Board of Directors - Public meeting

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

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

13:30 - 13:31
1 min

14. Declarations of Interest

Information *Mark Jones*

Verbal item

14.1. Register of directors' interests

Information *Mark Jones*

14.1. Directors DoIs - Feb 2025.pdf (3 pages)

13:31 - 13:32
1 min

15. Minutes of the previous meeting

Approval *Mark Jones*

15. Minutes_Board of Directors - Public Meeting _041224.pdf (6 pages)

13:32 - 13:34
2 min

16. Action Log

Discussion *Mark Jones*

16. Public Board Action Log 2024.pdf (1 pages)

16.1. University Teaching Hospitals update

Information *Richard Mundon*

13:34 - 13:42
8 min

17. Patient Story

Information *Kevin Parker-Evans*

Video to be shared on screen

13:42 - 13:52
10 min

18. Chair's report and stakeholder update

Information *Mark Jones*

13:52 - 14:02
10 min

19. Chief Executive's report

Information *Mary Fleming*

19. CEO Board Report_Feb 2025_Final.pdf (5 pages)

14:02 - 14:17
15 min

20. Board Assurance Framework

Information *Steven Parsons*

20. BAF Report Board February 2025.pdf (31 pages)

14:17 - 14:37
20 min

21. Integrated performance report

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

21. Board of Directors M9 2425 IPR.pdf (3 pages)
21a. Board of Directors IPR_M9_2425.pdf (20 pages)

14:37 - 14:57
20 min

22. Committee chairs' reports

Information *Non Executive Directors*

22.1. Quality and Safety

Information *Mary Moore*

22.1. AAA.QS - Jan 2025.pdf (2 pages)

22.2. Finance and Performance

Information *Julie Gill*

22.2. AAA - FP - Jan 2025.pdf (2 pages)

22.3. People Committee

Information *Mark Wilkinson*

22.3. AAA People - Dec 2024.pdf (2 pages)

14:57 - 15:07
10 min

23. CQC review of UEC

Information *Kevin Parker-Evans*

Presentation to be shared during the meeting.

15:07 - 15:17
10 min

24. Safe Nurse Staffing Bi-annual review

Discussion *Kevin Parker-Evans*

Paper to follow, following disucssion at ETM

24. Bi- Annual Nurse Staffing Review September 2024 inc Exec Summary FINAL.pdf (33 pages)

15:17 - 15:27
10 min

25. Finance report

Information *Tabitha Gardner*

25. Board Cover Sheet - Trust Finance Report December 2024.pdf (2 pages)
25a. Trust Finance Report 24-25 December Month 9 Board.pdf (15 pages)

15:27 - 15:42
15 min

26. Maternity reports

Information *Kevin Parker-Evans*

26.1. CNST Presentation

Cathy Stanford, Christos Zipitis, Shatha Attarbashi, Abdul Ashish

26.1. CNST YEAR 6 Quadrumvirate Presentation Feb 2025 (updated) Substantive.pdf (16 pages)

26.2. Consultant Attendance Audit

26.2.Cons attendance to Nov 24.pdf (5 pages)

26.3. Updated Paediatric Tier 1 Action Plan

26.3. (4.13) TIER 1 ACTION PLAN DECEMBER 2024 UPDATE.pdf (5 pages)

26.4. Q3 Perinatal Quality Surveillance Report

26.4. Perinatal Quality Surveillance Q3 24-25 Oct-Dec 24 (For Board).pdf (32 pages)

26.5. PMRT Report

26.5. Perinatal Mortality Report 2024 For Board.pdf (24 pages)

26.6. Biannual maternity staffing paper

26.6.Biannual Staffing Report December 2024 V3.pdf (15 pages)

15:42 - 15:52
10 min

27. Freedom to Speak Up Guardian's report

Information *Selina Morgan*

27. FTSU Board Report 21.01.25 v4.pdf (9 pages)

15:52 - 16:02
10 min

28. Health inequalities update

Information *Richard Mundon*

28. Health Inequalties Board Paper 2024_25 update.pdf (8 pages)

16:02 - 16:10
8 min

29. Reflections on equality, diversity and inclusion

Discussion *Mark Jones*

Consent Agenda

16:10 - 16:10
0 min

30. Maternity Dashboards

Information

30. Dashboard report December 24.pdf (10 pages)
30a. Maternity Dashboard - Dec 24.pdf (3 pages)
30b. Neonatal Dashboard - Dec 24.pdf (3 pages)
30c. Optimisation Dashboard - Dec 24.pdf (1 pages)
30d. Perinatal Dashboard - Dec 24.pdf (2 pages)
30e. Perinatal Exception Report - Dec 24.pdf (2 pages)

16:10 - 16:10
0 min

31. Annual Sustainability report 2023/24

Information

- 31. Annual Sustaniability Report - Front Cover.pdf (3 pages)
- 31a. Annual Sustainabilty Report 24 25.pdf (6 pages)

16:10 - 16:10
0 min

32. ED&I annual report

Approval

- 32. EDI front sheet.pdf (3 pages)
- 32a.EDI Annual Report 2023 - 2024 final.pdf (41 pages)

16:10 - 16:10
0 min

33. Guardian of Safe Working Hours

Information

- 33. GOSWH Quarter 3 Oct to Dec 2024.pdf (9 pages)

16:10 - 16:10
0 min

34. Safeguarding annual report

Approval

- 34. Safeguarding Annual Report 2023 2024 FINAL.pdf (25 pages)

16:10 - 16:10
0 min

35. Date, time and venue of the next meeting

Information

02 April 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:	February 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)
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 04 December 2024, 14:20 - 16:15

Boardroom, Trust Headquarters

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), Lynne Lobley (Non-Executive Director), Mary Fleming (Chief Executive), Simon Holden (Non-Executive Director), Tabitha Gardner (Chief Finance Officer), Julie Gill (Non-Executive Director), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Mary Moore (Non-Executive Director), Richard Mundon (Director of Strategy and Planning), Kevin Parker-Evans (Chief Nurse), Juliette Tait (Chief People Officer), Francine Thorpe (Non-Executive Director)

Absent: Paul Howard (Director of Corporate Affairs)

In attendance

Abbey Crossley (Graduate Trainee (HR), Present at: 189), Aydin Djemal (Development Non-Executive Director), Emma Filbin (Graduate Trainee (finance), Present at: 189), Nina Guymer (Deputy Company Secretary (Minutes)), Marcus Hannon (Graduate Trainee (operations), Present at: 189), Member of the public

Meeting minutes

186. Declarations of Interest

Information

Mark Jones

The table of declarations was noted and Prof C Austin added that she had that week updated her declarations, requesting that the table be updated prior to the next meeting. No further declarations were made.

186.1. Register of directors' interests

Information

17.1 Directors DoIs - Dec 2024.pdf

Mark Jones

187. 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.

18. Minutes_Board of Directors - Public Meetings _021024.pdf

188. Action Log

Discussion

Mark Jones

It was noted that no actions were due.

19. Public Board Action Log 2024.pdf

189. Staff Story

Information

WWL's three graduate trainees Abbey Crossley had joined the meeting to share their experience of orientation at WWL and how this had supported to integrate them in to their NHS careers, including the identification of key issues affecting the organisation and how services work to support one another. It was appreciated that there are very few graduate opportunities currently offered across the country and that WWL should be congratulated for the positive progress made.

The issue with theatre scheduling and that sometimes, parts of the relevant teams did not work as seamlessly as they could to ensure the best use of time and reduction of delayed although it was noted the the team

In response to a query from Mrs L Lobley around how the word can be spread around how great an NHS

career can be to the younger demographic.

The graduates agreed that attendance at career fairs would be beneficial, to emphasise the range of careers available, wider than the doctor and nursing careers that most people are aware of.

Note was made of the benefit of the trainees being from three different but key overarching portfolio areas, being finance, people and operations.

The Chair thanked the graduate trainees for sharing their ‘staff story’.

190. Chair's report and stakeholder update

Information

Mark Jones

The Chair shared a update on his contact with external stakeholders since the last meeting.

He began by praising WWL's annual Continuous Improvement Conference at the Edge, which provides an opportunity to think differently and put staff ideas into action. There was great attendance from across the sector and a focus on prevention, in equalities, diversity and system working.

He had been also been to a meeting to hear about the 10 Year Health Plan of the North -West Leadership in November Chaired by Louise Sheppard, North West Regional Director and a previous Chief Executive of Alder Hey Children’s Hospital. Chairs and chief executives were invited to the meeting which focussed largely on prevention, inequalities and digital work. He noted for this to be a potentially valuable forum moving forwards.

He went on to detail that himself and the Chief Executive had attended the North West Region System Leaders Team meeting once again Chaired by Louise where they heard that the North West on current performance have missed plan for the year by £159m, trusts nationally having a £850m variance. A concern was expressed that the public may think that the budget allocation of £22 Billion for the NHS will mean fast improvement but in reality, pressures will continue to worsen nationally due to patient demographic and the current financial position.

He advised that he had been appointed as the Deputy Chair of the Greater Manchester Chairs’ group. The last meeting saw a significant focus on community working with better ways of measuring community performance with a need to recognise performance and financial benefits from provider investment.

He had been to a coffee morning with Melissa Taylor, Community Health-building Lead from Groundwork, attended by workers from different organisations which work in the community - a great opportunity to make connections with local voluntary sector service providers!

Finally, he described a visit earlier that day with other non-executive director (NED) colleagues to the Family Hub in Hindley where they made several observations including the wide range of skill sets held by staff in the community division and the importance of holistic care being offered to families (for example, where appointments are made for a child but the parent is displaying symptoms requiring care).

191. Chief Executive's report

Information

Mary Fleming

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

Before moving on with the agenda, the Chair reminded the board that all of the reports on the agenda have already been scrutinised by its assurance committees, he noted therefore that discussion would likely not descend in to the same level of detail, which he emphasised would indicate that committees are adequately assured.

22. CEO Board Report_December 2024_Public.pdf

192. Committee chairs' reports

Information

Non Executive Directors

The non-executive directors listed presented their respective reports.

192.1. Quality and Safety

Information

Francine Thorpe

Mrs F Thorpe wished to highlight that the matter of deteriorating patients is a wide spanning one and the areas underpinning the theme will be explored individually in more detail, however, it does remain an area of concern for the Committee.

It was highlighted that the corporate objectives CO1 and CO3 were noted to have no risks against them thus far and therefore will be brought back for consideration at the next meeting.

24.1. AAA.QS.Nov.24.pdf

192.2. Finance and Performance

Information

Julie Gill

No queries were raised.

24.2. AAA - F&P - Nov 2024.pdf

192.3. Audit Committee

Information

The Chair noted that the Non-Executive Chair of the Audit Committee would not be present, due to a close family bereavement and condolences were expressed to Mr S Holden by the Board.

24.3 AAA - Audit Committee - 25 Nov 2024.pdf

192.4. People Committee

Information

Lynne Lobley

Mrs L Lobley wished to highlight that whilst the Workforce Race Equality Standard and Workforce Disability Equality Standard results have noticeably improved, this being reflected in the reports later on the agenda, there has also been a culture change and an enthusiasm amongst colleagues to do better. She noted that this is hard to measure but that the change can be seen and felt out around the organisation.

Mrs F Thorpe asked if mandatory training compliance in non-clinical areas is skewing the overall compliance rate here.

The Chief People Officer advised that there are areas where compliance is a real issue and agreed that therefore the picture is skewed. She noted that work is ongoing to streamline the training required where safe, to ease the burden on staff, which is hoped to aid compliance. The Medical Director acknowledged the need for improvement amongst clinicians and noted that his team are working to support this.

The Chief Executive and Chief People Officer agreed to discuss whether anything additional can be done to support Board members to speak up where they have concerns.

ACTION: J Tait

24.4. AAA People - 8 Oct 2024.pdf

192.5. Research

Information

Clare Austin

Prof C Austin noted that the report would be provided at the next meeting but wished to alert the board around two key and recurring issues, being:

- The amount of time that colleagues across all disciplines are afforded for research, this being less than anticipated;
- The number of joint clinical appointments still required to attain university hospital status.

Finally she advised that Prof C Watts's SOFFT study (suture fixation versus tension band wiring for simple olecranon fracture fixation) has been concluded and shown that both types of joint compared are equally clinically effective but that one is more financially favourable than the other, meaning that an opportunity for savings has been identified.

The Board received and noted the assurance committee reports.

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

Discussion

Juliette Tait

The Chief People Officer summarised the report, reiterated that it has been endorsed by the People Committee and noted that it has been presented to the Board for ratification of the proposed action plans to improve staff's experience at WWL. Upon ratification, the final version of the reports and action plans will be uploaded on the Trust's website.

Mrs L Lobley's earlier sentiments were echoed by the Medical Director, who felt that the mood and confidence of BAME colleagues, particularly those in the global majority nursing group has greatly increased.

Lady R Bradley noted the creation of the Equality Diversity and Inclusion Steering Group and asked how the Board will received information which illustrates the impact of that group's work. It was noted that assurance would be reported to the People Committee but agreed to consider other Board focussed updates.

ACTION: J Tait

The Board received and **RATIFIED** the report for publication on the Trust's website.

25. Board Meeting WRES and WDES Report 2024 December2024 final.pdf

194. 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.

Mrs L Lobley observed the cost of corridor care at £0.5m and asked whether this can be challenged outside of the organisation.

The Chief Executive noted that the Chief Executive of the GM ICB has asked to see herself and the Place Based Lead to discuss delays in ambulance handovers and the sustained escalation position and that this meeting will go ahead in the following week.

