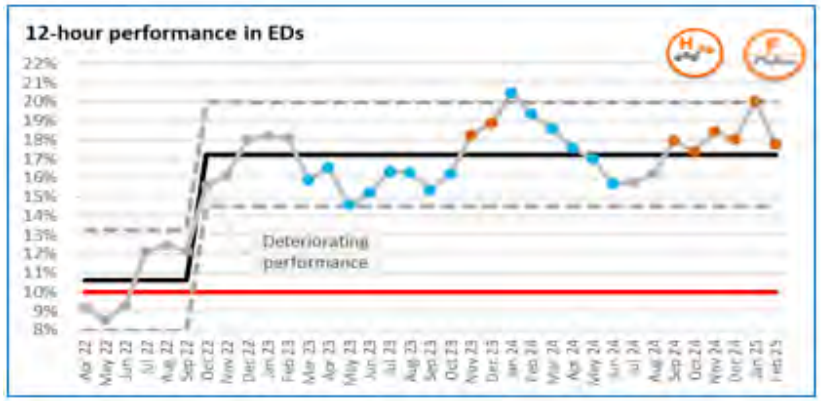
There has been some improvement in ED 4 hour standard alongside ambulance handover and 12 hour in February. Performance against the 4-hour care standard in A&E, shows a steady deterioration from August 2024 (73.84%) to January 2025 (65.34%) however this decline has been reversed in February 2025 with an improvement to 67.76%. Type 1 performance experienced a similar deterioration however improved to 52.2% in February 2025.
Failure to deliver the national standard for ambulance handovers is attributable in the main to over-occupancy in the Emergency Department and the ISAT becoming blocked. All three measures (15-, 30- and 60- minute handovers) remain in special cause concerning variation and fail to meet the 30 minute standard however performance shows an improving position in February despite ongoing operational pressures.

Virtual ward occupancy sat at 79.6% against a target of 80%. Screeners from the virtual ward team are on site at RAEI to look to identify patients who are suitable to be cared for as part of the service but further confidence and pathways need to be developed with clinicians to maximize its use and reduced bed pressures on the acute site. A decision has been made at a GM level to reduce the funding envelope for virtual ward. Further information will follow re impact on our current model.

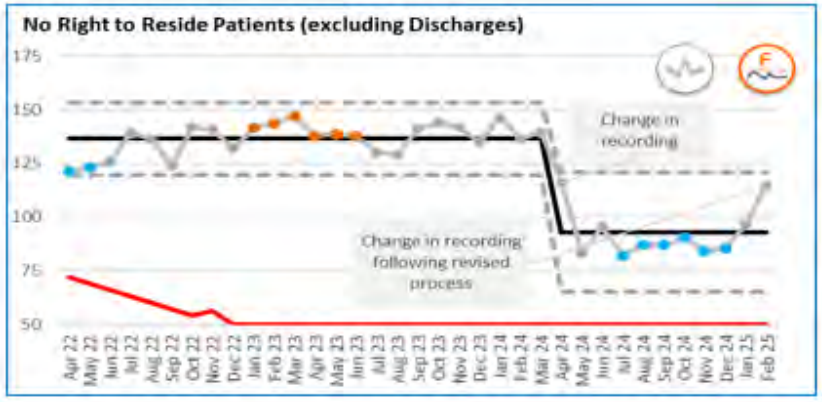
For the 65 week wait position the final the final submission at the end of February for the end of year out turn was predicted that there would be the potential that 154 would exceed the a 65 week wait, this included either patients that had chosen to defer until the following month, where still not fit (or required specialist input for example a custom implant or the type of procedure required 2 surgeons) or due to capacity. It remains that the only 2 areas were there have been capacity breaches; Dermatology and Gynecology. Significant scrutiny and focus is being given to improve the year end position. We have declared zero 104-week breaches, however ongoing work around the 'W' code means there is some residual risk of patients flipping into this category. Proactive work is being undertaken to minimise this impact.

Work is still continuing to improve the position in relation to the percentage of patients waiting less than 6 weeks for diagnostics, particularly in relation to NOUS and this is showing an improving position. The 2 hour urgent community response service continued to exceed the 70% target at 88.3%, however there has again been an increase in the number of referrals which the team have been unable to accept due to capacity whilst the service supports the Better Lives programme.

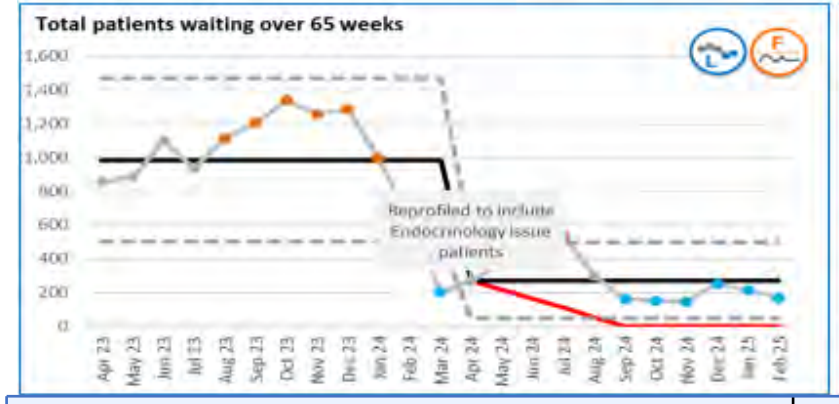
Our Performance Insight Report : M11 February 25



Feb-25
17.8%
Variance Type
Concerning special cause variation point
Target
10%
Target achievement
Metric is constantly failing the target



Feb-25
115
Variance Type
Inconsistent performance compared to target
Target
50
Target achievement
Metric is constantly failing the target



Feb-25
166
Variance Type
Special cause improving variation trend
Target
0
Target achievement
Metric is constantly failing target

Feb-25
100.4%
Variance Type
Inconsistent performance compared to target
Target
100%
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. Improvement in 12 hour performance from 20% in Jan to 18% in Feb 2. The NCTR figure has been consistently above target. There has been some data quality challenges since the changes in where the NCTR is recorded and these should hopefully now be resolved. There are numerous schemes and initiatives as part of the Discharge & Flow Programme Board and Ward Improvement Group with the aim of increasing discharges over the coming year. 3. Total number of patients waiting over 65 weeks is falling 4. Total achieved during February.	1. Implementation of strategies to increase flow through beds by identifying delays in patient's journeys. 2. Continued focus on NRTR list, safely challenging delays where appropriate - Twice weekly call chaired by ICB Deputy Place Lead to review all patients with a NCTR 4> days. - Daily review of all patients awaiting inpatient IMC to see if their needs can met at home. - Ward improvement project to further embed Red to Green principles. 3. The number of patients being dated and treated in Dermatology is reducing due to the appointment of additional locums and the use of an insourced provider. 4. Targeted focus in increasing elective activity.	1. Daily monitoring of numbers of patients in ED for more than 12 hours 2. Continued steps taken towards integration of TOCH and Acute Discharge Team alongside the increased presence of Adult Social Care on the acute site to reduce LoS for our NCTR patients. Red to Green project moving to next phase of clear allocation and accountability for actions to improve ward flow 3. Weekly 65 week mtg with COO to go through each service area. This is now progressing to 52 weeks 4. Continue to maximise all available capacity.

Our Finance Performance Overview : M11 February 25

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Surplus /Deficit (£ms)	Feb 25	0.61	-0.13	H	?	-0.77	-6.88	5.33
2	Adjusted Financial Performance (£ms)	Feb 25	0.63	-0.12		?	-0.27	-5.07	4.53
3	ERF Income (£ms)	Feb 25	10.46	10.19		?	10.06	7.81	12.31
4	Agency Expenditure (£ms)	Feb 25	0.69	0.68		?	0.79	0.49	1.08
5	Agency % of Total Pay	Feb 25	2.1%	3.2%	L	?	2.5%	1.6%	3.4%
6	Escalation (£ms)	Feb 25	0.51	0		F	0.58	0.40	0.77
7	Capital Expenditure (£ms)	Feb 25	1.96	1.87		?	1.69	0.24	3.15
8	Cash (£ms)	Feb 25	19.18	7.42		?	14.89	1.38	28.40
9	Cost Improvement Programme (CIP) (£ms)	Feb 25	3.00	2.28		?	2.46	1.92	3.01
10	Better Payment Practice Code (BPPC)	Feb 25	95.1%	95%	H	?	94.1%	90.7%	97.5%

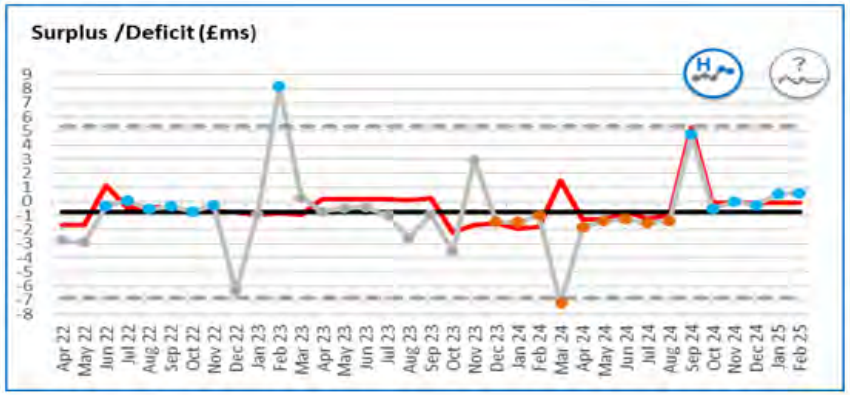
The finance slides in the IPR should be viewed alongside the monthly finance report for wider context

Summary icons key:

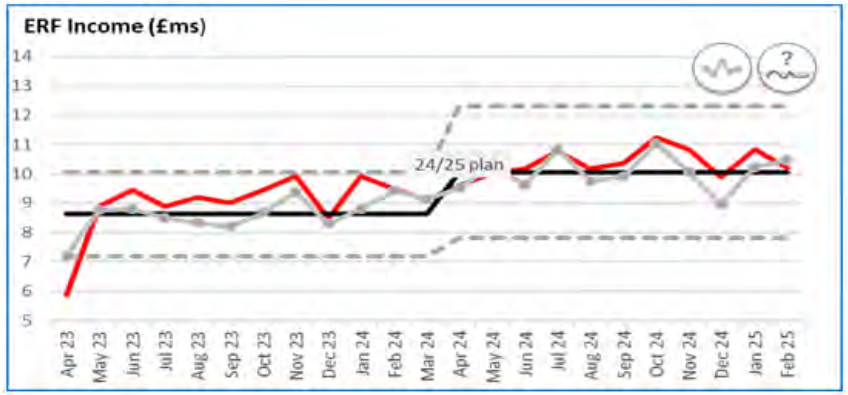
Our Finance Performance Narrative : M11 February 25

Description	Performance Target	Performance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Amber	We are reporting an actual surplus of £0.6m for month 11 (February) which is an improvement on prior months. The year to date deficit has reduced to £2.3m. The forecast provided to NHSE is to deliver the full year plan of £0.8m deficit. This will require an improvement on the current run rate of £1.6m in month to achieve the plan. Following the improvement in recent months, we expect to deliver our revenue plan for 2024/25. It is essential that pay and non pay controls remain in place to support this.
	Adjusted financial position: Achieve the financial plan for 2024/25.	Amber	
ERF Income	Achieve the elective activity plan for 2024/25.	Amber	Elective activity is £0.3m above plan in month 11 and £2.0m behind plan year to date. This includes Advice & Guidance income of £1.3m YTD which has been included for diverted activity.
Agency	To remain within the agency ceiling set by NHSE.	Amber	Agency expenditure is £0.7m in month 11, a slight improvement from last month. This is below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure. This reflects 2.1% of total pay spend in month and 2.4% YTD.
Escalation	Sustained reduction in escalation spend for 2024/25.	Green	Reported escalation costs for February was £0.7m. Expenditure decreased by £0.1m in month with reductions in discharge lounge and corridor escalation and use of 1:1 enhanced care. Additional doctors on the corridor and outlier wards are expected to continue until at least the end of March but outlier spend was lower in month.
Capital expenditure	Achieve capital plan for 2024/25.	Green	Capital expenditure in month is £0.1m behind plan and £3.0m below plan YTD. The YTD underspend is due to leases £1.9m, operational CDEL £0.6m and PDC £0.4m. PDC capital incentives of £2.3m agreed with the system for this financial year will be transacted in month 12. This is cash backed and includes £0.4m of new capital and £1.9m for the transfer of capital between CDEL and PDC.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber	There is a closing cash balance of £18.8m for February 2025 which an increase of £4.6m from last month and £11.1m above plan. This is due to timing differences in the receipt and payment of invoices. This includes £2.0m PDC capital receipts and £3.0m final instalment of education income received ahead of the corresponding cash outflows.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red	The Trust has delivered £2.3m CIP in month 11 which was on plan. The YTD position is now in balance with the plan of £25.0m. The total target is now fully identified, although a small amount remains high risk. Recurrent CIP delivery is behind plan mitigated in year by non-recurrent CIP, this will impact on the timescale to deliver the Financial Sustainability Plan.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Amber	BPPC performance to end of February is 94.6% by volume and 96.1% by value, which is a slight improvement to previous months.

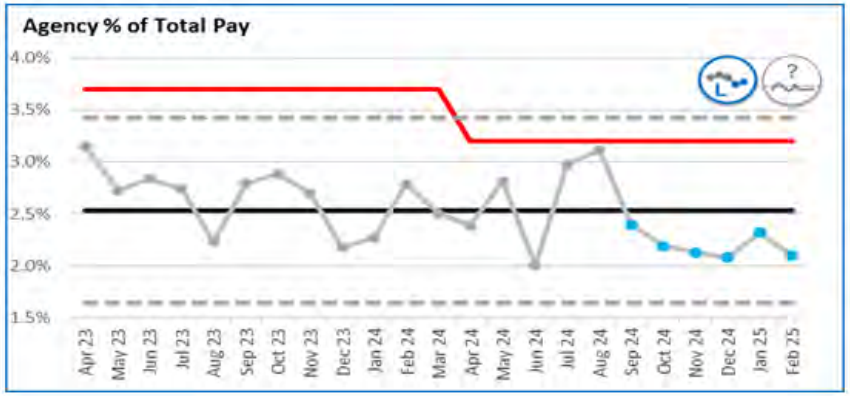
Our Finance Performance Insight Report : M11 February 25



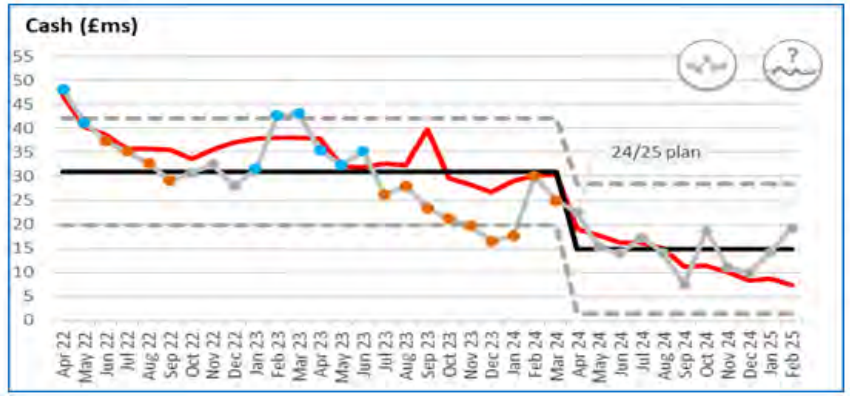
Feb-25
0.61
Variance Type
Special cause improving variation
Target
-0.13
Target achievement
Inconsistent performance compared to target



Feb-25
10.46
Variance Type
Inconsistent performance compared to target
Target
10.19
Target achievement
Inconsistent performance compared to target



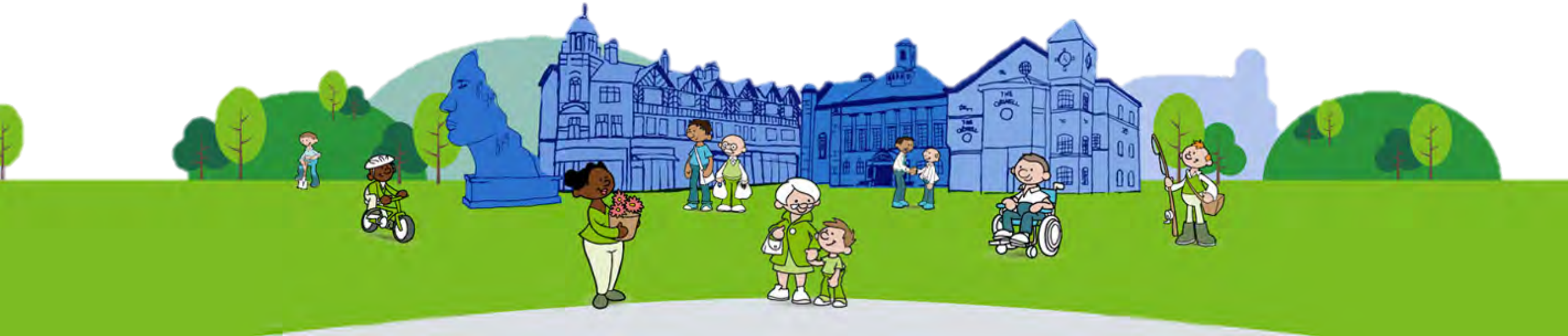
Feb-25
2.1%
Variance Type
Special cause improving variation
Target
3.2%
Target achievement
Inconsistent performance compared to target



Feb-25
19.18
Variance Type
Inconsistent performance compared to target
Target
7.42
Target achievement
Inconsistent performance compared to target

Summary:	Actions:	Assurance:
1. Actual surplus of £0.6m in month 11, £0.7m favourable to plan. The surplus in month was due to two reasons; the ERF plan was achieved in month (an improvement in run rate) and backdated education training income. 2. In month 11 we are £0.3m favourable to the internal ERF plan and £2.0m adverse YTD inclusive of advice & guidance income which has been allocated out to Divisions. 3. Agency spend in month is £0.6m, a decrease of £0.2m from prior month, therefore the trend is showing common cause variation as this is still within the typical process limits. 4. There is a closing cash balance of £18.8m for February 2025 which an increase of £4.6m from last month. In month there was £2.0m PDC capital receipts and £3.0m final instalment of education income received ahead of the corresponding cash outflows.	1. To deliver the year end plan an improvement on run rate of £1.6m is required in month 12. It is essential that pay and non-pay controls remain in place. There are several items that require concluding with GM ICB before the year end. 2. Specialist Services underperformance is predominantly due to lost theatre sessions in Trauma & Orthopaedics, and a recovery plan is in place with a further forecast improvement in month 12. 3. Grip and control measures on temporary spend remain in place. 4. Cash management strategy in place with detailed cash forecasting. As a result of the deficit support, there is a sufficient cash balance for the remainder of the year.	1. Divisional Assurance Meetings, Finance Improvement Group, Finance and Performance Committee 2. ERF is monitored at the Elective Recovery programme board and the divisional assurance meetings, both held monthly. The recovery plan for Specialist Services is executive led with updates provided to ETM. 3. Medical and Non-Medical Establishment Review Groups, Divisional Assurance Meetings, Finance and Performance Committee. 4. Cash Management Group, Finance and Performance Committee.

Wigan Locality
System Priorities Update

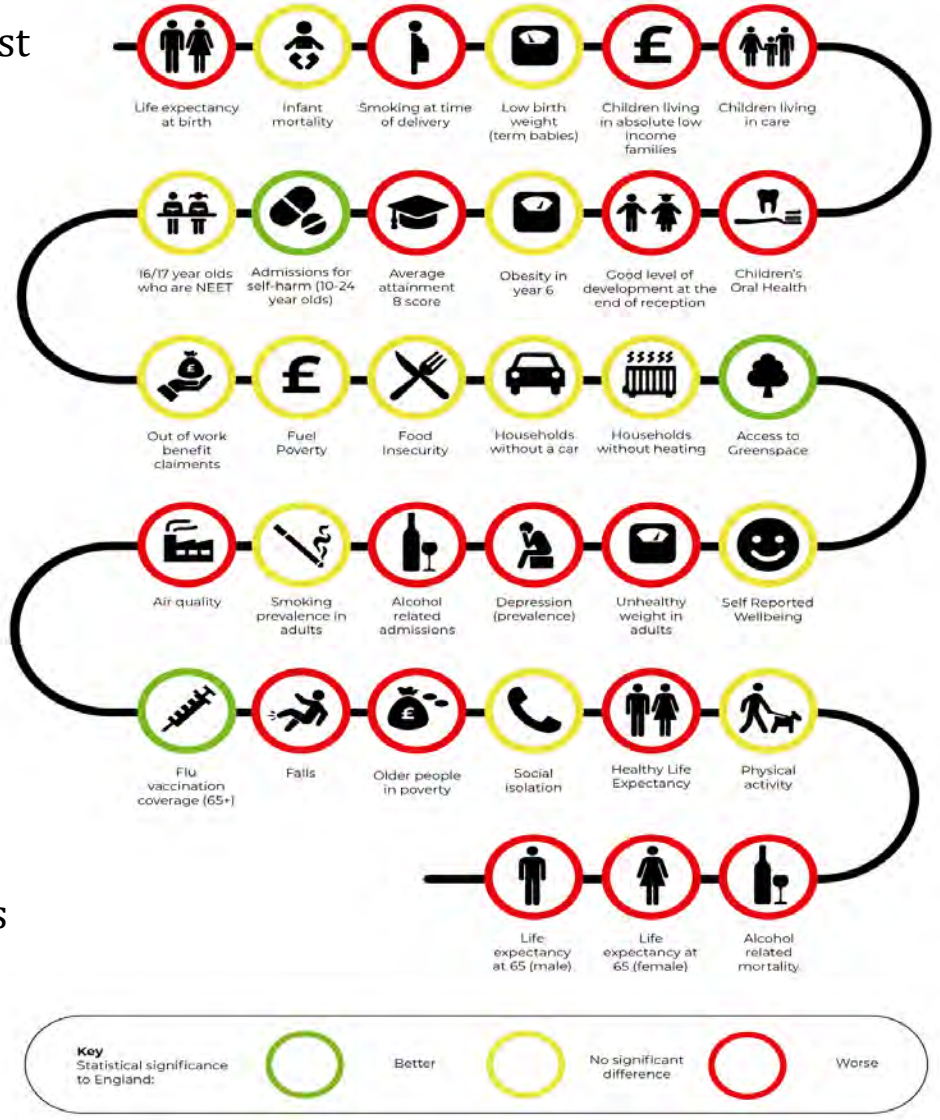


Overview

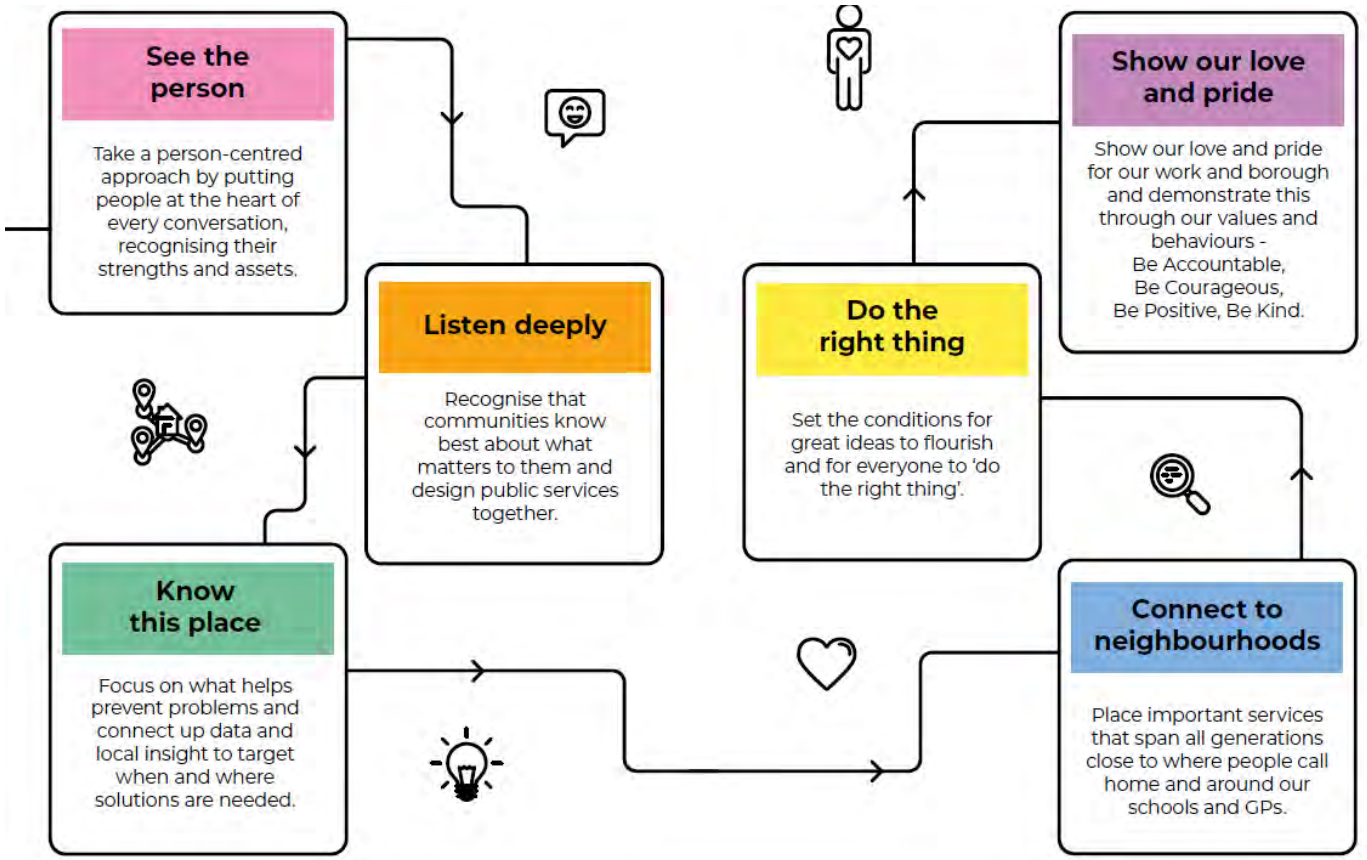
- General Overview
- Locality System Priorities
- Addressing Inequalities with Communities
- Better Lives Programme
- Improving Neighbourhood Health
- Workforce Planning Together
- Summary

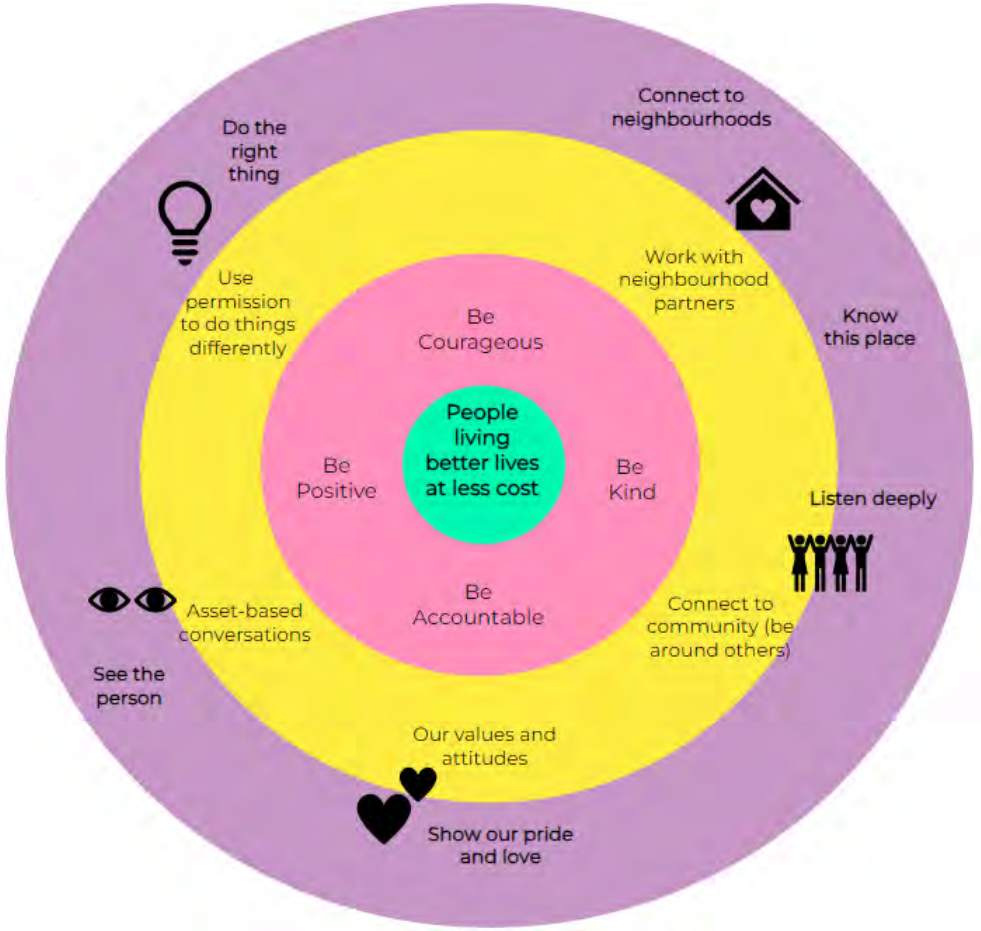
Wigan Borough

- 351,000 Patients. Ninth-largest metropolitan authority in England, with the fastest ageing population in Greater Manchester.
- The Borough covers 77 square miles, with two-thirds green space.
- Made up of 14 proud neighbourhoods and towns.
- Rich Industrial heritage and sporting tradition.
- 1 in 3 people in the borough live in the 20% most deprived areas in the country. Life expectancy below the national average.
- £800m annual investment in local health and care services. Over 16,000 people employed in health and social care.
- Strong foundation of integrated working. Our Healthier Wigan Partnership brings together local NHS, Council, Primary Care and VCSE organisations to improve population health and wellbeing.



Progress with Unity





Our Borough Missions

Our new era is a whole place movement for Wigan Borough. It draws on the strengths of our individual organisations, recognising that together we can achieve much more for our communities. This shared commitment sees us working together as one system, moving in the same direction.

Significant aspects of the delivery of the place missions will be achieved through our collaborative partnerships and strategies, including our Health and Wellbeing Strategy, Economic Strategy, Civic University Agreement and in our role as Corporate Parents.

PROGRESS WITH UNITY

Locality System Priorities

Addressing Inequalities with Communities

Better Lives Programme

Improving Neighbourhood Health

Workforce Planning Together

Locality System Priorities

Health and Wellbeing Strategy

Partners have reaffirmed their commitment to working together to put integrated health and care services at the heart of the community following the launch of Progress with Unity.

Addressing Inequalities with Communities

Addressing inequalities is at the heart of our commitment to prevention and population health. It requires a multifaceted approach focused on community engagement and partnership building on our learning through the work with Scholes and Westleigh. Engaging with residents and local leaders to tailor interventions that meet specific community needs.

Better Lives Programme

The Better Lives Programme is underpinned by a commitment to improving health and care outcomes for Wigan residents through a more integrated and efficient system. This means reducing avoidable hospital admissions, enhancing the discharge process, and strengthening community-based support to deliver the most independent outcomes possible, helping more people live safely and well in their own homes.

Improving Neighbourhood Health

Reforming community health services is essential in response to our ageing population and pressures on hospital services. We are committed to going further through an integrated service delivery model in neighbourhoods working across primary care, community and mental health, adult social care, children's services, public health and the wider voluntary sector services.

Workforce Planning Together

Workforce planning is critical to ensure a sustainable health and care workforce for the borough. Engaging young people and creating clear pathways for careers in health and care is essential. This involves collaboration with educational partners and local employers to create training and employment opportunities that are attractive to future generations.

Addressing Inequalities with Communities

Case Study : A neighbourhood partnership

- An innovative project led through primary care and the community, building community health through collaboration in a part of our borough called Westleigh.

- Addresses inequalities in partnership with the community - building on the assets, insights and opportunities of the place. Including the collective strength of health, social, community partners and residents.

- Putting it simply, we would like Westleigh to be a “nice place to live”.

- **Strengths:** community champions, schools, green spaces and GP Practice.
- **Challenges:** anti-social behaviour, drugs and crime, and a lack of trust in public services.
- **The Innovation:** activities for young people, development of green spaces, community development, reconnect with schools, intergenerational activities.

Better Live Programme

Admission Avoidance

KEY UPCOMING MILESTONES		
SDEC Working Group Live	24/03	
Refreshed Admission Avoidance Working Group Live	27/03	
Case Review Workshop	27/03	
Live CAAT and Frailty SDEC KPI tracking	31/03	
Front Door Model Patient Stories	31/03	
CAAT model evaluation sign off	08/04	
SDEC revised pathways go live	07/04	
Frailty SDEC streaming review	07/04	
Comms plan roll out	11/04	
Sustainability Matrix review	21/04	

Admission Avoidance – KPI Performance Reporting

CAAT @ FD

Daily Admissions Avoided:
The number of patients discharged by the Community Admissions Avoidance Team. Patients are avoided through increased use of community services and by intervening early into their patient journey within the emergency village.

Current
3
Daily Admissions Avoided

Baseline	Target
0	5
Daily Adms. Avoided	Daily Adms. Avoided

Frailty SDEC

Daily Admissions Avoided:
The average number of patients which are discharged by the Frailty SDEC team. Patients seen in the frailty unit will have a comprehensive geriatric assessment and may be discharged with community follow up.

Current
1.85
Daily Admissions Avoided

Baseline	Target
1.45	TBC
Daily Adms. Avoided	Daily Adms. Avoided

SDEC

Weekly Patient Flow:
The number of patients seen on weekdays by Medical SDEC. By increasing the number of patients seen in SDEC and reducing the number of non-same day reviews, SDEC can increase the number of patients that are pulled from A&E.

Current
196
Weekly Patient Throughput

Baseline	Target
155	215
Weekly Patient Throughput	Weekly Patient Throughput

PROGRESS HIGHLIGHTS

- CAAT Model extended to end of March with existing resource with some gaps due to staffing resource
- SDEC Working Group commenced 24/03
- Workstream reset workshop held to address areas of concern and agree plan for remainder of this work

KEY NEXT STEPS:

- Complete CAAT model evaluation
- Review admission avoidance case review outputs with medicine and community colleagues to inform potential improvements to model and KPI tracking

KEY RISKS/SYSTEM SUPPORT REQUIRED:

- Potential long lead time for sustainable resource for CAAT model

Admission Avoidance

Admission Avoidance – KPI Performance Reporting

CAAT @ FD

Daily Admissions Avoided: *The number of patients discharged by the Community Admissions Avoidance Team. Patients are avoided through increased use of community services and by intervening early into their patient journey within the emergency village.*

Baseline	Current	Target
0	3	5
Daily Adms. Avoided	*Daily Adms. Avoided*	*Daily Adms. Avoided*

Frailty SDEC

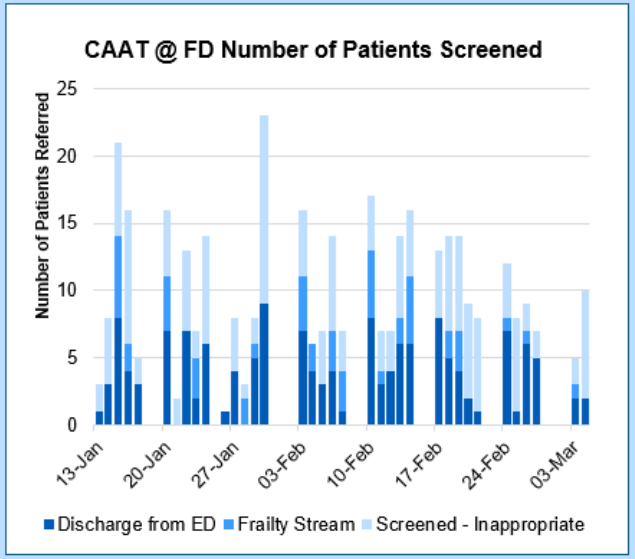
Daily Patient Throughput: *The average number of patients which are discharged by the Frailty SDEC team. Patients seen in the frailty unit will have a comprehensive geriatric assessment and may be discharged with community follow up.*

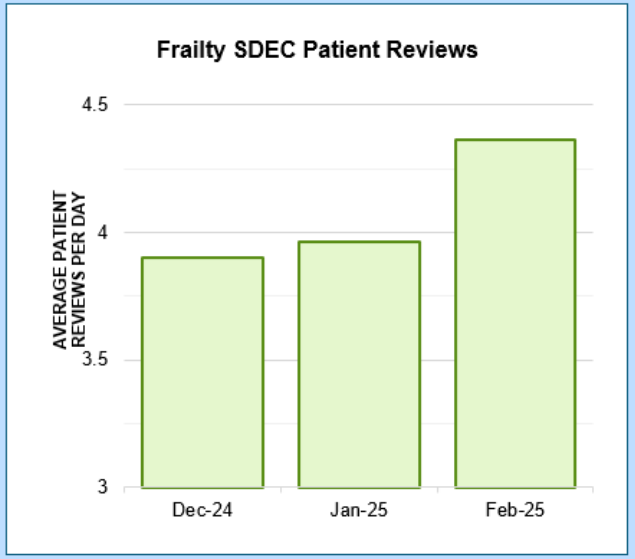
Baseline	Current	Target
1.45	1.85	TBC
Daily Adms. Avoided	*Daily Adms. Avoided*	*Daily Adms. Avoided*

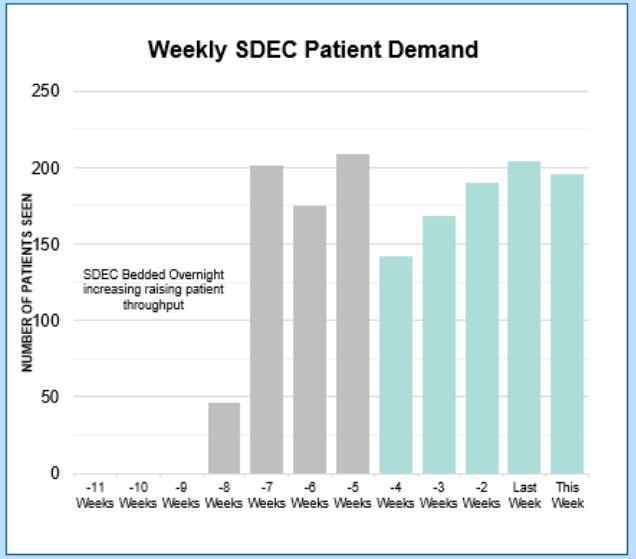
SDEC

Weekly Patient Throughput: *The number of patients seen on weekdays by Medical SDEC. By increasing the number of patients seen in SDEC and reducing the number of non-same day reviews, SDEC can increase the number of patients that are pulled from A&E.*

Baseline	Current	Target
155	196	215
Weekly Patient Throughput	*Weekly Patient Throughput*	*Weekly Patient Throughput*







Discharge and Flow

Programme Aim: To reduce total LOS for our patients. Through ensuring board rounds processes are embedded across all RAEI wards and internal processes are in place to reduce unnecessary patient delays + increase their LOS with us.