Mr M Wilkinson asked for further information around the specifics of the Better Lives Programme.

The Chief Operating Officer advised that externally the key workstreams of the programme are admission avoidance and system visibility, whilst internally WWL maintains a ward accreditation programme and has frequent key focus events to increase discharges. An update would be provided at an upcoming Board away day.

The Chief Executive emphasised the need for a holistic output dashboard to measure the effect of the programme on the system as a whole and provide one version of the truth for any stakeholder holding WWL to account.

The Chief People Officer wished to note that although turnover is not meeting the target, WWL consistently has the lowest turnover in GM.

The Board received and noted the report.

26. Board of Directors IPR M7 2425.pdf
26a. Board of Directors_IPR_M7_2425.pdf

195. Finance report

Information

Tabitha Gardner

The Chief Finance Officer presented the report with no queries raised.

The Board received and noted the report.

27. Board Cover Sheet - Trust Finance Report October 2024.pdf
27a. Trust Finance Report 24-25 October Month 7 Board.pdf

196. Financial plan deficit funding adjustment

Approval

Tabitha Gardner

The Board **APPROVED** the adjustment to the revenue plan for 2024/25 for the £13.4m non-recurrent deficit support revenue allocation. The revised revenue plan was noted to be a technical deficit of £1.0m and an adjusted financial performance deficit of £0.8m.

28. Board paper - Financial plan deficit funding adjustment.pdf

197. Multi Storey Car Park

Approval

Tabitha Gardner

The Chief Finance Officer presented the report with no queries raised. She noted that the Finance and Performance Committee had already affirmed formal support for the paper provided at its meeting on 26 November 2024.

The Board noted the progress made to date on negotiating the revenue impact, such that the proposal now makes a financial contribution across all years.

The Board **AGREED** to progress to financial close based on the figures set out in the paper, which were noted to still be under negotiation but with assurance noted that they will not increase, subject to completion of stage 2 of the legal process.

29. Trust Board - Multi Storey Car Park – Full Business Case Update - 04.12.24.pdf

198. Maternity reports

Information

Kevin Parker-Evans

The Chief Nurse summarised the reports which had been shared prior to the meeting.

198.1. Q2 Perinatal Quality Surveillance report

The Board noted the report and the assurance that it provided around the effective systems of clinical governance and monitoring for maternity and neonatal services in place at WWL.

30.1. Perinatal Quality Surveillance Q2 24-25 Jul-Sep 24 (For Board).pdf

198.2. SCORE culture survey

The Board received and noted the report.

30.2. SCORE Culture Survey Paper for Trust Board December 2024.pdf

199. University Teaching Hospitals update

Information

Sanjay Arya

The Medical Director summarised the report, highlighting the previously mentioned challenge in identifying enough shared posts to meet the requirements of the University Hospital Association (UHA) for the granting of 'university hospital' status.

The Chief Executive asked what it will mean in terms of new consultant appointments to dedicate more time to research and whether there will be any issues associated with that.

The patient benefit derived from research was emphasised and it was also noted that many consultants do wish to develop their research skills and portfolios, therefore, a focus on research through job descriptions is likely to have a positive effect on recruitment.

Prof C Austin explained that the aspiration is that newly appointed consultants will receive funding which will alleviate the financial and operational pressures caused by the need to apportion an appropriate amount of their time to research.

The Director of Strategy and Planning advised that portfolio of evidence provided for the UHA and how this is presented will be key.

ACTION: R Mundon

The Board received and noted the report.

31. University Hospital Status Progress Report Nov 24 Final.pdf
31a. Live tracker - Clinical Academic Appointments Live Tracker.pdf

200. Board Assurance Framework

Decision

Nina Guymer

The Board considered each of the four objective pillars in turn.

The positions in respect of the People and Partnerships risks and objectives were accepted.

Mrs F Thorpe noted that the Patients objectives CO1 and CO3 currently have no risks identified against them and queried if this reflects the current position.

The Medical Director advised that he has asked his team to consider risks to the achievement of CO3, improvements in the paediatric diabetes service, which he hoped to review before the Christmas break although he was confident that the objective is being achieved overall and agreed to provide an update for the Quality and Safety Committee in January 2025. CO1 around digital transformation would also be considered at that time.

The increases to the risk scores for PR7 and PR10 were **APPROVED**.

The board **ENDORSED** the document, accepting that the Quality and Safety Committee will review the position around potential risks to CO1 and CO3, with any risks identified being articulated through the February 2025 BAF report.

32. BAF Report Board December 2024.pdf

201. Reflections on equality, diversity and inclusion

Discussion

Mark Jones

It was noted that there has been much work done out in the community since the last board meeting, to support board members and governors to learn how it feels to live in health inequality, particularly in the local area. The work at the Community Diagnostics Centre in Leigh was highlighted as levelling up access to care in that part of the borough and the respiratory pilot in primary care was noted to be reducing attendance in A&E. Finally, the role of the WRES and WDRES reports and how effective they are in terms of highlighting areas of concern for the board was mentioned.

Consent Agenda

202. Standing Financial Instructions (SFIs)

Endorsement

The Board **APPROVED** the changes to the SFIs as set out.

34a. SFIs 24-25 Nov 2024.pdf
34. SFI annual review Board.pdf

203. Maternity Dashboards and Achieving National ambition reduction in Stillbirths report

Information

The Board noted the October 2024 dashboard.

35. Maternity Dashboard Report October 24 - Consent agenda.pdf
35b.Optimisation Dashboard - Oct 24 - Consent agenda.pdf
35a. Maternity Dashboard - Oct 2024 - Consent agenda.pdf
35c. Perinatal Exception Report - Oct 24 - Consent agenda.pdf
35d. Perinatal Dashboard - Oct 24 - Consent agenda.pdf

204. Date, time and venue of the next meeting

Information

5 February 2025, 1.15pm, Trust Headquarters

Action log: December 2024

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
4 Dec 2024	200/24	University Teaching Hospitals update	Provide an update on the current position with shared posts	R Mundon	5 Feb 2025	
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	2 April 2025	**Not yet due.**
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	2 April 2025	**Not yet due.**

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	05/02/25
Item purpose:	Information
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy and corporate objectives

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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.

Introduction

I would like to start by expressing my thanks to our local community for their support and to our dedicated team for their tireless efforts, especially during the challenging pre-Christmas and New Year periods. Like most NHS Trusts across the country, our organisation has faced significant pressures, particularly in our Urgent and Emergency Care services. Despite these pressures, our teams have demonstrated resilience and commitment to ensuring the safe care of our patients. I am proud of the collaborative efforts across various departments, which have enabled us to manage patient flow effectively and maintain safe standards of care. During 2025, we have a number of ambitious transformational programmes underway, and I will regularly provide progress updates on these through this report. I am optimistic and confident that we will continue to make great progress on our journey to outstanding.

Urgent and Emergency Care Experience

Our Urgent and Emergency Care services continue to experience a pressured position, with a decline in performance against both the 4-hour and 12-hour care standards, and with ambulance handover times. Our teams across WWL regardless of roles, worked tirelessly and in different places during the pre-Christmas and New Year Bank Holiday periods to ensure the safe care of our patients. We effectively managed the flow of acutely ill patients by increasing temporary escalation areas at the Royal Albert Edward Infirmary (RAEI) and utilising a ward at Wrightington Hospital; this was done while planned elective work had a scheduled pause.

At WWL, there are times when we need to use the Emergency Department corridor for additional capacity due to insufficient flow across our system. This happens when we are unable to clinically accept patients and need to release ambulances back to our sickest patients in the Wigan Borough. We do not normalise the use of the corridor for capacity and only escalate this measure in accordance with our patient safety guidelines and safe staffing procedures.

We are working hard to improve our performance and aim to see 78% of our patients within the 4-hour care standard. We expect to achieve this target by March, benefiting from our internal and system transformation programmes.

Better Lives

As previously reported, we are addressing this challenge in a sustainable way through WWL, Wigan Council and NHS Greater Manchester ICB (NHS GM ICB) working together to deliver a joint transformation programme - 'Better Lives'. The programme has been designed to make a rapid, meaningful and sustained improvement to the lives of residents, patients and health and care staff in Wigan. The programme is allowing us to move away from a traditional approach of increasing hospital inpatient beds, and to supporting residents to remain in their own homes for longer. The four key focus areas of the programme include admission avoidance, acute patient flow and length of stay, defining and creating a community model to support care in the right settings, increasing independence, and the creation of one single, data-driven dashboard for system visibility across WWL/NHS GM ICB/Wigan Council.

The programme is currently focusing on two of the workstreams – system visibility and admission avoidance. One example of admission avoidance is our Community Admission Avoidance Team (CAAT), who've been running since December 2024 with Community Advanced Clinical Practitioners, assessing and redirecting patients for treatment in the community. So far, they've assessed over 200 patients, supported over 80 patients to get home, (of these, we expect over 50 of them to have been admitted if CAAT hadn't intervened) and over 80% of patients we interacted with were conveyed by ambulance. Our system visibility dashboard now has a first iteration, and this will enable our teams and leaders in the Wigan place to recognise pressures across the system and to identify where there is capacity to support our patients to receive the best possible care and to return to their own homes as quickly as possible so they can be with

their families and friends. In conjunction with this, there are also a number of internal transformation programmes underway supporting improved discharge and flow across our hospital wards.

Commitment to Reducing Waiting Times

In addition to a key focus on urgent and emergency care standards, we are working hard to ensure that by 31st March 2025, no patients will be waiting over 65 weeks to be seen across any of our specialties; this aligns with the Government's commitment to reducing waiting times. We aim to consistently achieve the 18-week review to treatment (RTT) standard by 2028/2029. We recognise the importance of timely access to care and are committed to finding innovative solutions to address capacity challenges in certain specialties.

We have a key role in reducing long waits for elective procedures with our two dedicated Surgical Elective Hubs, and we have utilised them to help treat a significant number of patients via mutual aid requests from other Greater Manchester/Our plans to utilise the theatre capacity on the Wrightington Hospital site for other surgical procedures commenced in January, with Ear Nose and Throat, Dental and General Surgery patients booked. We are also working with GIRFT (Getting It Right First Time) to help our Specialist Services Division increase the number of orthopaedic patients that we see within our Centre of Excellence.

Innovation Through Virtual Ward in Care Homes

In late December, our Virtual Ward care home pilot went live at Carrington Court care home; this is our pilot site and it's the very first time we connected a care home to our Virtual Ward. We know how important it is for our patients to stay in the place they call home, as it's much better for their own recovery, while also making sure our hospitals have beds available for those who need them. The true focus of this pathway is earlier intervention, with a view to supporting admission avoidance, where appropriate and possible. In time, it's hoped that all care homes will be connected to our Virtual Ward which can only help in reducing inappropriate presentations to our Emergency Department. These are true transformative services, and I am very much looking forward to seeing the impact this great service will have on people's lives in the future.

Working Towards Financial Sustainability

WWL continues to experience financial challenges with a £3.4m deficit in month 9, which is £2.9m worse than plan. We are delivering lower than expected elective activity, particularly in Orthopaedics, with December seeing significant bed pressures in the Trust which impacted on our ability to deliver surgical work and opening up additional escalated areas; these are two key risks to our plan. However, we are making good progress in delivering our Cost Improvement Programme (CIP) as a whole, the strongest performance WWL has experienced with CIP so far, but the element of CIP that is recurrently delivered is less than we had planned. So far this year we have delivered £7.5m of recurrent financial savings against an in year-to-date target of £14.3m. Other non-recurrent CIP has been delivered and this mitigates the recurrent delivery; we are all working hard to deliver a total cost improvement of £27.3m by the end of the financial year. Recurrent CIP is around 35% of what we have delivered to date, although in month this figure was better at around 50%, so the level of recurrent CIP is improving. We continue to engage with our colleagues to seek out those smaller, local changes that can collectively make a big difference and where appropriate, we are working in collaboration with other organisations to provide safe and resilient services for our patients.

Other action taken to recover the financial position includes aligning nursing bank rates with other GM providers; enhancing non-medical vacancy controls; and introducing stricter controls on specific non-pay spending categories. We continue to work to reduce our overall pay bill, with ongoing scrutiny on bank and locum expenditure, and the offer of a Mutually Agreed Resignation scheme for staff. We will be considering additional measures across all areas and we will always ensure that any proposals are subject to rigorous quality impact assessment.

Celebrating our People

I have now appointed a new Deputy Chief Executive, Richard Mundon who took on this position alongside his current role as Chief Officer for Strategy, Partnerships and Digital. He will now be responsible for creating, strengthening, and accelerating partnership working within WWL, our locality and the Greater Manchester Integrated Care Board, while also becoming our Board champion of Compassionate Care.

I am delighted to report that our Medical Director and Consultant Cardiologist Professor Sanjay Arya was named on the King's New Year's Honours list 2025 and was awarded an OBE (Officers of the Order of the British Empire) for services to Black and Minority Ethnic Doctors and Healthcare in North-West England (Greater Manchester). This is a huge achievement and so well deserved.

Agenda item: 20

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF)
Presented to:	Board of Directors
On:	5 February 2025
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk
Contact details:	E: steven.parsons@wwl.nhs.uk

Executive summary

The latest assessment of the trust's sixteen key strategic risks 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.

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

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

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

2. BAF Review

2.1 The latest assessment of the trust's sixteen key strategic risks 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 15 January 2025. There have been no changes to the risk scores for the three existing risks since the last Board meeting in December 2024. No new risks have been escalated or removed from the BAF.

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 11 February 2025. There were no changes to the risk scores for the three existing risks at the last People Committee Meeting on 10 December. No new risks have been escalated or removed from the BAF since the last Board meeting in December 2024.