Outcome Measure:
Closure of escalation beds across the Trust, with agreed principles as to planned opening and closure, in appropriate times, such as winter pressures.

Process Measure:

Total Daily Discharges

Process Measure:

Total Pre-noon Daily Discharges

Process Measure:

NCTR as a % of occupied beds

Discharge and Flow

- Discharge and Flow has three main areas of focus:
    1) Tactical Improvements
    2) UEC Transformation
    3) Ward Improvement

- The Overarching KPIs for the programme have been strengthened by further adding A&E Performance KPIS and the COO and Chief Nurse are meeting to agree which Quality Metrics need to be included moving forward.

- Project charters for the new areas for 25/26 are currently in the process of being drafted and will be agreed at the next Programme Board along with their associated KPIs.

- Tactical Improvements : Review of OPEL Framework, Director of the Day, Review of SMOC/EXOC, SDEC Opportunities, Virtual Ward
- UEC Transformation : Ambulance Handovers, Integrated Discharge, Upstreaming Patient Attendance (Christopher Home)
- Ward Improvement : Board Round and Red2Green Rollout, Long LoS Reviews, Assessment Areas, Digital Reporting, Ward visibility of Data, Bed Reconfiguration

Community Modelling

Transfers of Care / Hospital Discharge

Our current discharge processes pathways and teams are overly complex with different teams with access to different pathways

As a result of this we know that currently:

- **Patients wait a longer than necessary time awaiting discharge**
- **Too many patients end up on a bedded pathway**

Home-Based Intermediate Care

We are currently sending patients directly to long-term packages who could benefit from reablement whilst offering reablement services to those that don't need them.

Our wider home-based intermediate care offer is under utilised.

This increases demand for long-term homecare and reduces residents' long-term independence

Short-Term Bedded Care

Our current bed-based offer is varied and often leads to patients moving between multiple facilities. Due to the high demand for these services patients often end up in short-term residential placements rather than receiving active therapy causing:

- **Longer than ideal stays in short-term bedded care**
- **Less independent outcomes for residents who have a spell in a short-term bedded facility**

What would this mean for Wigan?

2-day reduction in length of stay for pathway 1-3 patients resulting in

6000 – 9000 bed days saved each year

200 additional residents benefitting from home-based intermediate care services each year, reducing the demand for long-term homecare

50 fewer new residential placements each year

8 – 15 fewer short-term beds need to support demand through reduced starts and shorter length of stay

System Visibility / Active Leadership

System Visibility aims to improve resident outcomes and system-wide service delivery this can be tracked with the following success measures:

Independent resident outcomes
Number and size of long-term packages & placements

Improved flow/pressure/delays
Number of residents delayed across Wigan across acute &community

Outstanding service delivery
Bespoke measures for each service to manage performance

Utilising services to avoid escalations
Total hospital attendances & community service starts

System Visibility

Data

Data is shared between organisations regularly to understand entire pathways and resident outcomes and flow between services.

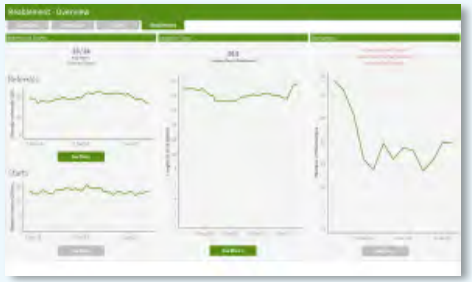
Surfacing data from source systems

Sustainable data architecture & flows

System wide data visibility & access

Insights

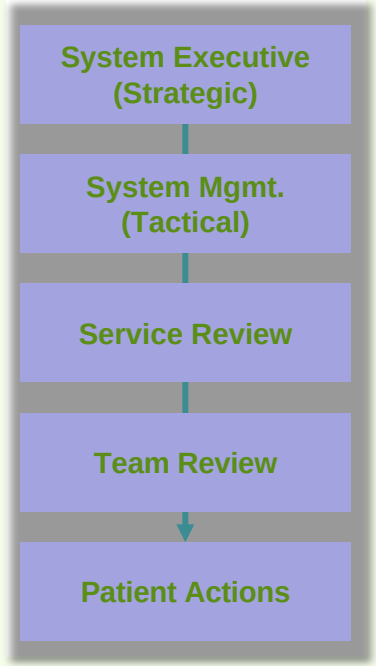
Visibility which allows us to monitor the overall system success measures whilst being able to root cause the drivers of challenges within services



Active Leadership

Decision-making

The right people getting together at each level to make data-driven decisions. These meeting structures are connected through accountability and consistent data visibility



Culture

Establishing the shared working principles for effective across organisation decision-making

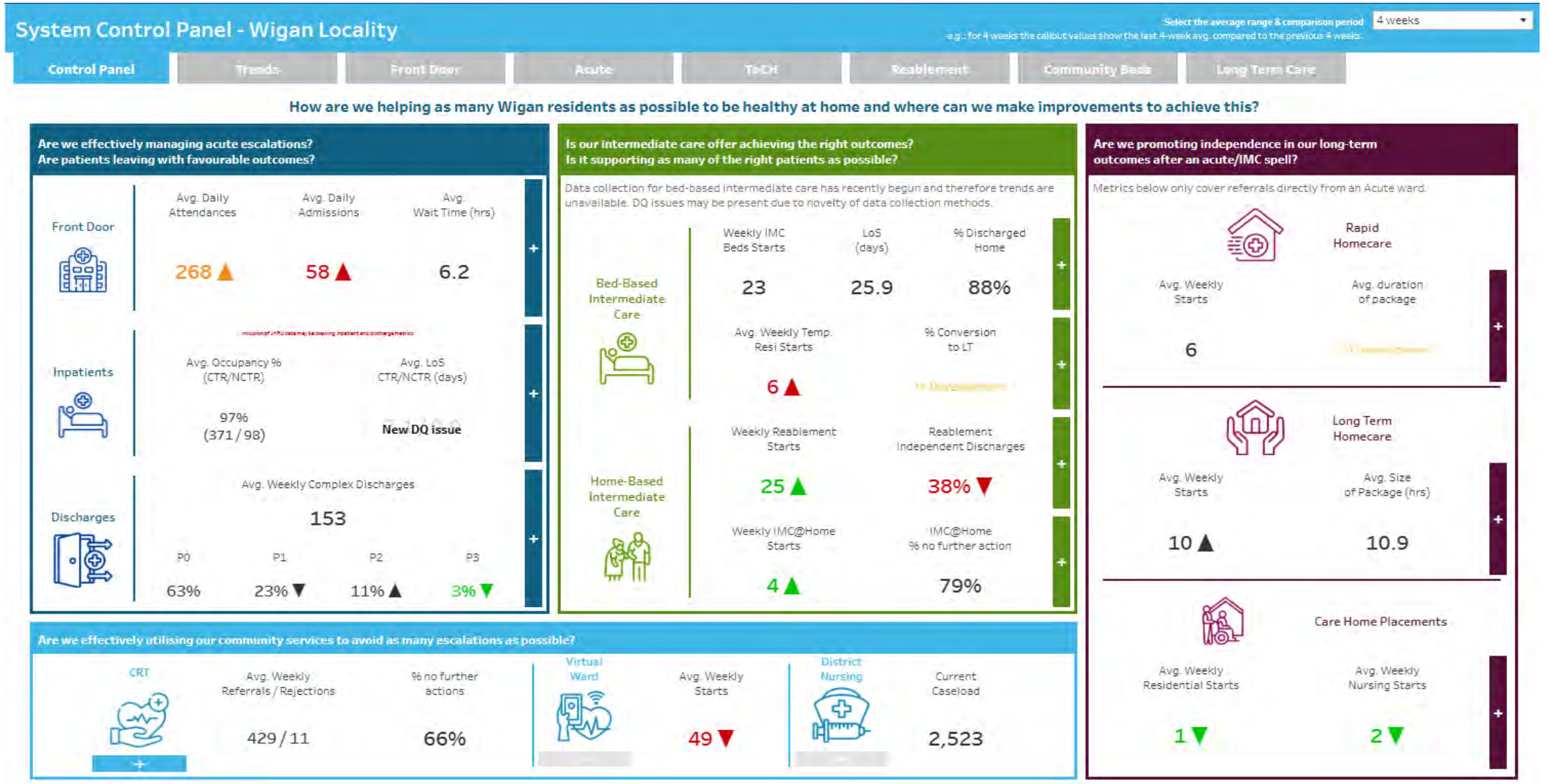
Data-driven decision-making

Root causing problems before acting

Shared accountability

Cross-service and organisation support

System Visibility / Active Leadership



System Visibility / Active Leadership

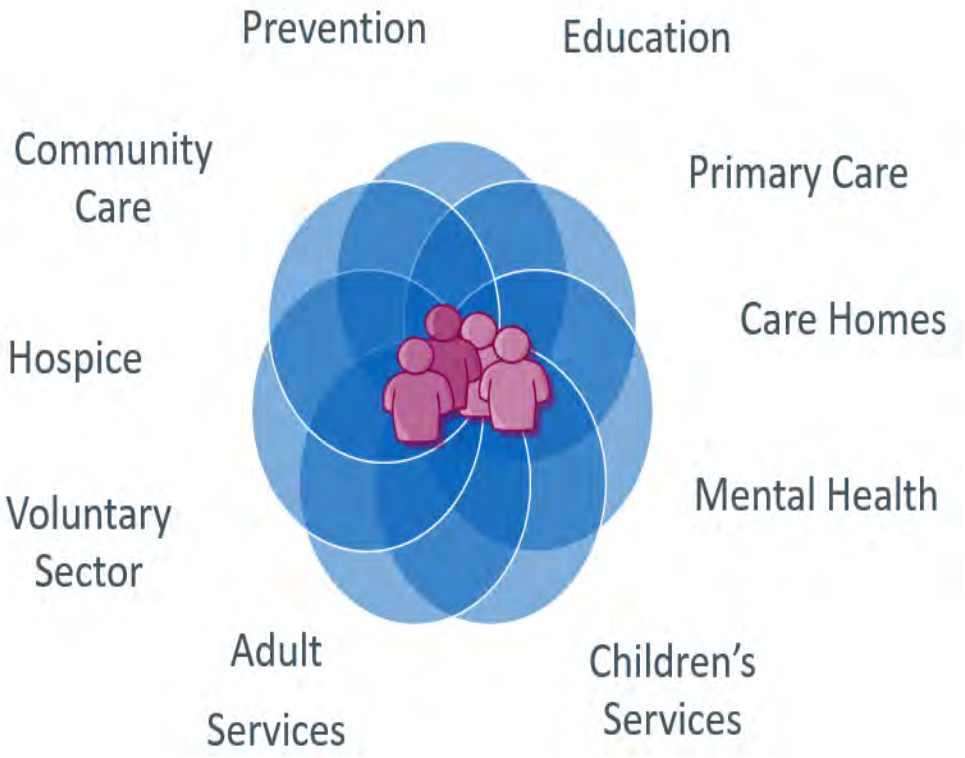
Improving Neighbourhood Health

Three core strands to our work to reform and transform community-based services, supported by communities...

- Understand the current position and baseline mapping

- A vision for the future
  - co-produced, high quality, evidence-based services that are accessible and meet the needs of our population,
  - strong focus on prevention,
  - pathways that are clearly understood and followed,
  - reduced health inequalities,
  - improved outcomes and independence for people,
  - understand any gaps in service provision.

- Empower our Teams/Organisational Development to support and ensure change is sustainable



Workforce Planning Together

- Health & Care identified as a priority growth sector in the borough's Economic Strategy
- Landmark Civic University Agreement signed October 2023
- Wigan Education and Skills Partnership (WESP) – collaborative integrated provision and pathways planning

Wigan Education and Skills Partnership

Continuing our own workforce strategies whilst creating and driving the integrated developments to strengthen our sector, its attractiveness and robustness.

1. Pathways & Placements	2. Believe In Your Future Schools	3. Apprentices	4. Equality, Equity & Inclusion	5. Integrated Developments
Young People Placements Education (T Level, BTEC, Degree) Traineeship **Adults** Pre-employment programmes Supported Internships Care To Join Us SWAPs Community Recruitment & Hyper Local Recruitment with values-based approach	School Career sessions – Y9&12 College Career sessions Work experience Support events, insight days Create team of H&C Career Ambassadors (linked with GM Employment Advisors)	Identify workforce need and apprenticeships as one potential solution Jobs post-training Degree apprentices Degree entry requirement identification and support Shared levy use – gifting Possibility of joint strategic approach	Support work readiness and employability EDI in attraction & recruitment Support global educated families EDI champions and shared equity standards?	Intel (data & engagement) to shape, need, direction, devel curriculum, test ideas “Academy” platform to position Wigan as pivotal place for H&C careers Develop health and care narrative Attract adults to the Centre of Excellence Roll out and embed Asset-Based Approach Blended Homecare community roles Nurse Associate Apprenticeship Create Care Passporting Establish Talent Pool Innovation Staff Giving Back Approach Workforce Reward and Benefits

Innovative Roles
Joint Care Sector Clinical Fellow

Joint Care Sector Clinical Fellow

Wrightington Wigan & Leigh Teaching Hospitals NHS Foundation Trust

The closing date is 09 April 2025

Job summary

The Joint Care Sector Clinical Fellow (JCSF) is a new innovative role working between WWL NHS FT, Edge Hill University and the social care sector to support social care organisations to foster an inclusive learning environment that will promote diverse career pathways. The JCSF will support the development of blended roles and delegated tasks in social careand create a shared learning environment that benefits social care staff and learners. The JCSF will support nursing students and nursing associates in the social care and HEI setting providing a conduit for learning that spans across academia and social care.

- Collaborative post across WWL, Edge Hill and Wigan Council
- 1st post of its type nationally
- Facilitate Health and Social Care learning capacity
- Coordinate interprofessional learning activity across Health and Social Care
- Review of learning pathway across Heath and Social Care
- Develop and implement Health and Social Care Preceptorship
- Develop and implement Health and Social Care NQN rotational post

Summary

Tackling Inequalities with Communities, Transforming through Better Lives, Improving Neighbourhood Health and Workforce Planning are not a task we can complete overnight, in a month or a single year…

We know that these are all programmes that will need to utilise the collective skills, relationships and opportunities that are abundant in Wigan Borough in order to make a real difference to our staff and population.

It is important to not just know "where" we want to get to, but how we holds ourselves collectively to account in the journey of getting "there".

Now is the time to ignite our burning ambition….

Title of report:	Board Assurance Framework (BAF) 2024/25 Closing Report
Presented to:	Board of Directors
On:	2 April 2025
Presented by:	Director of Corporate Governance
Prepared by:	Head of Risk
Contact details:	E: steven.parsons@wwl.nhs.uk

Executive summary

The closing report of the trust's key strategic risks to the achievement of the annual corporate objectives 2024/25 is presented here for approval by the Board.

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are four financial performance risks within this report.

Legal implications

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

People implications

There are three people risks within this report.

Wider implications

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

Recommendation(s)

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

1. Introduction

1.1 Our Board Assurance Framework (BAF) provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives. This is the closing report for the 2024/25 BAF.

1.2 The Board of Directors is responsible for reviewing the BAF to ensure that there is an appropriate spread of strategic objectives and that the main risks have been identified. The Board has reviewed the BAF on a bi-monthly basis during 2024/25.

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

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

2. BAF Review

2.1 The closing report of the trust's key strategic risks for 2024/25 is presented here for approval. The BAF is included in this report with detailed drill-down reports into all individual risks.

2.2 **Patients:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Quality and Safety Committee Meeting on 12 March 2025. There are currently three open patient focussed strategic risks, which will be carried over to the 2025/26 BAF and aligned with the 2025/26 corporate objectives.

2.3 **People:** Current risks are being reviewed and updated in line with the 2024/25 corporate objectives for approval at the People Committee Meeting on 8 April 2025. There are currently three open people focussed strategic risks, which will be carried over to the 2025/26 BAF and aligned with the 2025/26 corporate objectives.

2.4 **Finance and Performance:** Current risks were reviewed and updated in line with the 2024/25 corporate objectives at the F&P Committee meeting on 25 March 2025. There are currently six open finance and performance focussed strategic risks. The risk scores for the four finance risks have been reduced to their target score and closed. The risk scores for the two performance risks remain the same and will be carried over to the 2025/26 BAF and aligned with the 2025/26 corporate objectives.

2.5 **Partnership:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Board meeting on 2 April 2025. There are currently four open partnership focussed strategic risks. The risk score for the Net Zero risk has been reduced from 16 to 8 due to funding received for work on LED lighting and solar panels. The four risks will be carried over to the 2025/26 BAF and aligned with the 2025/26 corporate objectives.

3. New Risks Recommended for Inclusion to the BAF

No new risks have been added to the BAF since the last Board meeting in February 2025. The following risks were added to the BAF during 2024/25:

3.1 Finance Risk *ID329 PR8 Financial Sustainability: Efficiency targets* was added to the BAF in May 2024.
3.2 Finance Risk *ID3295 PR9 Capital Funding* was added to the BAF in May 2024.
3.3 Finance Risk *ID3998 PR10 Cash Balance* was added to the BAF in May 2024.

4. Risks Accepted and De-escalated from the BAF since the last Board Meeting

4.1 Finance Risk *ID3292 Financial Performance: Failure to meet the agreed I&E position*
4.2 Finance Risk *ID3291 PR8 Financial Sustainability: Efficiency targets*
4.3 Finance Risk *ID3295 PR9 Capital Funding*
4.4 Finance Risk *ID3998 PR10 Cash Balance*

5. Review Date

5.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for June 2025 and will include the 2025/26 corporate objectives.

6. Recommendations

6.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

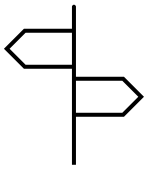
2024/25

The content of this report was last reviewed as follows:

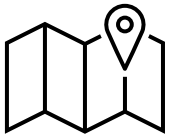
Board of Directors	February 2025
Quality and Safety Committee:	March 2025
Finance and Performance Committee:	March 2025
People Committee:	February 2025
Executive Team:	March 2025

> **assurance** (/əˈʃɔːrəns/) *noun*
>
> *(In relation to board assurance)* Providing confidence, evidence or certainty that what needs to be happening is actually happening in practice
>
> *Definition based on guidance jointly provided by NHS Providers and Baker Tilly*

How the Board Assurance Framework fits in

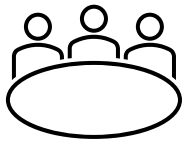


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how we will deliver against these. The strategy signposts the general direction which we need to travel in to achieve our goals and sets out where we want to go, what we want to do and what we want to be.

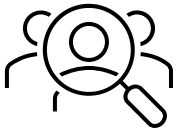


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives focus on delivery of the strategy and what the organisation needs to prioritise and focus on during the year to progress the longer-term ambitions within the strategy.

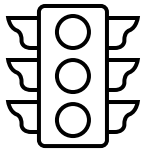
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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



Seeking assurance: To have effective oversight of the delivery of our corporate objectives, the Board of Directors uses its committee structure to seek assurance on its behalf. Whilst individual corporate objectives will cross a number of our strategic ambitions, each is allocated to one specific strategic ambition for the purposes of monitoring. Each strategic ambition is allocated to a monitoring body who will seek assurance on behalf of, and report back to, the Board of Directors.



Accountability: Each strategic risk has an allocated director who is responsible for leading on delivery. In practice, many of the strategic risks will require input from across the Executive Team, but the lead director is responsible for monitoring and updating the Board Assurance Framework and has overall responsibility for delivery of the objective.



Reporting: To make the Board Assurance Framework as easy to read as possible, we use visual scales based on a traffic light system to highlight overall assurance. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance.

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

Almost certain 5	5 Moderate	10 High	15 Significant	20 Significant	25 Significant
Likely 4	4 Moderate	8 High	12 High	16 Significant	20 Significant
Possible 3	3 Low	6 Moderate	9 High	12 High	15 Significant
Unlikely 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Rare 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate
↑ Likelihood	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Critical 5**
	Impact →				

DIRECTOR LEADS

CEO:	Chief Executive	DCA:	Director of Corporate Governance
COO:	Chief Operating Officer	DSP:	Deputy Chief Executive Chief Officer for Strategy, Partnerships and Digital
CFO:	Chief Finance Officer	CPO:	Chief People Officer
CN:	Chief Nurse	MD:	Medical Director
DCSE:	Director of Communications and Stakeholder Engagement		

DEFINITIONS	
Strategic ambition:	The strategic ambition which the corporate objective has been aligned to – one of the 4 Ps (patients, people, performance or partnerships)
Strategic risk:	Principal risks which populate the BAF; defined by the Board and managed through Lead Committees and Directors.
Linked risks:	The key risks from the operational risk register which align with the strategic priority and have the potential to impact on objectives
Controls:	The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the strategic objective
Gaps in controls:	Areas which require attention to ensure that systems and processes are in place to mitigate the strategic risk
Assurances:	The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively. 1st Line functions which own and manage the risks, 2nd line functions which oversee or specialise in compliance or management of risk, 3rd line function which provide independent assurance.
Gaps in assurance:	Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
Risk Treatment:	Actions required to close the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.
Monitoring:	The forum which will monitor completion of the required actions and progress with delivery of the allocated objectives
Three Assurance Alarm Bells:	The first bell is triggered if the current risk score has not changed in 6 months. The second bell is triggered if actions are overdue or have not been identified to reduce the risk to target score. The third bell is triggered if the risk has not been reviewed since the last Board meeting.

Our approach at a glance

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

Patients:	To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience
People:	To ensure wellbeing and motivation at work and to minimise workplace stress
Performance:	To consistently deliver efficient, effective and equitable patient care
Partnerships:	To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

FY024/25 Corporate Objectives

Patients

We will…

- improve the safety and quality of clinical services
- improve diabetes care for our paediatric population (up to age 19)
- improve the delivery of harm-free care
- promote a strong safety culture within the organisation
- improve the quality of care for our patients
- listen to our patients to improve their experience

People

We will…

- Enable better access to care by having the right people, in the right place, in the right number at the right time
- Ensure we improve experience at work by actively listening to our people, and turning understanding into positive action
- Have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish

Performance

We will…

- deliver our financial plan, providing value for money services
- minimise harm to patients through delivery of our elective recovery plan
- improve the responsiveness of urgent and emergency care

Partnerships

We will…

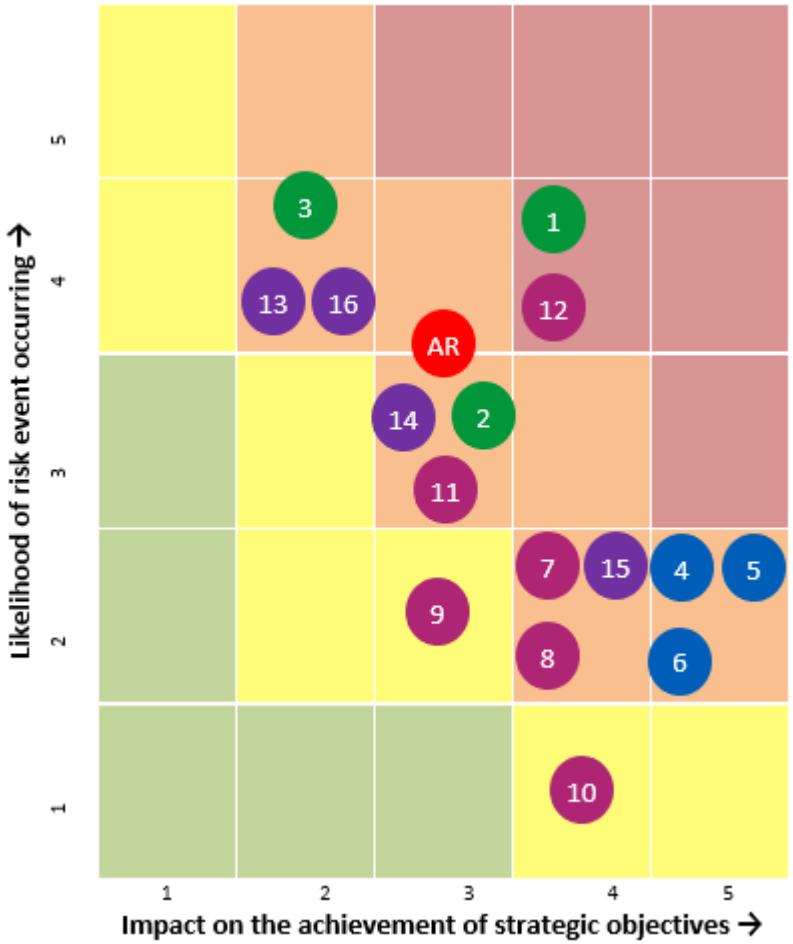
- improve the health and wellbeing of the population we serve
- develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable
- make progress towards becoming a Net Zero healthcare provider
- increase our research activities delivering high quality research with patients and partners across the Wigan Borough, strengthening our research capability and making progress towards our ambition to be a University Teaching Hospital.

Risk management

Our risk appetite position is summarised in the following table:

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Safety, quality of services and patient experience	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Data and information management	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Governance and regulatory standards	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Staff capacity and capability	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Staff experience	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 15 Eager
Staff wellbeing	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 15 Eager
Estates management	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Financial Duties	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Performance Targets	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Hospital Demand, Capacity & Flow	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Sustainability / Net Zero	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Technology	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Adverse publicity	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Contracts and demands	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Strategy	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Transformation	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 15 Eager

The heat map below shows the distribution of all 16 strategic principal risks based on their current scores:



Green: patients | Blue: people | Pink: performance | Purple: performance | Red: average risk score

Patients

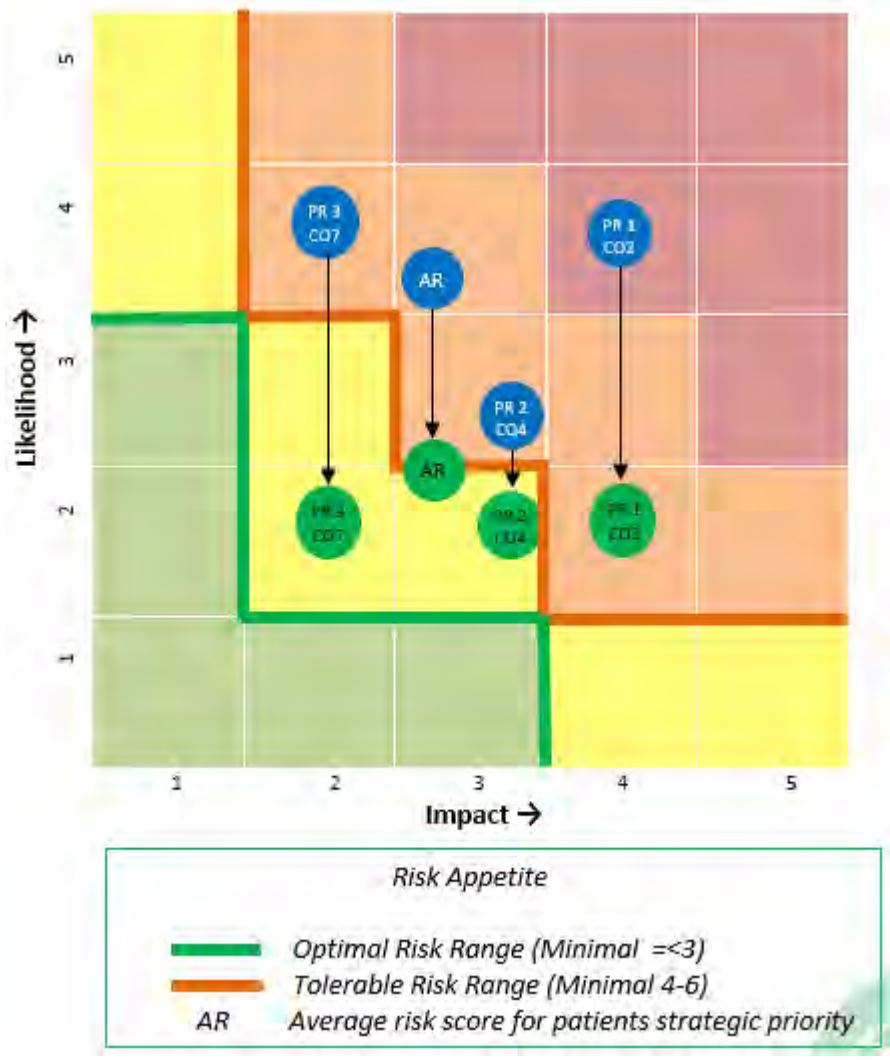
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

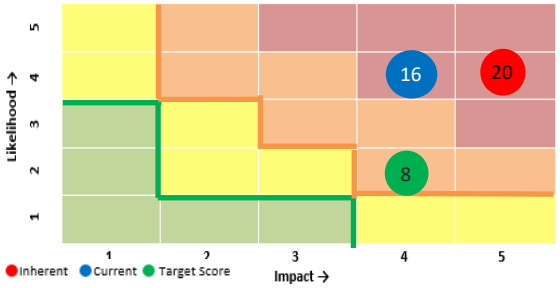
Monitoring: Quality and Safety Committee

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

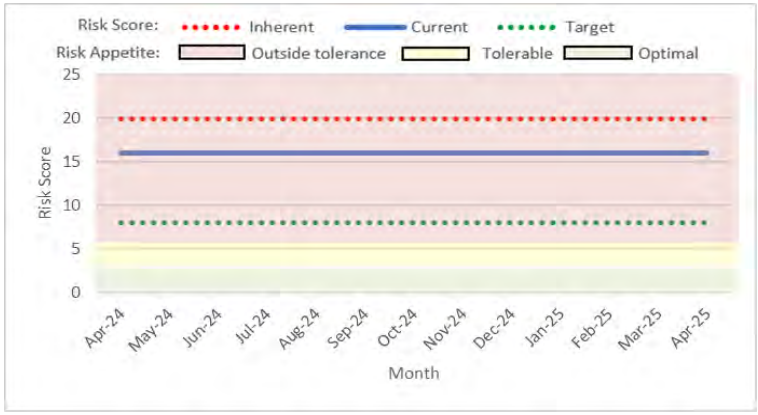
Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking
CO1	To improve the safety and quality of clinical services	To enhance patient care through digital transformation.	No risk currently identified
CO2 3805	To improve the safety and quality of clinical services	To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.	Risk to be reviewed with 2025/26 corporate objectives
CO3	To improve diabetes care for our population	Diabetic Foot Checks	No risk currently identified
CO4 3322	To improve the delivery of harm-free care	Continue improvements Pressure Ulcer Reduction. System Wide improvement for reducing pressure ulcers.	Risk to be reviewed with 2025/26 corporate objectives
CO5	To promote a strong safety culture within the organisation	Continue to strengthen a patient safety culture through embedding Human Factor awareness. Continue to increase staff psychological safety.	No risk currently identified
CO6	To improve the quality of care for our patients	Continue and build upon the accreditation programme	No risk currently identified
CO7 3676	Listening to our patients to improve their experience	Deliver timely and high quality responses to concerns raised by patients, friends and families.	Risk to be reviewed with 2025/26 corporate objectives.

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

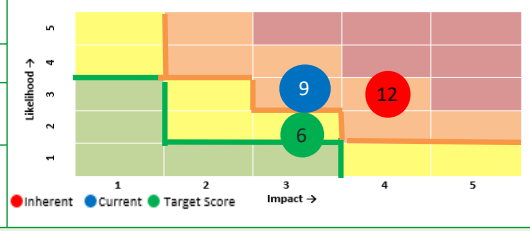


Corporate Objective: **CO2** To improve the safety and quality of clinical services							1	2	3	**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 1: Sepsis Recognition, Screening and Management**									
	Risk Statement:	There is a risk of the under diagnosing of patients with Sepsis, due to Health Care Professionals failing to recognise Sepsis in the deteriorating patient, which may result in patients not receiving Sepsis 6 treatment within one hour of triggering for Sepsis.									
Lead Committee	**Quality and Safety**			**Risk Appetite**	Minimal						
Lead Director	**MD**			**Risk category**	Safety, quality of services & patient exp.						
Date risk opened	**19.07.23**			**Linked system risks**	-						
Date of last review	**17.02.25**			**Risk treatment**	Treat						
Opportunity / Threat	**Existing controls**		**Gaps in existing controls**	**Assurances (and date)**		**Gap in assurances**		**Risk Treatment**		**Due Date By Whom**	

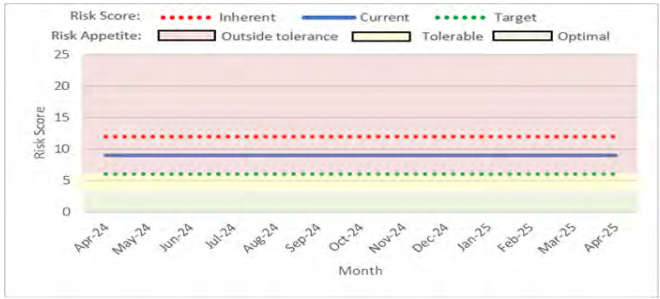
Risk Score Timeline



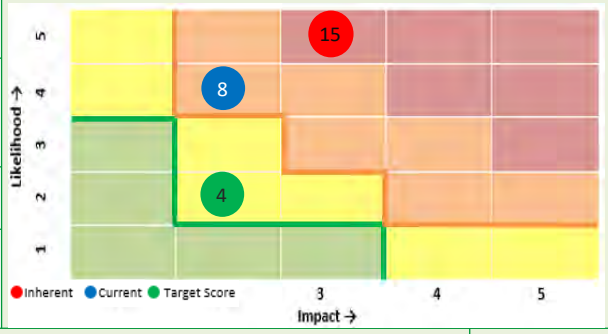
Threat: **(ID 3805)**	• Training on Sepsis has continued. • Training for Blood Culture Collection commenced January 2024 with dates available for staff booking. • Sepsis E-Learning is being reviewed with the aim to make Sepsis in HIS training mandatory. • Monthly E-Learning reviews are undertaken, non-compliance is highlighted to staff and Managers. • AQuA audits continue monthly. • Sepsis QI project in the Emergency Department completed in the month September 2023. • Coding meetings whereby Sepsis deaths and discharges are audited continues. • Visibility in clinical areas with a focus on the Emergency Department initially. • The Sepsis Recognition and Management Policy and subsequent SOP's are live, with additional Community Policy for Adults and Paediatrics currently undergoing review and ratification. • The team expanded in October 2023 with a Band 6 AKI/Sepsis Nurse who supports both the Sepsis and AKI agendas. • Sepsis Lead Nurse undertaking their Non-Medical Prescribing course to support with delivery of antibiotics. • Sepsis Link Nurses in the Emergency Department have been identified and Senior Leadership are supporting Sepsis recognition and management. • Blood Culture QI Project commenced in the Emergency Department following June 2024 AQ data and the ECC Red Flag Sepsis data. • Sepsis Awareness month in September 2024.	• In response to the updated NICE Guidance (NG51) and the Academy of Medical Royal Colleges' position statement on the initial antimicrobial treatment of Sepsis, the AQ Sepsis Clinical Expert Group (CEG) recently reviewed and revised the current Sepsis measure sets. These updated measures will be audited against from July 2024 data sets, available for audit in October 2024.	**2nd Line:** • Quality & Safety Committee January 2025 • Board February 2025 • ECC Red Flag Sepsis Audit • AQ Audit • Patient Safety Group – January 2025 • Deteriorating Patient Group	**External:** • NICE Guidance changes will directly affect the Corporate Objects as the Objectives utilise the AQuA audit to monitor against, however at this stage we are unsure if this will have a positive or negative effect on the audit results. Once the Sepsis Team have audited using the new measures over a couple of months, we can determine the effect they will have.	1. Sepsis Lead Nurse to continue with the AQuA audits monthly and incorporate any learning into the Sepsis Improvement Plan. 2. The Sepsis Improvement Plan for 2024/2025 to continue to be updated. 3. Sepsis Team to continue to support Sepsis and Blood Culture Training. 4. Sepsis Team to support in the review of the NICE NG51 baseline assessment to determine the Trust's standpoint with the guidance and what should be prioritised. 5. Working Group to be commenced to support all areas of Sepsis management, policy updates and guidance as well as support with the Sepsis in HIS document changes that may need to occur. 6. ED to continue with their Blood Culture improvement project with support from the Sepsis Team. 7. Sepsis Team to design a Trust Wide audit for Sepsis and how this can be undertaken effectively. 8. ED to undertake their departments Sepsis Audits as of October 2024. 9. Sepsis Team to continue to ensure visibility in all clinical areas to support the recognition and management of Sepsis. 10. Blood Culture training equipment to be purchased by the Sepsis Team. 11. Sepsis Team to continue to use the "Sepsis trolley" to support with the implementation of the Sepsis 6 and therefore the management of Suspected Sepsis. 12. Sepsis Team to continue to meet with Coding department to review Sepsis Deaths and Discharges to ensure correct coding. 13. Team to continue to review e-learning figures to ensure compliance. 14. Consultant Sepsis Leads to support the Sepsis Improvement Plan and to encourage the recognition and management of Sepsis within their clinical teams. 15. To open discussions about team expansion and what benefits this would mean for our patients, both paediatric and adult.	For update in April 2025 Sepsis Lead

Corporate Objective: CO4 To improve the delivery of harm-free care							Overall Assurance level	Medium
Principal risk	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**						
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.						
Lead Committee	**Q&S**			**Appetite**	Minimal			
Lead Director	**CN**			**Risk**	Safety, quality of services & patient exp			
Date risk opened	**19.10.21**			**Datix ID / Links**	Threat (ID 3322) No linked risks			
Date of last review	**15.01.24**			**Risk treatment**	Treat			

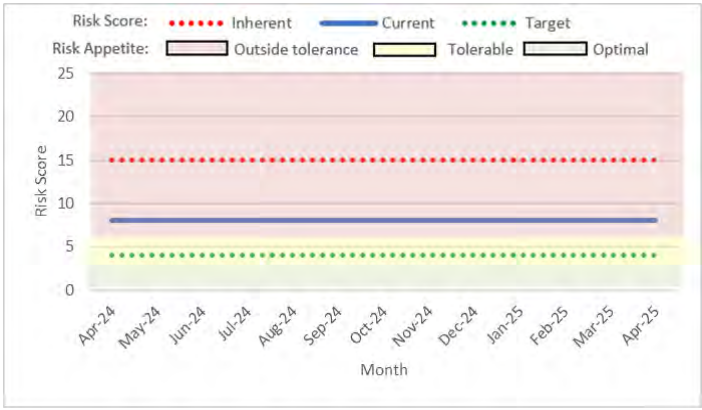
Risk Score Timeline



Existing controls	Gaps in existing controls	Assurances	Gaps	Risk Treatment	Due Date
• Pressure ulcer link nurses trained within all areas and extended to community care homes. • Category 2/DTI Pressure Ulcer Review Panels (PURP) in place and aligned to PSIRF framework. • Category 3/4 & Unstageable Pressure ulcer panels Review Panels (PURP) in place. • Commenced the scope of changes required in the category 3, 4 panels to align to the Patient Safety Incident Response Framework (PSIRF framework). • Compassionate engagement with the patient/carer added to the aSSKINg framework as a prompt. • Pressure ulcer policy and SOPs embedded. • PU prevention training in place and monitored via the Learning Hub. • Quarterly reports submitted to HFC group, Patient Safety group, NMAHP body and Q&S committee to provide assurance. • Data captured re incidence of moisture associated skin damage (MASD) • ED improvement plan updated for 24/25 and monitored by division with PU steering group oversight. • Aspull ward improvement plan updated for 24/25 and monitored division with PU steering group oversight. • Use of AAR to create opportunities for learning across divisions. • First contact data now captured. • All ward leaders and matrons trained in PU verification. • Tissue viability team at full establishment and the team working differently. Corporate risk 3323 closed. • Differential diagnosis training in Q4 (23/24) has resulted in a marked reduction in PU being stepped down at PURP. • Wards fully established to agreed staff ratios. • Total bed management system rolled out. • Increased scrutiny in use of bank and agency staff. • Substantive workforce now in place. • Human factors training embedded within organisation. • Steering group monitoring through audit programme implementation of PURP action plans • Omissions in complex wound care included into the PURP process, to allow a forum for review and identifying learning, monitored through the pressure ulcer prevention steering group. • Unstageable category removed from 1st April 2024 in line with National Wound Care Strategy Programme recommendations and in line with PSIRF reporting. Further changes will be implemented later in the year when implementation resources are released from NHS England. • REPOSE overlay provision increased for the escalated areas in ED. • MASD pathway and wound care formulary changed completed and rolled out in the organisation. • Annual engagement from the PU Prevention Steering Group in supporting the worldwide 'Stop the Pressure Event' arranged by the TVN leads.	• Staff being able to be released to undergo training. • Escalated areas continue. • Number of increased ED attendances, with the capacity demands continuing beyond its current footprint • Large number of patients on the list contribute to compromised patient flow which results in continued long waits to be seen and delays in patients being admitted to an inpatient area. • Delay in MASD pathway being update in line with GM MMG, awaiting confirmation and printing of final version. • Redeployment of staff to support escalation areas. • HIS freeze stalling required changes in care planning and terminology in relation to PU prevention and care. • Community teams have continued to maintain the position of not having an CAPUs developed due to an omission in care, however we have not been able to eliminate the development of pressure ulcers altogether.	**2nd Line:** • Quality & Safety Committee January 2025 • Board February 2025	Recommended that 25/26 objective to is re-worded to be Zero HAPU and CAPU category 3 and 4 developed or worsened, linked to an act or omission in care.	•TV service to work with the HIS team to revise the referral process on HIS to reduce inappropriate referrals. • paperwork and improve the compliance with repositioning. •Support the Medical Illustration team in the roll out of the SECTRA application to achieve timely photography of skin damage. •Commence the changes required in the category 3, 4 panels to align to the Patient Safety Incident Response Framework (PSIRF framework). •Further progress with Business Intelligence; a dashboard to illustrate PU data at a glance. •TV service to explore further, the relationship between end-of-life skin changes (SCALE) and PU development in the community. •Review the Purpose T gap analysis to assess what resource will be required for the implementation in the Trust as a whole via PU steering group. •Review of Aspull ward thematic analysis and ED compliance with improvement plan. •Engage in the back-to-basics programme of work. •Trial of URICAP as a MASD reduction aid in Aspull and BWN. •Explore reporting options per 1000 bed days with BI. • Explore with Governance teams the duplications in DATIX reporting of the same skin damage, to find a solution.	PU steering group For update in April 2025

Corporate Objective: CO7 Listening to our patients to improve their experience					1	2	3	**Overall Assurance level**	**Mediu m**
Principal risk	**Risk Title**	**PR 3: Complaint response rates**							
	Risk Statement	There is a risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures, resulting in missed targets, unresolved complaints and adverse publicity.							
Lead Committee	**Quality and Safety**			**Risk Appetite**	Minimal				
Lead Director	**CN**			**Risk category**	Safety, quality of services & patient exp.				
Date risk opened	**24.01.23**			**Linked system risks**	No linked risks				
Date of last review	**26.02.25**			**Risk treatment**	Treat				

Risk Score Timeline



Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **Datix ID 3676**	• Complaints SOP in place with defined roles, processes and timescales. • How to respond to a complaint training is being delivered. • Training time has been reduced from 6.5 to 4 hours. • Patient relations team provide support and guidance. • DATIX actions improvement plans have been used for each upheld or partially upheld complaint, a reduction for the top subjects will be realised as time passes. • 52% increase in the recording and cross organisational use of plaudits. • fortnightly performance meeting for complaints with the Divisions • Complaints review meeting chaired by CN and attended by the Divisions and NED. This is to have a deeper dive into quality of the complaint responses and associated learning • Following the recent MIAA audit on patient property (where we were found to have limited assurance), new Patient property Group, new TOR and agenda. This reports into Patient Experience.	• We have not achieved 90 % of complaints responded within our agreed time frame. • 2023/2024 showed a 13% increase in complaints related to loss of patient property therefore a working group was set up which commenced in Nov 2024 • Requirement to source venues to run further training courses. • Despite training and good feedback from the session, staff are not coming back to us so that we can critic their work • Although there has been the introduction of the boxes, the Patient Relations and PALS team, have recommenced recording concerns when the patient relative have stipulated a record - patients/relatives are directed to Legal when all other resolutions have been explored (following the path of the patient and ringing round).	**2nd Line:** • Quality & Safety Committee January 2025 • Board February 2025 • Task and finish group set up so that divisions use functionalities within Datix.	• No gaps currently identified.	1. Training is continuing with high attendance and waiting list – more dates are being provided.	For update in April 2025 CN

People

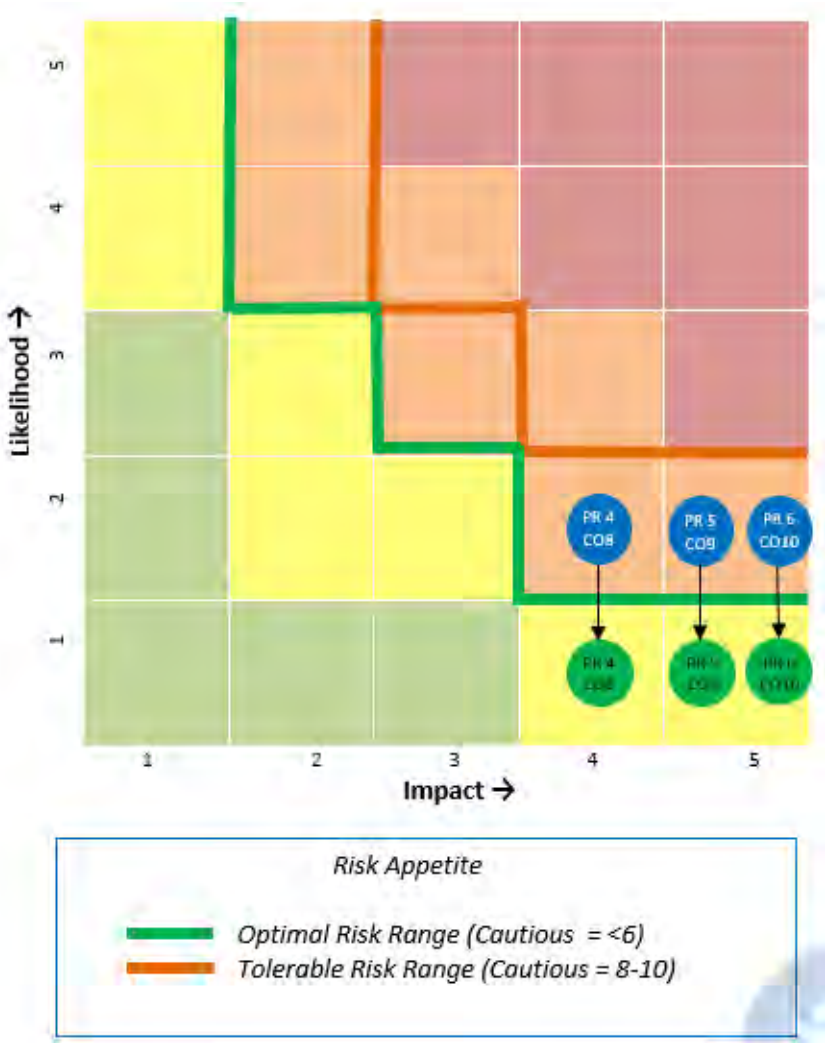
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

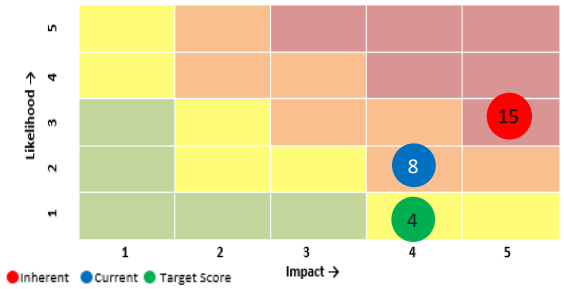
The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Status
CO8	To enable better access to the right people, in the right place, in the right number, at the right time.	• Produce a workforce plan that outlines the future demand of our workforce and how we will meet that demand, setting out how we will integrate new ways of working and new roles into our teams, particularly those that experience workforce supply challenges.	Risk to be reviewed with 2025/26 corporate objectives
CO9	To ensure we improve experience at work by actively listening to our people and turning into positive action.	• Recognising the valuable role our Leaders play in staff experience, we will roll out a single programme that develops our leaders to operate with compassion and inclusivity, and supports improvement of their own wellbeing. • Support our staff to work flexibly. • Gather feedback from staff who may chose to leave WWL, or those who are thinking of leaving. • Develop a robust local "self-service" approach to recognition as well as an efficient scheme that recognises service with the NHS. • Meet the conditions outlined within the NHS Sexual Safety Charter. • Embed the new arrangements for Freedom to Speak Up, including a review against the NHS Board Self-Assessment framework. • Implement a streamlined and supportive approach to line manager and staff conversations. • Undertake a self-assessment against the NHS Health & Wellbeing Framework and put strategies in place that meets gaps.	Risk to be reviewed with 2025/26 corporate objectives
CO10	We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.	• Establish formal governance mechanisms that will drive forward commitments outlined within the WWL EDI Strategy. • Deliver actions as outlined within the six high impact actions as set out in the NHS EDI Improvement Plan. • Improve experience of our black, Asian, minority ethnic workforce. • Improve the experience of our disabled workforce. • Increase the demographic of our workforce Band 7 and above. • Continue to grow and develop our Staff Networks.	Risk to be reviewed with 2025/26 corporate objectives

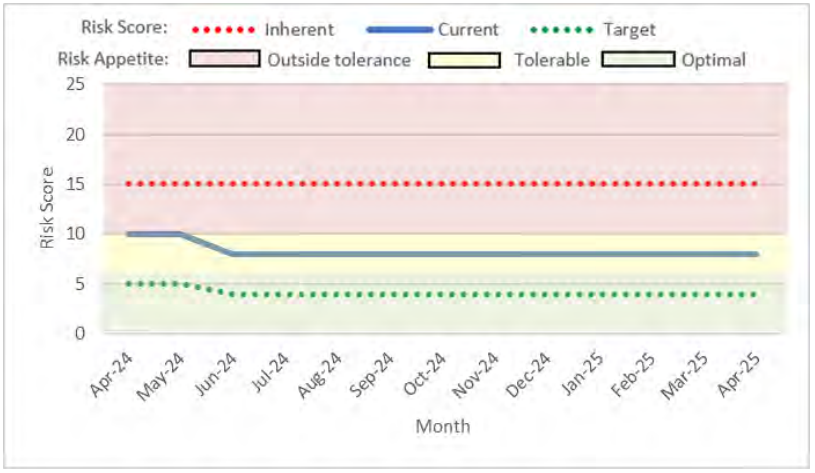
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for the people strategic risk:



Corporate Objective: CO8 To enable better access to the right people, in the right place, in the right number, at the right time	1	2	3	**Overall Assurance Level**	**Medium**

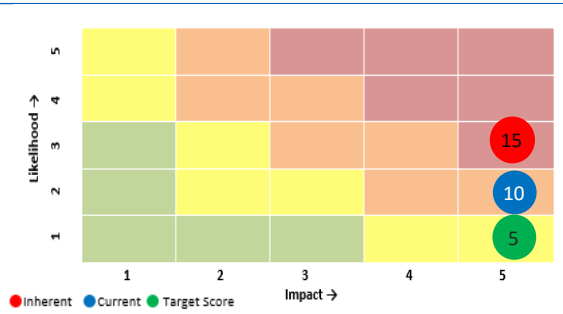
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 4 : Workforce Sustainability**		
	Risk Statement:	There is a risk that we may not deliver the workforce sustainability agenda objective, due to issues with staff retention and keeping colleagues well in work, that may result in an increase in sickness absence, vacancies, time to hire challenges and an increase in employee relations cases.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Capacity & Capability, Staff Engagement Staff Wellbeing.
Date risk opened	**19.06.23**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**11.02.25**		**Risk treatment**	Treat

Risk Score Timeline

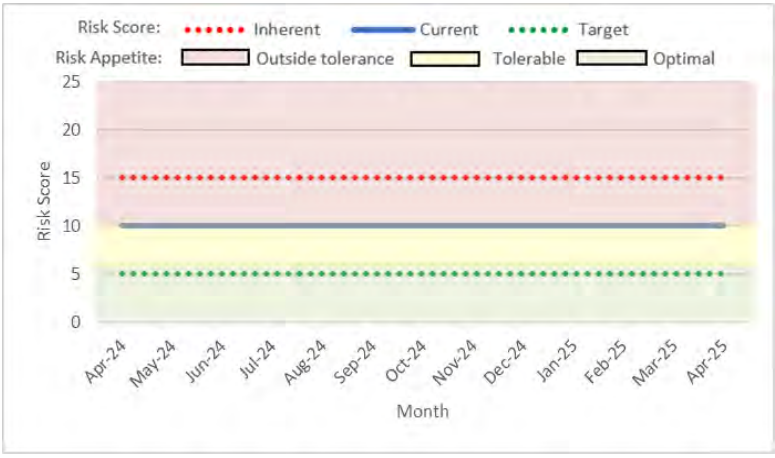


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3783**	• Workforce planning 2024/25 • Empactis relaunch • Civility Programme (just & learning culture) • People Dashboard refresh • Newton Europe Commission (pending) • National Staff Survey • ETM approved the establishment of 2 x workforce posts, including a Workforce Digital / Informatics Lead	• Lead for people dashboard refresh and reporting mechanisms • Workforce Planning is currently based round Operational Planning round and doesn't provide future strategic overview of workforce for the future	**2nd Line:** • Data produced by GM identify WWL as a lead performer in time to hire data. • Empactis relaunch reports to Transformation Board monthly under sustainable workforce workstream • Civility Programme now built into WWL work on Anti-Racism and actions defined within workstream. • Newton Europe Commission updates via ETM • Turnover benchmarks positively when compared to others in GM and nationally.	• Turnover reporting identifies that circa 25% of leavers, leave within the first 12 months of employment.	1. Deep dive work to be undertaken for those leaving within first 12 months and reasons for leaving, with associated action plan to be developed. 2. Development of a People Strategy to address overall workforce sustainability risk. First draft developed and presented to People Committee June 2024, further engagement and refinement underway to support final ratification at future Board Away Day. 3. Funding approved for a Workforce Transformation Lead and Digital Workforce Manager. Recruitment underway.	1. For update in April 2025 – D/CPO & AD for SE & W 2. For update in April 2025 -CPO 3. For update in April 2025 - CPO

Corporate Objective: CO9 To ensure we improve experience at work by actively listening to our people and turning into positive action.	1	2	3	**Overall Assurance Level**	**Medium**

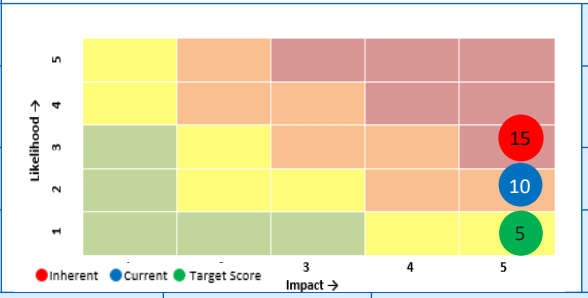
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 5 : Staff Engagement**		
	Risk Statement:	There is a risk that we may not deliver the cultural development agenda objective, due to a lack of staff engagement and low morale.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**02.11.23**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**11.02.25**		**Risk treatment**	Treat

Risk Score Timeline

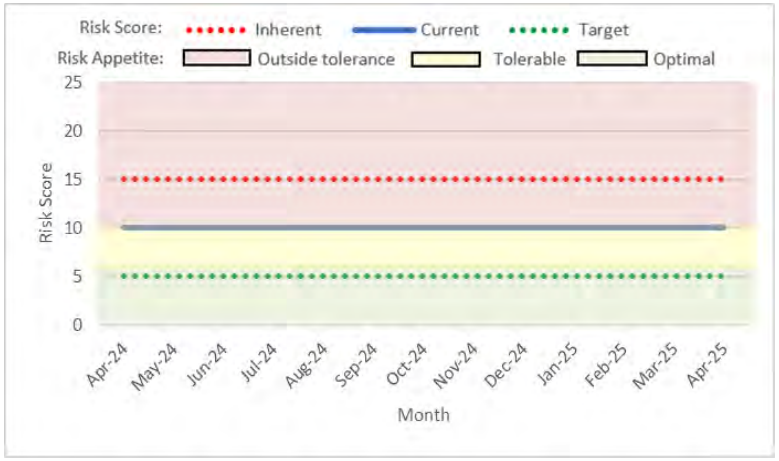


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3871**	• Actions contained within the Draft People & Culture Strategy • National Staff Survey • New Appraisal Framework "My Route Planner" • Local divisions to provide assurance on local staff engagement activities via Divisional Assurance Meetings.	• People Strategy, which will align and coordinate activity under development.	• Culture & Engagement Programme launched. • Turnover of staff, and staff engagement actively monitored at Divisional Assurance and RAPID meetings. • Recruitment and retention standing agenda item for People Committee to enable high level monitoring and assurance. • WWL ranked high nationally in Morale score in 2023 National Staff Survey.	• Data linked to protected characteristics signifies lower staff experience for black, Asian and minority ethnic staff and Disabled staff.	1. Increase understanding of why staff leave through introduction of Exit Questionnaires 2. Development of a Leadership Development Strategy	1. For update in April 2025 - Deputy CPO 2. For update in April 2025 – AD SE

Corporate Objective: CO10 We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.	1	2	3	**Overall Assurance Level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 6 : Workforce EDI**		
	Risk Statement:	The Trust has taken significant steps to fill ongoing qualified nursing gaps through the recruitment of over 405 internationally educated nurses. There is a risk that we will not retain this valued workforce. Feedback received highlights that colleagues who have been educated internationally have a negative work experience. The Trust also reports less positively with our Disabled workforce.		
Lead Committee	**People**		**Risk Appetite**	Cautious
Lead Director	**CPO**		**Risk category**	Staff Engagement Staff Wellbeing.
Date risk opened	**31.01.24**		**Linked system risks**	LSR5: support and develop workforce
Date of last review	**11.02.25**		**Risk treatment**	Treat

Risk Score Timeline



Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3928**	• Pastoral Support post within the Nursing Professional Practice Team, who will now be a qualified nurse with lived experience. • Mechanisms in place to enable feedback. • Understanding of data in WRES, WDES and Gender Pay Gap Report • NHSE EDI High Impact Improvement Targets • Board Development Workshop focussing on EDI 14.3.24 Workshop took place January 2024. • WWL accepted on national CNO Global Majority 90 Day Challenge. • EDI Strategy Group now established.	• EDI resource temporarily funded until November 2024.	• Feedback shared with Board colleagues ensuring full understanding of experience of IEN. • Interim Chief Nurse recently recruited has experience of successfully supporting the IEN workforce. • Enhanced EDI Support arranged for Ward Leaders, Matrons and other senior nursing colleagues, in the form of Active Bystander training • New IEN Improvement Group established. • Staff network established. • EDI Steering Group	• Actions are very early in implementation and it is difficult to measure and see success at this stage. • Further information required to support organisation review NHSE EDI Objectives.	1. Request funding to support Senior IEN to work within Professional Practice Team. 2. Establish Chief Nurse led IEN Improvement Group, reporting into newly established EDI Steering Group. 3. Increase visibility of senior leaders to IEN workforce. 4. Establish full action plan with improvement actions required. 5. Develop business case for substantive EDI funding, or establish operating model for EDI moving forward 6. Develop WRES Action Plan with engagement of FAME Network 7. Develop WDES Action Plan with engagement of Disability Staff Network. 8. Implementation of EDI High Impact Objectives.	1. June 2024 (CPO/CFO) COMPLETE 2. June 2024 (CN) COMPLETE 3. June 2024 (CN) COMPLETE 4. For update in April 2025 (CN/CPO) 5. For update in April 2025 (AD SE & W) 6. For update in April 2025 (EDI Lead) 7. For update in April 2025 (EDI Lead) 8. For update in April 2025 (CPO, EDI Lead)

Performance

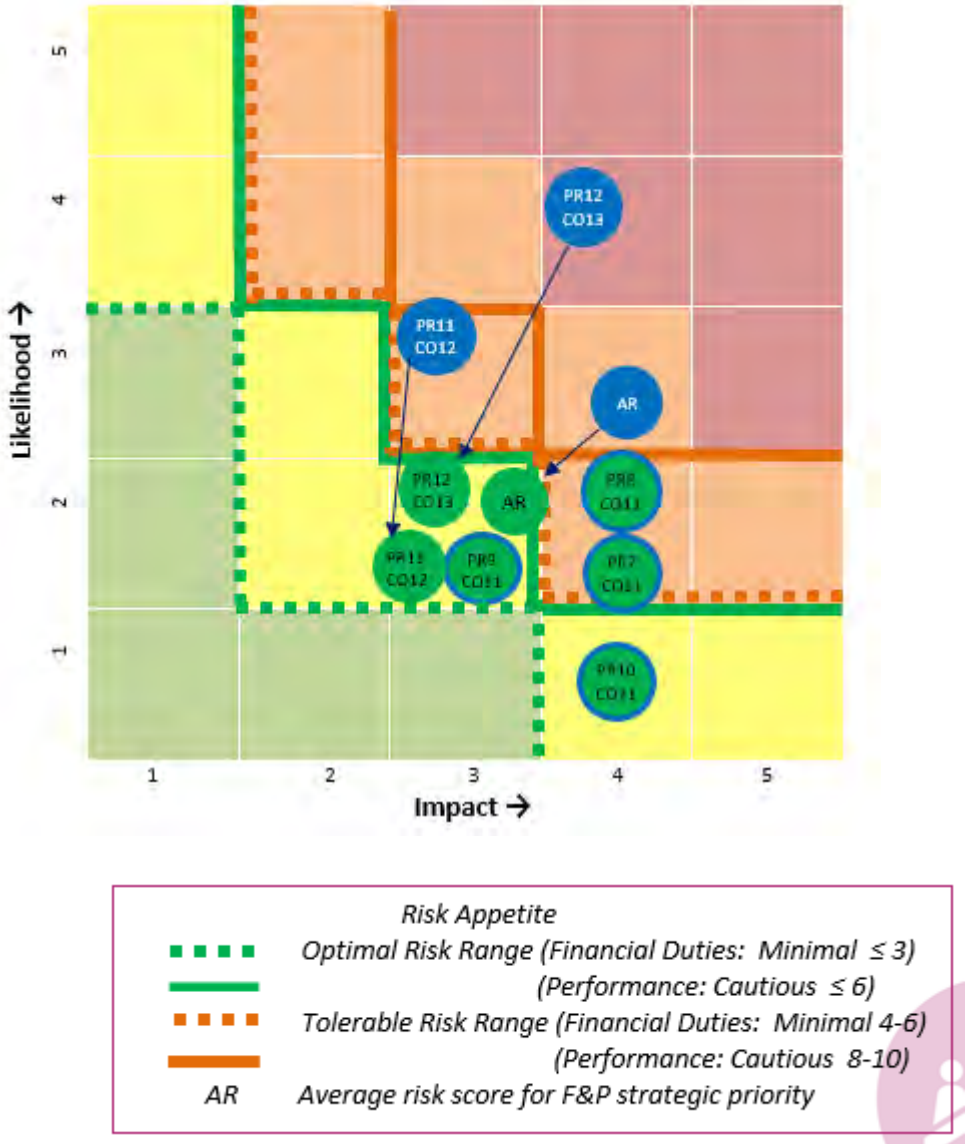
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

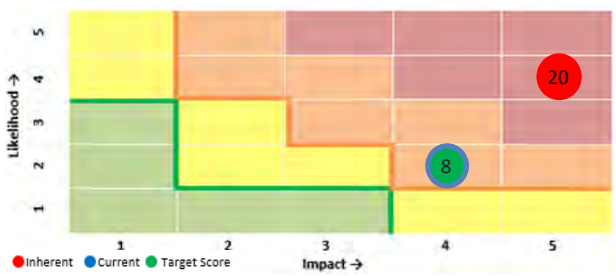
The following objectives are aligned to the **performance** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective	Objective Status
CO11	To deliver our financial plan, providing value for money services	✓ Delivery of the agreed capital and revenue plans for 2024/25. ✓ Delivery of a medium to long term financial strategy focused on sustainability, positive value and success within a financially constrained environment.	Objective met – risk target scores achieved.
CO12	To minimise harm to patients through delivery of our elective recovery plan	✓Delivery of more elective care to reduce elective backlog, long waits and improve performance against cancer waiting times standards, working in partnership with providers across Greater Manchester to maximise our collective assets and ensure equity of access and with locality partners to manage demand effectively.	Risk to be reviewed with 2025/26 corporate objectives
CO13	To improve the responsiveness of urgent and emergency care	✓Working with our partners across the Borough, we will continue reforms to community and urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay. ✓We will work collaboratively with partners to keep people independent at home, through developing and expanding new models of care, making use of technology where appropriate (e.g. virtual wards) and ensuring sufficient community capacity is in place.	Risk to be reviewed with 2025/26 corporate objectives

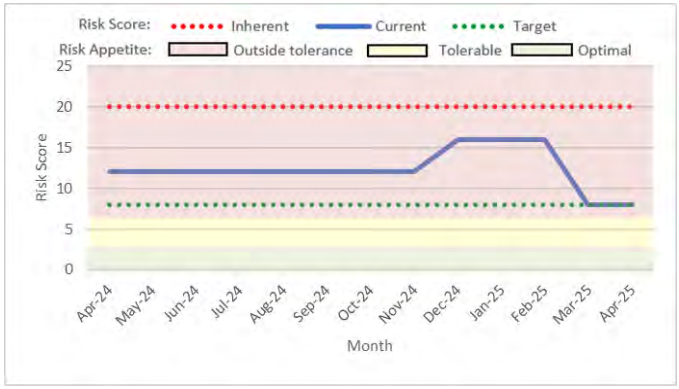
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for these risks:



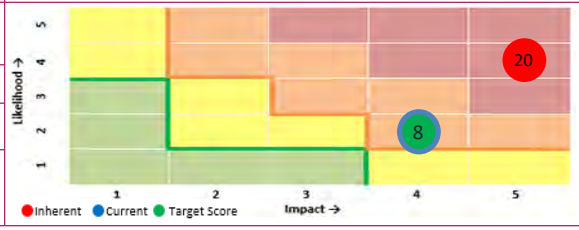
Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

Principal risk	**Risk Title:**	**PR 7: Financial Performance: Failure to meet the agreed I&E position**			
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties. This includes ERF, CIP (see PR8), further impact of industrial action, inflationary pressures and any other unforeseen pressures arising in the year.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal	
Lead Director	**CFO**		**Risk category**	Financial Duties	
Date opened	**20.05.24**		**Threat: System risk**	ID 3292 LSR6 Financial plans	
Date of last review	**14.03.25**		**Risk treatment**	Treat	

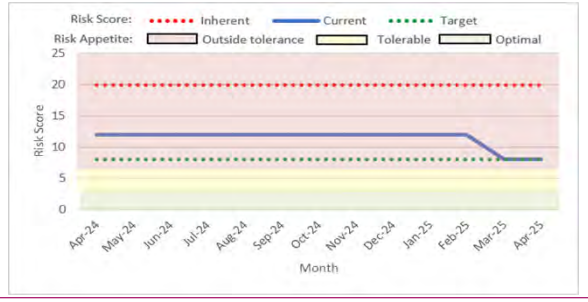
Risk Score Timeline



Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
• Final plan signed off by Board and submitted to NHSE – 2nd May 24. Resubmission on 12th June 24in line with GM ICS control total. • Draft and final plans scrutinised through monthly FPRM meetings with GM ICB, NHSE and PWC. • PWC led planning oversight process on behalf of GM ICB during Q4 2023/24 with significant scrutiny on assumptions (Ext) • Final plan is reflective of year 1 of the approved WWL Financial Sustainability Plan (FSP). • FSP was developed during 2023/24 and had F&P and Board Approval. • All divisions accepted budgets in April 24. • CIP target agreed with programme for delivery and actions. • Robust forecasting including scenario planning for worst, most likely and best case will continue from quarter 2. • Executive oversight and challenge of CIP & Financial performance through Divisional Assurance Meetings, Financial Improvement Group, Transformation Board. • Establishment control groups established for non medical and medical staffing with scrutiny and rigour over agency spend in line with national agency controls. • Stringent business case criteria to ensure only business critical investments are approved. • Full review of financial position by locality partners. • GM standardised financial controls implemented in 2023/24 remain in place across WWL. • ERF baseline of 103.6% is in line with NHSE guidance – based on 2023/24 baseline before adjustments for industrial action. • Activity plans based on theoretical maximum capacity have been approved by divisions and submitted to NHSE on 2nd May 24. • ERF plan submitted in excess of baseline to include activity associated with NHSE approved developments • Revenue plan includes income in line with GM ICB contract offer excluding the growth on ERF for developments noted above • Improvement Director with operational portfolio continues to work with the Trust • Finance Improvement Group meeting monthly, chaired by Chief Finance Officer and attended by Chief Executive • Monthly Provider Oversight Meetings established from May 24 (Ext) • GM Controls in place for new expenditure above £100k not within plan (STAR process) (Ext) • All headcount increases are required to be taken through an Exec led QIA process • Piloting GM vacancy control panel (Ext) • National Financial Improvement Programme established (Ext) • PWC engaged by GM to provide investigation and intervention support (Ext) • Year end scenario modelling – worst case, mid case, most likely – in place and reported through Trust Finance Report • AFC and Junior Doctor medical and dental pay awards confirmed August 24 • I&I report issued October 24 with 20 recommendations, discussed through FIG and all being implemented • Mid year review assessing risk to delivery of deficit plan including mitigations developed. Discussed through ETM and FIG with tactical action plan agreed • Change in deficit plan due to nationally agreed deficit funding • Funding for pay award confirmed and calculations indicate no material pressure in year	• No medium to long term resource confirmation or financial planning (Ext)	**1st Line:** Monthly Divisional Assurance meetings for all clinical divisions and Finance Improvement Group (FIG) **2nd Line:** Finance & Performance Committee March 2025. **External:** Monthly Provider Oversight Meeting with GM ICB (Ext)	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	Organisational wide communication of the financial position, challenges and controls	Throughout 2024/25 CFO

Corporate Objective: **C11** Deliver our financial plan, providing value for money services						1	2	3	**Overall Assurance level**	**High**
Principal risk	**Risk Title:**	**PR 8: Financial Sustainability: Efficiency targets**								
	Risk Statement:	There is a risk that the CIP plan will not be achieved and/or will not be cash releasing, resulting in a significant overspend.								
Lead Committee	**Finance & Performance**			**Risk Appetite**	Minimal					
Lead Director	**CFO**			**Risk category**	Financial Duties					
Date opened	**20.05.24**			**Threat: System Risk:**	**ID 3291** LSR6 Financial plans					
Date of last review	**14.03.25**			**Risk treatment**	Treat					

Risk Score Timeline

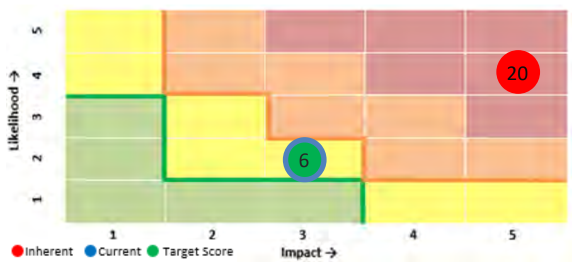


Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• Robust CIP divisional delivery approach and governance. • Monitored via Divisional Assurance Meetings, with additional escalation to Finance Improvement Group (FIG) • Further oversight at Executive Team, Finance Improvement Group, Transformation Board, F&P Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • CIP plan for 2024/25 is made up of Transformation schemes, FSP schemes (Exec Led) and core divisional CIP • CIP Handbook developed providing guidance and oversight processes • MIAA review during 2023/24 gave substantial assurance • Transformation Board input & oversight of strategic programmes. • GM Provider CIP meeting established and meets monthly reviewing all schemes and potential opportunities (Ext) • Diagnostic completed with Newton Europe to address UEC pressures and escalation costs. Discussions ongoing with Wigan Council and ICB re. further work with Newton to implement the changes and deliver recurrent efficiency savings. • Divisional finance performance metrics include recurrent CIP delivery. • Clinical leadership established reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings. • System savings group established across Wigan locality, to be chaired by Deputy Place Based Lead • CIP fully identified in year • Finance Improvement Group meeting monthly with agreed workplan • Executive led Divisional task and finish groups implemented where escalation required • Established QIA process led by Chief Nurse and Medical Director • CIP delivery proposals discussed at ETM June 24 and additional Exec led CIP/FSP schemes identified • Consultancy support engaged to review current approach to project management to ensure that we have the right processes and infrastructure to both maximise delivery and provide assurance • PWC investigation and intervention support will have a key focus on Robustness 2024/25 efficiency programmes and the governance supporting these (Ext) • Newton Europe contract signed August 24 to mobilise UEC transformation project from September 24 • Mid year review discussed at ETM and FIG including tactical actions to improve CIP delivery • Cross divisional CIP group established and chaired by Divisional Director of Ops for Community Services • GM Sustainability Plan endorsed by NHS GM Board to ensure appropriate management of finances and use of resources across GM (Ext)	• Limited mechanisms to facilitate delivery of system wide savings. • Limited PMO resource internally to support delivery of CIP plans	**1st Line:** Monthly Divisional Assurance meetings for applicable divisions and monthly finance improvement group (FIG) **2nd Line:** Finance & Performance Committee March 2025	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams.	Throughout 2024/25 CFO/COO

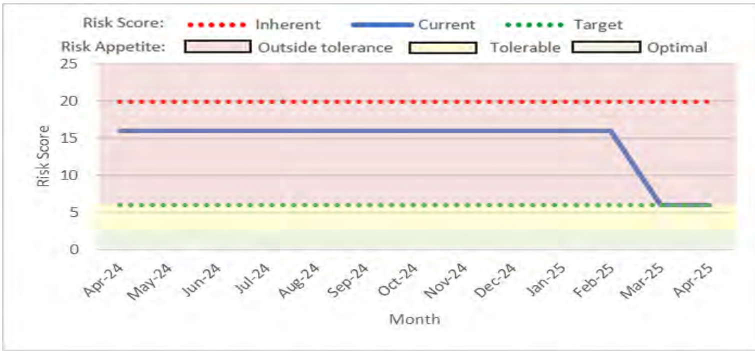
Corporate Objective: C11 Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 9: Capital Funding**
	Risk Statement:	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.

Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal
Lead Director	**CFO**		**Risk category**	Financial Duties
Date risk opened	**20.05.24**		**Threat: System Risk:**	**ID 3295** LSR6 Financial plans
Date of last review	**14.03.25**		**Risk treatment**	Treat



Risk Score Timeline

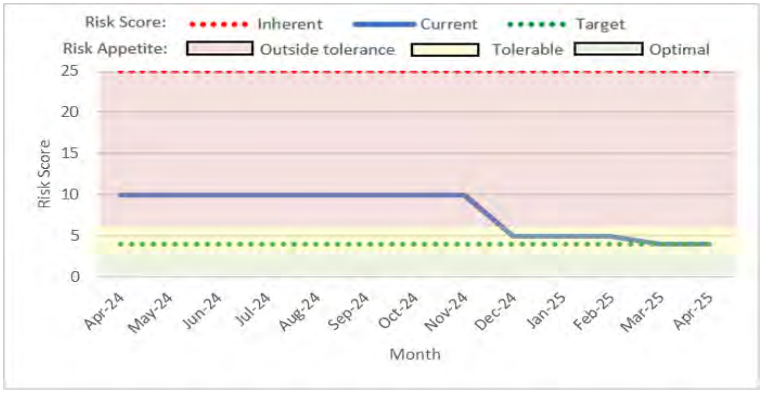


Strategic Opportunity / Threat Existing controls	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
• Lobbying via Greater Manchester for additional capital into the national process. (Ext). • Capital priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified within plan. • Strategic capital group meeting monthly with oversight of full capital programme. • Operational capital group meeting monthly to manage the detailed programme. • GM Capital and Cash group established, reporting to the Financial Advisory Committee (Ext). • GM Capital Resource Allocation Group (CRAG) established to support prioritisation of capital in 2024/25. • Programme Boards established for major capital schemes. • Design work undertaken for schemes aligned to strategic priorities to support bids for national PDC funding. • Exploring options with commercial partners to facilitate capital investments outside of CDEL in line with strategy. • Cash balances split between revenue and capital, with capital plans below depreciation, to ensure there is sufficient cash balance to support the capital plan. • Five year forward view developed internally to support medium term capital planning and prioritisation • GM ICB required to sign off all new right of use leases (Ext.) • Strategic scheme governance document developed to provide guidance and support decision making. • WWL capital plan is within operational CDEL envelope • Peer review process established for 2024/25 plans focused on clinical, operational and financial risk (Ext) • 10 year infrastructure plan completed and submitted to GM August 24 – refresh ongoing to be submitted 29th November. • Indicative 2025/26 allocation received for planning purposes • GM CDEL plan balances (Ext) • GM approval for all lease schemes (Ext)	• Further work required on five year forward view to refine plan.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - March 2025	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory.	Throughout 2024/25 CFO

Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

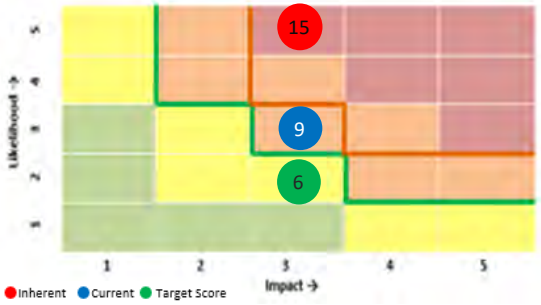
Principal risk	**Risk Title:**	**PR 10: Cash Balance**		
	Risk Statement:	There is a risk a that the Trust may have insufficient cash balance to meet normal business activities on a day-to-day basis, due to cash balances potentially becoming too low, resulting in the need to request additional support, financial obligations not being met, or the capital programme being restricted.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Minimal
Lead Director	**CFO**		**Risk category**	Financial Duties
Date opened	**20.05.24**		**Threat: System Risk:**	**ID 3998** LSR6 Financial plans
Date of last review	**14.03.25**		**Risk treatment**	Treat

Risk Score Timeline

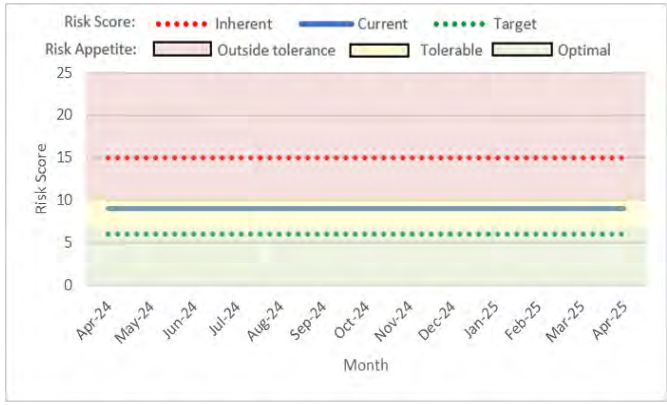


Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• NHSE process exists for providers requesting cash support which is done ahead of each financial quarter. There is an additional mechanism to draw down emergency cash support within the quarter is this becomes necessary, which is subject to additional authorisation. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report. • GM Capital and Cash Group established (Ext.) • Internal cash management group established and strategy developed. • Cash forecast reviewed with no support required in Q1 or Q2 2024/25. • Cash is a standing item on the F&P Committee agenda with papers providing an assessment of the cash position, forecast and mechanism for accessing cash support. • GM cash planning ongoing as part of Trust Provider Collaborative (Ext). • GM ICB continue to make contract payments on 1st of month (rather than 15th) to support cash management. (Ext) • All GM ICB payments outside of contract to be made in a timely manner (Ext) • GM ICB paying additional ERF based on plan (Ext) • See PR 8 for additional controls to ensure that CIP delivery is cash releasing. • GM Deficit plan confirmed cash backed with WWL receiving £7.8m in October 24, £13.4m in total for 2024/25. • Ongoing treasury management processes	• Best practice Cash Management document under development via the GM Technical Issues Group (Ext)	**1st Line:** Cash management Group **2nd Line:** Finance & Performance Committee March 2025	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring and forecasting of the cash balance	Throughout 2024/25 CFO

Corporate Objective: **CO12** To minimise harm to patients through delivery of our elective recovery plan	1	2	3	**Overall Assurance level**	**Medium**

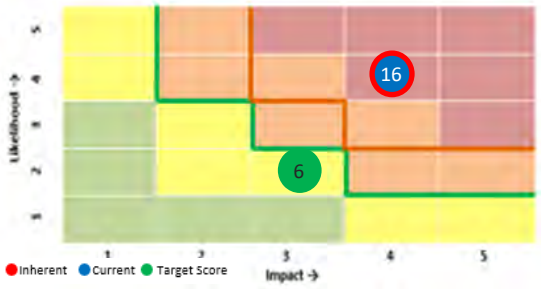
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 11: Elective services**			
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting in a reduction in demand and insufficient diagnostic capacity to deliver elective waiting times, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious	
Lead Director	**COO**		**Risk category**	Performance Targets	
Date risk opened	**19.10.21**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets	
Date of last review	**05.03.25**		**Risk treatment**	Treat	

Risk Score Timeline

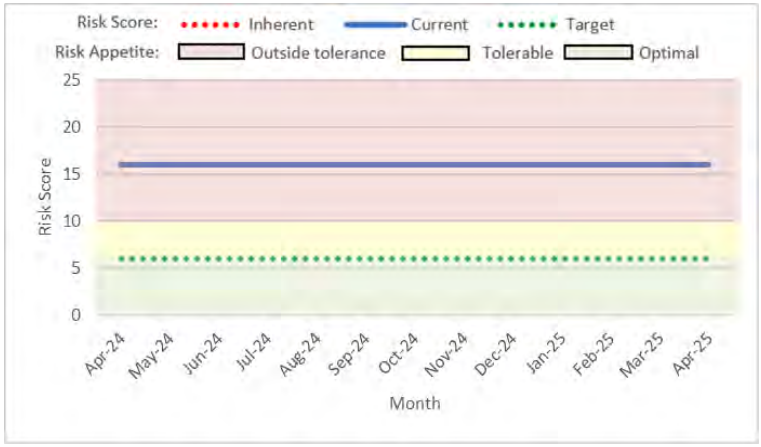


Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: (ID 3289)	• On track to eliminate waits over 65 weeks, except for Gynaecology patients. Exploring options for mutual aid. • Bi weekly meetings with ICB. • Continue to exceed the trajectory for the cancer faster diagnosis standard. • Implementation of Community Diagnostic Centres which will provide more capacity without waiting list initiatives. • Monitor through divisional assurance meetings with clear escalation protocols to exec team meetings and F&P Committee - developed into an app. • Transformation Plan - elective productivity and capacity aims to increase diagnostics and support delivery of electives and develop elective capacity. • Providing mutual support from GM and region for high volume low complexity plus orthopaedic work. • Digital validation of waiting lists.	• Demand for patients on cancer pathways exceeds capacity and impacts on delivery of non-cancer elective work. • Diagnostic capacity insufficient to deliver elective waiting times in some modalities. • Follow up waiting list is increasing. • Increase productivity to meet organisational targets • Impact of Estates issues on elective activity.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – March 2025 • Elective activity and efficiency board chaired by CFO.	•No gaps in assurance currently identified.	1. Revised endocrine clinic templates agreed. 2. Exploring mutual aid and insourcing options for Gynaecology. 3. GM pilot of external referral management.	For update in April 2025 For update in April 2025 For update in April 2025

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care	1	2	3	**Overall Assurance level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 12: Urgent and Emergency Care**			
	Risk Statement:	There is a risk to urgent and emergency care delivery as we are consistently operating above 92% occupancy levels, due to insufficient capacity and bed base in comparison to Acute Trust's across GM and nationally, resulting in longer waits, delayed ambulance handovers, reduced patient flow and more scrutiny through NHS England.			
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious	
Lead Director	**COO**		**Risk category**	Performance / Hospital Demand, Capacity and Flow	
Date risk opened	**05.09.22**		**Linked system risks**	LSR8: Statutory duties including the NHS Constitutional targets	
Date of last review	**05.03.25**		**Risk treatment**	Treat	

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3533)** Linked risk on corporate risk register: **3423** ED – insufficient patient flow	• Better Lives Programme to support residents to remain in their own homes for longer. Reducing admissions and timely and appropriate discharges are crucial, and making sure patients are seen where they need to be. • Red2Green approach is helping remove the blocks that prevent staff from discharging patients as soon as it is safe to do so. • 'Four Hour Sprint to March' aims to reduce the over four-hour wait for patients in our Emergency Department (ED). Over the last few weeks we have seen an improved performance against the 4-hour care standard in ED / UTCs. Fewer patients waiting over 12 hours in ED. • Director and Manager of the Day initiative. • Much improved ambulance handovers. • Reduced use of escalated areas to care for our patients and at times we have not used the corridor at all. • More timely discharges for our patients	• Our current four hour target performance is 68% and we need improve this to 78%. • Corridor care in spells rather than consistent, but is still occurring. • Work required further upstream regarding higher acuity of patients in borough.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – March 2025 • Discharge and Flow chaired by COO	•No gaps in assurance currently identified.	1. Work closely with colleagues in Wigan locality to progress WWL Transformation Plan and Hospital Discharge and flow programme.	For update in April 2025 COO

Partnerships

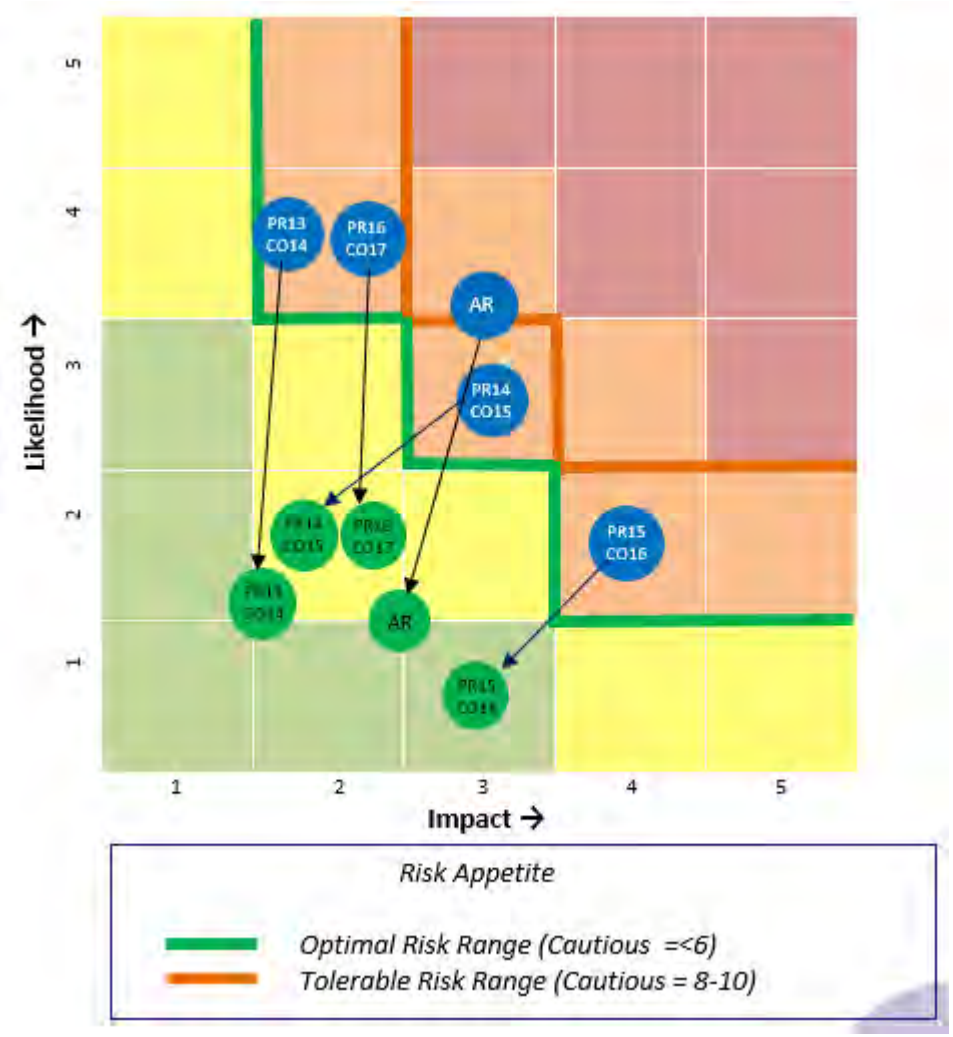
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

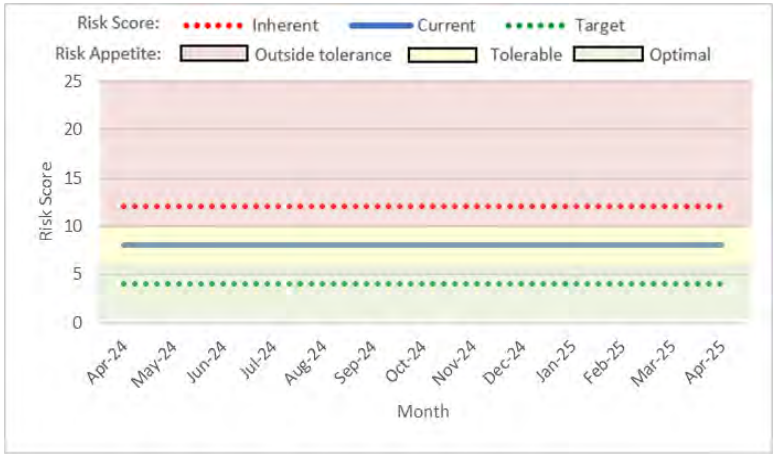
Ref.	Purpose of the objective	Scope and focus of objective	Objective Status
CO14	To improve the health and wellbeing of the population we serve	✓ As an Anchor Institution we will work with partners to improve the health of the whole population we serve, supporting development of a thriving local economy and reducing health inequalities. ✓ Playing an active role in the Healthier Wigan Partnership to develop and deliver programmes which reduce health inequalities	Risk to be reviewed with 2025/26 corporate objectives
CO15	To develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable	✓Work with partners across GM to develop and implement plans which deliver efficient corporate services ✓Work with partners across GM to develop and implement clinical service strategies which deliver services that are clinically and financially sustainable. ✓Work with our partners across the Wigan locality to deliver system transformation programmes aligned to agreed priorities.	Risk to be reviewed with 2025/26 corporate objectives
CO16	To make progress towards becoming a Net Zero healthcare provider	✓Implementation of priority actions following completion of carbon footprint analyst and heat decarbonisation plan.	Risk score reduced to from 16 to 8.
CO17	To increase our research activities delivering high quality research with patients and partners across the Wigan Borough, strengthening our research capability and making progress towards our ambition to be a University Teaching Hospital.	✓Increase research taking place across the Trust and Primary Care. ✓Increase number of commercial trials delivered with high performance meeting national KPIs. ✓Increase research knowledge and capability to deliver research. ✓Increasing NIHR funded research studies/programmes led by WWL. ✓Increasing the number of WWL honorary clinical academics employed substantively with EHU.	Risk to be reviewed with 2025/26 corporate objectives

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

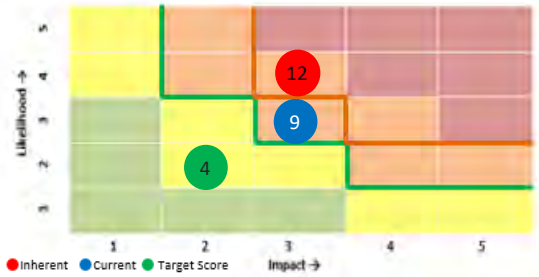


Corporate Objective: **CO14** To improve the health and wellbeing of the population we serve					1	2	3	**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 13: Supporting widening access to employment for local residents**							
	Risk Statement:	There is a risk that access to funding for support initiatives which support widening access to employment for local residents is less certain, due to pressures on the Trust's financial position, which may impact on delivery of the objective.							
Lead Committee	**Board of Directors**			**Risk Appetite**	Cautious				
Lead Director	**DSP**			**Risk category**	Strategy				
Date risk opened	**25.09.23**			**Linked system risks**	SR6 Financial plans				
Date of last review	**24.03.25**			**Risk treatment**	Treat				

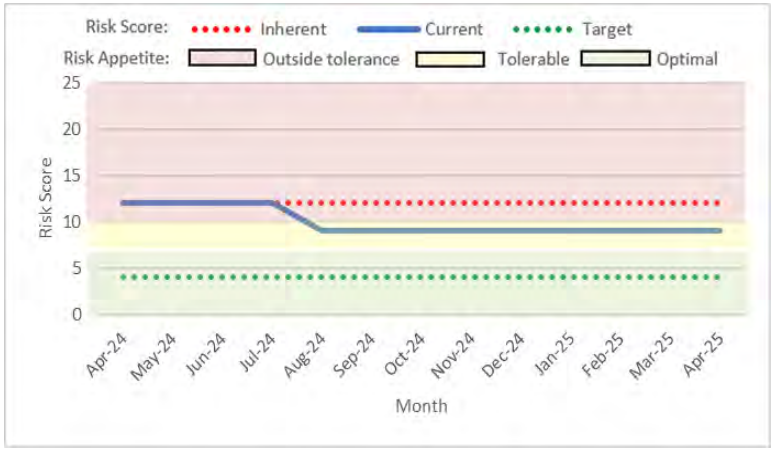
Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3852**	• Progress reviewed through Anchor Institution Steering Group. • Wigan and Leigh College have funded a role for 12 months to support our Talent4Care programme. The Talent4Care lead has been in post since September. This is increasing our representation at local careers events and two new cohorts of our sector-based work academy programme to support people boost their employability through placements at the college and WWL.	•Recurrent funding to support ongoing development and delivery of widening access to employment schemes.	**2nd Line:** • Bi-monthly Anchor Institution Steering Group • Bi-annual report to Trust Board	•None currently identified	1. Review current and potential widening access to employment schemes through the Anchor Institution Steering Group 2. Consider development of approach to business cases which take into account quantifiable social benefits.	For update in April 2025 - DSP

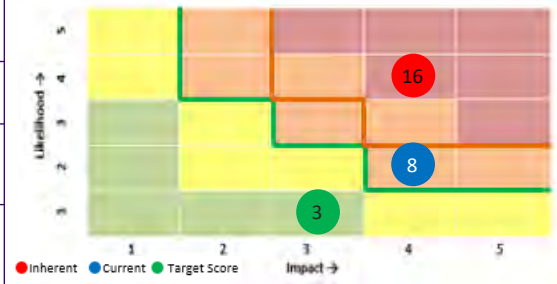
Corporate Objective: **CO15** To develop effective partnerships across GM and the Wigan Locality					1	2	3	**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 14: Partnership working - CCG changes**							
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.							
Lead Committee	**Board of Directors**			**Risk Appetite**	Cautious				
Lead Director	**DSP**			**Risk category**	Strategy				
Date risk opened	**19.10.21**			**Linked risks**	SR7 - system leadership				
Date of last review	**24.03.25**			**Risk treatment**	Treat				

Risk Score Timeline

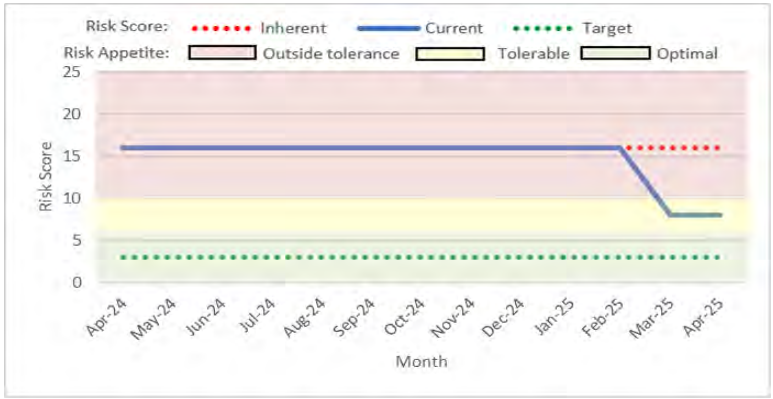


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3300**	• Locality meeting structures in place to support lasting corporate knowledge. • Development of locality UEC transformation programme – expected to begin in September 2024 subject to final approvals, bringing in external support from Newton Europe.	• Despite bringing people from the ICB and other system partners together through specific fora, there is still huge uncertainty about how we deploy our limited capacity to best effect and further resignations have exacerbated that. • Reduced locality capacity is currently having a much more material impact on managing patient flow and on our system finances. The impact of this should reduce as the UEC transformation programme progresses.	**2nd Line:** • Board of Directors – bi-monthly • **External:** System Board meetings – monthly	Uncertainty around CCG changes, in particular responsibilities and resources held centrally in GM versus those delegated to localities.	1. Attendance at System Board meetings with Partners.	DSP - Monthly

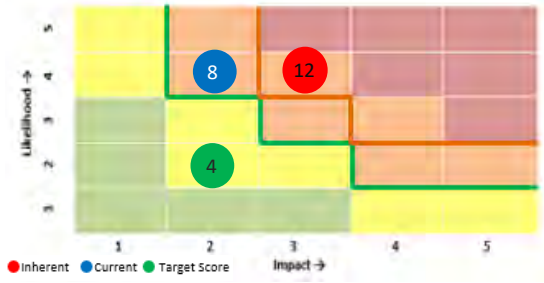
Corporate Objective: C16 Progress towards becoming a Net Zero healthcare provider	1	2	3	**Overall Assurance level**	**Medium**

Principal risk	**Risk Title:**	**PR 15: Estate Strategy - net carbon zero requirements**		
	Risk Statement:	There is a risk that the Trust will not meet its net zero commitments and Climate Change will have an impact on the Trust delivering services, that cannot be mitigated.		
Lead Committee	**Finance & Performance**		**Risk Appetite**	Cautious
Lead Director	**DSP**		**Risk category**	Sustainability /Net Zero
Date risk opened	**19.10.21**		**Linked system risks**	SR9 – Drive innovation
Date of last review	**24.03.25**		**Risk treatment**	Treat

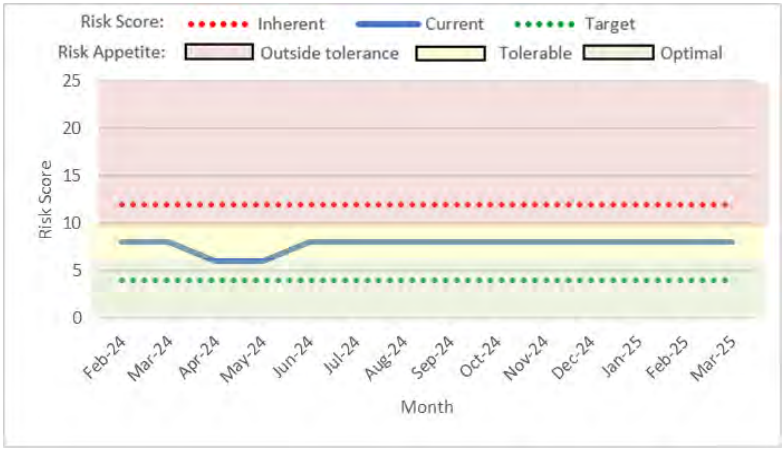
Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3296**	• Funding received for wok on LED lighting and solar panels. • Sustainability Manager in post. • Band 7 Energy Manager approved. Have not been successful in appointing to post. • Climate Change Adaptation Plan is in development. • Heat Decarbonisation Plan in place. • Sustainable Travel Plan in place. • Prioritised investment plan, Net Zero Strategy and Green Plan have been produced to outline how the trust will address its impact on climate change. • Net Zero and sustainability e-learning programme rolled out. Governance structures set up to address divisional sustainability issues. • Sustainability and Net zero expected to be included in corporate objectives process for 2025-26.	• Department is under-resourced and has no resilience. The Environmental and Sustainability Officer has resigned. The sustainability manager is acting as energy manager and administrator which takes up the majority of the working week. • Climate Change Adaptation Plan development has paused due to resourcing issues • Sustainability Impact Assessment has been developed but has not been adopted into the QIA process despite requests to. • Capital funds required to fund adaptation measures. Funds this year have been reallocated to next financial year. This places us significantly behind target. • Lack of functioning sub meters to monitor energy use • Struggling to recruit B7 energy manager. Advertised as an apprenticeship post through UCLans matching scheme. Chosen applicants did not respond to our requests to interview. • Our carbon footprint is increasing and investment into sustainability has been cancelled this year. We are significantly behind having any impact on reducing our environmental impact.	**2nd Line:** • Bimonthly Finance & Performance Committee AAA reporting • Bimonthly Greener WWL Steering Group • Annual Sustainability report • Annual Carbon Footprint • Response plans for business continuity, critical and major incidents • Annual self-assessment against the NHS EPRR framework	**2nd Line:** • EPRR Self assessments reflecting climate change risk assessments (in development)	1. Climate change adaptation plan to be produced, approved, and implemented. 2. Complete carbon footprint assessment annually. 3. Map annual progress towards net zero against net zero trajectory 4. Net Zero Investment Plan and Climate Change Adaptation Plan to be integrated into Capital planning. 5. Climate Change Adaptation to be incorporated into Estates Strategy and site masterplans. 6. Heat Decarbonisation strategy to be integrated into Estates Strategy and site masterplans. 7. Sustainable Travel Plan to be produced and incorporated into Estates strategy and site masterplans. 8. Incorporate Sustainability Impact Assessment into Quality Improvement Assessment 9. Further develop governance structures to ensure all areas captured.	4.For update in April 2025 / DSP

Corporate Objective: CO17 To increase our research activities delivering high quality research with patients and partners across the Wigan Borough					1	2	3	**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 16: University Teaching Hospital - University Hospital Association criteria**							
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to uncertainty regarding achieving the required core number of university Principal Investigators, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.							
Lead Committee	**Board of Directors**			**Risk Appetite**	Cautious				
Lead Director	**MD**			**Risk category**	Strategy				
Date risk opened	**19.10.21**			**Linked system risks**	SR9 – Drive innovation				
Date of last review	**24.03.25**			**Risk treatment**	Treat				

Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3299**	• Project documentation including action log in place. • Research Committee assurance • 5 colleagues confirmed as meeting the substantive employment to EHU.	• A core number of university Principal Investigators. There must be a minimum of 6% of the consultant workforce (for WWL this is 13 individuals) with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •We are achieving the criteria of a 2 year average of £200k/annum Research Capacity Funding awarded by end of March 2026. (An extension grant has been awarded to the NIHR funded SOFF trial which raises the NIHR grant income profile over the next 2 years.)	**2nd Line:** • Board of Directors – December 2024	• None currently identified.	The key actions for increasing University employed research Principal Investigators. Current status: Target is 13. (Based on 217 wte Consultants in post). 5 (previously 6 but 1 EHU substantive has retired) clinical academics in place. (2024 appointments - Diabetes (Banerjee) and Surgery (Lamb - with University of Bristol). 1 in recruitment (readvertised) EHU/WWL Clinical Academic in Microbiology/Infectious Diseases. Therefore 8 (previously 7) appointments required in final 1.5 years to achieve target of April 2026 for UHA application. NEW (REF eligible) criteria being applied to review all potential staff.	AR/AW For update in April 2025

Appendix 1: Summary of Wigan Locality Strategic Risk Register Risks – Q3 January 2025

Risk Reference	Risk Description	Current risk score
SR1	Maintain and improve the quality and safety of patient care	15
SR2	Failure to plan effectively for a pandemic situation or other significant business interruption event including digital resilience	6
SR3	Failure to improve population health and care outcomes and to reduce health inequalities	12
SR4	Failure to implement and manage effectively the systems, processes, and culture which enhances our reputation with our communities and stakeholders	15
SR5	Failure to support and develop our workforce	10
SR6	Achieving our financial plans and to maintain financial balance	15
SR7	Discharging our system leadership responsibilities and supporting the effective integration of the locality's health and care system	15
SR8	Statutory duties including the NHS Constitutional targets	16
SR9	Opportunity to drive innovation and maximise digital opportunities to deliver system transformation	15

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Committee report

Report from:	Quality and Safety Committee
Date of meeting:	12 March 2025
Chair:	Francine Thorpe

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

ALERT

- The quarterly patient safety incidents for Q3 report highlighted that 4 of the 5 incidents meeting the criteria for patient safety incident investigations were never events. The committee requested information on the application of National Safety Standards for Invasive Procedures (Natsips) and Local Safety Standards for Invasive Procedures (Locsips) to seek further assurance in relation to this issue.
- Risks highlighted by the Community Division Deep Dive included:
  - Delay in children's audiology appointments which negatively impact educational attainment and social development
  - Non-compliance with national standards set by Paediatric Hearing Services Improvement Programme
  - Potential inability to meet national accreditation programme linked to NHS contractual requirements
  - The service is working with a GM-wide oversight group to provide support and monitor action plans. The committee requested an update on progress for the next meeting.
- The Q3 harm free care report highlighted an increase in hospital and community acquired pressure ulcers compared to Q2. Non-achievement of corporate objective (CO4) for 2024/25 was confirmed.
- The patient relations report for Q2 and Q3 indicated that despite improvements being made; the Trust is unlikely to meet corporate objective (CO7) for 2024/25 relating to complaints response times.
- The sepsis report indicated a decline in the advancing quality (AQ) audit scores from October 2024 to December 2024. There is a risk that the Trust will not achieve the trajectory outlined within corporate objective (CO2) relating to improvement in AQ scores, due to ongoing operational pressures.

ASSURE

- The community division deep dive highlighted:
  - Low numbers of complaints and consistent achievement of 100% response rate within the given timescale
  - Quality improvement projects linked to Trust priorities including the Better Lives Programme
- The Q3 perinatal quality surveillance report and perinatal mortality report provided assurance on a range of quality and safety indicators which included:

- Full compliance with MBBRACE reporting
- Full compliance with Perinatal Mortality Review Tool (PMRT) standards
- Positive results from the national Picker Survey
- Over a rolling 12-month period, a steady decline in stillbirths
- Maternity mandatory training over 90% compliant in all staff groups
- Significant reduction in smoking rates at time of delivery

- The annual learning from deaths report highlighted improvements in compliance with good sepsis care and good renal care compared to the previous year. Five potentially preventable deaths were identified, a reduction from the previous year. Evidence was included in relation to learning and actions taken.
- The Q3 learning from deaths report provided assurance that national guidance is robustly adhered to. No Prevention of Future Deaths notifications were received.
- Evidence was provided within the patient relations report of learning and actions taken as a result of complaints as well as good progress made in complaint de-escalation and the establishment of the Independent Complaints Review Panel.
- The harm free care Q3 Report evidenced targeted work in areas with higher harms relating to falls and pressure ulcers which had secured improvement.

ADVISE

- The committee supported the launch of the Fundamentals Framework for Nursing, Midwifery and AHP's. It was noted that it has been produced with due consideration of feedback from staff and patients as well as linking with national strategy and Trust objectives.
- The committee received the action plan from maternity and neonatal services following the Score Culture Survey. Progress will be monitored through the Safety Champions meetings.
- Maternity reports highlighted two areas where ongoing improvement plans are being implemented to improve performance against GMEC standards. These are closely scrutinised at the Maternity Safety Champions meetings.
- A patient story was received which highlighted exceptional care provided within maternity services for a woman who experienced an extremely difficult journey.
- The Committee's reflections on Equality Diversity and Inclusion included:
  - Concerns in relation to the potential negative impact on children related to the paediatric audiology issues
  - Maternity reports including ethnicity, inequalities data and reduction in smoking at time of delivery
  - Patient story evidencing personalised care and support within maternity services

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the board assurance framework were reviewed; no amendments were made.
- The community divisional risks were presented as part of their deep dive

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Committee report

Report from:	People Committee
Date of meeting:	12 February 2025
Chair:	Mark Wilkinson

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

ALERT

- Whilst the people performance dashboard has developed in maturity over the last 9 months the Committee lacked some visibility on the impact of the Financial Sustainability Plan on pay and people. The next Committee meeting will receive a draft revised people dashboard (already in progress) seeking greater alignment between the dashboard and those aspects of our 'people performance' that directly impact on the financial position of the Trust.
- Compliance in fire safety training level 2 was highlighted to be of concern. It was agreed that this would be picked up by the Executive Management Team and progress reported back to the Committee.

ASSURE

- The Committee noted the relevant sections of the Board Assurance Framework, and requested that the risk (PR6) relating to Workforce Equality Diversity and Inclusion be considered for broadening out from its current focus on internationally educated nurses into our organisation wide responsibilities and across all staff groups.
- The development of the Freedom to Speak Up (FTSU) biannual report would be enhanced by addition of reporting by protected characteristics when available and consideration of any connection between FTSU and patient safety issues.
- The quarterly report of the Guardian of Safe Working Hours highlighted some immediate safety concerns that will be address in the relevant divisional and Trust wide meetings.

ADVISE

- Initial results from the staff survey and the most recent pulse survey were presented. At our next meeting we look forward to the full analysis and details of divisional action plans in response, together with a mini plan to boost participation in both surveys.
- The subject of the divisional deep dive this time was Estates and Facilities.
    - Some good progress being made with apprentice recruitment – a much needed step given our significantly ageing workforce in these teams.
    - Sickness absence is high – in absolute and also relative terms – when benchmarked a neighbouring organisation appear to be performing well and the Committee was keen to understand why.
    - A key contributor to sickness absence is Musculo-skeletal problems, and the Committee discussed bringing further support in from our staff physiotherapy team
    - The success of the innovative research centre in Ashton in Makerfield was recognised.

- The Committee noted the following through the consent agenda - in respect of which no concerns or actions were raised:
    - People services corporate benchmarking data
    - The audit and risk report
    - AAA reports and minutes of relevant reporting groups

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- No new risks identified.

Committee report

Report from:	Audit Committee
Date of meeting:	20 February 2025
Chair:	Simon Holden

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

ALERT

- The Chief Nurse attended to discuss the enhanced care limited assurance audit and the Committee heard about plans being put in place to address the issues.
- The Chief People Officer attended to discuss the high-risk recommendations around employee relations and retention of documents. Although this was not provision of assurance as such, the Committee were content that MIAA will be working with them to progress the plans and close the recommendations.
- Waivers raised in estates require work to ensure no repetition without demonstrating due process.

ASSURE

- The Audit Committee annual report was shared, in line with best practice.
- Internal audit are on plan to complete the program and support the annual governance statement. MIAA are pleased with the progress made with WWL's overall position.
- A high assurance internal audit was received for risk management core controls.
- Substantial assurance internal audits were received for:
  - ESR payroll, which important given materiality of expenditure
  - IT asset management
  - Freedom to speak up
- KPMG's plan is in place for the 2024/25 annual accounts audit in line with the DHSE timetable of 30 June 2025.
- The counter fraud work plan for 2025/26 was agreed, to prevent and detect fraud, with the progress report 24/25 on plan to deliver.

ADVISE

- The self assessment on national safety standards for invasive procedures (NatSSIPS) and LocSSIPs (Local Safety Standards for Invasive Procedures) will be shared at the next meeting.
- The IT asset management audit identified that £0.8m of devices are not Windows 11 compatible which creates a potential security risk.
- A review of the business case realisation processes was undertaken by MIAA.

- Follow up internal audit recommendations are all on all on track.
- KPMG have indicated a materiality limit of £11m (21%) of resource in advance of the 2024/25 audit.
- KPMG have been reappointed on a 2+2 contract by the Council of Governors, with partner responsible, Tim Cutler to continue this role.
- The losses and special payments report was received.
- The annual review and update of accounting policies took place with revisions approved.
- The waiver report was received with assurance requested at the next meeting on the number of estates and facilities single tender actions to demonstrate that they are very low in the grand scheme of total orders as well as how RAAC funding provision has effected the procurement policy position.
- The committee effectiveness review was carried out through discussion, with suggested changes noted and to be considered.
- The committee noted matters where it had reflected upon equality diversity and inclusion (ED&I) considerations along with health inequalities:

  Assistance being provided to patients who are being asked to sign indemnities

  Noting how other assurance committees consider this, through their minutes.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Following the annual review of the risk register and management process, the committee noted three risks escalated to 16 namely:

  IQIPSA - Improving Quality in Physiological Services Accreditation

  Children's audiology - delayed appointments

  PASQAT - Paediatric Audiology Services Quality Assurance Team

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Committee report

Report from:	Research Committee
Date of meeting:	4 March 2025
Chair:	Clare Austin

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

ALERT

- The number of clinical academic posts required to attain university status remains a concern – the financial challenges ahead were made note of and it was appreciated that the impact on research could be significant. Research capability funding is forecast to reach its required level at the end of 2025/26. There is a risk that this funding level (which will be met at the requisite average at that point in time) will not be maintained, which will mean that the related criterion is no longer met.
- Financial pressure in 2025/26 may make it more difficult to sustain investment in research, particularly since there is often a significant passage of time between research work being done and any sort of return on investment being realised.

ASSURE

- Significant assurance was noted around progression of the research workplan, with most metrics highlighted as green on the research assurance framework.
- Assurance was provided around management of Good Clinical Practice in research.
- Assurance on recruitment to, and above the recruitment target for the National Institute of Health and Care Research was received.
- Progression of research activity in the community division was noted, with significant progress with embedding this as 'business as usual' noted.
- Prof Adam Watt's 'SOFFT' trial has been successfully completed, with a clear outcome which will shape care moving forwards and implementation of the new process can now begin nationally.

ADVISE

- The research financial report was received and showed that progress is significantly above plan by £0.5m.
- A discussion ensued around the need to better embed research communications on a Trust wide basis, although this does happen, feedback suggests that information relating to research can be overlooked.
- In respect of health inequalities the committee had discussed:
  - How WWL can use the local joint strategic needs assessment to identify priorities for the borough and focus research on those areas.
  - How the Patient and Public Involvement Group will work with the Wigan Health and Care Forum to support its membership in becoming more representative.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ No significant risks were noted.

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Trust Finance Report

Month 11 – February 2025

Contents

Main report

Statistical Process Chart (SPC) Key

Key Financial Messages

For February 2025, the in-month position was a surplus of £0.6m, which is £0.7m favourable to plan. This is an improvement on previous months and the surplus has reduced the YTD deficit to £2.3m, which is £1.6m adverse to plan. The surplus in month was due primarily to two items: an increase in ERF activity and backdated income from a revision to the education training contract. We are forecasting to deliver our agreed revenue plan for 2024/25. All existing controls will remain in place to achieve this.

Divisional CIP was on plan in February which brings the YTD delivery to £25.0m, which is in line with the plan. However, recurrent delivery is £7.2m behind plan, which is supported by non-recurrent schemes. There has been a reduction in the recurrent amount identified from £17.5m to £16.3m.

There has been an improvement in divisional ERF performance; this was £0.3m above plan in month. Surgery and Medicine were above plan in month, and the under performance in Specialist Services reduced. The YTD performance remains below plan with an adverse variance of £2.0m. An ERF ceiling has been introduced at system level and discussions are ongoing around any potential impact from this on our year end position.

The closing cash balance at the end of the month is £18.8m, which is an increase of £4.6m from last month. The non-recurrent deficit funding (£12.3m YTD, £13.4m full year) means that cash support Is not anticipated in 2024/25, but the current run rate indicates this will be required from Q1 2025/26, pending confirmation of system deficit funding arrangements for 2025/26.

Workforce in February is at 7,021 WTE which is a decrease of 11 WTE on last month. This remains 181 WTE above the workforce plan of 6,840 WTE. Pay expenditure is above plan £0.4m adverse in month (£3.5m adverse YTD). There has been a reduction in temporary staffing WTE and expenditure on bank and agency, when compared to last month, associated partly with reduced escalation expenditure.

Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Amber		We are reporting an actual surplus of £0.6m for month 11 (February) which is an improvement on prior months. The year to date deficit has reduced to £2.3m. The forecast provided to NHSE is to deliver the full year plan of £0.8m deficit. This will require an improvement on the current run rate of £1.6m in month to achieve the plan. Following the improvement in recent months, we expect to deliver our revenue plan for 2024/25. It is essential that pay and non pay controls remain in place to support this.
	Adjusted financial position: Achieve the financial plan for 2024/25.	Amber		
ERF Income	Achieve the elective activity plan for 2024/25.	Amber		Elective activity is £0.3m above plan in month 11 and £2.0m behind plan year to date. This includes Advice & Guidance income of £1.3m YTD which has been included for diverted activity.
Agency	To remain within the agency ceiling set by NHSE.	Amber		Agency expenditure is £0.7m in month 11, a slight improvement from last month. This is below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure. This reflects 2.1% of total pay spend in month and 2.4% YTD.
Escalation	Sustained reduction in escalation spend for 2024/25.	Green		Reported escalation costs for February was £0.7m. Expenditure decreased by £0.1m in month with reductions in discharge lounge and corridor escalation and use of 1:1 enhanced care. Additional doctors on the corridor and outlier wards are expected to continue until at least the end of March but outlier spend was lower in month.
Capital expenditure	Achieve capital plan for 2024/25.	Green		Capital expenditure in month is £0.1m behind plan and £3.0m below plan YTD. The YTD underspend is due to leases £1.9m, operational CDEL £0.6m and PDC £0.4m. PDC capital incentives of £2.3m agreed with the system for this financial year will be transacted in month 12. This is cash backed and includes £0.4m of new capital and £1.9m for the transfer of capital between CDEL and PDC.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		There is a closing cash balance of £18.8m for February 2025 which an increase of £4.6m from last month and £11.1m above plan. This is due to timing differences in the receipt and payment of invoices. This includes £2.0m PDC capital receipts and £3.0m final instalment of education income received ahead of the corresponding cash outflows.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red		The Trust has delivered £2.3m CIP in month 11 which was on plan. The YTD position is now in balance with the plan of £25.0m. The total target is now fully identified, although a small amount remains high risk. Recurrent CIP delivery is behind plan mitigated in year by non-recurrent CIP, this will impact on the timescale to deliver the Financial Sustainability Plan.
Better Payments Practices Code (BPPC)	Pay 95% of invoices within 30 days.	Amber		BPPC performance to end of February is 94.6% by volume and 96.1% by value, which is a slight improvement to previous months.

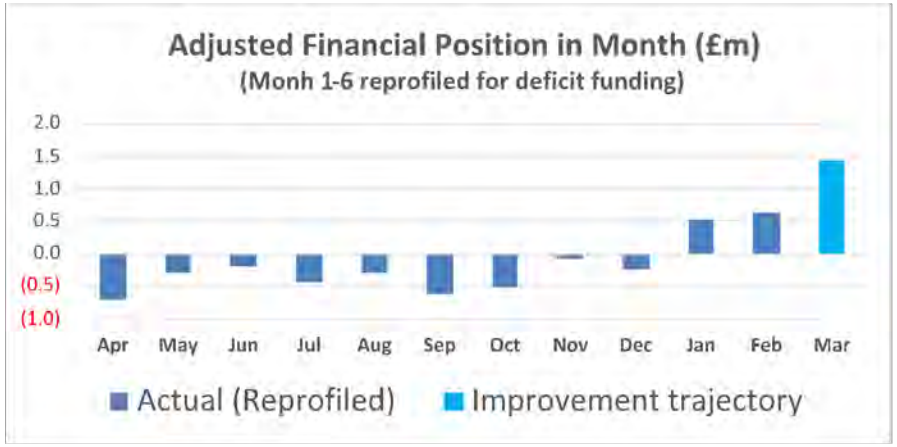
Financial Performance

Headlines

- Actual surplus of £0.6m in month 11, **£0.7m favourable to plan**. The surplus in month was due to two reasons; the ERF plan was achieved in month (an improvement in run rate) and backdated education training income.
- YTD is actual deficit of £2.3m, which **is £1.6m adverse to plan** including the non-recurrent deficit funding.
- Following the improvement in recent months, we expect to deliver our revenue plan for 2024/25. It is essential that pay and non pay controls remain in place to support this. There are several items that require concluding with GM ICB before the year end.

Improvement Trajectory to Deliver Revenue Plan

Based on the current run rate there needs to be a **£1.6m improvement** in month 12 to deliver the 2024/25 plan.



Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	48,565	45,974	2,591	510,239	504,189	6,049	550,200
Pay	(32,631)	(32,157)	(475)	(357,091)	(353,556)	(3,535)	(385,714)
Non Pay	(13,147)	(11,892)	(1,256)	(133,393)	(128,844)	(4,549)	(140,768)
Financing / Technical	(2,179)	(2,060)	(119)	(22,105)	(22,665)	559	(24,725)
Surplus / Deficit	607	(135)	742	(2,350)	(875)	(1,474)	(1,008)
Adjusted Financial Performance *	629	(119)	748	(2,253)	(698)	(1,555)	(815)

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

Income

Division	In Month (£000)			Year to Date (£000)		
	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	698	439	259	4,503	4,109	394
Surgery	1,219	234	984	5,872	2,385	3,487
Specialist Services	1,644	1,605	39	13,648	16,902	(3,253)
Community Services	880	741	139	6,574	6,461	113
Non Divisional Income	43,310	41,974	1,335	465,508	462,440	3,068
Finance	16	11	5	184	126	58
Digital Services	(39)	7	(47)	56	80	(24)
Dir of Strat & Planning	183	230	(46)	2,435	2,529	(94)
Chief Operating Officer	0	0	0	0	0	0
Human Resources	17	1	16	250	10	239
Medical Director	106	52	54	1,062	569	493
Estates & Facilities	418	459	(42)	4,895	5,054	(159)
Nurse Director	57	65	(7)	1,165	711	455
Trust Executive	8	26	(18)	53	283	(230)
GTEC	(9)	195	(204)	1,987	2,339	(352)
Corporate	59	(65)	124	2,047	192	1,855
Total	**48,565**	**45,974**	**2,591**	**510,239**	**504,189**	**6,049**

Headline

- Income is £2.6m favourable in month and £5.9m favourable YTD.

Medicine

- £0.3m favourable in month. ERF income is £0.1m favourable in month. £0.2m favourable due to over performance on drugs and devices and £0.1m adverse due to CDC under performance.

Surgery

- Surgery's income is £1.0m favourable in month due to £0.6m over performance on ERF income of which £0.3m relates to prior months coding. £0.1m over performance on unbundled drugs and devices.

Specialist Services

- On plan in month due to £0.2m underperformance on ERF offset by £0.2m over performance on unbundled drugs and devices.

Non – Divisional Income

- £1.3m favourable in month. £1.2m is due to the revised Education contract including the uplifted tariffs backdated to month 1. £0.1m benefit of the ERF underperformance relating to low value activity (LVA) contracts that are blocked.

GTEC

- £0.2m adverse in month due to credit notes associated with international nurse placements at other NHS organisations.

Divisional ERF Activity and Income v Final Plan

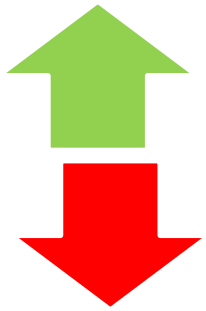
ERF Ceiling

- An ERF ceiling has been introduced at system level and the forecasted risk to WWL is circa £1m and all relates to the GM ICB. Discussions are ongoing with GM ICB and providers to mitigate the risk and remove any potential impact from this on our year end position.

ERF Performance

- In month 11 we are £0.3m favourable to the internal ERF plan and £2.0m adverse YTD inclusive of advice & guidance income which has been allocated out to Divisions.
- Specialist Services are £0.2m adverse in month and £4.4m adverse YTD predominantly within Trauma & Orthopaedics, this is a result of not utilising all available theatre sessions.
- Surgery have overperformed against their plan by £0.3m in month and are £2.4m favourable YTD.
- Medicine are £0.1m favourable to plan in month and £38k YTD.
- Advice and Guidance income of £1.3m YTD has been included in the financial position and has been allocated out to Divisions from Non-Divisional Income.

		In Month Activity			In Month (£000)			YTD Activity			YTD (£000)		
Division	POD	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
Medicine	Day Cases	1,527	1,599	(72)	982	1,032	(50)	16,521	18,627	(2,106)	10,807	12,017	(1,210)
Medicine	Electives	13	26	(13)	23	41	(18)	408	300	108	586	472	113
Medicine	OP Proc New	86	187	(101)	24	64	(41)	1,410	2,177	(767)	463	751	(288)
Medicine	OP Proc FUP	501	346	155	104	69	35	6,919	4,030	2,889	1,280	803	477
Medicine	OPA New	2,479	2,158	321	616	525	90	25,858	25,141	717	6,437	6,121	316
Medicine	A&G				57		57				629		629
Medicine Total		**4,606**	**4,315**	**291**	**1,806**	**1,731**	**75**	**51,116**	**50,275**	**841**	**20,202**	**20,164**	**38**
Specialist Services	Day Cases	792	801	(9)	1,305	1,332	(27)	7,818	8,652	(834)	13,062	14,230	(1,168)
Specialist Services	Electives	410	428	(18)	2,960	3,108	(148)	4,020	4,525	(505)	29,192	32,872	(3,679)
Specialist Services	OP Proc New	734	806	(72)	121	133	(12)	9,924	9,391	533	1,583	1,551	32
Specialist Services	OP Proc FUP	1,160	1,017	143	158	139	19	14,834	11,844	2,990	2,021	1,624	398
Specialist Services	OPA New	2,995	3,086	(91)	615	634	(19)	34,088	35,957	(1,869)	6,976	7,384	(408)
Specialist Services	A&G				36		36				398		398
Specialist Services Total		**6,091**	**6,138**	**(47)**	**5,195**	**5,346**	**(151)**	**70,684**	**70,369**	**315**	**53,233**	**57,660**	**(4,428)**
Surgery	Day Cases	888	789	99	1,211	1,036	175	9,544	9,181	363	12,757	12,069	688
Surgery	Electives	166	114	52	418	437	(19)	1,889	1,324	565	5,375	5,094	281
Surgery	OP Proc New	1,722	1,601	121	362	341	22	19,809	18,646	1,163	4,130	3,971	159
Surgery	OP Proc FUP	3,562	2,891	671	672	537	136	37,569	33,685	3,884	7,263	6,252	1,011
Surgery	OPA New	3,862	3,859	3	770	765	5	45,047	44,959	88	8,953	8,916	37
Surgery	A&G				23		23				257		257
Surgery Total		**10,200**	**9,253**	**947**	**3,457**	**3,116**	**341**	**113,858**	**107,796**	**6,062**	**38,735**	**36,302**	**2,433**
Divisional ERF Totals		**20,897**	**19,706**	**1,191**	**10,458**	**10,194**	**264**	**235,658**	**228,440**	**7,218**	**112,169**	**114,126**	**(1,957)**



Overperformance

- Surgery £2.4m YTD
- Medicine £38k YTD

Underperformance

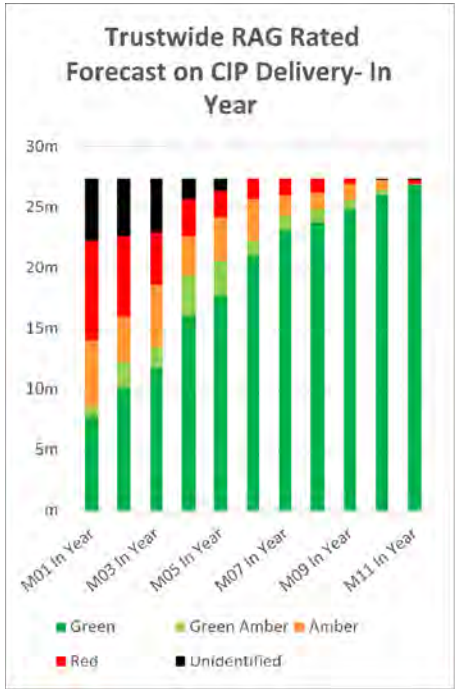
- Specialist Services £4.4m YTD

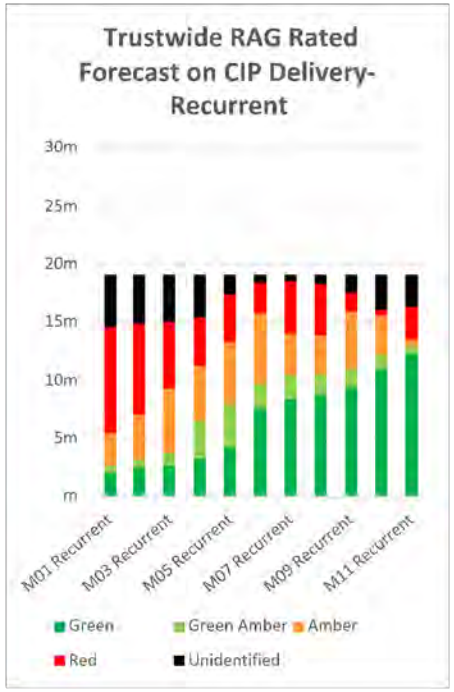
Trust Wide CIP Delivery 2024/25

2024/25 CIP Plans

The CIP Tracker currently includes schemes totalling £27.3m – less than 1% is categorised as high risk.

The total in year target is now fully identified, however there has been a slight increase in the recurrent amount identified from £16.1m to £16.3m. As at Month 11, £0.2m of our recurrent forecast is rated as high risk.





February 2025 Reported Position

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

- £27.3m identified, £16.3m recurrent

January 2025 Reported Position

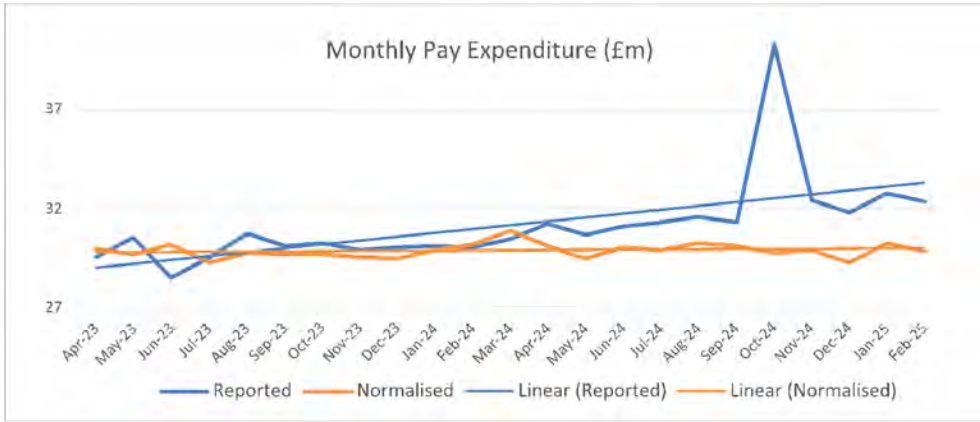
RAG	Value £'000
	-
	103
	648
	26,549
CIP Total	27,300

- £27.3m identified, £16.1m recurrent

Workforce

Pay expenditure

- The in-month pay expenditure is £32.6m which is £0.4m below plan in month, and £3.5m adverse to plan YTD.
- The normalised pay average for month 10 to 11 average is slightly lower than Q4 of last year £30.3m. Overall pay expenditure remains relatively static.



Pay £0.4m below plan in month

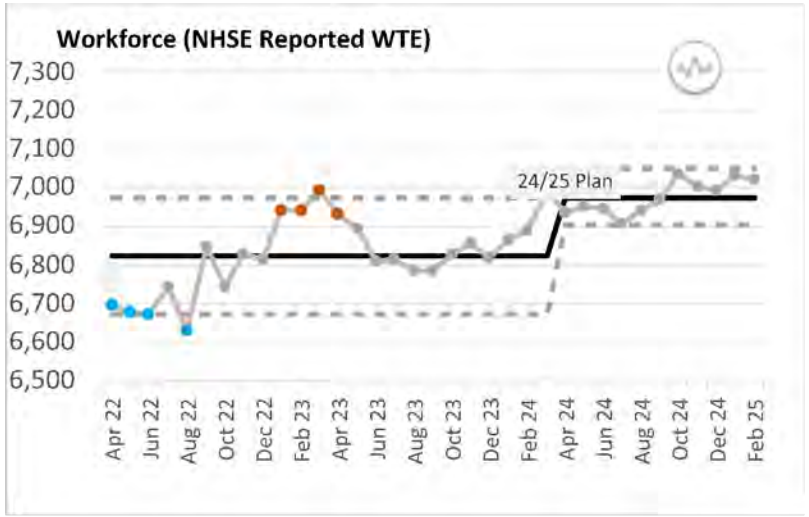
Normalised pay remains static

Normalised quarterly average

Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	M10-11
£29.9m	£29.6m	£29.5m	£30.3m	£29.8m	£30.0m	£29.6m	£30.0m

Workforce (WTE)

- Actual workforce 7,021 WTE in February. This is a decrease of 11 WTE from last month and remains 181 WTE above the workforce plan of 6,840 WTE.
- Substantive staffing has increased by 20 WTE.
- Bank staffing has decreased by 27 WTE in Surgery (theatres and wards) and, Medicine (medical and nursing staff).
- Agency has decreased by 5 WTE on last month, largely found in Medicine



Minor fluctuations in WTE numbers across recent months

WTE above plan by 181 WTE

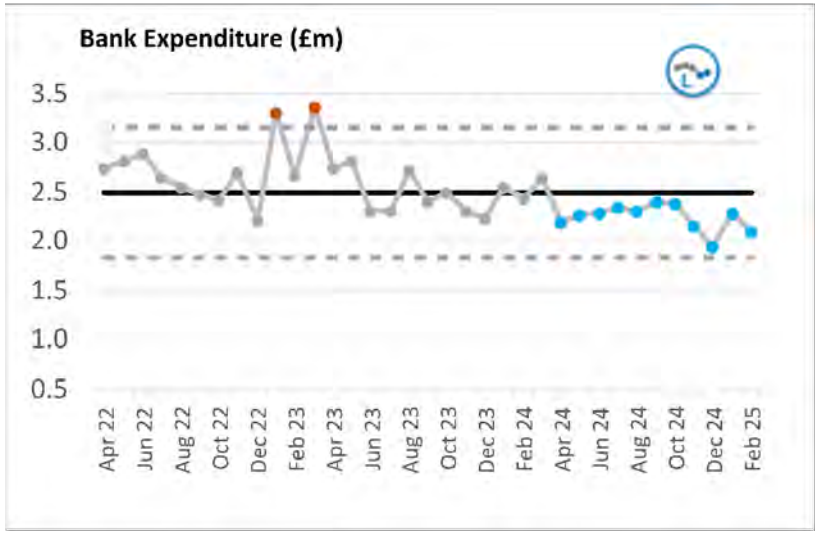
Temporary Staffing

Bank expenditure

- Bank costs were £2.0m in February, a £0.3m improvement from the prior month. This can be seen across Medicine and Surgery divisions.
- Standardised bank rates based on AfC top of scale applied from 1st December 2024, removing the premium cost.
- Bank WTE also fell by 26 WTE compared to the prior month.
- The chart is showing a special cause of a worsening variation.
- In month 11, Medicine (£1.2m) and Surgery (£0.5m) continue to be the biggest users.

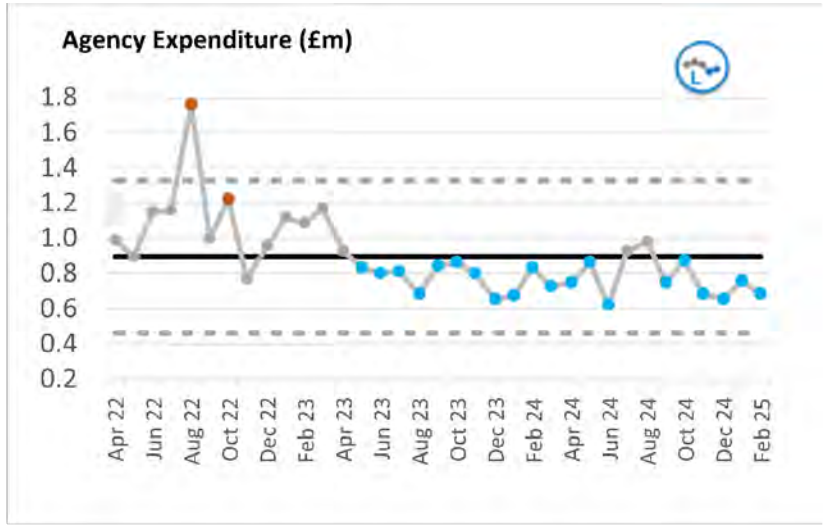
Agency expenditure

- Agency spend in month is £0.6m, a decrease of £0.2m from prior month, therefore the trend is showing common cause variation as this is still within the typical process limits.
- There was no material change in agency expenditure despite the standardisation of NHSP bank rates from 1st December 2024.
- Agency spend in month is 1.7% of the total pay spend, which is below the NHSE agency ceiling set at 3.2%
- Medicine (£0.5m) continues to have the highest level of agency within the Trust.



Bank expenditure decreased in month

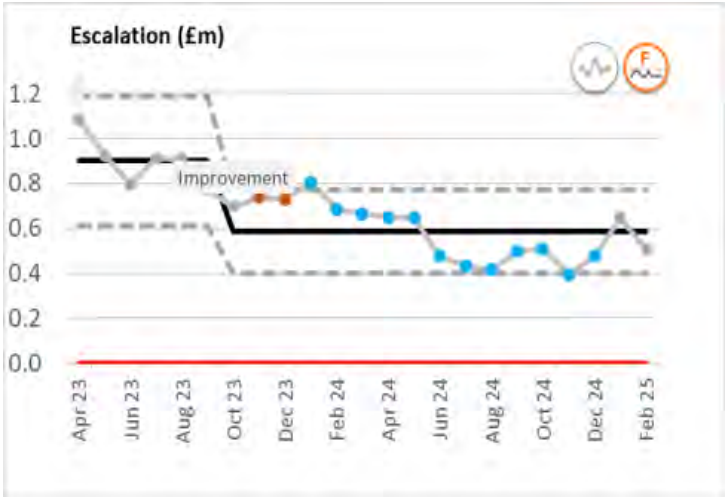
Standardised rates implemented from December



Below the NHSE agency ceiling, however scrutiny remains high

Escalation – Medicine Division

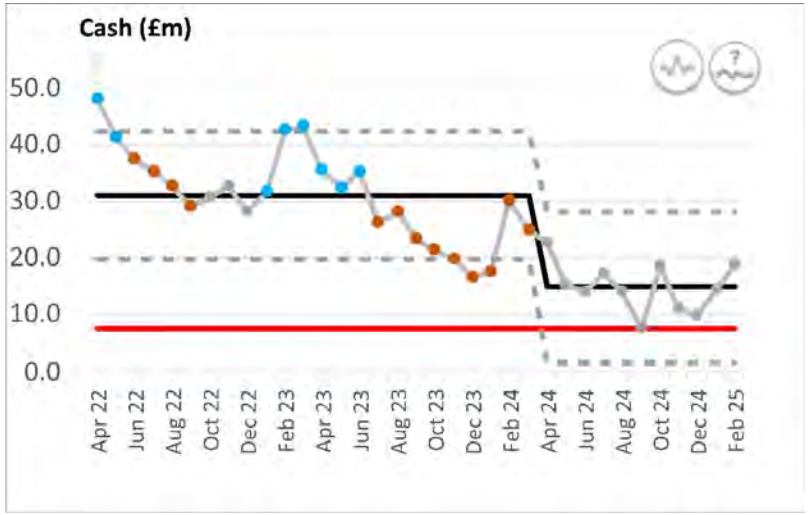
Area	2023/24 (£000)	M1 Actual (£000)	M2 Actual (£000)	M3 Actual (£000)	M4 Actual (£000)	M5 Actual (£000)	M6 Actual (£000)	M7 Actual (£000)	M8 Actual (£000)	M9 Actual (£000)	M10 Actual (£000)	M11 Actual (£000)	2024/25 Forecast (£000)
A&E Rota Issues	3,248	128	147	103	103	103	103	103	103	103	103	103	1,304
Paeds rota issues	1,014	67	67	67	67	67	67	67	67	38	38	38	689
Acute Rota Issues	809	51	51	51	51	28	21	21	21	21	21	21	374
Acute Outliers	517	26	26	26	26	26	26	26	12	12	12	12	244
Outlier Additional Doctor	0									5	21	5	54
AAA	129	79	77	68	0	0	0	7	15	51	51	49	424
Discharge Lounge	157	53	46	18	24	14	26	19	35	43	29	0	337
Corridor	1,748	71	31	15	41	21	78	98	60	54	118	87	783
Corridor - Extra Medics	0									21	34	31	118
Waiting room	374	31	31	31	31	31	31	31	31	31	31	31	372
1:1 Enhanced Care	1,724	123	154	84	87	125	79	86	50	61	143	89	1,156
Wrightington Escalation	0									36	12	0	49
SDEC Overnight	0										35	41	117
BWN Decant Costs	0						67	51					119
Total	**9,721**	**629**	**630**	**463**	**430**	**415**	**498**	**509**	**394**	**477**	**648**	**506**	**6,139**
Winter Business Cases	570	140	140	148	148	148	148	148	148	148	148	148	1,760
Grand Total	**10,291**	**769**	**770**	**611**	**578**	**563**	**646**	**657**	**542**	**625**	**796**	**654**	**7,899**

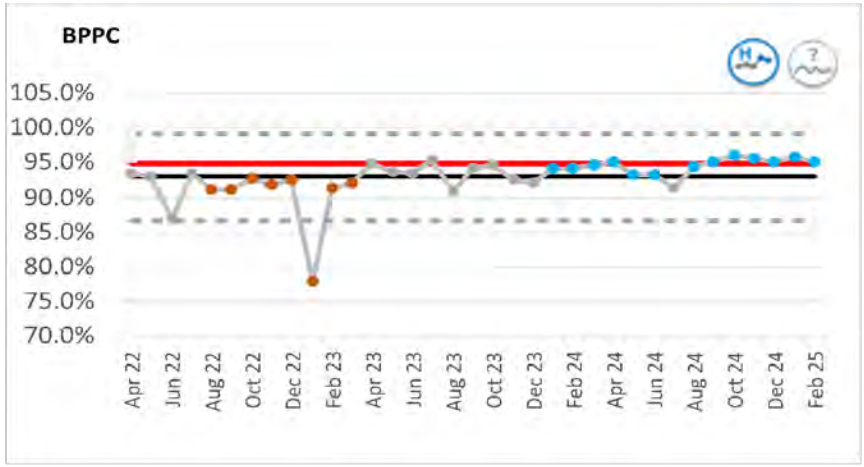


Headlines

- Total escalation spend decreased by £143k in month with reductions in DL and corridor escalation and use of 1:1 enhanced care.
- Additional doctors on the corridor and outlier wards are expected to continue until at least the end of March but outlier spend was lower in month.
- SDEC was escalated and staffed overnight 12 times during February.

Cash and BPPC





Current cash position

- Closing cash at the end of February was £18.8m, an increase of £4.6m from January. This is due to timing differences in the receipt and payment of invoices. This includes £2.0m PDC capital receipts and £3.0m final instalment of education income received ahead of the corresponding cash outflows.
- The closing cash balance is £11.1m above the plan of £7.7m largely due to the provider deficit funding, pay award funding, additional PDC funding, variance to the revenue plan and other timing differences in payment of invoices.

Cash forecast

- Deficit funding support of £13.4m has been confirmed, £12.3m received to date with the final balance if £1m to be received in March.
- As a result of this support the forecast indicates there will be sufficient cash balances for the remainder of the financial year.

Better Payment Practice Code (BPPC)

- The in-month performance was 95.1% by volume and 95.1% by value.
- YTD performance 94.6% by volume which is slightly under target, and 96.1% by value which is above target.
- The task and finish group continues to progress the action plan to improve the performance.

Capital

Scheme	In Month (£000) Actual	Plan	Var	Year to date (£000) Actual	Plan	Var	Full Year (£000) Plan	Forecast (£000) Plan	YTD Actual of Full Year Plan (%)
Operational capital (CDEL)	718	819	101	8,140	8,726	586	9,287	9,287	88%
Lease expenditure (IFRS16)	0	292	292	708	2,655	1,947	2,655	1,761	27%
Capital Incentive Programme								(1,916)	
Sub total internally funded	**718**	**1,111**	**393**	**8,848**	**11,381**	**2,533**	**11,942**	**9,132**	**74%**
National funding (PDC)									
Theatre 11, Wrightington	(0)	0	0	1,325	1,325	(0)	1,325	1,325	100%
Endoscopy	659	555	(104)	6,134	6,343	209	6,886	6,886	89%
RAAC Eradication Programme	203	118	(85)	541	590	49	711	711	76%
Transnasal Endoscopy	0	0	0	0	267	267	267	267	0%
LED Lighting	472	405	(67)	1,890	1,822	(68)	2,362	2,362	80%
I-refer Clinical Descision Support (CDS)	0	0	0	0	0	0	162	162	0%
Paediatrics at Leigh	35	0	(35)	35	0	(35)	400	400	9%
Capital Incentive Programme								1,916	
Sub total national funding	**1,369**	**1,078**	**(291)**	**9,924**	**10,347**	**423**	**12,113**	**14,029**	**82%**
Total capital programme	**2,086**	**2,189**	**103**	**18,772**	**21,728**	**2,956**	**24,055**	**23,161**	**78%**

Capital plan 2024/25

- Total capital plan for the financial year of £21.1m broken down as:
  - Internal operational CDEL £9.3m.
  - Lease expenditure £2.7m.
  - PDC £9.2m.
- Additional PDC support of £3.5m approved by NHSE in year:
  - £0.7m to eradicate Reinforced Autoclaved Aerated Concrete (RAAC)
  - £0.3m Trans Nasal Endoscopy equipment
  - £2.4m Led lighting
  - £0.1m Irefer CDS Tool

Month 11 Headlines

- Capital expenditure is £0.1m behind plan in month and £3.0m below plan YTD.
- The YTD underspend is due to leases £1.9m, operational CDEL £0.6m and PDC £0.4m.

Operational CDEL

- £0.1m below plan in month and £0.6m behind plan YTD.
- Variance to plan largely due to underspend against Endoscopy, Bryn Ward and STA disposal.
- PDC capital incentive of £1.9m agreed with system which will reduce our operational CDEL limit. Draw down of funding has been actioned and cash will be received in March.

PDC funded schemes

- £0.3m above plan in month and £0.4m below plan year to date, largely due to Endoscopy and Trans nasal Endoscopy.
- £0.4m PDC funding agreed for Paediatric surgical equipment for Leigh.
- Draw down of funding has been actioned in month for all remaining PDC funded schemes and cash will be received in March.

Lease Expenditure

- Below plan in month £0.3m and £1.9m below plan year to date.
- Lease expenditure will continue to trigger ICB red line metrics until expenditure is back on plan and this is not expected until March.

Full Year Forecast Scenarios

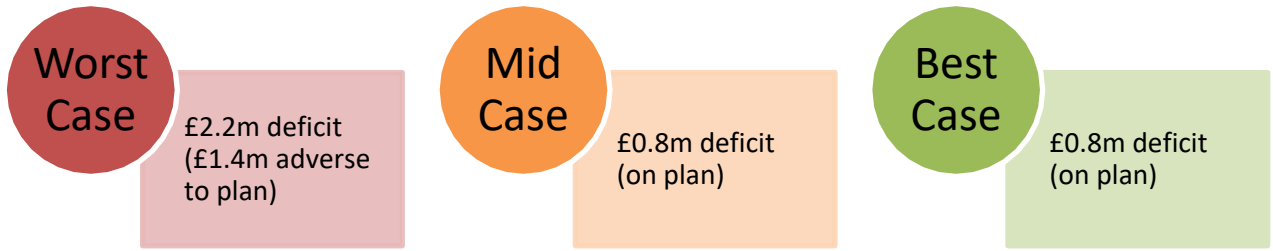
Bridge from straight line forecast to actual forecast. This sets out the assumption and improvement required to hit plan.

Straight line forecast £2.5m deficit	Remove non-recurrent items & phasing adjustments -£0.9m	ERF Forecast +£0.5m	Improvement required to deliver plan +£2.0m	Current forecast £0.8m deficit (as per plan)
• Extrapolated from £2.3m YTD deficit at month 11	•Non recurrent items, extrapolated impact -£0.7m: •Prior year income -£0.2m •Non pay mitigations -£0.5m •Month 12 phasing adjustments -£0.2m	• Assumes no ERF ceiling applied by GM ICB or other commissioners. • Includes £0.9m for Specialist Services and Surgery as per divisional forecast. • Assumes direct non pay expenditure of £0.4m.	•CIP needs to remain on plan. •Other tactical plan improvements in month 12 £2.0m (excluding ERF) with additional mitigations agreed to offset slippage.	• As submitted to NHSE. • All other pressures to be mitigated within existing plan.

Key assumptions to achieve plan

- From month 11, the mid case and best case both reflect delivery of plan.
- The worst case reflects risks associated with GM ICB clawback, associated with ERF overperformance above the ceiling (if not mitigated within the system) and CDC activity.
- Ongoing discussion with system partners should further mitigation be needed to deliver the plan.

High level scenarios for full year forecast



Risk Management and Mitigation

Revenue position

Recurrent CIP delivery: Recurrent CIP is below plan by £7.2m YTD which will impact on delivery of the Financial Sustainability Plan and timescale to return to a break-even position

ERF activity: The activity and income plan for 2024/25 includes an increase within the final month of the financial year, primarily within T&O. A step change in activity is required to deliver our plan.

ERF ceiling: This has been introduced at system level on ERF overperformance with the ceiling based on the system forecast outturn at month 8. Currently WWL are above the ceiling which will need to be offset by under performance in other GM providers for us to be paid in full for activity delivered. An updated position statement is awaited from GM ICB.

Winter/ Escalation: The forecast assumes no unplanned increase in expenditure, due to the Better Lives programme. The forecast assumes that the increase seen in January does not continue.

Contract income clawback: There is a risk of clawback associated with several ICB contract items in year, which would impact on delivery of the financial position, most notably around the activity for the Community Diagnostic Centre.

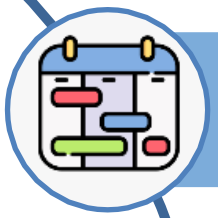
Non pay pressures: Creep in non-pay expenditure for clinical supplies and drugs, including inflationary pressures, to be managed in year.

Other

Cash: The non-recurrent deficit funding has mitigated the need for cash support in this financial year but cash balances remain a concern. The NHSE process for cash applications has been paused for April. The cash balance continues to be monitored closely.

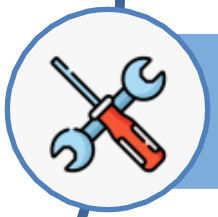
Financial environment: The financial environment for 2024/25 for both revenue and capital is highly constrained, and the Trust is operating at a deficit. These may impact on the ability of the Trust to deliver its strategic objectives.

Forward look



The final plan submission for 2025/26 is required by NHSE by 27 March 2025. National planning guidance was released early February, which included an increase to the national efficiency requirement from 1.1% to 2.0%. Discussions about the system financial plan and adoption of the control total continue at DOF and CEO level. There is an extraordinary board meeting on 18 March 2025 for approval of the final plan submissions.

CIP plans for 2025/26 are being developed across the divisions, whilst we continue to ensure delivery of our 2024/25 CIP programme. An increase to the CIP target for 2025/26 was agreed by the Board on 5 March 2025. This target is planned to be £35.7m, of which 60% is recurrent. Currently all schemes that have been transacted on a non-recurrent basis are under review to assess where these could be converted to a recurrent saving to support the financial sustainability plan.



Capital planning for 2025/26 is continuing both internally and across the GM system. Provider allocations are not yet known but capital is expected to remain highly constrained. It is expected that a capital control total will be issued to all GM providers via the Capital Resource Allocation Group (CRAG).

The new Procurement Act 2023 was introduced on 24 February 2025. The new act replaces the Procurement Contracts Regulations 2015 which were aligned to the EU. The aim of the new act is to introduce flexibility in the procurement process, apply greater transparency to procurement, application of contract management principles and encourage the participation of small to medium enterprises.

Agenda item: [22]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Trust finance report for February 2025 (Month 11)
Presented to:	Board of Directors
On:	2nd April 2025
Item purpose:	Information
Presented by:	Tabitha Garder, Chief Finance Officer
Prepared by:	Senior Finance Team
Contact details:	E: Heather.Shelton@wwl.nhs.uk

Executive summary

The presentation provides the full finance report on the Trust financial position for month 11 (February 2025).

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

Link to strategy

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

Risks associated with this report and proposed mitigations

Please see slide 15 for the current risk assessment.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Equality, diversity and inclusion implications

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

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

The finance flash metrics report was reviewed by ETM on 6th March 2025. The full finance report was reviewed by the Finance and Performance Committee on 25th March 2025.

Wider implications

There are no wider implications of this report.

Recommendation(s)

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

Agenda item: [23]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Partnerships Report
Presented to:	Board of Directors
On:	2nd April 2025
Purpose:	Information
Presented by:	Richard Mundon, Director of Strategy and Planning
Prepared by:	Chris Clark, Director of Strategic Transformation
Contact details:	Email: chris.clark@wwl.nhs.uk

Executive summary

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

This report is the third biannual report to Trust board on system partnerships, following the previous reports on the 7th February 2024 and 2nd October 2024.

Link to strategy

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

Risks associated with this report and proposed mitigations

No specific risks linked to this report. Risk to partnerships included within the Board Assurance Framework (see PR12)

Financial implications

No financial implications to this report.

Legal implications

No financial implications to this report.

People implications

No financial implications to this report.

Wider implications

None noted.

Recommendation

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

Background

The latest version of the NHS Foundation Trust Code of Governance (published in April 2023) highlighted an expectation that "*providers will work effectively on all issues, including those that may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation. The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver high quality care and effective use of resources*"[1].

This update to the code reflects the establishment of Integrated Care Systems (ICSs) on a statutory footing. Each ICS now has: an Integrate Care Board (ICB) which bring NHS bodies together locally to improve population health and care and manage the financial allocation; an Integrated Care Partnership (ICP) which is statutory joint committee of the ICB and upper tier local authorities, with a focus on improving the care health and wellbeing of the population. The ICP and ICB, along with place-based partnerships (such as our Healthier Wigan Partnership) and provider collaboratives, are tasked with bringing together all partners within an ICS.

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

Table 1 – Code of Governance Principles

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

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

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

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

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

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

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

[1] NHS Foundation Trust Code of Governance – Paragraph 2.3

Alignment of Strategy

As part of developing the Our Strategy 2030, the Trust engaged widely with partners across the Wigan locality alongside considering strategies at a Greater Manchester level. Delivery of the Trust's strategy is then focussed on an annual basis as part of the corporate objective setting and supporting divisional plans. In addition to Our Strategy 2030, several other drivers are considered as part of setting the annual corporate objectives including: changes in national planning guidance and/or expectations; and any new partnership strategies as they emerge. In 2024/25 we had specific partnership objectives: to improve the health and wellbeing of the population we serve (CO14); and to develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable (Corporate Objective 15). Risks to achievement of these objectives are monitored through the Board Assurance Framework (BAF) with updates on Trust Board brought biannually. The Corporate Objectives for 2025/26 are currently being developed and partnerships will continue to be a key focus as one of our "4 Ps" that underpin the strategy.