2.4 **Performance:** Current risks were reviewed and updated in line with the 2024/25 corporate objectives at the F&P Committee meeting on 28 January 2025. No new risks have been escalated or removed from the BAF.

2.5 **Partnership:** Current risks have been reviewed and updated in line with the 2024/25 corporate objectives prior to the Board meeting on 5 February 2025. There have been no changes to the risk scores for the four existing risks since the last Board meeting in December 2024. No new risks have been escalated or removed from the BAF.

3. New Risks Recommended for Inclusion to the BAF

3.1 No new risks has been added to the BAF since the last Board meeting in December 2024.

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

4.1 No risks have been accepted and de-escalated from the BAF since the last Board meeting in December 2024.

6. Review Date

6.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for April 2025.

7. Recommendations

7.1 The Board of Directors are asked to:

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

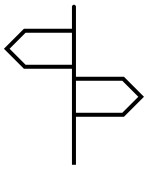
2024/25

The content of this report was last reviewed as follows:

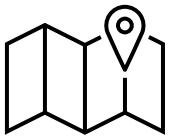
Board of Directors	December 2024
Quality and Safety Committee:	January 2025
Finance and Performance Committee:	January 2025
People Committee:	December 2024
Executive Team:	January 2025

> **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

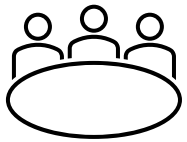


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

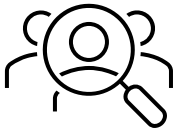


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

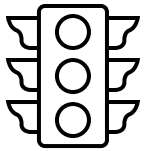
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have 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 Affairs
COO:	Chief Operating Officer	DSP:	Director of Strategy and Planning
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…

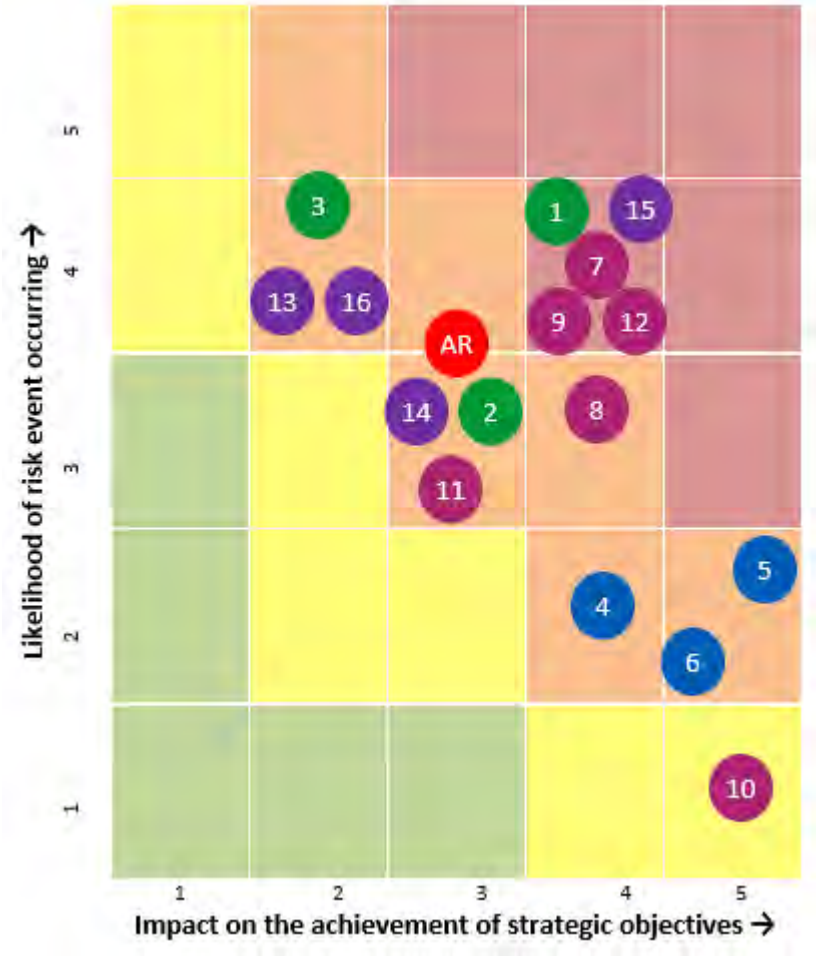
- improve the health and wellbeing of the population we serve
- develop effective partnerships across GM and the Wigan Locality which support services that are clinically and financially sustainable
- make progress towards becoming a Net Zero healthcare provider
- increase our research activities delivering 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

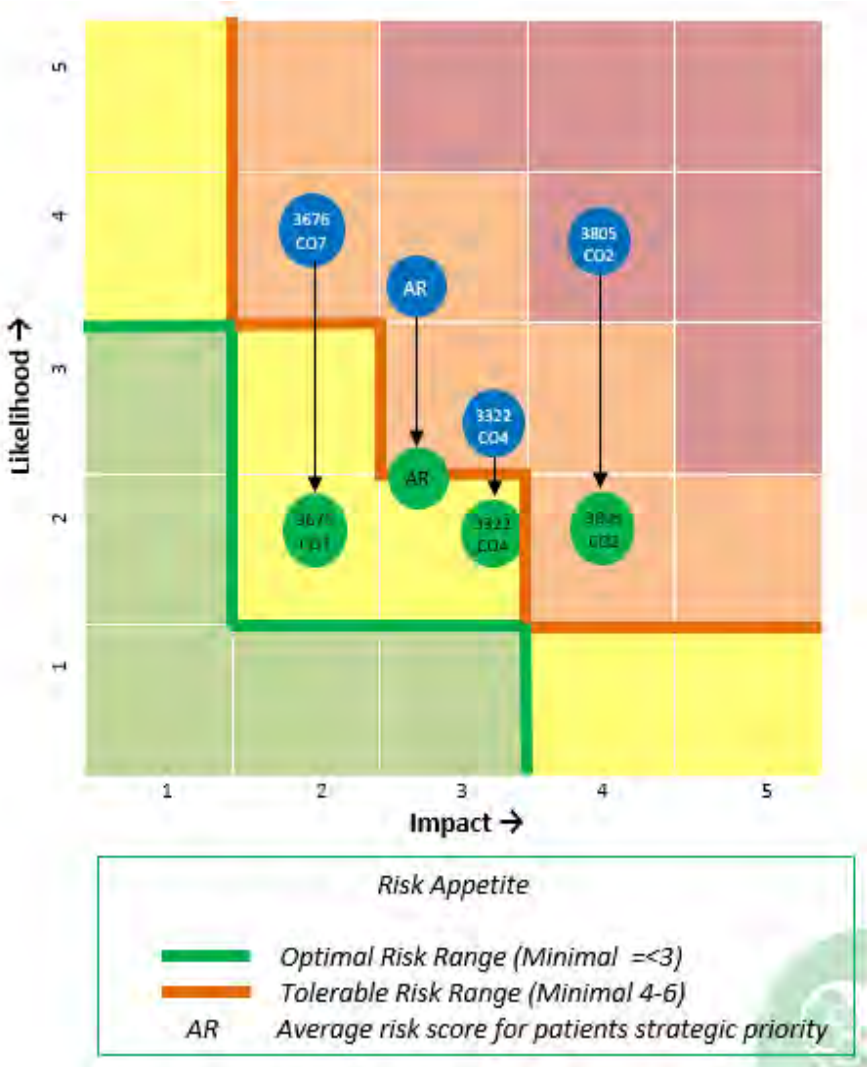
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

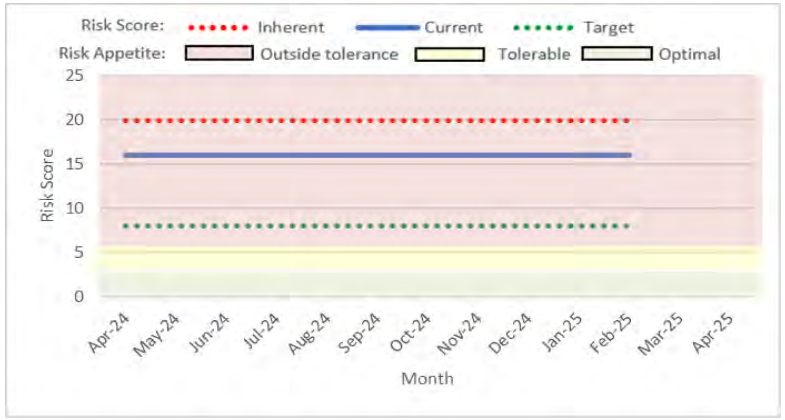
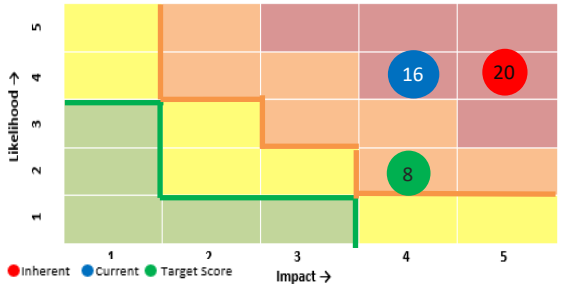
Monitoring: Quality and Safety Committee

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

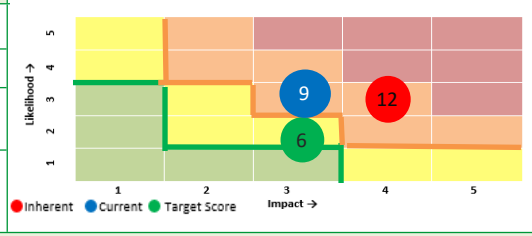
Ref.	Purpose of the objective	Scope and focus of objective	Objective Tracking
CO1	To improve the safety and quality of clinical services	To enhance patient care through digital transformation.	No risk currently identified
CO2 3805	To improve the safety and quality of clinical services	To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.	On Track – AQ data shows great progress
CO3	To improve diabetes care for our population	Diabetic Foot Checks	On Track -multidisciplinary foot clinic is up and running
CO4 3322	To improve the delivery of harm-free care	Continue improvements Pressure Ulcer Reduction. System Wide improvement for reducing pressure ulcers.	Off Track for zero cat 3 and 4 HAPU and CAPU On Track for 50% reduction in CAPUs and a 14% reduction in HAPUs by the end of 24/25.
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.	On Track
CO6	To improve the quality of care for our patients	Continue and build upon the accreditation programme	On Track – potential risk due to long term absence of the lead for accreditation
CO7 3676	Listening to our patients to improve their experience	Deliver timely and high quality responses to concerns raised by patients, friends and families.	Off Track for 90% of complaints responded to within our agreed timeframes.

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

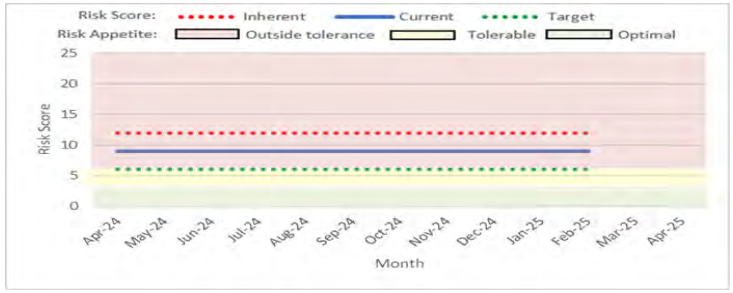


Corporate Objective: **CO2** To improve the safety and quality of clinical services										**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 1: Sepsis Recognition, Screening and Management**								Risk Score Timeline	
	Risk Statement:	There is a risk of the under diagnosing 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	**15.01.25**						**Risk treatment**	Treat			
Opportunity / Threat	**Existing controls**		**Gaps in existing controls**		**Assurances (and date)**		**Gap in assurances**		**Risk Treatment**		**Due Date By Whom**

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 November 2024 • Board December 2024 • 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

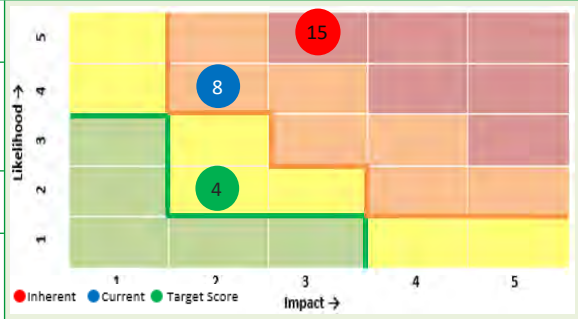
Corporate Objective: CO4 To improve the delivery of harm-free care							Overall Assurance level	Medium
Principal risk	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**						
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not 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	**15.01.25**			**Risk treatment**	Treat			

Risk Score Timeline

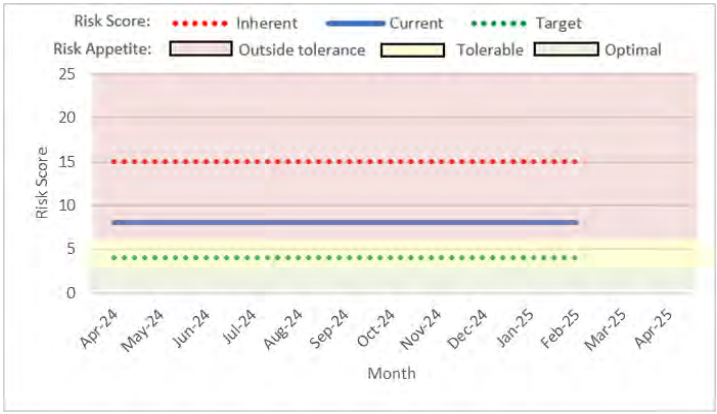


Existing controls	Gaps in existing controls	Assurances	Gaps	Risk Treatment	Due Date
• Pressure ulcer link nurses trained within all areas and extended to community care homes. • Category 2/DTI Pressure Ulcer Review Panels (PURP) in place and aligned to PSIRF framework. • Category 3/4 & Unstageable Pressure 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 November 2024 • Board December 2024	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 March 2025

Corporate Objective: CO7 Listening to our patients to improve their experience	1	2	3	**Overall Assurance level**	**Medium**

Principal risk What could prevent us achieving our strategic objective?	**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	**15.01.25**		**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.	• 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 November 2024 • Board December 2024 • 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.	March 2025 CN

People

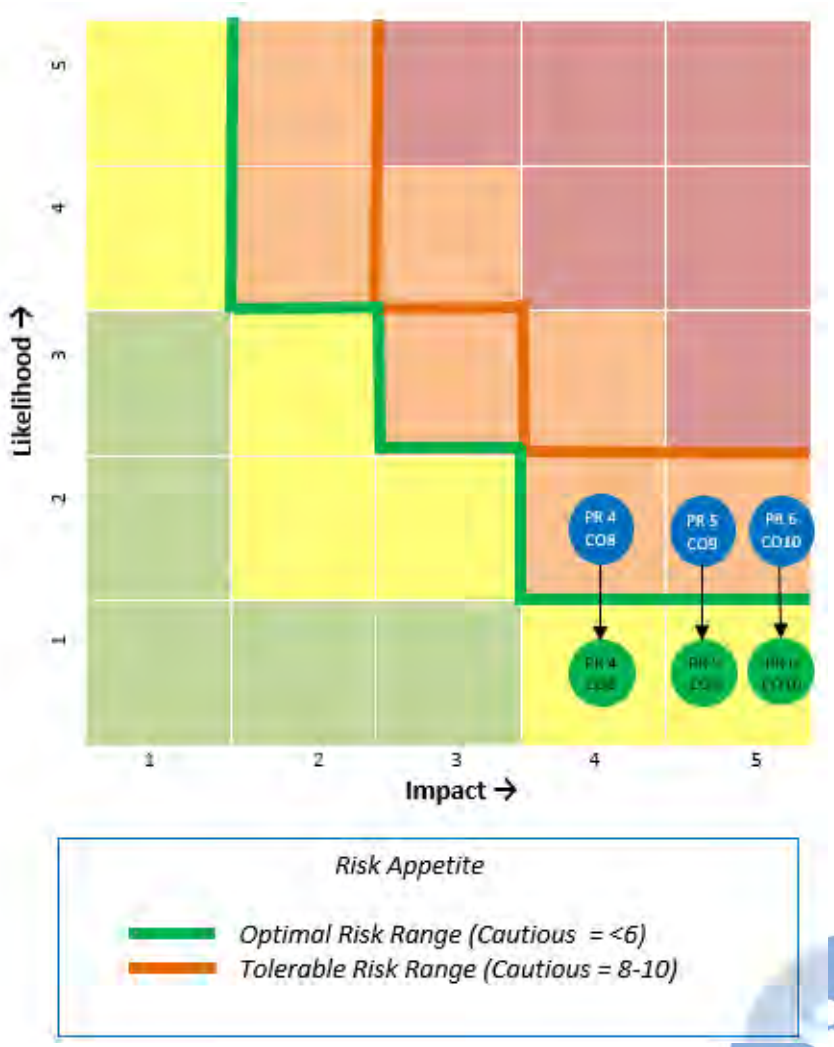
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

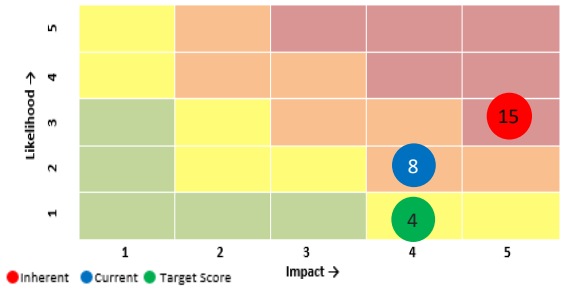
The following corporate objectives are aligned to the **people** strategic priority:

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.	On Track
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.	On Track
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.	On Track

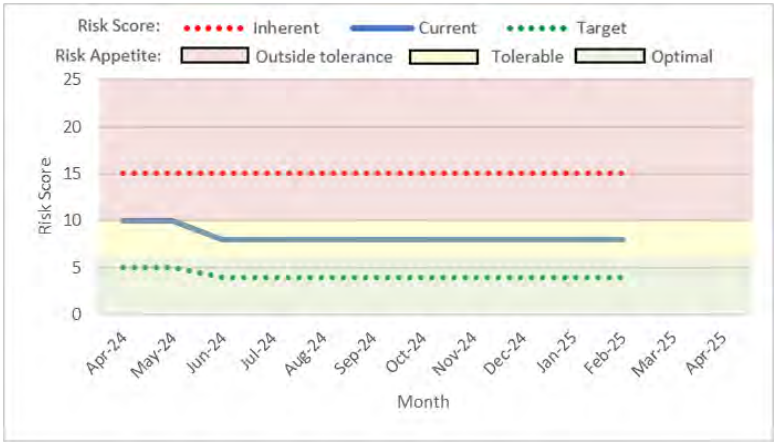
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for the people strategic risk:



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	**10.12.24**		**Risk treatment**	Treat

Risk Score Timeline

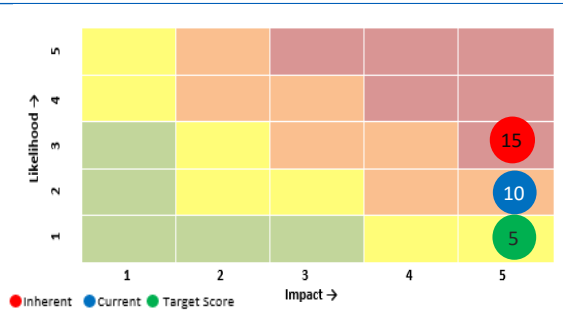


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3783**	• Workforce planning 2024/25 • Empactis relaunch • Civility Programme (just & learning culture) • People Dashboard refresh • Newton 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. March 2025 – D/CPO & AD for SE & W 2. March 2025 -CPO 3. March 2025 - CPO

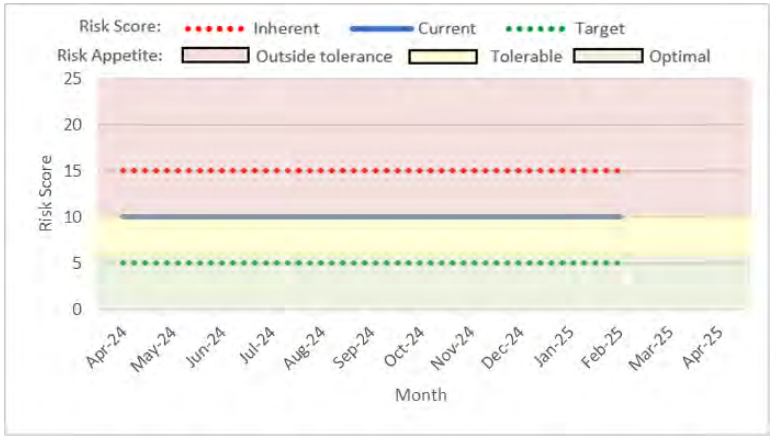
Corporate Objective: CO9 To ensure we improve experience at work by actively listening to our people and turning into positive action.	1	2	3	**Overall Assurance Level**	**Medium**

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	**10.12.24**	**Risk treatment**	Treat

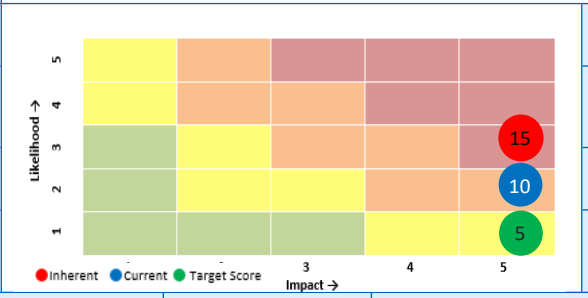


Risk Score Timeline

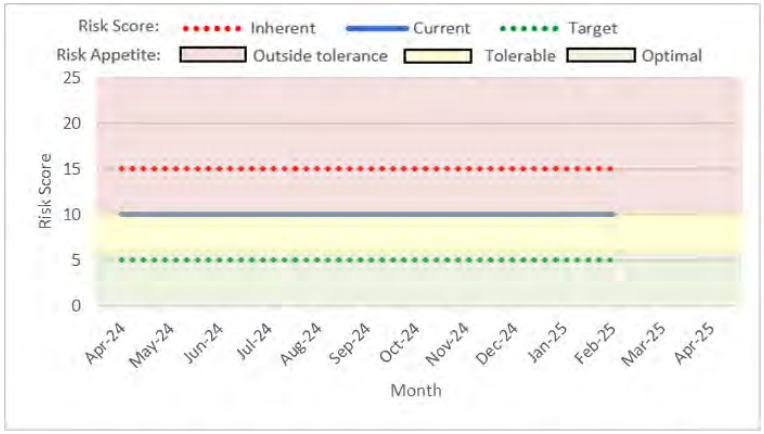


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3871**	• Actions contained within the Draft People & Culture Strategy • National Staff Survey • New Appraisal Framework "My Route Planner" • 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. March 2025 - Deputy CPO 2. March 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	**10.12.24**		**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. March 2025 (CN/CPO) 5. March 2025 (AD SE & W) 6. March 2025 (EDI Lead) 7. March 2025 (EDI Lead) 8. March 2025 (CPO, EDI Lead)

Performance

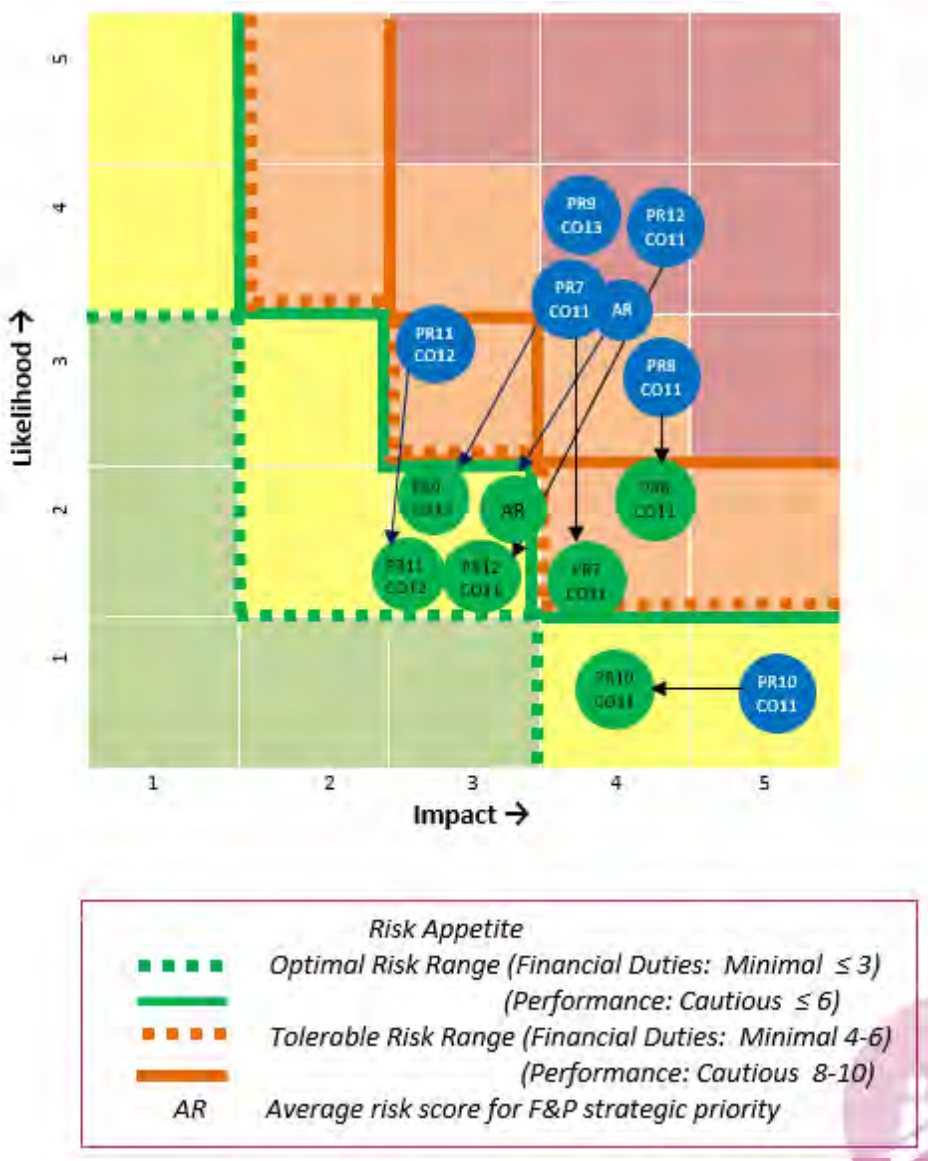
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