Participation in NHS Greater Manchester ICS

WWL has been significantly involved at multiple levels throughout the organisation to ensure that our 2025/26 operational plan submission is been consistent with planning assumptions within the GM ICS and that it contributes towards delivery of the GM ICS plan to meet national operational planning requirements. This includes: the weekly operational planning hub meeting; 1-1 meetings between GM ICB and WWL Executives; and the Trust Provider Collaborative (TPC). At the time of writing the Trust and the GM ICS has a gap to the financial control total and we will continue to be involved in the system discussions and work to address this.

The recent announcements that ICBs will be required to reduce their costs by 50% does potentially increase the risk to effective partnership working, given the disruption that this is likely to generate. We do however continue to be actively involved wherever possible with partners in the ICB which will support us in mitigating this risk. As previously reported, all executive directors play an active role in their relevant sub-group or network across GM as well as the GM wide programme boards such as elective care or sustainable services, which track system wide actions against priority areas. Several of the Executive Team have key roles within the GM Trust Provider Collaborative including the Director of Strategy and Planning who chairs the GM Directors of Strategy group, which help to shape the system response to challenges and develop future plans.

The Trust Provider Collaborative has identified four key areas which it is seeking to make significant progress focus on, and where there is opportunity to deli

- Pathology; to support Manchester Foundation Trust & Northern Care Alliance to develop a best practice pathology function – this would also link to microbiology provision which is a fragile service area within WWL. Given our existing partnership arrangement with the NCA, this is something that we will continue to be closely involved in.
- Asceptic service
- Procurement
- Convergence of Patient Information Systems (secondary care, primary care, mental health)

WWL are also active participants within the GM Commissioning Oversight Group which is seeking reviewing the commissioning intentions for GM. It is doing this by undertaking a systematic assessment of services against an agreed set of outcome, efficiency, effectiveness and quality measures to determine which services must be maintained, those which need review and potentially transformed to a different delivery model and those which could be considered for disinvestment as no longer affordable or core to the NHS GM vision and aims. The initial outcome from this is due at the end of September. Bilateral commissioning meetings between WWL Executives and the ICB have also been established.

Since the last report to Trust Board, at which the surgical hub accreditation for Leigh Infirmary from the NHSE Getting It Right First Time (GIRFT) programme was noted, we have continued to work with NHS GM to identify opportunities to further develop the role of Leigh in supporting reduction of elective waits across the system, and efficient use of NHS assets. As part of the 25/26 planning round, discussions are continuing

about the potential for Leigh to support the wider system in both provision of general surgery and ophthalmology. In addition, GM are looking to implement a Single Point of Access which provides opportunity to further cement the roles of both Leigh and Wrightington as system assets.

Since the last partnerships report to Trust Board, the work to create additional endoscopy rooms at Leigh Infirmary, as part of the GM endoscopy programme, has completed and one of these rooms is now delivering additional lists. This increase in diagnostic capacity will support earlier diagnosis, and an opportunity to reduce health inequalities both for residents of the Borough and GM. The work at Wigan is progressing well and when completed this will support the delivery of Bowel Cancer Screening lists at both Wigan and Leigh (they are currently just undertaken at Leigh); this will increase accessibility of screening and support a reduction in health inequalities given the variation in screening take up across the Borough.

The Trust continue to be closely involved in the processes to allocate capital funding across the GM ICS. These arrangements have been strengthened recently, with the Chief Finance Officer joining the GM Capital Resource Allocation Group (CRAG). In addition to the core capital allocation (CDEL), there continue to be several different capital funding allocations for specific purposes. The Trust has recently submitted bids into funding for elective recovery, estates safety and urgent and emergency care, with successful bids against the elective and estates safety allocations. The outcome of the urgent and emergency care bidding process is awaited at the time of this report being written.

Collaboration with Bolton NHS Foundation Trust

Since the last report to Trust Board, the Bolton and WWL Collaboration Board has formed, and held the first two meetings, with future meetings scheduled on a recurring 6-weekly frequency. The Board has been established to oversee collaborative projects between WWL and Bolton NHS Foundation Trust which improve efficiency and service sustainability in line with the principles below that have previously been agreed:

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

The following areas have been identified as priorities to progress with immediately, focussing on areas which address clinical sustainability issues, provide opportunity for financial efficiencies (which can be delivered within 12 months), and where a Bolton/WWL partnership is preferable and does not rely on changes to other partnership arrangements:

- Maximise theatre utilisation at Wrightington, Leigh and Bolton through 25/26 planning round
- Microbiology
- Dermatology
- Strategic finance expertise, general ledger and payroll
- HR Transactional services
- Digital (Identify alignment opportunities, data centre, sharing info across Altera EPR)

The Transformation Unit have been engaged to support the work across finance, HR and digital to identified opportunities to work more effectively and efficiently across our two organisations.

Healthier Wigan Partnership

WWL Executives continue to play an active role in the Healthier Wigan Partnership Board which brings together key partners across the Wigan Locality including Wigan Council, WWL, the locality ICB team,

Healthwatch and representation from the voluntary, community and faith sectors (VCFS). Key WWL stakeholders also contribute to the sub-groups to the Partnership Board. The Chief Executive co-chairs the Wigan Integrated Delivery Board with Director of Public Health from Wigan Council.

The HWP Partnership Board has identified three key system priorities to put integrated health and care services at the heart of the community following the launch of "Progress with Unity":

Addressing Inequalities with Communities	Addressing inequalities is at the heart of our commitment to prevention and population health. It requires a multifaceted approach focused on community engagement and partnership building on our learning through the work with Scholes and Westleigh. Engaging with residents and local leaders to tailor interventions that meet specific community needs.
Reforming Community Based Services	Reforming community health services is essential in response to our ageing population and pressures on hospital services. We are committed to going further through an integrated service delivery model in neighbourhoods working across primary care, community and mental health, adult social care, children's services, public health and the wider voluntary sector services.
Workforce Planning Together	Workforce planning is critical to ensure a sustainable health and care workforce for the borough. Engaging young people and creating clear pathways for careers in health and care is essential. This involves collaboration with educational partners and local employers to create training and employment opportunities that are attractive to future generations.

Since the last report to Trust Board, progress has been made in establishing the "Better Lives" programme; a shared programme across Wigan Council, NHS GM ICB and WWL to support our residents to live independently and transform urgent and care. The co-designed programme has three key aims:

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

Three key workstreams have now been established (Admissions Avoidance, Community and System Leadership and Visibility.

Health Inequalities

Partnership working brings opportunities to focus not just on provision of health services, but also on tackling the wider determinants of health. One key approach to this is our role as active participant in the Wigan Anchor Partnership, recognising that community wealth leads to strong community health (one of the fundamental "Progress with Unity" pillars). We know that a good job, access to education, a good place to live, connections to the community are important building blocks that can really improve the health and wellbeing of our residents. Through this partnership, we are actively engaged in supporting improvements in the socio-economics of the Borough by leveraging the economic clout we have as the largest employer and our significant spending power.

To date the partnership has achieved significant progress supporting local people to access work, progress in their careers, created local jobs and run local buildings and facilities for the benefit of their community. We have also seen an increase in the value of non-pay spend with organisations based in Wigan and across GM.

Whilst there has been significant progress, there is much more to do. Through focussing a sustained effort on the right activities from all partners we have the potential to make lifetime changes for people living in the borough, improving population health and making a significant contribution to reducing health inequalities and enabling thriving communities.

As a result, the anchor partnership has recently been reviewing its priorities and has identified the following 6 themes for focus whilst also working on developing a Community Wealth Building strategy.

The Trust is going to be significantly engaged in the development of the work programme under these key priorities; working with partners to identify and focus delivery on those areas which will deliver the greatest benefit for our residents. The development of the work programme is being taken forward through a series of workshops over the coming months.

In 2024/25, the first two biannual Trust reports were presented to outline the work that that has been undertaken to both identify and address health inequalities in our Borough; it is planned for these to continue into 2025/26.

Recommendation

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

Title of report:	Seven Day Hospital Services Audit 2024/2025
Presented to:	Board of Directors
On:	2nd April 2025
Presented by:	Prof S Arya, Medical Director
Prepared by:	Alison Unsworth Head of Clinical Audit and Effectiveness
Contact details:	Alison.Unsworth@wwl.nhs.uk

Executive summary

This audit compares WWL to the Seven Day Hospital Services (7DS) Clinical Standards set by NHS Services, Seven Days A Week forum. The audit was completed for a full seven-day period in December 2024 (Sat 7th December to 13th December 2024). It indicates a relatively high level of achievement of the standards. 148 patient records were analysed. The table below compares the previous audits.

Standard	Percentage Achieved 2022/2023 Audit	Percentage Achieved 2023/2024 Audit	Percentage Achieved 2024/25 Audit
Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.	**92% patients seen within 14 hours of admission to the ward**	**89% patients seen within 14 hours of admission to the ward**	**88% patients seen within 14 hours of admission to the ward**
Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.	**100% available**	**100% available**	**100% available**
Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should	**100% available**	**100% available**	**100% available**

Standard	Percentage Achieved 2022/2023 Audit	Percentage Achieved 2023/2024 Audit	Percentage Achieved 2024/25 Audit
include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.			
Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.	**Day 2: 98% Day 3: 93% Day 4: 84% Day 5: 88% Day 6: 92% Day 7: 96% (average 93%)**	**Day 2: 97% Day 3: 91% Day 4: 91% Day 5: 87% Day 6: 84% Day 7: 91% (average 90%)**	**Day 2: 93% Day 3: 92% Day 4: 91% Day 5: 88% Day 6: 85% Day 7: 83% (average 90%)**

It is evident from the Audit that patients routinely get a review by a Consultant within the first 24 hours of their stay, wherever that might be.

Summary of findings:

Review within **14** hours of Admission:

- 130/148 **(88%)** patients were seen by a Consultant within 14 hours of admission to the ward.
- 18/145 (**12%**) patients were not seen within 14 hours by a consultant but did have appropriate Senior Review and plan within 14 hours of admission.
- 4/145 (**2.7**%) of patients were not seen by a Consultant but received appropriate plan and review by appropriate senior.
- 100% of patients had appropriate review and plan.
- The average time to be seen by a **CONSULTANT** from arrival in A&E is 19 hours 51 minutes.
- 66/148 (**45%)** patients were seen by a **CONSULTANT** prior to admission to the ward

Review within **24** hours of Admission:

- 140/148 (**96**%) of patients were seen by a Consultant within 24 hours of admission.
- 4/148 (**2.7**%) of patients were not seen by a Consultant but received appropriate Senior Review and appropriate plan.

Beyond the first day, the audit looks at whether there is a Senior Review and shows this is normally provided, with 93% reviewed on Day 2 / 92% reviewed on Day 3 / 91% reviewed on Day 4 / 88% Day 5 / 85% Day 6 / 83% Day 7. These are high levels of daily review.

Further standards (Standards 5 and 6) are about the availability of Consultant led investigation (such as CT / MRI with results) and Consultant Led Services (such as emergency theatre, PCI, ICU etc). These services were found to be fully available and meet the standards with 100% compliance.

Despite the current pressures suffered by WWL the audit provides a high level of assurance that patients are seen within 14 hours by a Consultant and are typically seen daily thereafter. Most patients will be reviewed on a daily basis over the weekend and there will be appropriate services available to them 7 days a week.

Risks associated with this report and proposed mitigations

None known

Financial implications

None known

Legal implications

None known

People implications

None known

Wider implications

The Audit provides a high level of assurance about Consultant delivered care within WWL and the 7-day standards set.

Recommendation(s)

The Board of Directors are asked to review the report and note the contents. The report provides evidence that 88% of patients achieve Clinical Standard 2 (Review by a consultant within 14 hours of admission), the average daily review is 90% for Clinical Standard 8 (Daily review by Consultant or Delegate). Clinical standards 5 and 6 (availability of certain investigations/interventions) both achieve 100%.

Seven Day Hospital Services
Main Report

Background

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

Further information is available here: https://www.england.nhs.uk/wp-content/uploads/2022/02/B1231-board-assurance-framework-for-seven-day-hospital-services-08-feb-2022.pdf.

The importance of ensuring that patients receive the same level of high quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals. The standards have been reviewed in 2021 by a clinical reference group that confirmed they remain relevant and important in the NHS today.

The purpose of this report is to provide evidence of compliance to the four priority standards.

Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI, ultrasound imaging, endoscopy and echocardiography.

Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

Methodology

The Board Assurance Framework suggest a snapshot or sampling approach should be used to identify the patients.

Patients were identified for **Standard 2 and 8** using Hospital Episode Statistics data for patients admitted via the Emergency Department for a seven-day period from: **Saturday 7th December 2024 until Friday 13th December 2024.**

148 patients were selected at random for review.
Patients who stayed less than 14 hours were excluded from analysis.
HIS was used to analyse the patient details.

A proforma was created on AMaT (Audit Management and Tracking – the Trusts electronic management system) and data was collected and analysed by members of the clinical audit and effectiveness team.

Information for **standards 5 and 6** was provided by the subject experts

Findings

Clinical Standard 2

Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

Summary of Standard 2:

- 130/148 patients **(88%)** seen by a consultant within 14 hours of admission to the ward
- 18/148 patients **(12%)** seen by a consultant over 14 hours after admission to the ward

Breakdown of Standard 2 data:

Chart 1 shows the number of patients who were seen within 14 hours of admission to the ward per speciality by a consultant:

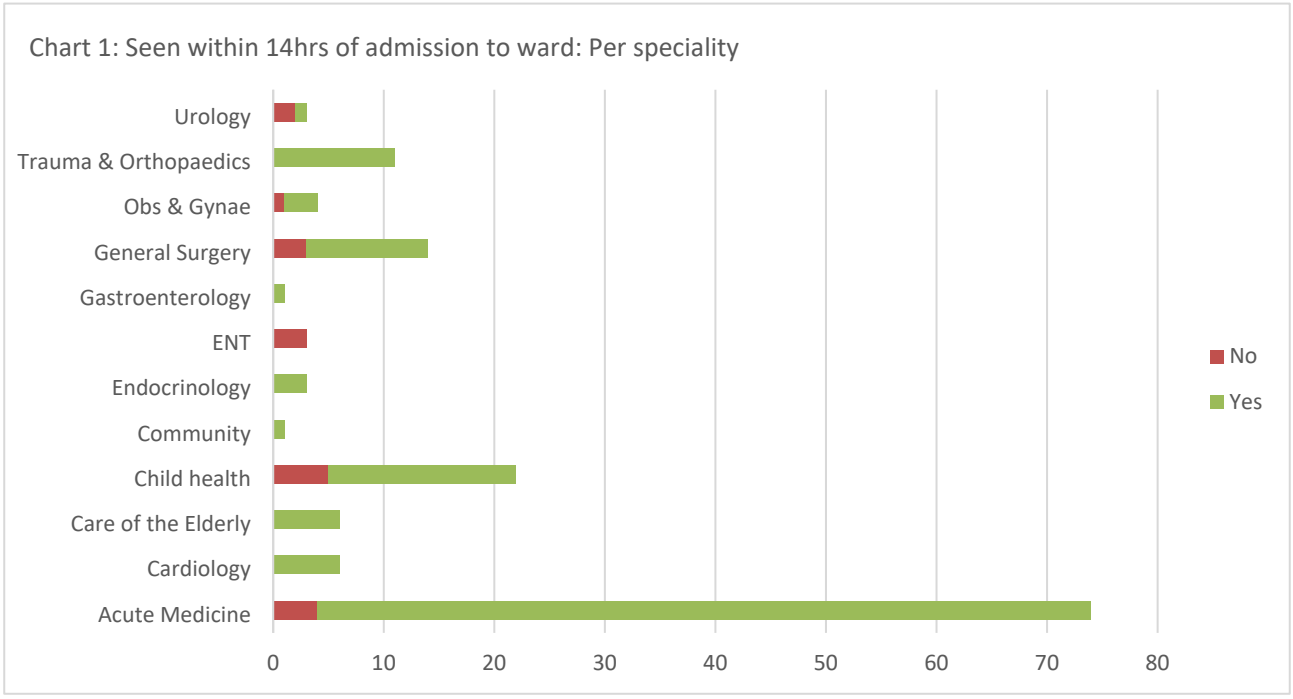
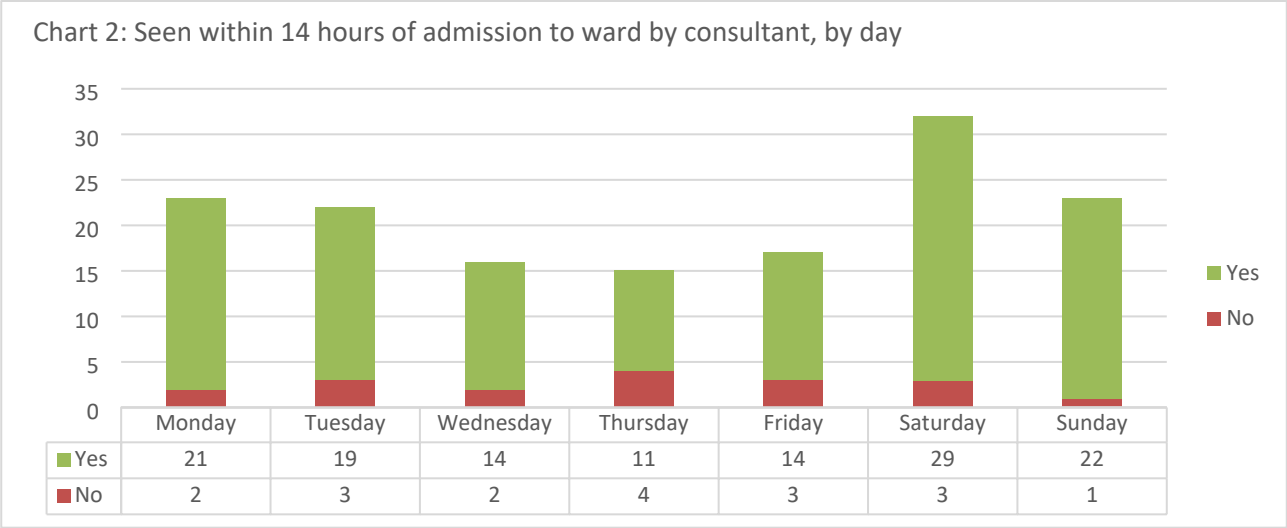


Chart 2 shows the number of patients seen by a consultant according to the day they were admitted.



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Yes	21	19	14	11	14	29	22
No	2	3	2	4	3	3	1

There were 18 patients who were not reviewed within the required standard of 14 hours from admission to the ward by a Consultant. Chart 3 shows a summary of each patient.

There were 2 patients under the care of ENT who did not see an consultant during admission but had an appropriate senior review within 14 hours of admission with appropriate plan.

There were 2 patients under the care of child health who did not see a consultant during admission, but did have senior review within 14 hours of admission and appropriate plan in place

Of the remaining 14 patients who did not get consultant review within 14 hours, 10/14 patients were seen by a Consultant within 24 hours of admission to the ward, and also had senior review within 14 hours of admission.

Chart 3 has information on the 14 patients.

Chart 3 Admission Day	Time of ADMISSION to WARD	Speciality	Difference in 1st cons review and time of admission to ward	Summary of each patient.
Wednesday	18:45	Child Health	15hr 24	Senior review within 14 hours of admission and plan in place
Monday	18:16	Gen Surgery	16hr 05	Reviewed by SPR within 14 hours of admission – plan in place
Tuesday	22:41	Acute Med	18hr 52	Seen by SPR within 14 hours of admission – plan in place
Thursday	17:03	Obs & Gyn	19hr 02	Seen by SPR within 14 hours of admission – plan in place
Friday	15:11	Acute Med	19hr 28	Seen by SPR within 14 hours of admission – plan in place
Thursday	13:06	Gen Surgery	19hr 48	Seen by SPR within 14 hours of admission – plan in place
Saturday	13:24	Gen Surgery	19hr 53	Seen by SPR within 14 hours of admission – plan in place
Friday	14:09	Acute Med	20hr 52	Seen by SPR within 14 hours of admission – plan in place

Chart 3 Admission Day	Time of ADMISSION to WARD	Speciality	Difference in 1st cons review and time of admission to ward	Summary of each patient.
Sunday	13:47	Urology	21hr 13	Senior review within 14 hours of admission and plan in place
Friday	12:02	Child Health	23hr 26	Senior review within 14 hours of admission and plan in place
Thursday	01:28	Acute Med	30hr:53	Senior review within 14 hours of admission and plan in place
Saturday	20:36	Urology	37hr:09	Senior review within 14 hours of admission and plan in place
Wednesday	01:22	Child Health	46hr:43	Senior review within 14 hours of admission and plan in place
Thursday	18:15	ENT	Over 48hr	Senior review within 14 hours of admission and plan in place

Clinical Standard 8:

Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

This has been determined by analysing the notes of each of the 148 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.
Chart 4 shows the number of patients admitted on day 1 (first day of admission) and the number of admissions per subsequent day. By day 7, 54 (36%) out of the 148 patients were still admitted.

Chart 4	Number of Patients still admitted	
	Number of in patients	% of patients still admitted
Day 1	148	100%
Day 2	138	93%
Day 3	118	80%
Day 4	93	63%
Day 5	77	52%
Day 6	64	43%
Day 7	54	36%

Summary of Standard 8

Chart 5 shows the cumulative number of patients and percentage that were seen by a consultant or delegate and the day of admission.

For example, 22 patients had their second day stay on a Monday and all 22 patients received a review.
11 patients had their 4th day stay on Saturday and 78% (7/11) had a review.

5		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Day 2	% achieved	100%	95%	95%	100%	92%	88%	88%
	Number of patients	22/22	19/20	19/20	16/16	11/12	14/16	28/32
Day 3	% achieved	93%	95%	83%	100%	100%	90%	69%
	Number of patients	28/30	20/21	13/14	17/17	13/13	9/10	9/13
Day 4	% achieved	100%	96%	92%	92%	100%	64%	86%
	Number of patients	13/13	23/24	12/13	12/13	12/12	7/11	6/7
Day 5	% achieved	100%	100%	100%	92%	73%	78%	67%
	Number of patients	7/7	9/9	18/18	11/12	8/11	7/9	6/9
Day 6	% achieved	88%	100%	100%	100%	100%	38%	63%
	Number of patients	7/8	6/6	9/9	13/13	7/7	3/8	5/8
Day 7	% achieved	88%	83%	100%	100%	100%	83%	14%
	Number of patients	7/8	5/6	6/6	8/8	13/13	5/6	1/7
Total	**Achieved**	**84/88 95%**	**82/86 95%**	**77/80 96%**	**77/79 97%**	**64/68 94%**	**45/60 75%**	**55/76 72%**

Chart 6 shows the percentage of patients reviewed by day by day of admission:

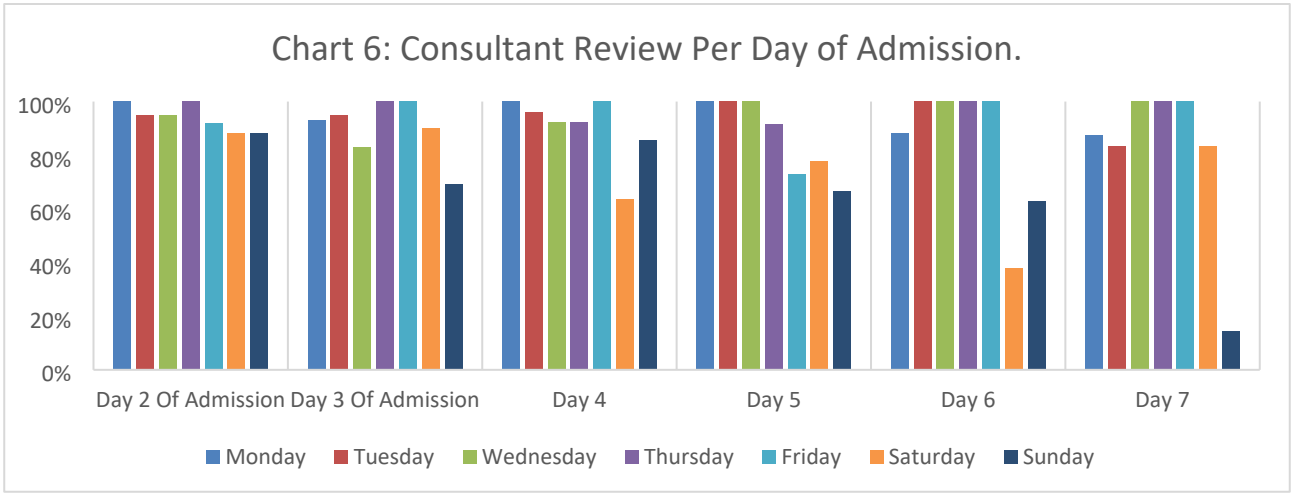
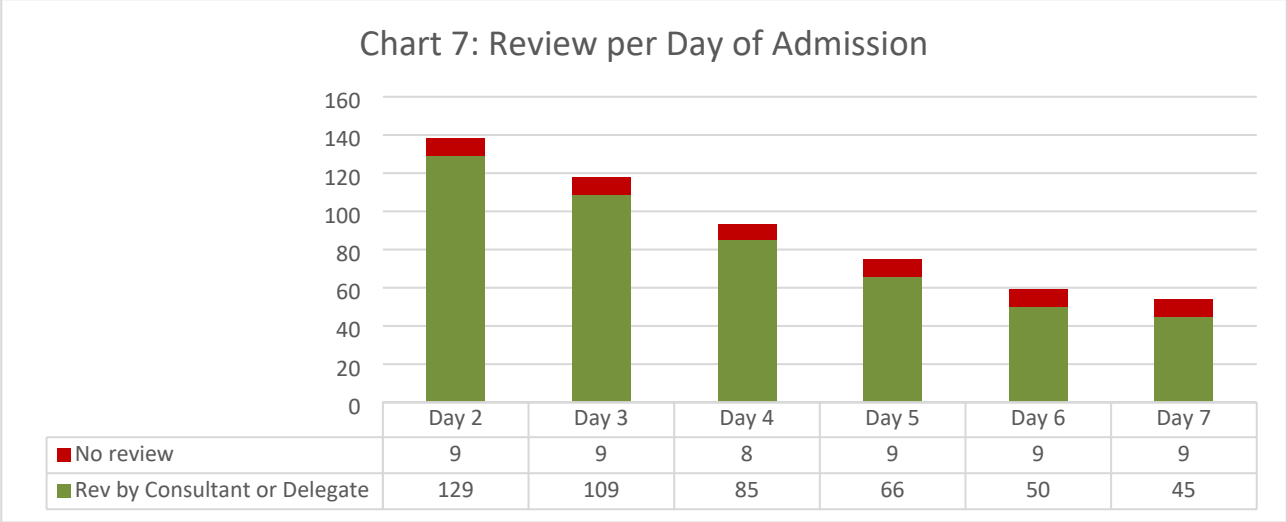


Chart 7 shows the number of reviews that did and did not take place per day of admission. For example, on day 2 of admission, 129/138 patients were reviewed by a consultant or delegate and 9 were not. On day 7, 54/148 patients were still in hospital and 45 were reviewed, 9 were not.



Clinical Standard 5

Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.

Information has been sought from the relevant departments regarding availability of the tests. Chart S5.1 shows the diagnostic tests and availability. All are available:

S5.1 Emergency Diagnostic Test	Available on Site at weekends	Available via network at weekends	Not available
USS	Yes		
CT	Yes		
MRI	Yes		
Endoscopy	Yes		
Echocardiography	Yes		
Microbiology	No	Yes	

Additional narrative:
USS: Available 9am – 8pm with consultant discussion. Typically converted to CT scanning or deferred until the next working day
Echocardiogram: Available by the on-call consultants
MRI: Limited to spinal cord compression/cauda equina syndrome
Microbiology: On call service by microbiology consultants, done remotely

Clinical Standard 6

Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

Information has been sought from the relevant departments regarding availability of the interventions.
Chart S6.2 shows the intervention availability. All are available:

S6.2 Emergency Intervention	Available on Site at weekends	Available via network at weekends	Not available
Intensive Care	Yes		
Interventional radiology		Yes	
Interventional endoscopy	Yes	Yes	
Surgery	Yes		

Additional narrative:
Interventional endoscopy for gastrointestinal bleeding/foreign body removal/oesophageal stenting/polypectomy is available on site. Other interventions, such as ERCP are available via network at weekends.

Interventional radiology: Available via network at weekends, case by case referral with usually consultant to consultant discussion

Conclusion

Standard	Percentage Achieved 2022/2023 Audit	Percentage Achieved 2023/2024 Audit	Percentage Achieved 2024/25 Audit
Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.	**92% patients seen within 14 hours of admission to the ward**	**89% patients seen within 14 hours of admission to the ward**	**88% patients seen within 14 hours of admission to the ward**
Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.	**100% available**	**100% available**	**100% available**
Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.	**100% available**	**100% available**	**100% available**
Clinical standard 8 states that patients admitted in an emergency	**Day 2: 98% Day 3: 93%**	**Day 2: 97% Day 3: 91%**	**Day 2: 93% Day 3: 92%**

Standard	Percentage Achieved 2022/2023 Audit	Percentage Achieved 2023/2024 Audit	Percentage Achieved 2024/25 Audit
should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.	**Day 4: 84%** **Day 5: 88%** **Day 6: 92%** **Day 7: 96%** **(average 93%)**	**Day 4: 91%** **Day 5: 87%** **Day 6: 84%** **Day 7: 91%** **(average 90%)**	**Day 4: 91%** **Day 5: 88%** **Day 6: 85%** **Day 7: 83%** **(average 90%)**

Agenda item: 26

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Risk Appetite 2025/26 Review
Presented to:	Boar of Directors
On:	02 April 2025
Presented by:	Director of Corporate Governance
Prepared by:	Director of Corporate Governance Head of Risk
Contact details:	E: steven.parsons@wwl.nhs.uk

Executive summary

This paper proposes our risk appetite statement for 2025/26 and recommends that we generally move up the risk appetite/ tolerance by one notch across the Board, to reflect that the Trust will have to be more accepting of risk to achieve the national targets and financial requirements being set for it. The WWL risk appetite statement has been cross referenced with the NHS GM risk appetite statement, which will aid the escalation of risks from WWL to the Wigan locality and NHS GM risk registers where required.

Link to strategy

The risks identified within this report relate to the achievement of the trust's objectives.

Risks associated with this report and proposed mitigations

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

Financial & Legal implications

There are no financial or legal implications associated with this report.

People implications

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

Wider implications

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

Recommendation(s)

The Board of Directors are asked to approve the trust's risk appetite statement for 2025/26.

1. Background

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

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

1.3 In 2024, the risk management framework and risk appetite statement were updated and approved by Audit Committee and the Board. In December 2024, the Trust achieved High Assurance in the MIAA Risk Management - Core Controls Review Assignment Report. The report highlighted the risk appetite statement as an area of good practice.

1.4 The Risk Appetite statement was postponed from the Board meeting in February, at the Chair's request, so that the Directors could have an informal discussion about it. That discussion has now taken place, in the context of the developing planning round and what that would require from the Trust. In that context, Directors asked for-

- Generally moving up the risk appetite/ tolerance by one notch across the Board, to reflect that the Trust will have to be more accepting of risk to achieve the national targets and financial requirements being set for it;
- Again generally, having at least one category between the 'threat' risk appetite and the 'opportunity' risk appetite for each category.

2. Definitions

Within the WWL Risk Management Framework, risk appetite is referred to as a concept. Within this concept, we refer to optimal and tolerable risk positions using the following definitions:

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

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

3. Risk Appetite

3.1 Our proposed risk appetite position for 2025/26 is summarised in the following table:

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Safety, quality of services and patient experience	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Data and information management	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Governance and regulatory standards	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Staff capacity and capability	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Staff Engagement	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Staff wellbeing and safety	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Estates and Facilities	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Financial Duties	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Performance Targets	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Hospital Demand, Capacity and Flow	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Sustainability / Net Zero	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Technology	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Adverse publicity	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Contracts and demands	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 16 Eager
Strategy	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager
Transformation	≤ 8 Open	≤ 12 Open	≤ 15 Eager	≤ 16 Eager

3.2 For each risk category, a risk appetite has been set based on whether the risk poses a threat or an opportunity. Detail on the optimal and tolerable risk scores is also provided to guide risk leads in their decision-making.

3.3 The scores shown in the matrix above provide guidance to risk leads as to the optimum and tolerable score for each individual risk. More specific definitions for each of these is included in appendices 1 and 2.

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

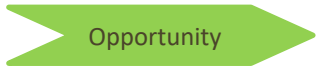
Least risk		← →		Most risk
Adverse	Minimal	Cautious	Open	Eager

4.0 Recommendations for risk appetite scoring

4.1 The Board are asked to approve the trust's risk appetite statement for 2025/26.

Appendix 1: Risk Appetite Statements 2025/26

Patients	Our ambition is to be widely recognised for delivering safe, personalised, and compassionate care, leading to excellent outcomes and patient experience				
Risk Appetite **Risk Category**	**Adverse**	**Minimal**	**Cautious** Threat	**Open**	**Eager** Opportunity
Safety, Quality of Services & Patient Experience	We will avoid anything that may impact on quality outcomes unless essential. Defensive approach to operational delivery – aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Innovations largely avoided unless essential. Decision making authority held by senior management.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer term rewards. Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	We will pursue innovation wherever appropriate, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	We seek to lead the way and will prioritize new innovations, even in emerging fields. Desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control.
Data & Information Management	We lock down data & information. Access tightly controlled, high levels of monitoring.	We minimise the level of risk due to potential damage from disclosure.	We accept the need for operational effectiveness with risk mitigated through careful management limiting distribution.	We accept the need for operational effectiveness in distribution and information sharing.	We minimise the level of controls with data and information openly shared.

Risk Appetite Risk Category	Adverse	Minimal	Cautious 	Open	Eager 
Governance	We will avoid actions with associated risk. No decisions are taken outside of processes and oversight / monitoring arrangements. Trust controls minimise risk of fraud, with significant levels of resource focused on detection and prevention.	We are willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Trust controls maximise fraud prevention, detection and deterrence through robust controls and sanctions.	We are willing to consider actions where benefits outweigh risks. Processes, and oversight / monitoring arrangements enable cautious risk taking. Controls enable fraud prevention, detection, and deterrence by maintaining appropriate controls and sanctions.	We are receptive to taking difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements enable considered risk taking. Levels of fraud controls are varied to reflect scale of risks with costs.	We are ready to take difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements support informed risk taking. Levels of fraud controls are varied to reflect scale of risk with costs.
Regulatory Standards	We will avoid any decisions that may result in heightened regulatory challenge unless essential. Play safe and avoid anything which could be challenged, even unsuccessfully.	We are prepared to accept the possibility of limited regulatory challenge. Want to be very sure we would win any challenge.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably sure we would win any challenge.	We are willing to take decisions that will likely result in regulatory intervention if we are likely to win, and the gain will outweigh the adverse impact.	We are comfortable challenging regulatory practice. Chances of losing are high but exceptional benefits could be realised.

People

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

Risk Appetite Risk Category	Adverse	Minimal	Cautious	Open Threat	Eager Opportunity
Staff Capacity & Capability	We will avoid all risk relating to our workforce unless essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards our workforce. Where attempting to innovate, we would seek to understand where similar action had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result of from innovation as long as there is the potential for improved recruitment and retention, and development opportunities for staff.	We will pursue workforce innovation. We are willing to take risk which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.
Staff Experience	Our priority is to maintain close management control & oversight. Limited devolved authority. Limited flexibility in relation to working practices. Development investment in standard practices only.	Our decision-making authority is held by senior management. Development investment generally in standard practices.	We seek safe and standard people policy. Decision making authority generally held by senior management.	We are prepared to invest in our people to create innovative mix of skills environment. Responsibility for noncritical decisions may be devolved.	We pursue innovation – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control.