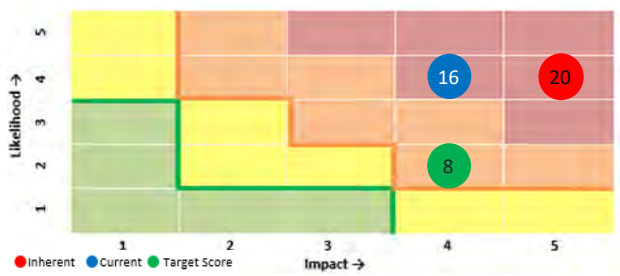
The following objectives are aligned to the **performance** strategic priority:

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.	On Track
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.	On Track
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.	On Track

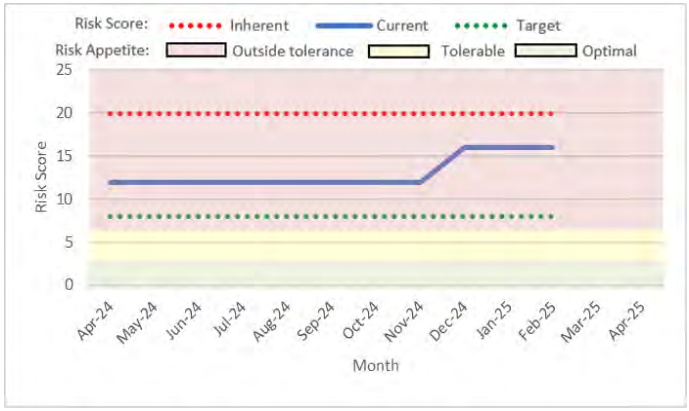
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for these risks:



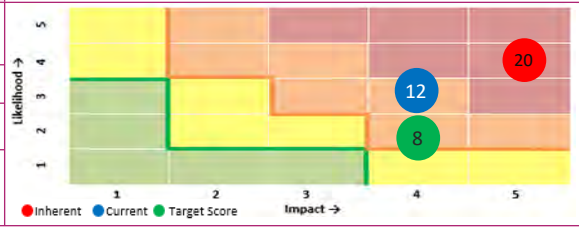
Corporate Objective: **C11** Deliver our financial plan, providing value for money services	1	2	3	**Overall Assurance level**	**High**

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	**28.01.25**		**Risk treatment**	Treat	

Risk Score Timeline

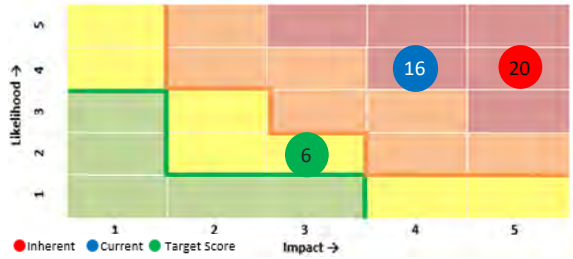


Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date/ By Whom
• Final plan signed off by Board and submitted to NHSE – 2nd May 24. Resubmission on 12th June 24in line with GM ICS control total. • Draft and final plans scrutinised through monthly 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	• NHSE have not confirmed acceptance of the final GM ICS revenue plan (control total discussions ongoing) • FSP to be refreshed to ensure the 3 year trajectory for recovery is achievable • No medium to long term resource confirmation or financial planning (Ext) • Unidentified gap remains in tactical actions	**1st Line:** Monthly Divisional Assurance meetings for all clinical divisions and Finance Improvement Group (FIG) **2nd Line:** Finance & Performance Committee January 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

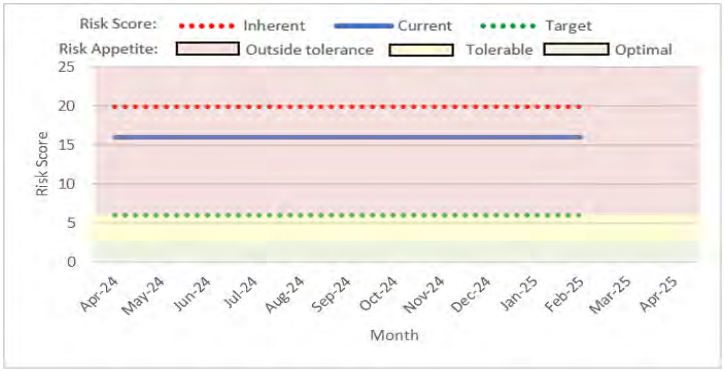
Corporate Objective: **C11** Deliver our financial plan, providing value for money services					1	2	3	**Overall Assurance level**	**High**
Principal risk	**Risk Title:**	**PR 8: Financial Sustainability: Efficiency targets**							
	Risk Statement:	There is a risk that the CIP plan will not be achieved 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	**28.01.25**			**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 January 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. 2. GM PMO established leading on system efficiency (Ext).	Throughout 2024/25 CFO/COO Throughout 2024/25 CFO/COO

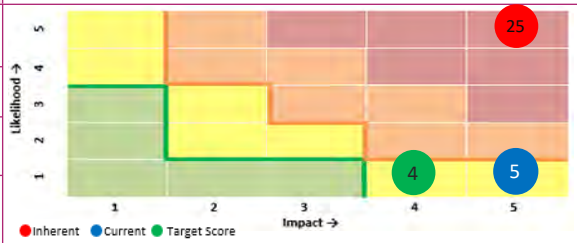
Corporate Objective: C11 Deliver our financial plan, providing value for money services					1	2	3	**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 9: Capital Funding**							
	Risk Statement:	There is a risk that there is 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	**28.01.25**			**Risk treatment**	Treat				

Risk Score Timeline

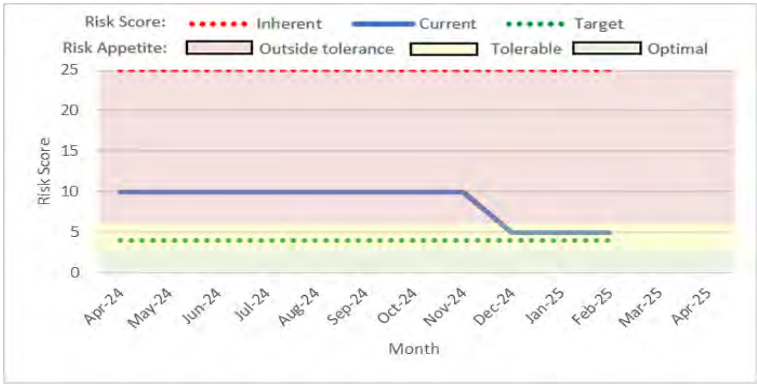


Strategic Opportunity / Threat Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• Lobbying via Greater Manchester for additional capital into the national process. (Ext). • Capital priorities agreed by Executive Team & Trust Board. • 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	• Impact of inflation in terms of project costs and timescales. • GM CDEL plan currently overcommitted by £38m (mitigations yet to be confirmed) – discussions ongoing with NHSE (Ext) • GM lease plan (IFRS16) overcommitted against envelope (significantly reduced from previous reports). • Leases schemes have not all been through GM approval process to progress • Further work required on five year forward view to refine plan.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - January 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. 2. Development of capital reporting through the refreshed DFM App. 3. Discussions ongoing between GM ICB and NHSE national team to confirm whether additional CDEL will be made available to cover GM overcommitment (Ext)	Throughout 2024/25 CFO Q3 2024/25 CFO Q3 2024/25 GM ICB (Ext)

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

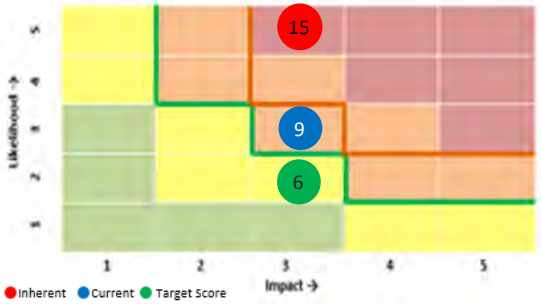
Principal risk	**Risk Title:**	**PR 10: Cash Balance**		
	Risk Statement:	There is a risk a that the Trust may have insufficient cash balance to meet normal business activities on a day-to-day basis, due to cash balances potentially becoming too low, resulting in the need to request additional support, 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	**28.01.25**		**Risk treatment**	Treat

Risk Score Timeline

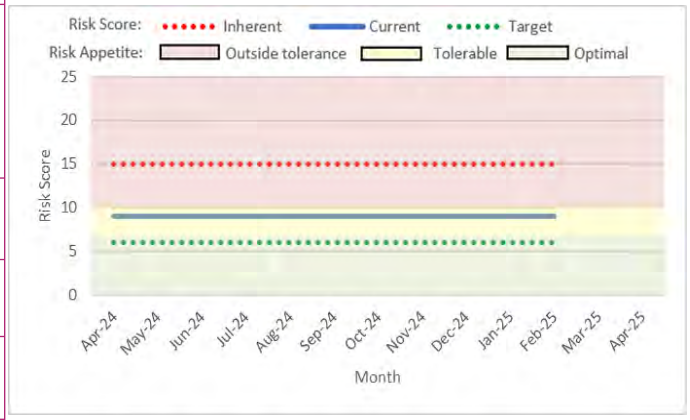


Existing controls	Gaps in controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
• NHSE process exists for providers requesting cash support which is done ahead of each financial quarter. There is an additional mechanism to draw down emergency cash support within the quarter 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.	• Best practice Cash Management document under development via the GM Technical Issues Group (Ext)	**1st Line:** Cash management Group **2nd Line:** Finance & Performance Committee January 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 2. Application to NHSE in advance of each quarter if cash support may be required	Throughout 2024/25 CFO 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**

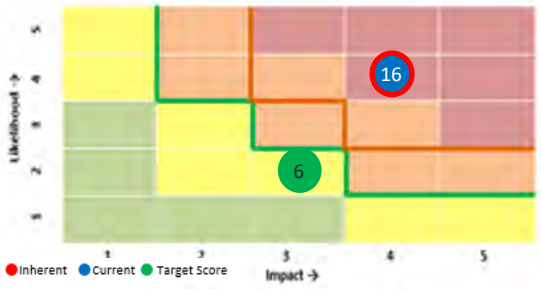
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 11: Elective services**			
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting 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	**28.01.25**		**Risk treatment**	Treat	

Risk Score Timeline

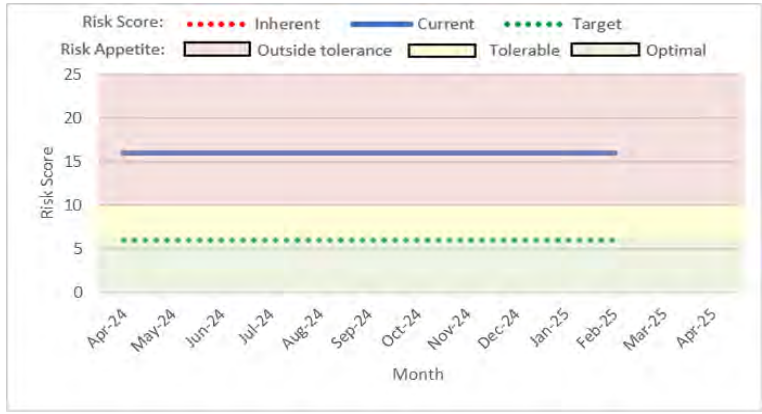


Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: (ID 3289)	• On track to eliminate waits over 65 weeks, except for Gynaecology patients. Exploring options for mutual aid. • Bi weekly meetings with ICB. • 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.	• No new dates for Industrial action announced, but no resolution provided. • 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 – January 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.	March 2025 March 2025 March 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	**28.01.25**		**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	• Emergency Care Intensive Support Team (ECIST) and Newton Europe programme of works to support the existing hospital transformation programme. • A&E 4 hour performance is improving • GM Super Multi agency Discharge Event (MaDE) took place 6th to 12th September. • Flagged to the system that WWL bed base per population is considerably lower than the rest of GM. • Delay in ambulance handovers within 60 minutes has increased due insufficient capacity. • No right to reside recording has been reviewed in line with national guidance which will result in a reduction in number reported. • Hospital Discharge and Flow Programme led by COO. • The urgent and emergency care transformation board supports system wide change. • Full capacity protocol. • Urgent Care Village rated as 'good' at recent CQC assessment.	• Insufficient capacity with over 100% occupancy rate. • 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 – January 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.	March 2025 COO

Partnerships

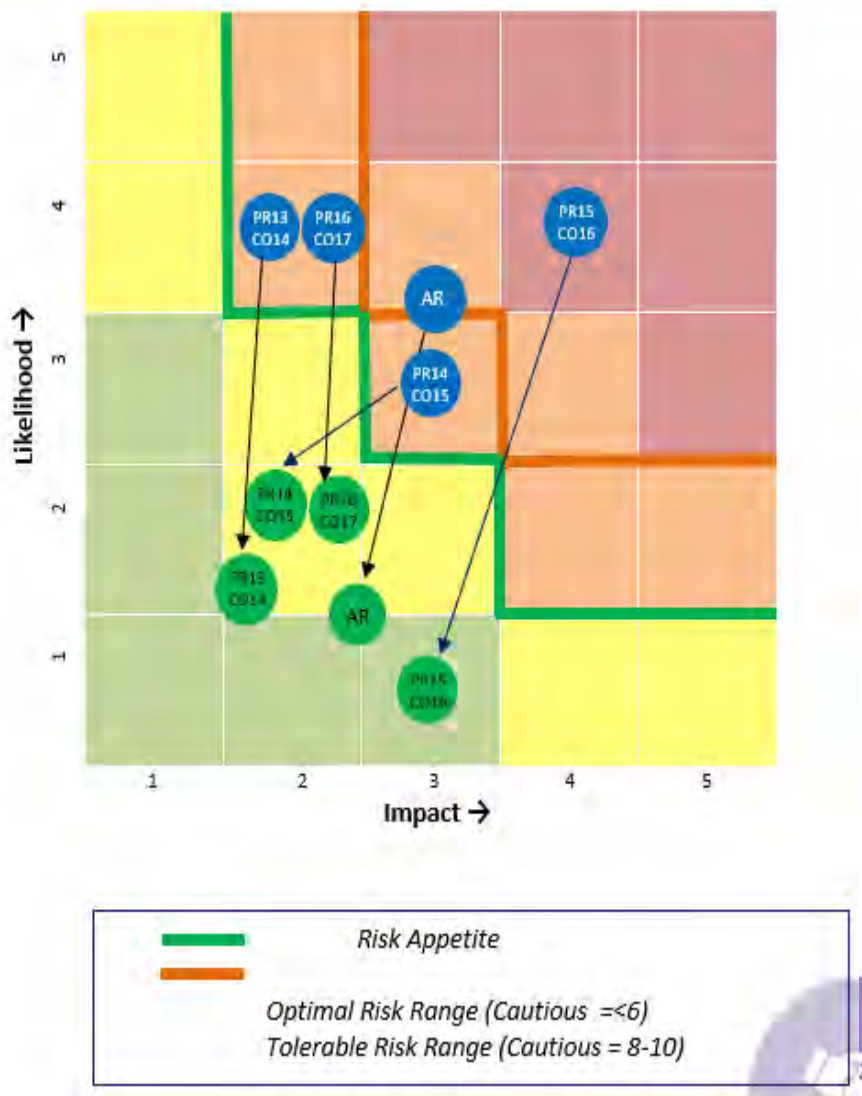
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

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	On Track
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.	On Track
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.	Off Track
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.	On Track

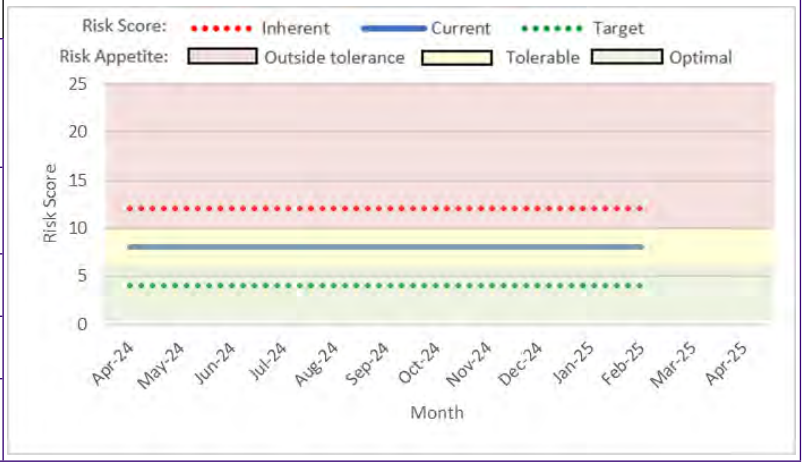
The heat map below sets out the current risk score (blue shading) and the target risk score (green shading) for these risks:



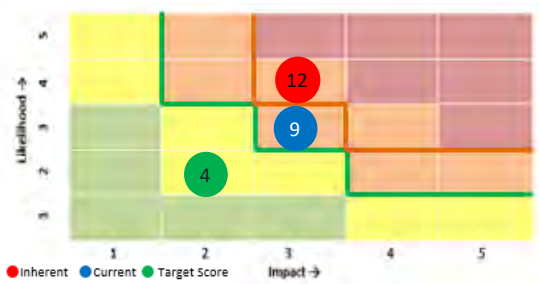
Corporate Objective: **CO14** To improve the health and wellbeing of the population we serve	1	2	3	**Overall Assurance level**	**Medium**

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	**21.01.25**		**Risk treatment**	Treat	

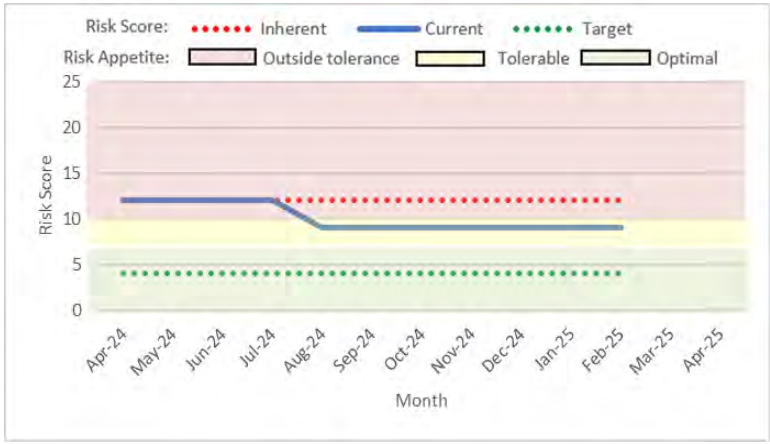
Risk Score Timeline



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.	March 2025 - DSP

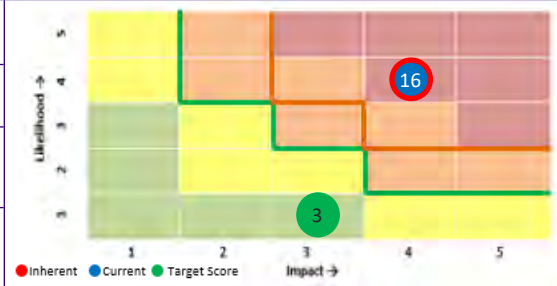
Corporate Objective: **CO15** To develop effective partnerships across GM and the Wigan Locality						1	2	3	**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 14: Partnership working - CCG changes**								
	Risk Statement:	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	**21.01.25**			**Risk treatment**	Treat					

Risk Score Timeline

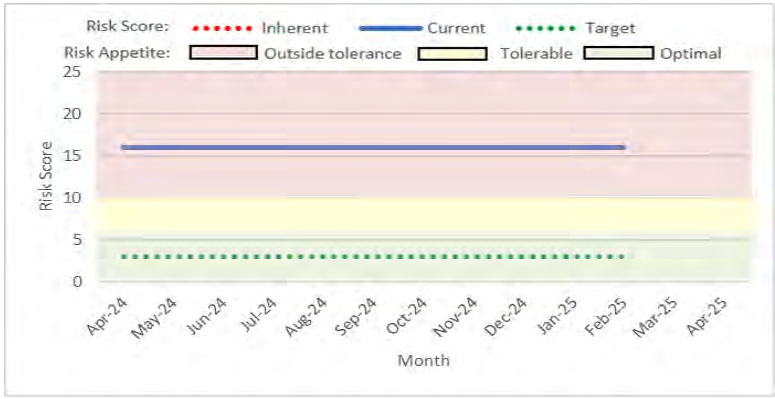


Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **Datix ID 3300**	• Locality meeting structures in place to support lasting corporate knowledge. • Development of locality UEC transformation programme – 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

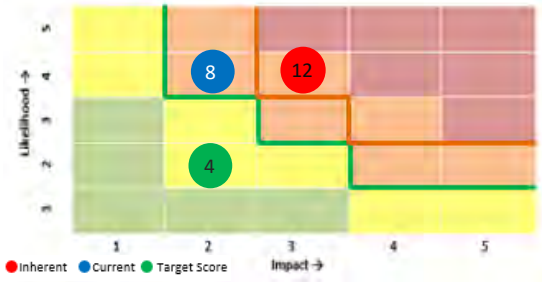
Corporate Objective: C16 Progress towards becoming a Net Zero healthcare provider	1	2	3	**Overall Assurance level**	**Medium**

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	**21.01.25**		**Risk treatment**	Treat

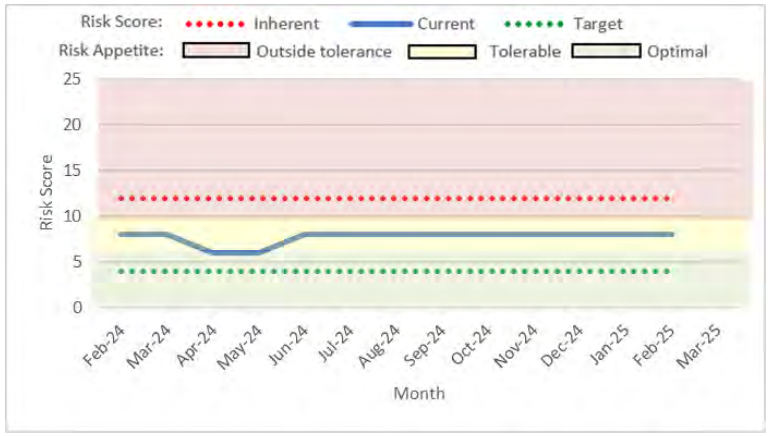
Risk Score Timeline



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**	• 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 has been produced. • Sustainable Travel Plan has been produced. • 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 2024-25.	• 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.	March 2025 / DSP

Corporate Objective: CO17 To increase our research activities delivering high quality research with patients and partners across the Wigan Borough						**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	**21.01.25**			**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 March 2025

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	M9 2425 Integrated Performance Report
Presented to:	Board of Directors Meeting
On:	05.02.25
Item purpose:	Information
Presented by:	Director of Strategy & Planning
Prepared by:	Principal Data Analyst, Data Analytics and Assurance
Contact details:	BIPerformanceReport@wwl.nhs.uk

Executive summary

The latest month, for M9 December 24 update of the Trust's Integrated Performance Report (IPR) is presented to the Board of Directors.

The Integrated Performance Report presents a holistic overview of the Trust's key metrics and how each are performing compared to set (national where available) targets. The IPR has been developed using NHS England's Making Data Count (MDC) methodology, which uses Statistical Process Control (SPC) Charts to clearly identify trends in performance and comparison to targets.

Following the Trust level view and holistic narrative, for each specific area: Quality & Safety, People, Performance and Finance, there is then a summary page, narrative and insight report which focuses on 4 specific metrics from each area. The detail in the report enables evaluation against key metrics to identify where the Trust is performing well and where there are opportunities for improvement. Additional insight reports can be added to the IPR if necessary, by contacting the DAA team.

Link to strategy and corporate objectives

2030 Strategy
Patient
Performance
People
Partnerships

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 Meetings 23/1/25 and 30/1/25.

Recommendation(s)

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

Report

Please see the attached M9 IPR report.

The DAA team have reviewed the SPC charts which form the basis of the report, and where appropriate have added step changes. For those metrics where a step change has been added, DAA have included a slide which outlines the rationale and shows whether this has resulted in a change in the variation or performance icons.

The IPR report currently shows 4 insight charts for each area; additional charts can be added, if necessary, by contacting the DAA team by emailing: BIPerformanceReport@wwl.nhs.uk or messaging on the shared Integrated Performance Report Teams channel.