Staff Wellbeing and Safety	Well-being is a minor consideration in our decision making	We recognise the importance of well-being and seek opportunities to enhance it, but this is not our major consideration	We look for opportunities to improve well-being but we prefer to use methodology which is tried and tested and there is a strong expectation that productivity efficiencies will be demonstrable in the short term	We actively prioritise well-being and are willing to be a front runner in new or novel approaches, where there is a strong underpinning evidence base that would predict successful delivery in the medium term	Well-being is our primary consideration and we are willing to innovate or collaborate where there is no current established evidence base and take a longer term view of achieving productivity benefits

Performance

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

Risk Appetite Risk Category	Adverse	Minimal	Cautious	Open Threat	Eager Opportunity
Estates and Facilities	We are obliged to comply with strict policies for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	We will follow strict policies for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	We will adopt a range of agreed solutions for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money.	We will consider the benefits of agreed solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements.	We will apply dynamic solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements.
Financial Duties	We are only willing to accept the possibility of limited financial risk. Avoidance of any financial impact or loss, is a key objective.	We are only willing to accept the possibility of limited financial risk if essential to delivery.	We are prepared to accept the possibility of some financial risk as long as appropriate controls are in place. Seek safe delivery options with little residual financial loss only if it could yield upside opportunities.	We will invest for the best possible return and accept the possibility of increased financial risk. We will minimise the possibility of financial loss by managing the risks to tolerable levels.	We will consistently invest for best possible benefit and accept possibility of financial loss (controls must be in place).
Risk Appetite Risk Category	**Adverse**	**Minimal**	**Cautious**	**Open** Threat	**Eager** Opportunity

Performance Targets	We will avoid anything that may impact on performance targets unless essential. Defensive approach to operational delivery – aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority.	Our preference is for risk avoidance. However, if necessary, we will take decisions on performance targets where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Innovations largely avoided unless essential. Decision making authority held by senior management.	We are prepared to accept the possibility of a short-term impact on performance targets with potential for longer term rewards. Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	We will pursue innovation wherever appropriate, with clear demonstration of benefit / improvement in management control. Responsibility for non critical decisions may be devolved.	We seek to lead the way and will prioritize new innovations, even in emerging fields. Desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control.
Risk Appetite Risk Category	**Adverse**	**Minimal**	**Cautious**	**Open** Threat	**Eager** Opportunity

Hospital Demand, Capacity and Patient Flow	We will avoid actions associated with risk. Our risk appetite increases when OPEL level 4 and/or a critical incident is declared and we will follow the actions within the Hospital Full Protocol and Incident Response Plan to discharge patients when it is safe to do so.	We are willing to consider low risk actions which support delivery of our patient flow and discharge priorities and objectives. Our risk appetite increases when OPEL level 4 and/or a critical incident is declared and we will follow the actions within the Hospital Full Protocol and Incident Response Plan to discharge patients when it is safe to do so.	We are willing to consider actions where benefits outweigh risks. We ensure that people are discharged via pathways where they receive the care and support, they need to recover. Multi-disciplinary discharge teams work together when discharging people to manage risk carefully with the individual, and their unpaid carer, representative or advocate, as there can be negative consequences from decisions that are either too risk averse, or do not sufficiently identify the level of risk.	We are receptive to taking difficult decisions to safely discharge patients when benefits outweigh risks. Where there is an opportunity to discharge a medically optimised person, multi-disciplinary discharge teams work with the individual, and their unpaid carer, representative or advocate to safely discharge the person as soon as possible via the most appropriate pathway working towards home first when it is safe to do so.	We are ready to take difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements support informed risk taking.
Risk Appetite Risk Category	**Adverse**	**Minimal**	**Cautious**	**Open** Threat	**Eager** Opportunity

Sustainability / Net Zero	We generally avoid net zero developments.	Net zero is a minor consideration in our decision making. cognise the importance of reducing our carbon footprint and seek opportunities to do this, but this is not our major consideration	We look for opportunities to reduce our carbon footprint, but we prefer to use methodology which is tried and tested and there is a strong expectation that improvements will be demonstrable in the short term	We actively prioritise reducing or carbon footprint and are willing to be a front runner in new or novel approaches, where there is a strong underpinning evidence base that would predict successful delivery in the medium term	Reducing our carbon footprint is our primary consideration and we are willing to innovate or collaborate where there is no current established evidence base and take a longer term view of achieving sustainability benefits
Technology	We generally avoid systems / technology developments.	We are prepared to take only essential systems / technology developments to protect current operations.	We will consider the adoption of established / mature systems and technology improvements. Agile principles are considered.	We will consider systems / technology developments to enable improved delivery. Agile principles may be followed.	We view new technologies as a key enabler of operational delivery. Agile principles are embraced.
Partnerships	To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester				

Risk Appetite Risk Category	**Adverse**	**Minimal**	**Cautious** 	**Open**	**Eager** 
Adverse Publicity	We have zero appetite for any decisions with high chance of repercussion for trust's reputation.	We have an appetite for risk taking limited to those events where there is no chance of any significant repercussion for the trust.	We have an appetite for risk taking limited to those events where there is little chance of any significant repercussion for the trust.	We have an appetite to take decisions with potential to expose the trust to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	We have an appetite to take decisions which are likely to bring additional scrutiny only where potential benefits outweigh risks.
Contracts & demands	We have zero appetite for untested commercial agreements. Priority for close management controls and oversight with limited devolved authority.	We have an appetite for risk taking limited to low scale procurement activity. Decision making authority held by senior management.	We have a tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	We support Innovation, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	We pursue innovation – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control.
Risk Appetite Risk Category	**Adverse**	**Minimal**	**Cautious**	**Open** 	**Eager** 

Strategy	We will follow guiding principles or rules that limit risk in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 5+ year intervals	We will follow guiding principles or rules that minimise risk in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 4–5-year intervals	We will follow guiding principles or rules that allow considered risk taking in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 3–4-year intervals	We will follow guiding principles or rules that are receptive to considered risk taking in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 2–3-year intervals	We will follow guiding principles or rules that welcome considered risk taking in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 1–2-year intervals
Transformation	We have a defensive approach to transformational activity. We aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority. Benefits led plans fully aligned with strategic priorities, functional standards.	We aim to avoid innovations unless essential. Decision making authority held by senior management. Benefits led plans aligned with strategic priorities, functional standards.	We tend to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Plans aligned with strategic priorities, functional standards.	We support innovation with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance.	We pursue innovation–desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. Plans aligned with organisational governance.

Appendix 2: Risk Appetite Statement 2025/26

Principle Objective	Risk Appetite **A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager 	Risk Statement	Optimal Risk Position	Tolerable Risk Position
Patient		We have an **EAGER** appetite for risks that present an opportunity relating to safety, quality of services and patient experience. We have an **EAGER** appetite for risks that present an opportunity relating to data and information management. We have an **EAGER** appetite for risks that present an opportunity relating to governance and regulatory standards.	**= < 15 Significant** **= < 15 Significant** **= < 15 Significant**	**= < 16 Significant** **= < 16 Significant** **= < 16 Significant**
		We have a **CAUTIOUS** appetite for risks that present a threat to safety, quality of services and patient experience. We have a **CAUTIOUS** appetite for risks that present a threat to data and information management. We have a **CAUTIOUS** appetite for risks that present a threat to governance and regulatory standards.	**= < 6 Moderate** **= < 6 Moderate** **= < 6 Moderate**	**8 - 10 High** **8 - 10 High** **8 - 10 High**

People		We have an **EAGER** appetite for risks that present an opportunity relating to staff capacity and capability We have an **EAGER** appetite for risks that present an opportunity relating to experience. We have an **EAGER** appetite for risks that present an opportunity relating to staff wellbeing.	**= < 15 Significant** **= < 15 Significant** **= < 15 Significant**	**= < 16 Significant** **= < 16 Significant** **= < 16 Significant**
Principle Objective	**Risk Appetite** **A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager 	**Risk Statement**	**Optimal Risk Position**	**Tolerable Risk Position**
People		We have an **OPEN** appetite for risks that present a threat to staff capacity and capability. We have an **OPEN** appetite for risks that present a threat to staff engagement. We have an **OPEN** appetite for risks that present a threat to staff wellbeing.	**= < 8 High** **= < 8 High** **= < 8 High**	**=<12 High** **=<12 High** **=<12 High**
Performance		We have an **EAGER** appetite for risks that present an opportunity relating to estates management. We have an **EAGER** appetite for risks that present an opportunity relating to financial duties. We have an **EAGER** appetite for risks that present an opportunity relating to performance targets.	**= < 15 Significant** **= < 15 Significant**	**= < 16 Significant** **= < 16 Significant**

		We have an **EAGER** appetite for risks that present an opportunity relating to hospital demand, capacity and patient flow. We have an **EAGER** appetite for risks that present an opportunity relating to sustainability and net zero. We have an **EAGER** appetite for risks that present an opportunity relating to technology.	**= < 15 Significant** **= < 15 Significant** **= < 15 Significant** **= < 15 Significant**	**= < 16 Significant** **= < 16 Significant** **= < 16 Significant** **= < 16 Significant**
Principle Objective	**Risk Appetite** **A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager 	**Risk Statement**	**Optimal Risk Position**	**Tolerable Risk Position**
Performance		We have an **OPEN** appetite for risks that present a threat to estates management. We have a **CAUTIOUS** appetite for risks that present a threat to financial duties. We have an **OPEN** appetite for risks that present a threat to performance targets. We have an **OPEN** appetite for risks that present a threat to hospital demand, capacity and patient flow. We have an **OPEN** appetite for risks that present a threat to sustainability and net zero.	**= < 8 High** **= < 6 Moderate** **= < 8 High** **= < 8 High** **= < 8**	**=<12 High** **8 - 10 High** **=<12 High** **=<12 High**

		We have an **OPEN** appetite for risks that present a threat to technology.	**High** **= < 8 High**	**=<12 High** **=<12 High**
Partnerships		We have an **EAGER** appetite for risks that present an opportunity relating to potential adverse publicity. We have an **EAGER** appetite for risks that present an opportunity relating to contracts and demands. We have an **EAGER** appetite for risks that present an opportunity relating to strategy. We have an **EAGER** appetite for risks that present an opportunity relating to transformation.	**= < 15 Significant** **= < 15 Significant** **= < 15 Significant** **= < 15 Significant**	**= < 16 Significant** **= < 16 Significant** **= < 16 Significant** **= < 16 Significant**
Principle Objective	**Risk Appetite** **A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager 	**Risk Statement**	**Optimal Risk Position**	**Tolerable Risk Position**
Partnerships		We have a **CAUTIOUS** appetite for risks that present a threat of adverse publicity. We have a **CAUTIOUS** appetite for risks that present a threat to contracts and demands.	**= < 6 Moderate** **= < 6 Moderate**	**8 - 10 High** **8 - 10 High**

	A M C O E	We have an **OPEN** appetite for risks that present a threat to strategy. We have an **OPEN** appetite for risks that present a threat to transformation.	**= < 8** **High** **= < 8** **High**	**=<12** **High** **=<12** **High**

Agenda item: 27

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Use of the common seal during FY2024/25
Presented to:	Board of Directors
On:	02 April 2025
Purpose:	Information
Presented by:	Director of Corporate Governance
Prepared by:	Director of Corporate Governance/Corporate Governance Officer
Contact details:	E: Steven.parsons@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 2024/25.

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 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 26 occasions, as shown in the table below:

Seal №	Date seal applied	Description of document	Use attested by:
37	21 Mar 2024	JCT Design & Build contract 2016 for installation in Fluoroscopy Room 1 at Wrightington Hospital	1. P Howard 2. R Mundon
38	21 Mar 2024	TP1 form to transfer freehold of 19 Clifton Crescent to WWL.	1. P Howard 2. R Mundon
39	21 Mar 2024	TP1 form to transfer freehold of 19 Clifton Crescent to WWL.	1. P Howard 2. R Mundon
40	21 Mar 2024	TP1 form to transfer freehold of 19 Clifton Crescent to WWL.	1. P Howard 2. R Mundon
41	30 May 2024	13 collateral warranties for insurance to cover construction works undertaken on Aspull Health Centre,	1. R Mundon 2. P Howard
42	13 Jun 2024	JCT intermediate building contract for works undertaken on the Hanover Building at Leigh Infirmary.	1. M Fleming 2. P Howard
43	13 Jun 2024	Contract between Wigan Borough Council and WWL for the provision of 0-19 services: Healthy Child programme	1. P Howard 2. M Fleming
44	23 Jul 2024	JCT Standard Building Contract with Quantities for works on the Endoscopy extension at Royal Albert Edward Infirmary.	1. AM Miller 2. R Mundon

[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:
45	14 Aug 2024	Lease for Aspull Medical Centre	1. P Howard 2. K Parker-Evans
46	22 Aug 2024	Lease of office G1 andS40 at Wigan Investment Centre	1. K Parker-Evans 2. R Mundon
47	22 Aug 2024	A deed of undertaking granting planning permission of the development of land at the Freckleton Street Carpark	1. K Parker-Evans 2. R Mundon
48	12 Sep 2024	Documents in relation to stage 1 of the Freckleton Street Multistorey Carpark scheme	1. S Brennan 2. P Howard
49	3 Oct 2024	Deed for surrender relating to the underlease of part od Platt Bridge Health Centre	1. R Mundon 2. S Brennan
50	3 Oct 2024	Deed of covenant relating to Leigh Health Centre	1. R Mundon 2. AM Miller
51	9 Dec 2024	VOID – New Seal no 54	
52	19 Dec 2024	VOID – New Seal no 55	
53	19 Dec 2024	VOID – New Seal no 56	
54	16 Jan 2025	Rent review for a duration of 4-years, Unit 7 Martland Point	1. R Mundon 2. AM Miller
55	16 Jan 2025	VOID – New Seal no 57	
56	16 Jan 2025	Retrospective Licence for alternations at Buckingham Row	1. R Mundon 2. AM Miller
57	23 Jan 2025	Renewal of lease for Buckingham Row	1. R Mundon 2. AM Miller
58	20 Feb 2025	JCT Minor Works Building Contract 2016 of works on Block 8 Old Nursers Home, Royal Albert Edwards Infirmary	1. R Mundon 2. T Gardner
59	16 Feb 2025	Underlease for part of Platt Bridge Health Centre	1. M Fleming 2. T Gardner
60	5 Mar 2025	Documents relating to the Freckleton Street Multi-Storey Carpark development	1. T Gardner 2. F Thorpe

Seal №	Date seal applied	Description of document	Use attested by:
61	19 Mar 2025	Deed of Collateral Warranty in respect of Freckleton Street Carpark (Golbeck Construction Ltd)	1. M Jones 2. AM Miller
62	19 Mar 2025	Deed of Collateral Warranty in respect of Freckleton Street Carpark (GIA Surveyors)	1. M Jones 2. AM Miller
63	19 Mar 2025	Deed of Collateral Warranty in respect of Freckleton Street Carpark (Demolition Consultancy Ltd)	1. M Jones 2. AM Miller
64	19 Mar 2025	Deed of Collateral Warranty in respect of Freckleton Street Carpark (PMC2 Ltd)	1. M Jones 2. AM Miller
65	19 Mar 2025	Renewal underlease for Boston House Health Centre	1. M Jones 2. AM Miller
66	19 Mar 2025	Renewal of underlease plus agreement for Chandler House Health Centre	1. M Jones 2. AM Miller

2.2. Any further use of the common seal in FY2024/25 after the date of writing will be reported to the board in April 2026 alongside the use in FY2025/26.

2.3. All occasions on which the common seal is applied are recorded in a register which is held by the Director of Corporate Affairs. 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 2024/25.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Gender Pay Gap Report 2024
Presented to:	Board of Directors
On:	02 April 2025
Item purpose:	Information
Presented by:	Juliette Tait, Chief People Officer
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Executive summary

This report provides an analysis of the Trust`s Gender Pay Gap information as at 31st March 2024 and is the seventh round of annual mandatory reporting the Trust has undertaken.

The data highlights that as at 31st March 2024 the Trust has a **26.82% mean average gender pay gap** with females earning **£6.54 an hour less** than males. This position is comparable to the 2023 figure of 27.46%. As at March 2024 the Trust has a **11.14% median hourly rate gender pay gap** with females earning **£2.02 an hour less** than males. This position has slightly improved since 2023 (12.69%)

A key factor underpinning the Trust`s gender pay gap is due to a significant proportion of male staff being constituted within the Medical & Dental staff group which is within the higher earning quartiles. If we exclude Medical & Dental staff from the Trust wide gender pay gap figures the Trust`s mean average gender pay gap is **2.40%** which equates to females earning **£0.43 less** than male staff per hour. Section 2.4 of the report provides granular analysis of the pay gap at staff group level.

As at 31st March 2024 male staff proportionately continue to be heavily constituted within the highest earning quartile (quartile 4) accounting for **29.9%** of quartile 4 when male staff represent 19% of the overall Trust workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 65% and this staff group are predominantly constituted within the highest earning quartile. Compared to the previous year in 2023 there were a similar percentage of males in the highest earning quartile at **30.12%**.

As at 31st March 2024 female staff proportionately continue to have lower representation in the highest earning quartile at **71%** compared with their overall representation of 81% of the workforce. Compared to the previous year in 2023, there were a similar percentage of females in the highest earning quartile at **69.88%.**

The average bonus gender pay gap as at 31st March 2024 is 57.93%. This is a decrease compared to the previous year when the figure was 63.47%. in 2023. The bonus pay is primarily related to

clinical excellence awards that are awarded to recognise and reward consultants who perform `over and above` the standard expected in their role, but awards made in the reporting year were distributed equitably among all eligible consultants. New local clinical excellence awards are not paid in the same month each year, though are always backdated to April. This can also impact slightly on the reported pay gap position.

Since this report was presented to People Committee in December 2024, a Pay Equality Workstream has been established, chaired by the Medical Director, reporting to the EDI Strategy Group. An initial meeting took place on 17th March 2025. The workstream comprises Medical & Dental and HR representatives. Membership will be reviewed to broaden representation as appropriate, recognising Gender Pay Gap actions will relate to reducing the overall gender pay gap in addition to specifically targeting the Medical & Dental staffing group. As a result of discussions at the meeting, an action plan to reduce gender pay inequality is under development. Initial actions identified include:

- Inclusive recruitment - promoting flexible working and Less Than Full Time opportunities to attract more females to apply for roles
- Promoting flexible working to support females to balance home and work life and continue to progress through their careers
- Consistent application of starting salary guidance, to remove negotiation of increased starting salaries
- Active promotion of National Clinical Impact Awards, additional support with applications available for female doctors, if required
- Supporting talent management and leadership development of female doctors to move into more senior roles
- Reviewing meeting arrangements to support those with caring responsibilities to attend

The group will also review the Gender Pay Gap 2025 information, once available, and use this data to further inform the development of impactful actions.

Link to strategy and corporate objectives

People Strategy
Corporate People Objective 2024: “We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.”
NHS EDI Improvement plan High Impact Action 3

Risks associated with this report and proposed mitigations

There is the risk of employment tribunal claims relating to discrimination arising from the gender pay gap.

Financial implications

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

Legal implications

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

People implications

Gender Pay Gap is a complex issue and there are many contributing factors including external societal factors and internal workforce factors. The people issues which arise from the gender pay gap are wide ranging and at the heart of this issue is fairness and equality of opportunity for staff within the organisation.

Equality, diversity and inclusion implications

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

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

ETM and People Committee

Recommendation(s)

The Board of Directors are recommended to receive the report and note the actions being developed to reduce inequalities in gender pay.

Report

Statutory Gender Pay Gap Reporting

1. Background

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

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

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

The Trust is obliged to publish the following information on our public-facing website and report to government by the 31st March 2025:

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

2 Gender Pay Gap Reporting Key points

Appendix 1 includes a full copy of the Trust`s Gender Pay Gap information which has been obtained from the Electronic Staff Record (ESR) standard reports. The ESR standard reports are nationally produced to ensure the NHS meet their gender pay gap reporting requirements and the reporting period for the gender pay gap data is as at 31st March 2024.

2.1 Key Points to note are:

- The Trust workforce is **81% female and 19% male.**
- The Trust Medical & Dental workforce is 65% male and 35% female with 25% of the Trust`s overall male workforce being constituted within the Medical & Dental staff group.
- As at March 2024 the Trust has a has a **26.82% mean average** gender pay gap with females earning **£6.54 an hour less** than males. The mean average gender pay gap in 2024 is comparable to 2023 data when as at 31st March 2023 females earned **£6.46 an hour** less than males with a 27.46% mean average gender pay gap.

- As at March 2024 the Trust has a **11.14% median hourly rate** gender pay gap with females earning **£2.02 an hour less** than males. The median hourly rate gender pay gap in 2023 has slightly improved in comparison with 2023 data when as at 31st March 2023 females earned **£2.19 an hour less** than males with a **12.69%** median gender pay gap.
- As at 31st March 2024 male staff proportionately continue to be heavily constituted within the highest earning quartile at 29.9% within quartile 4 compared to male staff representing 19% of the overall workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 65% and this staff group are predominantly constituted within the highest earning quartile.
- As at 31st March 2024 female staff proportionately continue to have lower representation in the highest earning quartile at 70.1% compared with female staff representing 81% of the overall workforce. Compared to the previous year in 2023 there was a similar percentage of females in the highest earning quartile at 69.88%.
- The data highlights that the average bonus pay gap for females as at March 2024 is 57.93% and the median bonus pay gap is 0.00%. Compared to the previous year in 2023 the average bonus pay gap for females was 63.5% and this figure made the Trust an outlier comparison with other Trusts in Greater Manchester. The bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role. It should be noted the Consultant workforce is predominantly male at 72% excluding locum consultants.

2.2 Gender Pay Gap Granular reporting

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

Medical and dental staff group

The medical & dental staff group has a **20.59%** mean gender pay gap with female medical & dental staff earning **£9 per hour less** than male medical & dental staff. This is an improving position compared to the previous year where there was a 25.95% average pay gap with female medical and dental staff earning £10.90 an hour less than male female medical and dental staff in 2023. The gap is due to female medical & dental staff being primarily constituted within this staff group`s lower pay quartiles with them representing only 28% of the highest pay quartile (quartile 4).

If we exclude Medical & Dental staff from the Trust wide gender pay gap figures the Trust`s mean gender pay gap is **2.40%** which equates to females earning **£0.43** less than male staff per hour. Last year the Trust wide gender pay gap figure excluding medical and dental was 3.07% which equates to females earning £0.52 less than male staff per hour.

Administrative and clerical staff group

An analysis of the gender pay gap for the Administrative & Clerical staff group highlights this staff group has a **21.54%** average pay gap with female staff earning £**4.27 an hour less** than male staff. This is an improved position compared to the previous year where there was a 23.64% average pay gap with female administrative & clerical staff earning £4.51 an hour less than male administrative & clerical staff in 2023. Males within this staff group continue to remain significantly constituted within the highest pay quartile at 39% male in quartile 4 compared with 12% male in quartile 1, 13% male in quartile 2 and 30% male in quartile 3. Comparing these figures to the previous year, the percentage of males in the higher quartiles has reduced e.g. quartile 4 male representation was 42% and quartile 3 male representation was 26%.

Additional Professional Scientific and Technical staff group

An analysis of the gender pay gap for the Additional Professional Scientific and Technical staff group highlights this staff group has an 8.39% average pay gap with female staff earning £1.88 an hour less than male staff. This is an improved position compared to the previous year where there was a 13.98% average pay gap with female staff earning £3.23 an hour less than male staff in 2023. Representation in the higher quartiles are more proportionate to other staffing groups: quartile 4 male representation was 23% and quartile 3 male representation was 19%. Comparing these figures to the previous year the percentage of males in the quarter 4 was previously 27%.

It should be noted that in a number of staff groups there is a negative pay gap, i.e. females earn more than males, and these are within:

- Healthcare Scientists staff group **-5.59%** pay gap (females earn **£1.14** more than male staff per hour). The gap has reduced compared to last year when the figure was -9.94% with females earning £1.84 more than male staff per hour.
- Nursing and Midwifery registered staff group **-3.21%** pay gap (females earn **£0.64** more than male staff per hour). The gap has slightly reduced compared to last year when the figure was -4.07 with females earning £0.77 more than male staff per hour.
- Allied Health Professionals staff group with a **-1.31% pay** gap (females earn **£0.28** more than male staff per hour). The gap has increased compared to last year when the figure was -0.05 with females earning the same as male staff per hour (£0.01 difference).

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

3 Insights from Gender Pay Gap research

3.1 Mend the Gap Report

The Mend the Gap Report, an independent review into gender pay gaps in medicine in England has found that the causes are multiple and complex, requiring a deep dive into current career and pay structures and a sustained commitment.

Hours: Women are more likely to work less than full-time (LTFT), which helps to explain why their pay is lower. Men report working more unpaid overtime, which means that their effective pay is overstated. When these factors are adjusted for, the gender wage gap is smaller.

Grade and experience: Men doctors are more likely to be older, have more experience and hold more senior positions – all of these characteristics lead to higher pay. Periods of LTFT working have long-term implications for women's career and pay trajectories as they reduce their experience and slow down or stall their progress to senior positions.

Additional payments: Among hospital doctors, we find that gaps in total pay – which include Clinical Excellence Awards (CEAs), allowances and money from additional work – are larger than gaps in basic pay alone.

Their recommendations to minimise the pay gaps include:

Review pay-setting arrangements

- Among hospital doctors, this means using fewer scale points and greater use of job evaluation. The aim is to ensure that gaps related to grade are justified.

Give greater attention to the distribution of additional work and extra payments

- Increase transparency around additional allowances and individually negotiated pay (for example, for locums or waiting list initiatives). An expanded workforce would reduce dependence on these gender-segregated pay elements.
- Monitor the gender split of applications for CEAs; change the criteria to recognise excellent work in a broader range of specialties; and encourage more applications from women.

Promote flexible working for both men and women

- Advertise all jobs as available for less than full time (LTFT).
- Reconsider the structure of LTFT training, so that it focuses on competency not time served, reducing long-term career penalties.

3.2 Reducing the gender pay gap and improving gender equality in organisations report

The Government Equalities Office and Behavioural Insights Team (2021) published a report on evidence-based actions which have found to have a positive impact on reducing gender pay gaps. This includes:

1. Review percentage of women at shortlisting stage and set targets to improve shortlisting rate
2. Use skill-based assessment tasks in recruitment
3. Use structured interviews for recruitment and promotions
4. Encourage salary negotiation by showing salary ranges
5. Introduce transparency to promotion pay and reward processes
6. Appoint diversity managers/diversity task forces to increase accountability for recruitment decisions

4 Developing actions to reduce Gender Pay Gap

Using this year's Gender Pay Gap data, we will develop an action plan which will contribute to identifying root causes for gender pay gaps at WWL, improving fairness and transparency around pay setting, making recruitment processes more inclusive and supporting our staff with work life balance by providing flexible working options. The draft actions will include:

- Deep dive into data for Admin & Clerical and Medical and dental workforce – review ratio of staff being shortlisting/recruited, proportion of LTFT by gender, proportion of staff leaving by grade/banding, qualitative feedback on barriers
- Review pay setting arrangements for medical and dental, moving towards more transparency in how entry salaries and changes are negotiated
- Review of clinical excellence awards application process for medical and dental and explore changes to criteria for recognising excellent work
- Review and promote inclusive recruitment processes as part of the inclusive recruitment process workstream; including on focus on medical recruitment and setting targets to improve shortlisting rate
- Promote flexible working for all; Review job adverts for medical and dental and if flexible working is promoted
- Proactively promote talent management and leadership development offer to female medical staff

Action planning will be led by the Pay Equality workstream whilst recognising that elements of the action plan will also sit with other workstreams, such as the inclusive recruitment programme. To finalise the action plan, relevant stakeholders will be involved including People Services leaders,

recruitment teams, Staff Side and Medical and Dental workforce. The action plan will also be shared at EDI Strategy Group which will have oversight and monitor its implementation.

We ask the Committee to note the content of the report and approve the report for national reporting and publication on our Trust website.

Appendices

Appendix 1
Gender Pay Gap Report summary data as at 31st March 2024

2.1 Table 1- Average & Median Hourly rate

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	24.3854	18.0996
Female	17.8449	16.0835
Difference	6.54	2.02
Pay Gap %	26.82	11.14

2.1.1 Average Hourly rate

As at March 2024 the Trust has a has a 26.82% mean average gender pay gap with females earning £6.54 an hour less than males. The mean average gender pay gap in 2024 is comparable to 2023 data when as at 31st March 2023 females earned £6.46 an hour less than males with a 27.46% mean average gender pay gap.

2.1.2 Median Hourly rate

As at March 2024 the Trust has a 11.14% median hourly rate gender pay gap with females earning £2.02 an hour less than males. The median hourly rate gender pay gap in 2024 has slightly improved in comparison with 2023 data when as at 31st March 2023 females earned £2.19 an hour less than males with a 12.69% median gender pay gap.

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

Quartile	Female	Male	Female %	Male %
1	1514.00	276.00	84.6	15.4
2	1479.00	311.00	82.6	17.4
3	1496.00	293.00	83.6	16.4
4	1256.00	536.00	70.1	29.9

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

Compared with quartiles 1-3 males are more highly constituted within quarter 4 at 29.9% compared with an average of between 15.4% - 17.4% within the other quartiles. Comparatively the reverse is true for females and they constitute 70.1% of quartile 4 compared with an average of between 82.6%-84.6% within the other quartiles.

The information compares % within the individual quartiles. However, if we review the broader picture comparing the overall workforce constitution there are 1416 male employees and of these 536 are within quartile 4 which represents 38% of all male employees. Comparatively of 5745 female employees only 1256 females are constituted within quartile 4 which represents only 22% of all female employees.

2.3 Bonus information

Table 3

Gender	Avg. Pay	Median Pay
Male	10,849.51	3,794.57
Female	4,564.36	3,794.57
Difference	6,285.14	0.00
Pay Gap %	57.93	0.00

Table 4

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	52.00	5934.00	0.88
Male	138.00	1426.00	9.68

The data in tables 3 & 4 relates to clinical excellence awards for medical staff as this is the only payment identified within the ESR standard report which falls within the set definition of 'bonus pay'. Clinical Excellence Awards recognise and reward Consultants who perform 'over and above' the standard expected in their role. The payments within the Trust`s bonus information contains both local and national Clinical Excellence Awards. The Local CEAs are administered within the Trust on an annual basis and the national CEAs are determined externally and administered by the Department of Health. During the reference period, the process for submitting an application for a national CEA was subject to an initial application followed by a renewal process every five years, instigated by the consultant. However, for a local CEA, the award was equally split between consultants who had successfully applied for a CEA. This was the same for the previous year.

The data highlights that the average bonus pay gap for females as at March 2024 is 57.93% and the median pay gap is 0.00%.

As at 31st March 2024 0.88% of female staff received a bonus payment in comparison with 9.68% of male staff. All consultants with a minimum of 12-months service are eligible to submit an application for a CEA, so when reviewing these figures consideration should be given to the overall consultant workforce profile which is predominately male at 72%, and this should provide some context as to the disparity of the number of male applications compared to the number of female applications. Consideration should also be given to the number of consultants excluding locums and the proportion of these receiving a bonus. There were 223 consultants excluding locums, 83% of female consultants were paid a bonus and 86% of male consultants were paid a bonus.

Agenda item: 29

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Modern Slavery Statement 2025-2026
Presented to:	Board of Directors
On:	2nd April, 2025
Purpose:	Approval
Presented by:	Director of Corporate Governance
Prepared by:	Director of Corporate Governance, with workforce and procurement teams
Contact details:	E: Steve.Parsons@wwl.nhs.uk

Executive summary

Part 6 of the Modern Slavery Act 2015 requires commercial organisations to prepare a slavery and human trafficking statement in respect of each financial year, which sets out the steps that it has taken during the course of the year to ensure that slavery and human trafficking does not exist in its supply chains and its own business (or a statement that it hasn't taken any such steps). Although this does not formally apply to NHS organisations at the moment, making such a statement is recognised to be best practice across the NHS; and Parliament is currently considering legislation that would bring public sector organisations within the statutory requirement.

For the last several years, the Trust has made a statement as if the statutory requirement applies; and this report invites the Board to agree a statement for the 2025-2026 financial year. The statement is believed to meet the requirements of Part 6 of the Modern Slavery Act, and has been reviewed to ensure that it remains accurate and appropriate.

Link to strategy

N/A

Risks associated with this report and proposed mitigations

Whilst not a statutory requirement at this stage, there would be a significant reputational risk if the Board were to decide not to make a statement; and a statutory requirement is expected to be in place within the next 12 months. These would be resolved if the Board approves a statement for the 2025-2026 year.

Financial implications

N/A

Legal implications

Currently there are no legal implications; however, a statutory requirement is expected to come into place during the 2025-2026 year/

People implications

N/A

Wider implications

N/A

Recommendation(s)

The Board of Directors is recommended to approve the Modern Slavery Statement 2025-2026, as appended to this report.

Slavery and human trafficking statement

Wrightington, Wigan and Leigh Teaching Hospitals NHS FT (WWL) is an NHS foundation trust, providing acute hospital and community care to the population of Wigan Borough and beyond. Each year we treat around 85,000 inpatients and around 480,000 outpatients and we deal with around 90,000 Emergency Department attendances. We also provide around 44,000 walk-in centre appointments and deal with over 177,000 referrals from GPs. We employ over 6,000 members of staff and have an annual turnover of c.£400m. Further detail about what we do can be found on our website.

Policies and initiatives

We fully support the Government's objective to eradicate modern slavery and human trafficking and recognise the significant role that the NHS has to play in combatting it and in supporting victims.

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and, insofar as possible, we require our suppliers to adopt a similar approach. We are also committed to using our role as a healthcare provider and a key organisation in the borough to ensure that our staff and patients can access all available support and, as such, we are committed to the sharing of information and raising awareness.

At WWL, we:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues

For our workforce, we:

- Confirm the identities of all new employees and their right to work in the United Kingdom, and pay our employees in line with national terms and conditions, such as Agenda for Change
- Have dedicated policies in relation to grievances and raising concerns and we have a good working relationship with our staff side partners which gives our employees an outlet to raise any concerns about poor working practices
- Have an independent Freedom to Speak Up Guardian that colleagues can contact in person, by telephone or email to raise concerns about their own circumstances or those of others

For procurement and our wider supply chain, we:

- Encourage suppliers and contractors to take their own action and understand their obligations under the Modern Slavery and Human Trafficking Act 2015.
- Will ensure appropriate checks are made when making decisions to work with new suppliers and relevant commercial organisations which fall under the legislation. These organisations

will be required to make a declaration confirming their compliance with the Modern Slavery and Human Trafficking Act 2015.

- Share and promote best practice within our supply chain to raise awareness of Modern Slavery risks.
- Reserve the right to end business relationships where suppliers have failed to meet their obligations and/or meet our ethical standards.

The procurement team will:

- Include a minimum 10% weighting for Social Value in the selection and award criteria for appropriate tenders. The Social Value criteria will be dedicated to Net Zero and Social Value, including the elimination of Modern Slavery.
- Ensure specifications include a commitment from suppliers to support the requirements of the Act.
- Will not award contracts where suppliers will not commit to complying with the Act. We will continue to support the use of regional and national public sector frameworks which incorporate selection and award criteria to support goals of the Act.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2025.

The Board approved this statement at its meeting on [2nd April, 2025].

Signed: _____

Mary Fleming
Chief Executive

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard and Optimisation Report
Presented to:	Board of Directors
On:	02 April
Item purpose:	Information
Presented by:	Kevin Parker – Evans
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 February dashboard has highlighted that there are two areas for increased observation. Delay in category 1 CS and Apgars. The governance team is looking closely into the Apgars. A deep dive into the CS timings will be completed within the wider CS audit to look for themes and trends. These metrics are continually observed for any themes or trends by the governance team.

As many of the figures recorded are small numbers, they cannot be assessed for any themes immediately. Themes will usually be assessed over time using larger numbers of data.

Financial implications

N/A

Legal implications

N/A

People implications

Areas where the figures flag as red can indicate that there are areas which need auditing to ensure that birthing people and their families are receiving the safest possible care.

Equality, diversity, and inclusion implications

Where audits and deep dives are required, these factors are included to see if flagged issues are more prevalent in certain groups.

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

None

Recommendation(s)

The board are asked to note the February 2025 dashboard and overview of indicators as outlined below.

Report

February 2025 Exception report – Maternity Summary

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

- There were Five validated midwifery red flags reported in February, all for delay in IOL. It should be noted here that the method of collecting red flag reports has changed. We are now pulling these figures from the birth rate plus acuity app. The app enables us to have a better picture of any red flags. There is a separate red flag report which investigates the red flags in more detail.
- The shift coordinator was able to remain supernumerary for all shifts in February.
- 1:1 care is at 100% in February.
- There were 5 Maternity complaints received in February, but the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

PSII Commissioned Incidents

There was 1 PSII Commissioned incident reported in February. This incident was a dropped baby on the Maternity ward.

StEIS reported incidents

There was 1 StEIS reported incident reported in February. This incident was a dropped baby on the Maternity ward.

Green

The number of mothers who have opted to breastfeed (%) – This has seen a significant increase from the January figures for this metric. Work continues to improve this metric.

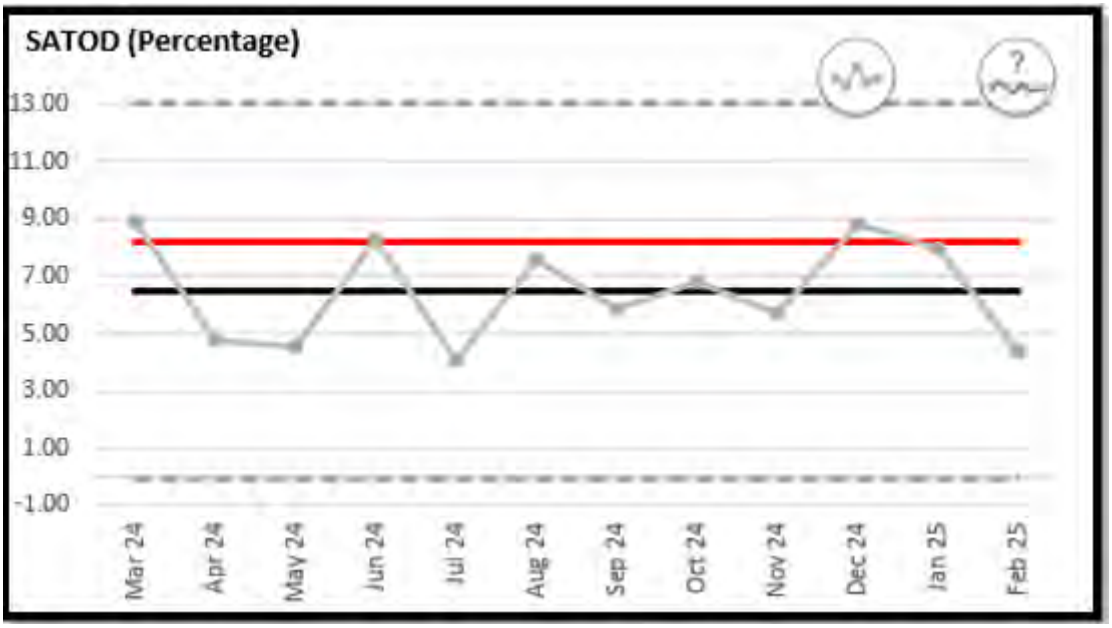
Supernumerary Shift coordinator (%) – There were no shifts in February where the shift coordinator was unable to remain supernumerary.