Appendices

None.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

M9 24/25 Integrated Performance Report

Board of Directors Meeting

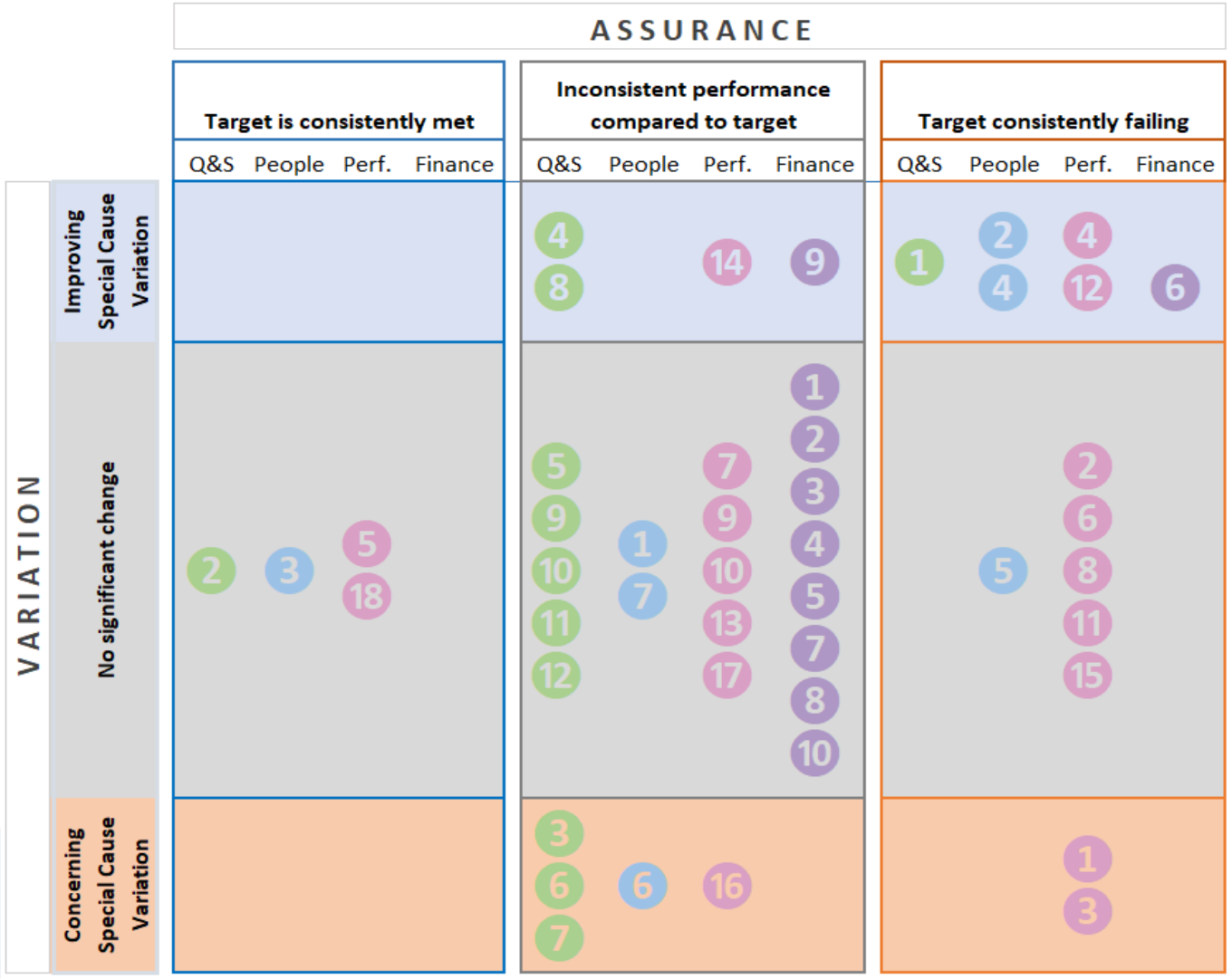
05.02.25

Contents

Trust Matrix : M9 December 24

VARIATION	ASSURANCE: Target is consistently met	ASSURANCE: Inconsistent performance compared to target	ASSURANCE: Target consistently failing
Improving Special Cause Variation		Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation Methicillin-Resistant Staphylococcus Aureus (MRSA) % of new outpatient attendances or with procedure completed Cost Improvement Programme (CIP) (£ms)	SHMI Rolling 12 Months Appraisal % Turnover Rate G&A Bed Occupancy - Acute Adult Inpatient Wards, WWL Percentage of patients waiting less than 6 weeks for diagnostic tests Escalation
No significant change	HSMR Rolling 12 months Rate card adherence (Medical) Non-elective Length of Stay, RAEI 2-hour urgent community response	How many incidents triggered a Patient Safety Review Methicillin-Susceptible Staphylococcus Aureus (MSSA) WWL Clostridium Difficile (CDT) Complaints Responses Patient Experience (FFT) - Patients who would recommend the service Mandatory training compliance Time to hire Virtual ward patients Cancer 62 day performance Total patients waiting over 65 weeks Cancer faster diagnosis (FDS) standard performance Elective Recovery Plan : Inpatient activity performance Surplus /Deficit (£ms) Adjusted Financial Performance (£ms) ERF Income (£ms) Agency % of Total Pay Agency Expenditure (£ms) Capital Expenditure (£ms) Cash (£ms) Better Payment Practice Code (BPPC)	Vacancy Rate 12-hour performance in EDs Critical Care Delayed step down No Right to Reside Patients (excluding Discharges) Total patients waiting over 52 weeks Elective Theatre Utilisation - Capped touchtime
Concerning Special Cause Variation		Never Events Category 3 and 4 Pressure Ulcers causing harm Moderate and Above Falls causing harm Sickness - %age time lost Elective Recovery Plan : Day case activity performance	Ambulance handovers 60+ minutes delay A&E waiting times : patients seen within 4 hours

Trust Matrix : M9 December 24



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 : M9 December 24

Our urgent and emergency care position remains challenging and this negatively impacts all four quadrants (operations, quality, people, and finance) of the Integrated Performance Report (IPR).

The IPR shows a further deterioration in 4-hours waits to 68.3% and ambulance handovers over 60 minutes remain consistently off target. Whilst 12-hour waits have remained stable, they are still below required performance levels. Sustained attendance levels and low discharges has driven the continued use of escalation areas, including the Emergency Department (ED) corridor. Delivery of care in these escalated areas impacts quality and patient experience, is creating ongoing cost pressures, and is one of the key risks to hitting our end of year financial targets.

Utilisation of the escalation spaces has a direct impact on the nursing and medical staffing with our substantive staff being moved to take charge of escalation areas, this has an impact on the wellbeing of our staff and has contributed to the increase in anxiety and stress related sickness absence. Across all staff groups the high levels of stress and the consistent pressures caused by working in such a challenged environment has impacted the sickness absence rate which has continued to increase to 6.5% and is above the target of 5%. Some sickness is attributable to seasonal variation and increases in community infection, such as norovirus.

The number of pressure related harms have seen a marginal increase, the root cause analysis themes pulled from these harms see a direct correlation with the time patients have been within ED. There is a direct correlation in the time patients spend within ED and Hospital acquired functional decline which will have an impact of patient's skin integrity and pressure management.

The Better Lives programme is beginning to show some encouraging signs, with the community admissions avoidance team making a material difference in ED. Attendances remain stable but there has been a slight drop in admissions, although length of stay has increased. There is a renewed effort to improve flow through our ward improvement programme and from the integration of our discharge and flow teams to ensure clear, simple processes are in place which facilitate discharge.

Mortality metrics remain strong, with Hospital Standardised Mortality Ratio (HSMR) at 91.66, comparing favourably with peers, and Summary Hospital-level Mortlaity Indicator (SHMI) remains within the funnel plot with peers and has shown an improvement since July. Improvements being implemented to support patients who require enhanced care have seen both a reduction in the falls reported for the month and drop in the utilisation of enhanced care requested and the associated spend.

Elective recovery rates are still behind plan despite significant support both financially for additional admin staff and from a leadership perspective from the Executive Team. This is driving a further financial risk to Elective Recovery Fund (ERF) income. Mitigations are in place to move surgical activity to Wrightington to compensate for Specialist Services being behind plan and further GM mutual aid is in train. Getting It Right First Time (GIRFT) support has also been sought. An action plan will be developed from the recommendations and capacity will be provided to support the transformational work required.

Turnover rates at 8.5% are in line with the target and have shown an improvement in month 9. Vacancy levels are above target, but this is an expected consequence of the more robust recruitment controls now in place.

Workforce numbers in December is static at 6,993 Whole Time Equivalent (WTE) when compared to last month (-9 WTE). This remains 122 WTE above the workforce plan of 6,871 WTE. Pay expenditure is below plan £0.3m favourable in month - £2.4m adverse year to date (YTD). There has been a consecutive month-on-month reduction in temporary staffing WTE and expenditure on bank and agency, supported by the standardisation of NHSP bank rates from 1 December 2024.

Whilst the Trust has broadly delivered the financial plan in month 9, year to date we remain £2.9m behind plan at a total deficit of £3.4m. The revenue position continues to trigger the red line Integrated Care Board (ICB) metric. Focus is ongoing on the agreed tactical action plan and mitigations to deliver the financial plan for 2024/25. The improvement trajectory required is steeper, with an improvement of £1.2m per month needed for the last financial quarter to achieve a best-case scenario of achieving plan.

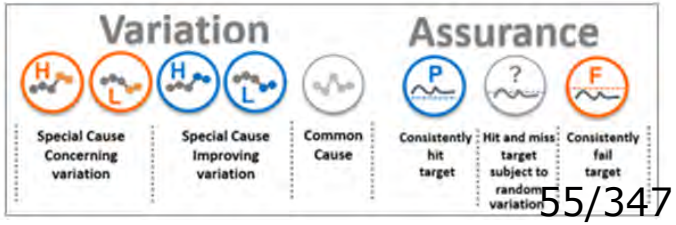
Divisional core Cost Improvement Programme (CIP) overachieved recurrently in month by £0.1m, however Transformation Schemes are significantly behind plan. The slippage YTD has reduced to £0.1m, and we remain on target to deliver the £27.3m CIP in full. The focus needs to remain on the delivery of recurrent savings to support our longer-term financial sustainability.

The closing cash balance at the end of the month is £9.9m, which is a decrease of £1.3m from last month. The non-recurrent deficit funding (£9.7m 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.

Quality & Safety Overview: M9 December 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	SHMI Rolling 12 Months	Aug 24	103.97	100	L	F	105.06	103.91	106.21
2	HSMR Rolling 12 months	Sep 24	91.66	100		P	91.22	89.23	93.21
3	Never Events	Dec 24	2	0	H	?	0	0	2
4	Number of Patient Safety Incident Response Framework priority incidents declared which triggered a PSI Investigation	Dec 24	2	4	L	?	3	0	8
5	How many incidents triggered a Patient Safety Review	Dec 24	10	33		?	29	0	55
6	Category 3 and 4 Pressure Ulcers causing harm	Dec 24	6	0	H	?	1	0	5
7	Moderate and Above Falls causing harm	Dec 24	3	1	H	?	2	0	5
8	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Dec 24	0	0	L	?	0	0	0
9	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Dec 24	0	0		?	1	0	6
10	WWL Clostridium Difficile (CDT)	Dec 24	2	5		?	6	0	18
11	Complaints Responses	Dec 24	68.6%	90%		?	64.5%	37.5%	91.5%
11	Patient Experience (FFT) - Patients who would recommend the service	Dec 24	86.9%	86.7%		?	87.1%	80.3%	93.9%

Summary icons key:



Quality & Safety Narrative: M9 December 24

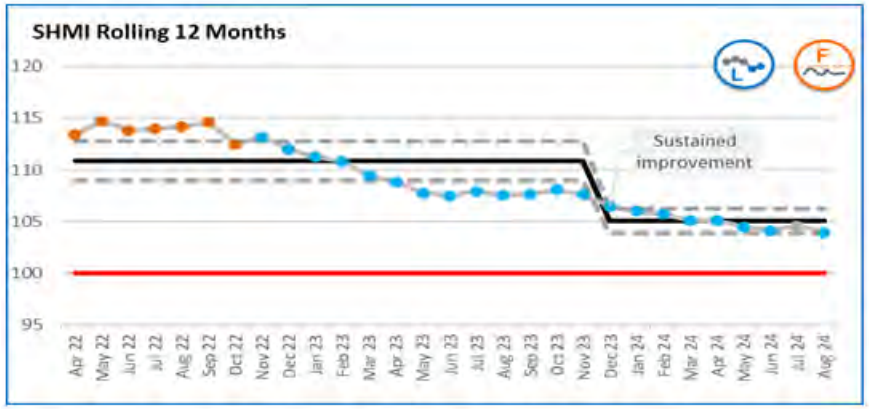
SHMI / HSMR
The Trust most up to date SHMI from August 2024 is 103.97 which is still well within the 'funnel plot' for expected range and lower than the July figure. As a comparison to GM Peers, SHMI values range from 94.09 to 115.83, with WWL having a proportionately lower bed base. HSMR remains strong for WWL at 91.66, with GM comparisons ranging from 85.86 to 113.81.

Incidents
In month 9 (December 2024), the Trust saw two never events reported. The first incident relates to a biopsy of the oesophagus being taken from the wrong patient during an OGD procedure. Two patients attended for an OGD procedure: Patient A, who was being investigated for Barrett's oesophagus, and Patent B, who was being investigated for iron deficiency anaemia. During the procedure, Patient A's notes were mistakenly used for Patient B. While Patient B underwent the correct procedure, the biopsy was taken to investigate Barrett's oesophagus rather than the intended duodenal biopsy. This incident has been categorised as a Never Event under the category of 'wrong site biopsy'. A PSII has been commissioned.

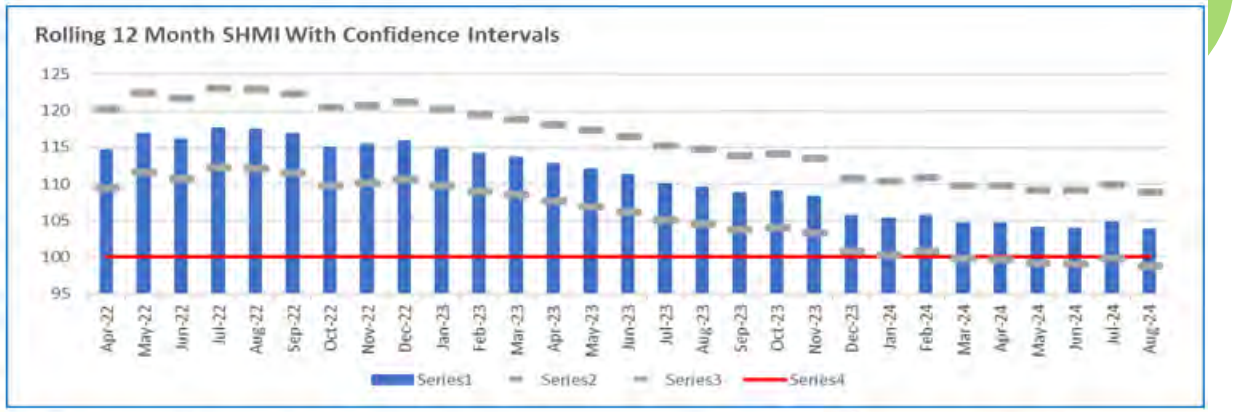
The second never event incident involved a patient transferred from ED to Winstanley Ward for inpatient treatment. The patient, who was receiving oxygen, was inadvertently connected to an air flow meter instead of an oxygen supply on transfer by the transferring healthcare assistant. The patient did briefly desaturate but did improve once they received the correct oxygen therapy. The patient recovered without further complications and has since been discharged home to the virtual ward for continued care.