Women readmitted within 28 days of Delivery (rate per 1000). There were 5 maternal readmissions to the obstetric unit in February. No omissions in care were noted. The admissions were for:

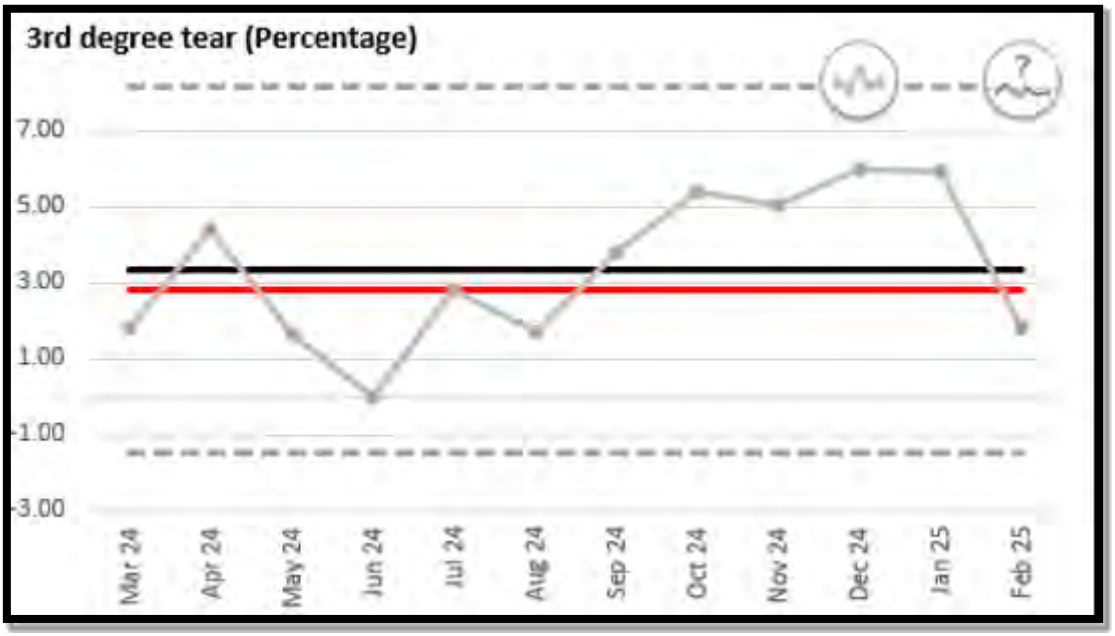
1. Anaemia
2. Wound infection
3. ? Sepsis
4. Unknown
5. Unknown

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

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



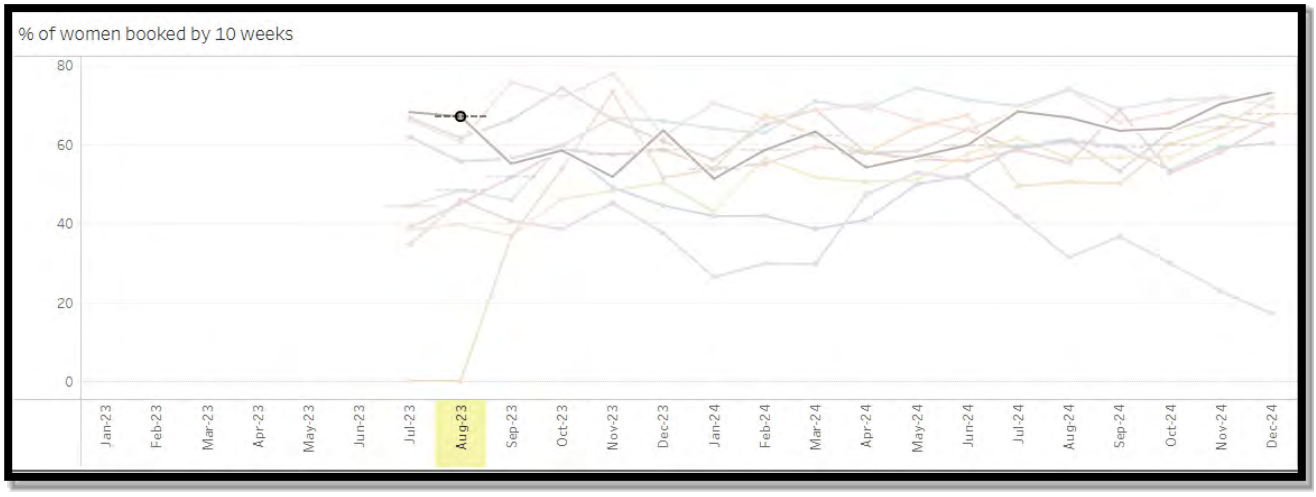
3rd / 4th degree tear (%). The figure is recorded as a rate per 1000. There were 2 women who had a 3rd degree tear February which is a significant decrease from previous months. The below SPC chart shows how we compare to the rest of GM for this metric. An audit and working group has been started to look at why the levels for this metric were rising.



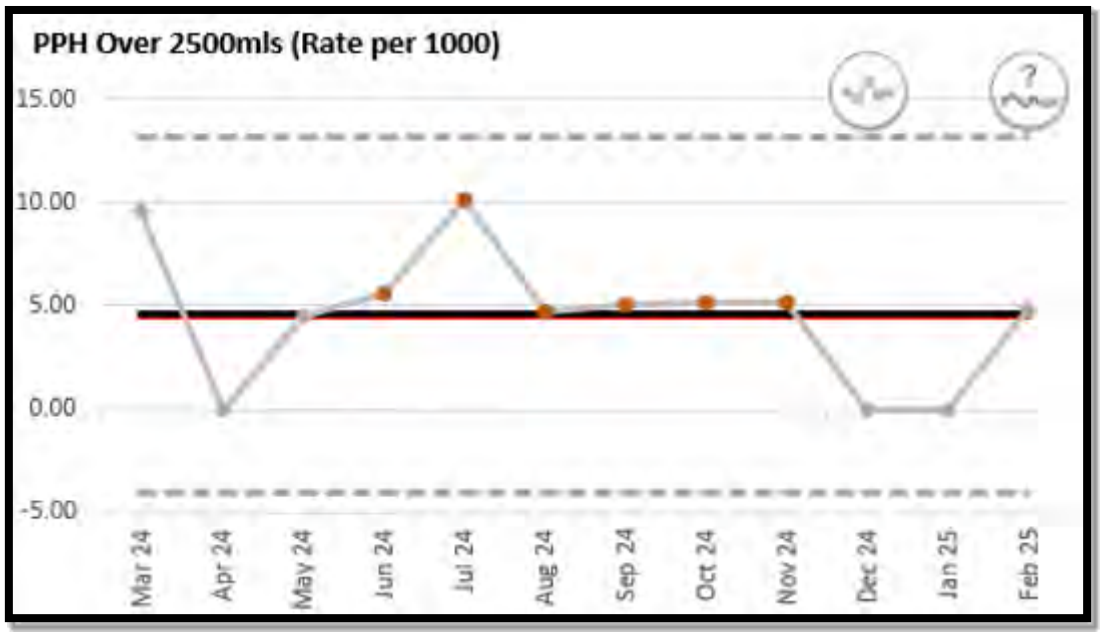
1:1 care in labour (%). There were no woman in February reported to have not had 1:1 care.

Amber

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



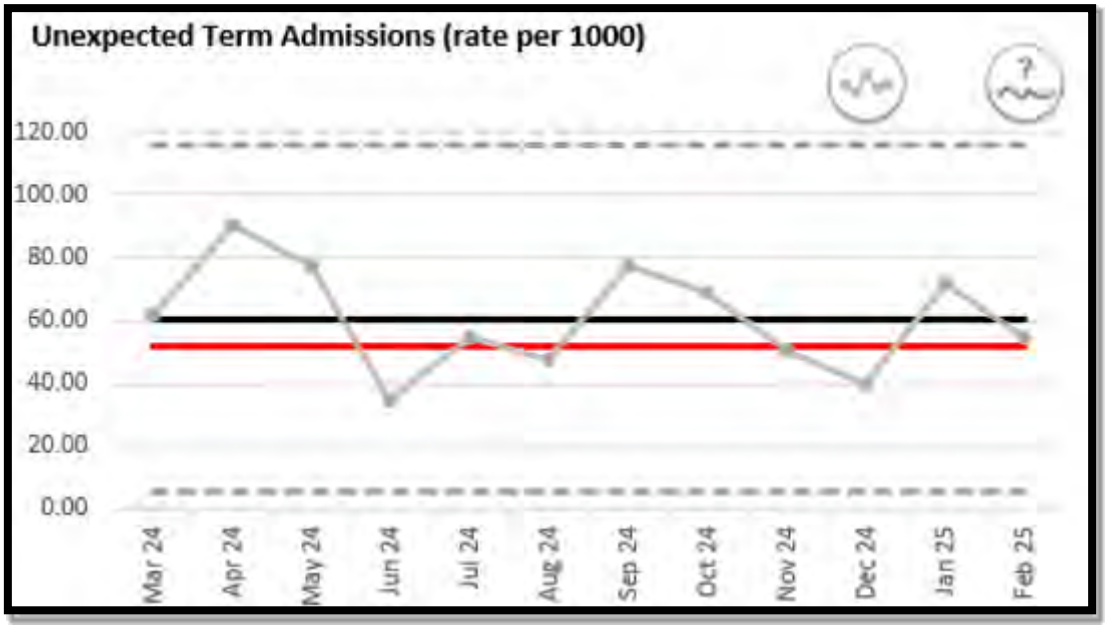
PPH over 2500mls (rate per 1000). There were no women who had a PPH of over 2500mls in January. The below SPC chart shows how WWL compare with GM (red line). The figures for this metric are recorded as rate per 1000.



Skin to skin contact (%) This metric saw a small dip in April, but it has seen a return to normal levels since, despite a slight drop in the January figure. Work continues to improve this metric.

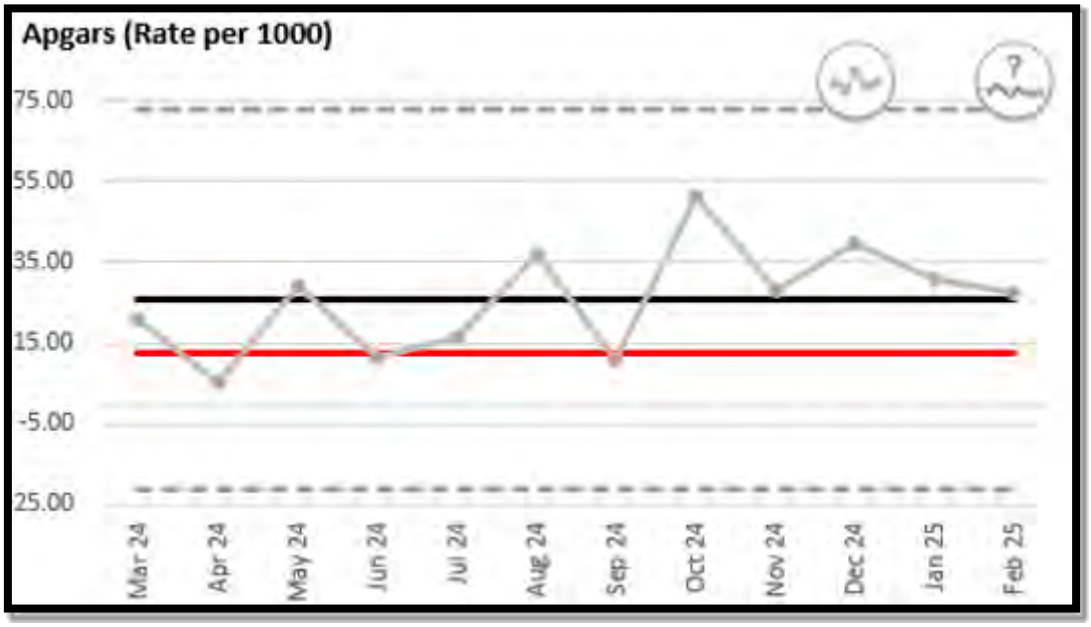
Category 2 Caesarean Sections with no Delay in Decision to Delivery interval (%). Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and knife to skin. In February there were 5 women out of 32 who had an interval time of more than 75 mins. The times where there was a delay ranged from 76 minutes to 2 hours 15 minutes.

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

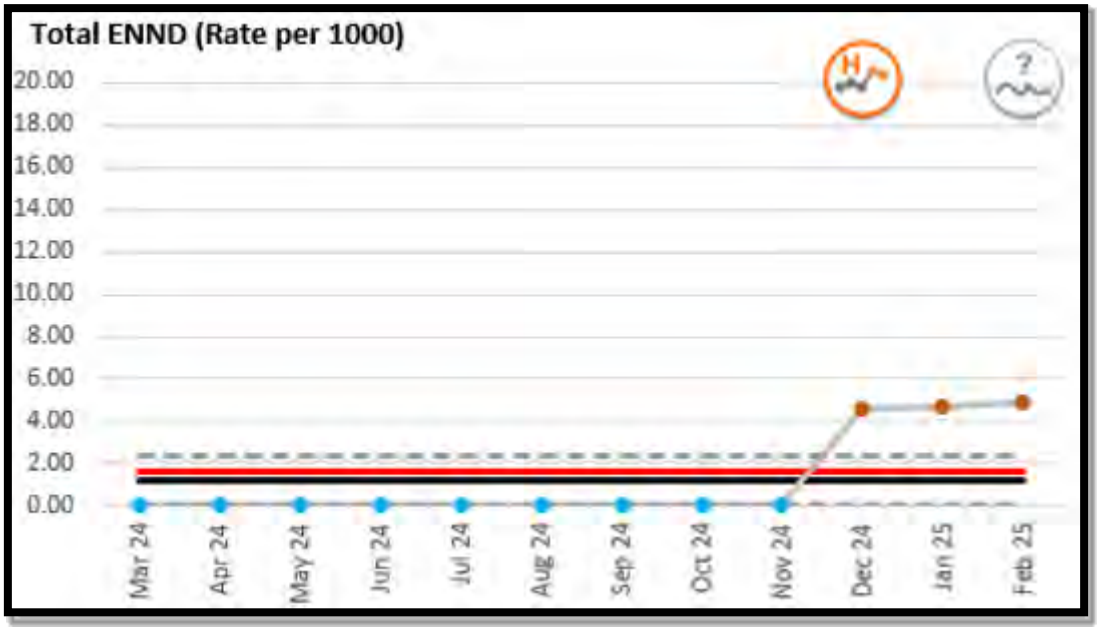


Red

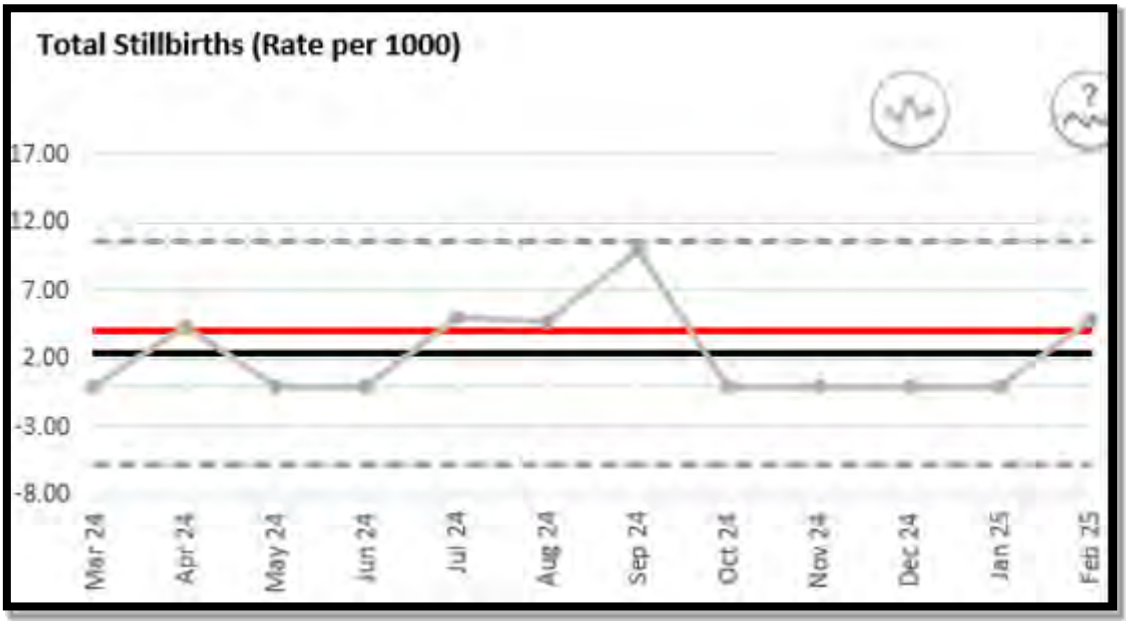
All infants with Apgar's less than 7 (rate per 1000). This metric remains red and has been for 5 months. The rate per 1000 in February equates to 5 babies. All cases are being fully investigated by the governance team. The below SPC chart shows how our figures compare to the GM average (red line).



Number of Neonatal Deaths (rate per 1000). The figure is recorded as a rate per 1000. There was 1 ENND in February. It was a 21 week late miscarriage which showed signs of life at delivery. The below SPC chart shows how WWL compare with GM (red line).



Number of stillbirths (rate per 1000). This figure is recorded as a rate per 1000. There was one stillbirth in February. The below SPC chart shows how WWL compare with GM (red line).

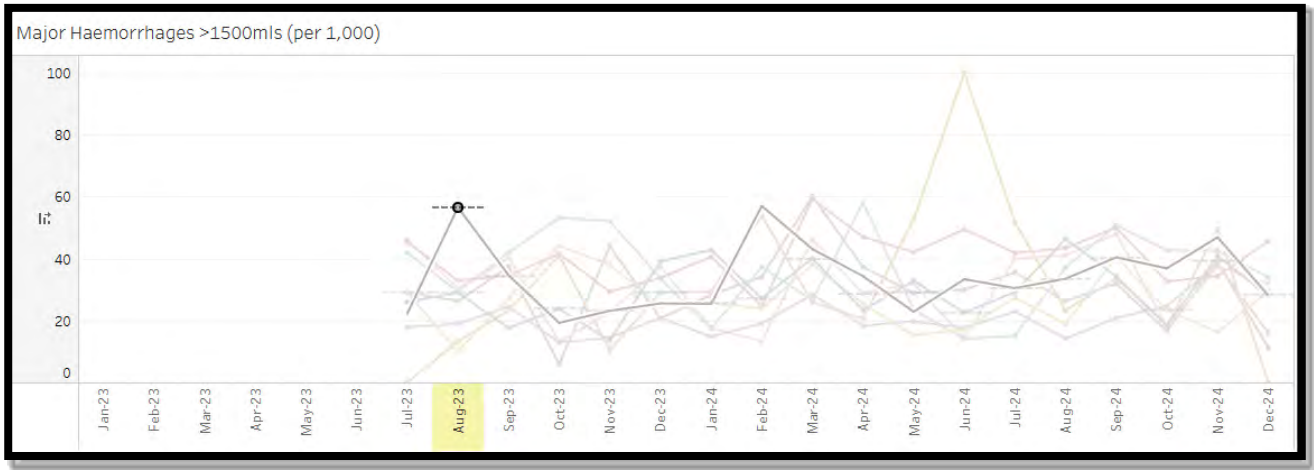


Induction of Labour (IOL) – (%) These levels have been very up and down over the past few months, with a significant spike in June and July. December and January saw a drop into green levels. February sees a significant spike in cases. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes.

Category 1 Caesarean Sections with no Delay in Decision to Delivery interval (%). Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and knife to skin. February figures show a continued rise into red levels. 4 women out of 13 had an interval of more than 30 minutes. The times where there was a delay ranged from 33 to 12 hours 35 minutes.

Other areas not RAG rated

PPH 1500mls – 2500mls – The figure shown on the dashboard is shown as a rate. The rate in February equates to 4 women. The chart below shows how WWL is performing in relation to the rest of GM. As this is not currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart. WWL are currently participating in a nation PPH study called OBSUK. It is hoped that the data from this study may help to reduce the PPH figure nationally in the future.

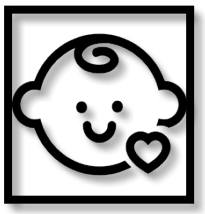


Conclusion

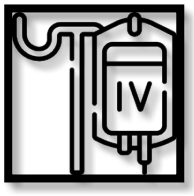
Normal variation and fluctuations are noted with the figures this month and positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green and amber indicators but do show several red areas which will be observed going forward. Persistently amber areas will also be closely observed for patterns. The maternity dashboard continues to be reviewed quarterly by GM and the Maternity Dashboard steering group.

Optimisation Metrics - February

The below relates to 7 mothers who delivered 11 babies.

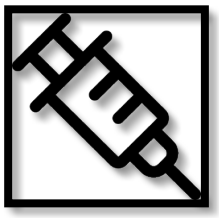


- There were 0 babies not born in an appropriate care setting.
- 0 babies born < 30 weeks gestation.
- 2 babies born < 34 weeks gestation.



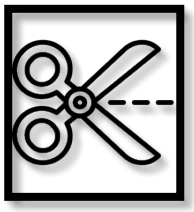
100% of Mothers received MgS04 24 hours prior to delivery.

- One mother (twins) received MgS04.



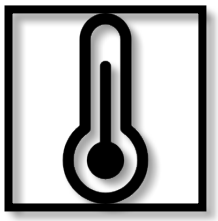
73% of babies received steroids within 7 days of delivery (< 34 weeks).

- 1 mother received a partial course.
- 1 mother (twins) received too early.



80% received optimal cord management (< 34 weeks).

- 2 babies did not receive delayed cord clamping at delivery as the Apgar was 2 at 1 minute.
- DCTA triplets – x1 did not receive delayed cord clamping at delivery.



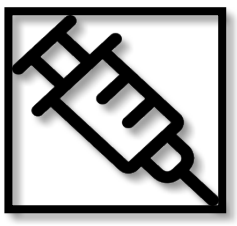
100% of babies had a Normothermic Temperature (36.5-37.5C) on admission to NNU, measured within one hour of birth (< 34 weeks).

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

100% of babies received maternal breast milk (EBM) within 24 hours of birth (< 34 weeks).

- 11 babies received EBM after 24 hours following birth.

66% received Intrapartum Antibiotics >4 hrs prior to delivery (< 34 weeks)



- 1 mother had a precipitate delivery.
- 8 babies N/A as CS prior to labour.

Safety Dashboard 2025

Maternity

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

		Goal	Red Flag	Measure	2025 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 Q1	Q2	Q3	Q4	YTD	Trend
Activity	Bookings (Total bookings)				245	231																\
	Booked by 10 weeks (as % of total bookings – Exclude transfer to area)	Above 80%	Below 50%		77.55%	69.30%																\
	Booked by 12+6 weeks (as % of total bookings – Exclude transfer to area)	Above 90%	Below 80.9%		92.65%	90.35%																\
	Registerable births				214	205																\
	Planned home births (as % of all births)				0.93%	0.00%																\
	Unplanned home births (as % all births) – BBA				0.93%	0.49%																\
	NVD (as % of total births)				40.65%	46.34%																/
	Instrumental deliveries (as % of total births)				6.54%	7.32%																/
	Total number of Caesarean Sections (all categories – as % of total births)				53.74%	46.34%																\
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				3	6																/
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				19	21																/
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				9	11																/
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				4	1																\
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				11	5																\
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				15	8																\
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				32	26																\
	Robson Group 6: Nulliparas; single breech pregnancy				5	2																\
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				5	2																\
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				6	5																\
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	0																-
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				6	8																/
	Number successful VBAC				6	4																\
	% of Category 1 Caesarean Sections with no Delay in decision to delivery (over 30 minutes) – as % total cat 1 CS	Above 90%	Below 80.9%		72.73%	71.43%																\
	% of Category 2 Caesarean Sections with no Delay in decision to delivery (over 75 minutes) – as % total cat 2 CS	Above 90%	Below 80.9%		80.65%	84.38%																/
	Number of Caesarean Section at Full Dilatation				8	2																\
	IOL (as % of all women delivered – excluding pre labour SROM)	Under 35.9%	Above 40%		33.18%	42.44%																/

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

	% of babies born <37 weeks whose mother received intrapartum IV Antibiotics (% of births under 37 weeks)				56.25%	92.31%																	
	Neonates with Apgars <7 at 5 minutes (>_37 weeks gestation) - Rate per 1000	Under 15	Above 21		30.61	27.32																	
	Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000	Under 54	Above 65		71.43	54.64																	
	Number of babies re-admitted with 28 days of birth				16	18																	
	Number of babies born < 3rd centile				13	5																	
	Number of babies born < 3rd centile >_ 38 weeks				6	1																	
Public Health	% women smoking at time of booking (as % of total bookings)				7.76%	3.95%																	
Public Health	% women smoking at time of delivery (as % of total births)	Under 8.5%	Above 10%		7.94%	4.39%																	
Public Health	Babies in Skin-to-Skin within 1 hour of birth (as % of total births)	Above 75%	Under 65%		75.23%	74.15%																	
Public Health	Percentage of Women Initiating Breastfeeding (as % of total births)	Above 58%	Under 50%		58.41%	62.44%																	
Public Health	Number of women who report that they are drinking alcohol at booking				0	1																	
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)		Under 100%		98.96%	100.00%																	
Workforce	Percentage of shifts where shift Co-ordinator able to remain supernumerary		Under 100%		100%	100%																	
Workforce	Diverts: Number of occasions unit unable to accept admissions				0	0																	
Workforce	Sickness (as % of overall staffing) – report quarterly																						
Workforce	Number of vacancies				1.82	2.22																	
Workforce	Prospective Consultant hours on Delivery Suite				60	60																	
Workforce	Number of Midwifery Red Flags Reported				8	9																	
Incidents	Number of incidents reported				87	77																	
Incidents	Number of MNSI Investigations				0	0																	
Incidents	Number of StEIS Reported Incidents				2	1																	
Incidents	Number of Complaints received in the month				3	5																	
Incidents	Number of Letters of Claim Received in the month				0	0																	
Incidents	HIE 2 &3 > 37 weeks (rate per 1000)			GM average 2023 0.555/1000	0	0																	

Safety Dashboard 2025

Neonatal

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

		Goal	Red Flag	Measure	2025 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 Q1	Q2	Q3	Q4	YTD	Trend
Safety	% of Shifts Staffed to BAPM	100.00%	< 90%	Badger	100%	90.74%																\
	% of Shifts with Supernumeary Shift Leader	100.00%	< 50%	Badger	98.36%	94.44%																\
	Unit Closed Due to Capacity	0	≥ 1	Datix	0	1																/
	Unit Closed Due to BAPM/Staffing	0	≥ 1	Datix	0	0																–
Admissions	Number of Births from Maternity			Maternity Data	214	205																\
	Admissions Under 27 Weeks to NNU	< 1	≥ 1	Badger	0	0																–
	Admissions 27+1 – 34 Weeks to NNU			Badger	2	8																/
	Total Admissions to Neonatal Unit			Badger	25	28																/
	Transitional Care Admissions: 34 – 36+6			Badger	2	4																/
	Transitional Care Admissions: 37+			Badger	11	9																\
	Total TC Admissions			Badger	13	13																–
	Postnatal Ward IVAB admissions 34-36+6 weeks			Badger	2	1																\
	Postnatal Ward IVAB admissions over 37 weeks			Badger	10	8																\
	Number of unexpected Term Admissions to NNU				14	10																\
	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)	5.4%	≥ 6.5%	Maternity/Badger	7.14%	5.46%																\
	Unexpected Term Admissions to NNU (*as % of Total Admissions*)			Badger/ NWNODN	56.00%	35.70%																\
	Mothers Eligible for AN Steroids (*< 34 Weeks*)			NNAP/ NWNODN	2	7																/
	% of Mothers Who Received Full Course of Antenatal Steroids	≥ 93%	< 89%	NNAP/ NWNODN	50.00%	57.10%																/
	Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*)			NNAP/ NWNODN	0	1																/
	% of Mothers Receiving Antenatal $MgSO_4$	≥ 85%	< 73%	NNAP/ NWNODN	N/A	100.00%																/
	Babies Eligible for Delayed Cord Clamping			NNAP/ NWNODN	2	11																/
	% of Babies Receiving Delayed Cord Clamping	≥ 85%	< 73%	NNAP/ NWNODN	100.00%	72.72%																\
	Babies Eligible for Temperature on Admission (*< 32 Weeks*)			NNAP/ NWNODN	2	11																/
	% of Babies With Temperature Within First Hour of Admission (*< 32 Weeks*)			NNAP/ NWNODN	100%	100%																–

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

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

Title of report:	Audit Committee annual report to the Board of Directors
Presented to:	Board of Directors
On:	2 April 2025
Item purpose:	Information
Presented by:	Audit Committee Chair
Prepared by:	Head of Corporate Governance/Deputy Company Secretary
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Executive summary

In line with best practice (therefore what is reflected in its terms of reference - ToR) and as the Board's most senior committee, the Audit Committee should report to the Board at least annually on its work in support of the annual governance statement and how the Committee has fulfilled its ToR.

A summary of the 'Alert, Assure, Advise' reports has been collated, which gives a succinct overview of the Committee's work in 2024/25 and aligns to the ToR requirements. It should be noted that term 7.11 'information governance and cyber security' was added to the ToR in November 2024 and therefore the Committee has not received any assurance around this to date, with reports scheduled on to the work plan for the year ahead.

Based on the material reviewed and assurance provided throughout 2024/25, the Committee is satisfied with the Trust's position in respect of the fitness for purpose of the overall assurance framework; the completeness and 'embeddedness' of risk management in the organisation; the effectiveness of governance arrangements and the appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

Link to strategy and corporate objectives

The Audit Committee oversees review of the Board Assurance Framework which houses the corporate objectives and risks to their achievement.

Risks associated with this report and proposed mitigations

Failure to comply with regulatory or statutory requirements could result in sanctions and reputational damage.

Financial implications

Noted below.

Legal implications

The Audit Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal functions. It does this through independent and objective review. The Committee must function effectively to ensure that there is no risk to compliance with associated regulatory and statutory requirements.

People implications

There have been no concerns noted in relation to chairship, membership, or attendance.

Equality, diversity and inclusion implications

None identified. Reflections are considered at the end of each meeting.

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

Audit Committee and then the Board of Directors.

Recommendation(s)

The report is for noting.

Annual report

Key discussion points and matters escalated by the Audit Committee to the Board of Directors from February 2024 – November 2025.

ALERT

- No alerts were raised in February, June or November 2024

May 2024

- In respect of the draft annual accounts, the committee were alerted to an omission which had been made on the revaluation and was corrected to the satisfaction of the external auditors, prior to the final version being submitted. This would not impact on the final adjusted financial position.

September 2024

- A limited assurance report around patient property was presented, although not material from a financial perspective and not expected to impact on the overall audit opinion. This audit was requested by the Trust itself from a quality and patient experience perspective and the Chief Nurse provided assurance around the speed of response to these audit findings.
- The committee provided authority for both write-off, and further negotiation, pertaining to a long-standing debt issue with primary care providers.

February 2025

- The Chief Nurse attended to discuss the enhanced care limited assurance audit and the Committee heard about plans being put in place to address the issues.
- The Chief People Officer attended to discuss the high-risk recommendations around employee relations and retention of documents. The Committee were content that MIAA will be working with them to progress the plans and close the recommendations.
- Waivers raised in estates require work to ensure no repetition without demonstrating due process.

ASSURE

February 2024

- The committee undertook a review of the risk register and was assured that a robust system of risk management is in place and that there is good, executive-led oversight of high-level risks within the organisation. The committee also received confirmation from the internal auditors that the assurance framework meets NHS requirements and is used by the organisation.
- The committee received five internal audit reports – one had received high assurance, three had received substantial assurance and one had received moderate assurance. The committee was satisfied that the management responses to the recommendations were appropriate
- The committee was pleased to note that the external auditor's work on Value For Money had concluded and that no significant risks in relation to the three areas of focus (financial sustainability, governance and improving economy, efficiency and effectiveness) had been identified.

May 2024

- The committee undertook a review of the risk register and was assured that a robust system of risk management is in place and that there is good, executive-led oversight of high-level risks within the organisation. Deep dives were undertaken into two key risk areas and mitigations were discussed to the committee's satisfaction.
- The counter fraud progress report, workplan and annual external audit report were received and the committee were assured around the robustness of the counter fraud policies and procedures in place at WWL.
- The Freedom to Speak Up (FTSU) Guardian provided a presentation on progress made with the FTSU process after recently taking up post.
- The committee received the draft Head of Internal Audit opinion, which gave WWL a substantial assurance rating.
- The committee received four internal audit reports – three with substantial assurance and one with limited assurance. The committee was satisfied that the management responses to the recommendations were appropriate. With respect to the limited assurance report on safe medical staffing, the committee noted that

the limited result was due to a lack of comparative data in this area being available across the system and was not a reflection of the control environment around safe medical staffing at WWL.

September 2024

- The committee took assurance from several audit reports received:

  Moderate:

  - Data quality external submissions

  Substantial:

  - Capital programme
  - Data Security and Protection Toolkit (DSPT)
  - Mandatory training
- The Freedom to Speak Up (FTSU) Guardian, after several months in post, had made significant progress in increasing contacts, developing a more open culture and evidenced that robust processes are in place for the service.
- A report on single tender waivers was received, and rationale for the waivers accepted.
- The internal audit plan was shown to be on track and two changes to the audits to be carried out in the current year were approved.
- The counter fraud progress report was noted.
- The Counter Fraud Risk Strategy was reviewed and approved.
- The risk management processes were reviewed and approved.

November 2024

- The committee took assurance from the update provided around the Multi Story Car Park (off balance sheet) transaction and the external auditors informal opinion that there are no concerns with the process and plan put forward. It accepted however that a formal opinion on the matter would not be given until the work has been completed.
- It noted the assurance provided by the freedom to speak up report only requested a more streamlined reporting format for FTSU moving forwards through an annual report, focussed more on process.
- The losses and special payments report was received.
- A high assurance internal audit on key financial controls audit was received.
- The internal audit plan is on track – and significant progress made with WWL's overall position
- High assurance was noted on general ledger, accounts payable and receivable and general financial management.
- The counter fraud report was noted and the plan on track.
- The annual review and update of standing financial instructions was reviewed and agreed for board approval.
- The independent review of the Charity's annual report and accounts had been received from Voisey & Co LLP, the committee therefore endorsed them for approval of the Charitable Trust Committee.

February 2025

- MIAA were on plan to complete the program and support the annual governance statement. MIAA were pleased with the progress made with WWL's overall position.
- A high assurance internal audit was received for risk management core controls.
- Substantial assurance internal audits were received for:
  - ESR payroll, which important given materiality of expenditure
  - IT asset management
  - Freedom to speak up

- KPMG's plan was noted to be in place for the 2024/25 annual accounts audit in line with the DHSE timetable of 30 June 2025.
- The counter fraud work plan for 2025/26 was agreed, to prevent and detect fraud, with the progress report 24/25 on plan to deliver.

ADVISE

February 2024

- The committee noted that a competitive procurement exercise in relation to the provision of internal audit services had recently been undertaken, and noted that this had been done in conjunction with The Christie NHS FT in order to achieve best value for money. The committee recommends that the board approves the contract.
- The committee received a report on single-tender waivers and undertook a deep dive into two of the waivers. As a result, the committee has asked for some further work to be done to refine the associated approval process.
- The draft accounting policies for 2023/24 were approved by the committee.
- The committee agreed to a request to amend the internal audit plan for 2023/24 and asked for further assurance to be provided to it on the management of service level agreements, noting that this was a specific area of focus within the Financial Sustainability Plan.
- The committee considered the internal audit follow-up report and was satisfied with progress made, although expressed some concern at deadlines which are subject to multiple revision or those where a year-end deadline is routinely provided. This was taken forward by the Chief Executive through the executive team's regular meeting.
- The committee agreed the external audit plan for 2023/24

May 2024

- The committee received the month 12 report on losses and special payments.
- The committee received a report on single-tender waivers and undertook a deep dive into two of the waivers, which it was satisfied were granted in line with procurement processes
- Changes to WWL's SFIs for 2023/24 were approved by the committee, together with the revised SFI document.
- The committee agreed the draft internal audit plan for 2023/24, noting that no concerns had been raised as to the audits listed by the Board's assurance committee chairs.
- The committee considered the internal audit follow-up report and was satisfied with progress made.
- The committee approved the going concern declaration for 2023/24.
- The draft annual accounts were received and noted.
- The internal audit charter was received.
- The committee received a progress update on WWL's accounts preparation for 2023/24 with no issues of concern identified at this point.

June 2024

- The agenda considered by the committee related to 2024/25 year-end matters and took assurance from the reports provided.
- In line with the delegated authority previously provided by the board, the committee approved the following documents which the foundation trust is statutorily required to complete:
  - The annual accounts, for submission to NHSE and to be laid before parliament
  - The annual report, which would be submitted to NHSE
  - The committee also approved the management representation letter which was in the standard form provided by the auditors, to be signed by the Chief Executive
- The committee received the external auditors' report to those charged with governance (the 'ISA260' report) and their annual report.
- Note was made of the fact that a copy of the annual report and accounts, and the external auditor's report, must be published on the foundation trust's website once laid before Parliament. Given the fact that Parliament is currently prorogued, it was appreciated that this would take some time and the corporate affairs team would maintain oversight of the issue.

September 2024

- The committee noted progress made with the service level agreement project and review process.
- The internal audit follow-up report was received.
- A technical update from KPMG, the Trust's external auditors was noted.
- The revised terms of reference for the Audit Committee for 2024 were reviewed and suggestions for two changes made prior to Board approval being sought.
- A report on losses and special payments was received.
- The committee reflected on how the papers it had received, and related discussions, had given consideration to potential inequalities, diversity, and inclusion:
    - The patient property audit and assurance provided by the Chief Nurse around associated actions, highlighted that the Trust is mindful of how lost property can particularly disadvantage patients with accessibility needs, such as hearing aids, and the overall negative effect this can have on the patient experience.
    - Concerns had been raised around how the lack of chemotherapy access, which has meant that some patients with urgent treatment needs have had to travel to the Christie NHS FT for care, and that this may present difficulties for various patient groups who would struggle to make this journey.
- It was noted how the FTSU service supports staff to speak up about discrimination and that this has been happening in practice.

November 2024

- A moderate assurance audit on employee relations was received with further assurance to be provided at next meeting by Chief People Officer around retention of documentation.
- The committee approved the draft responses for audit planning on management enquiries for those charged with governance.
- The committee noted several matters where it had reflected upon equality diversity and inclusion considerations along with health inequalities, noting how other assurance committees consider this, through their minutes:
    - Fraud – challenging in relation to IVF being withheld from patients with certain criminal convictions, on the basis that healthcare should be accessible to all.
    - Losses and special payments – seeking further assurance around actions in place to prevent loss of patient accessibility aids.

February 2025

- The self-assessment on national safety standards for invasive procedures (NatSSIPS) and LocSSIPs (Local Safety Standards for Invasive Procedures) will be shared at the next meeting.
- The IT asset management audit identified that £0.8m of devices are not Windows 11 compatible which creates a potential security risk.
- A review of the business case realisation processes was undertaken by MIAA.
- Follow up internal audit recommendations were all on all on track.
- KPMG have indicated a materiality limit of £11m (21%) of resource in advance of the 2024/25 audit.
- KPMG have been reappointed on a 2+2 contract by the Council of Governors, with partner responsible, Tim Cutler to continue this role.
- The losses and special payments report was received.
- The annual review and update of accounting policies took place with revisions approved.
- The waiver report was received with assurance requested at the next meeting on the number of estates and facilities single tender actions to demonstrate that they are very low in the grand scheme of total orders as well as how RAAC funding provision has effected the procurement policy position.
- The committee effectiveness review was carried out through discussion, with suggested changes noted and to be considered.
- The committee noted matters where it had reflected upon equality diversity and inclusion (ED&I) considerations along with health inequalities:
    - Assistance being provided to patients who are being asked to sign indemnities
    - Noting how other assurance committees consider this, through their minutes.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

February, May 2024

- The committee undertook a review of the risk register and was satisfied as to the arrangements for managing risks. No new risks were identified and no specific risks were highlighted during the meeting.

September 2024

- Risks deep dives were carried out in relation to two risks:
  - 3971 – an inadequate number of chemotherapy nurses on the Cancer Suite, given the increasing demands on the service
  - 3589 – Infection prevention and control service unable to operate sufficiently with the absence of substantive microbiology support

November 2024

- Following the annual review of the risk register and management process, the committee noted four new risks escalated to the corporate risk register, scoring 15 or above:
  - 4056: Sterile services decontamination air handling unit
  - 3912: Endocrinology patient waiting list
  - 3942: Sleep follow up waiting list
  - 4049: Insufficient medical resus cover at Leigh Infirmary

February 2025

- Following the annual review of the risk register and management process, the committee noted three risks escalated to 16 namely:
  - IQIPSA - Improving Quality in Physiological Services Accreditation
  - Children's audiology - delayed appointments
  - PASQAT - Paediatric Audiology Services Quality Assurance Team