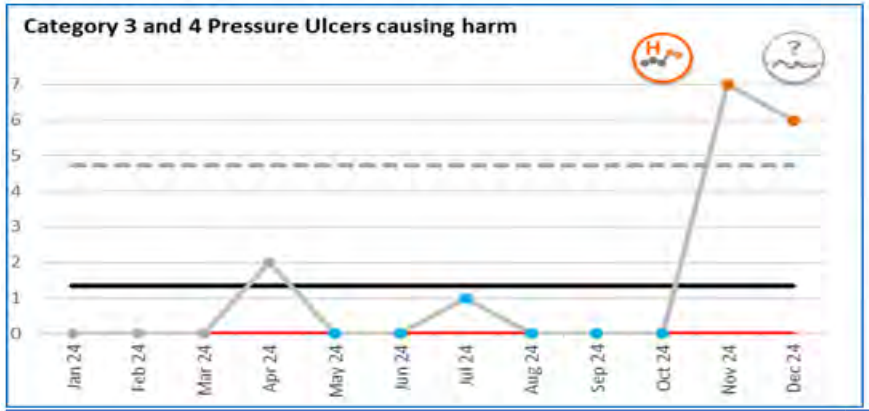
Complaints
The Trust saw a decrease in compliance in the M9 compliance figures. Some of the contributory factors for this related to operational pressures and gaps within the Division of Medicine Governance Team, however complaints review panels continue to ascertain what support can be provided, and resources have been added to support the Division of Medicine Governance Team

Quality & Safety Insight Report: M9 December 24

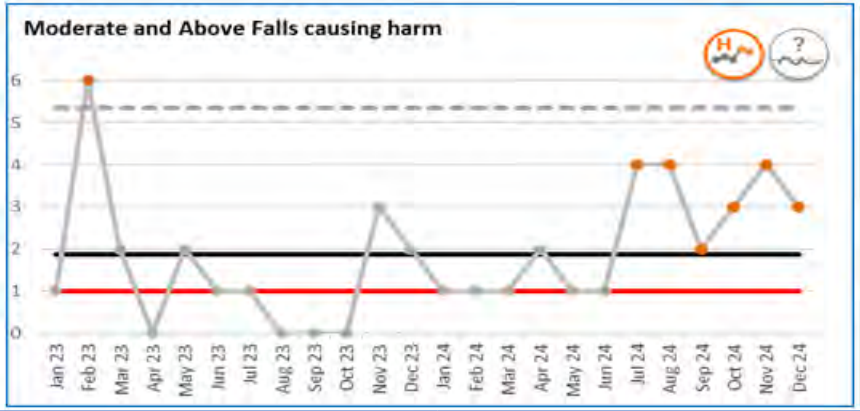


Aug-24
103.97
Variance Type
Special cause improving variation
Target
100
Target achievement
Metric is constantly failing the target





Dec-24
6
Variance Type
Concerning special cause variation point
Target
0
Target achievement
Inconsistent performance compared to target



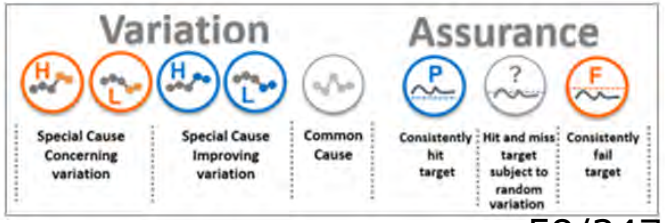
Dec-24
3
Variance Type
Concerning special cause variation point
Target
1
Target achievement
Inconsistent performance compared to target

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. **Category 3 and 4 Pressure Ulcers Causing Harm** There has been an increase in reported incidents and work is underway to review these so that any themes and trends can be identified. Initial review suggests there are issues around offloading of heels and support and education is being delivered to reduce the risk **Falls** The number of falls has begun to reduce	**SHMI** Continue improvement plans to ensure that patients are appropriately managed Work with system partners to ensure appropriate discharge placements for patients **Category 3 and 4 Pressure Ulcers Causing Harm** Work to provide support on the best way of offloading heels **Falls** Continue with falls improvements	**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 similar to other similar sized GM Trusts **Category 3 and 4 Pressure Ulcers Causing Harm** Work commenced to review any further trends **Falls** Reduction in number of falls

Our People Overview : M9 December 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Mandatory training compliance	Dec 24	94.7%	95%		?	94.9%	94.1%	95.8%
2	Appraisal	Dec 24	82.9%	90%	H	F	82.1%	81.2%	83.0%
3	Rate card adherence (Medical)	Dec 24	98.4%	80%		P	96.7%	92.3%	101.0%
4	% Turnover Rate	Dec 24	8.5%	8.5%	L	F	8.8%	8.6%	9.1%
5	Vacancy rate	Dec 24	6.1%	5%		F	6.2%	5.2%	7.3%
6	Sickness - %age time lost	Dec 24	6.5%	5%	H	?	5.4%	4.7%	6.1%
7	Time to hire	Dec 24	60.7	65		?	57.9	48.2	67.7

Summary icons key:



Our People Narrative : M9 December 24

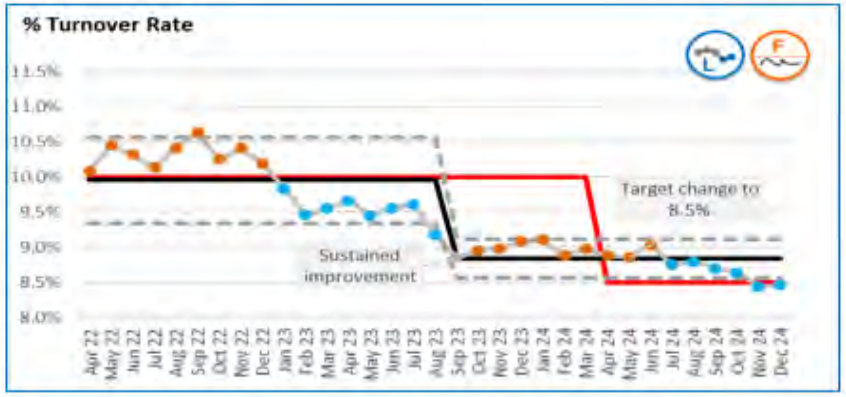
Turnover – continues to meet the revised target of 8.5% and represents a special cause improving variation. Consistent with previous months, the main recorded reasons for leaving include – relocation, retirement and promotion. Actions are being undertaken to improve the quality of leaver information, and to encourage leavers to complete an exit survey to enhance leaver insights. Engagement has taken place regarding the development of a behaviour framework, which is due to launch shortly, and actions are continuing to embed WWL values throughout the employee lifecycle.

Vacancy – at 6.1% the vacancy rate remains above the Trust target of 5%. Vacancy rates of Healthcare Scientists and Nurses/Midwives are below the Trust target. The AHP staff group has the highest vacancy percentage of 9.6%, however this figure has been reducing month on month. Medical vacancies are also continuing to decrease. The executive approval process of vacancies remains in place. Targeted recruitment also continues for hard to fill roles.

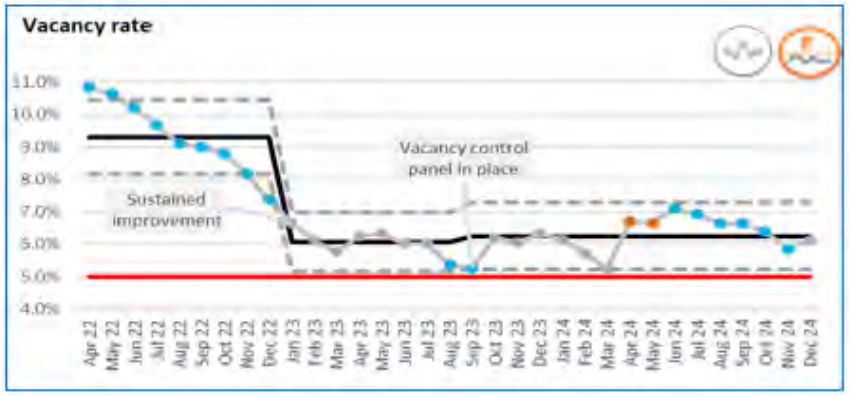
Sickness - Sickness absence rate has continued to increase and at 6.5% remains above the target of 5%, representing a special cause concerning variation. Long term absence continues to represent the greatest proportion of absence (3.8% of absence). The main reasons for absence remain consistent with previous months - anxiety/stress/depression (23%), MSK (12%) and coughs/cold/flu (11%). Engagement across the Trust is underway to redevelop the current sickness absence policy. The Strategic HR Lead continues to have oversight of all long term absence cases.

Time to Hire – at 60.7 days, time to hire continues to remain below the Trust target of 65 days. Focused action regarding medical time to hire is underway, including the introduction of electronic candidate forms to improve efficiency and candidate experience.

Our People Insight Report : M9 December 24

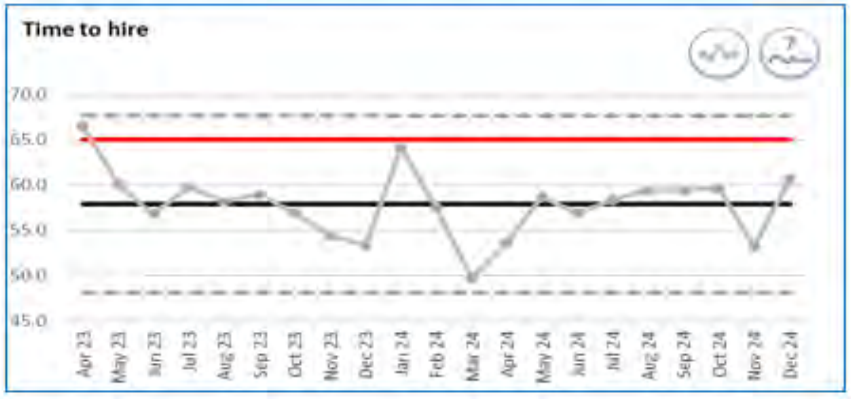


Dec-24
8.5%
Variance Type
Special cause improving variation
Target
8.5%
Target achievement
Metric is constantly failing the target



Dec-24
6.1%
Variance Type
Inconsistent performance compared to target
Target
5.0%
Target achievement
Metric is constantly failing the target

Dec-24
6.5%
Variance Type
Concerning special cause variation point
Target
5%
Target achievement
Inconsistent performance compared to target



Dec-24
60.7
Variance Type
Inconsistent performance compared to target
Target
65.0
Target achievement
Inconsistent performance compared to target

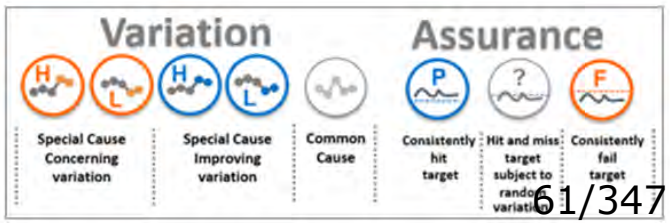
Summary:	Actions:	Assurance:
1. Turnover remains in line with the new target of 8.5%, with top reasons for leaving consistent with previous month 2. Vacancy rate continues to be above the target of 5%, low vacancy numbers in Healthcare Science and N&M staff groups 3. Sickness absence rate is at its highest level since December 2022, with the highest cause of absence due to anxiety/stress depression 4. Time to hire remains below the Trust target	1. Engagement undertaken regarding new behaviour framework to embed Trust values. Focus on improving data quality of reason for leaving and continued focus on encouraging leavers to complete exit questionnaires 2. Continue to undertake targeted recruitment of hard to fill roles. Recruitment events to be held with partners across Wigan 3. Engagement to be undertaken to shape development of new Sickness Absence Policy. Sickness absence task and finish group meeting to review opportunities to support a reduction in absence rates 4. Focus on medical time to hire to further reduce time to hire	1. Oversight and analysis of turnover rates through Workforce Metrics reports via Divisional Assurance Meetings, Wider Leadership Team Meeting and People Committee 2. Oversight of vacancy rates through Workforce Metrics reports via Divisional Assurance Meetings, Wider Leadership Team Meeting, People Committee and Finance Improvement Group 3. Oversight also via Divisional Assurance Meetings, Wider Leadership Team Meeting and People Committee, along with insight from HR Business Partners, and within HR leadership sessions 4. Oversight via workforce metrics, WLT, Divisional Assurance and quarterly recruitment report to People Committee

Our Performance Overview : M9 December 24

	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Ambulance handovers 60+ minutes delay	Dec 24	558	0	H	F	259	43	476
2	12-hour performance in EDs	Dec 24	18.0%	10%		F	17.1%	14.6%	19.6%
3	A&E waiting times : patients seen within 4 hours	Dec 24	68.3%	76%	L	F	69.4%	66.0%	72.8%
4	G&A Bed Occupancy - Acute Adult Inpatient Wards, WWL*	Dec 24	96.6%	96%	L	F	99.7%	98.8%	100.6%
5	Non-elective Length of Stay, RAEI	Dec 24	4.01	4.68		P	4.04	3.49	4.60
6	Critical Care Delayed step down	Dec 24	23	0		F	18	3	33
7	Virtual Ward Occupancy	Dec 24	59.7%	80%		?	69.6%	45.3%	93.8%
8	No Right to Reside Patients (excluding Discharges)	Dec 24	115	50		F	118	103	133
9	Cancer 62 day performance	Nov 24	79.7%	70%		?	78.3%	67.2%	89.4%
10	Total patients waiting over 65 weeks	Dec 24	252	0		?	348	-15	711
11	Total patients waiting over 52 weeks	Dec 24	2201	714		F	2275	1922	2629
12	Percentage of patients waiting less than 6 weeks for diagnostic tests	Dec 24	83.3%	95%	H	F	79.2%	76.3%	82.0%
13	Cancer faster diagnosis (FDS) standard performance	Nov 24	83.6%	77%		?	81.3%	75.2%	87.5%
14	% of new outpatient attendances or with procedure completed	Dec 24	46.6%	46%	H	?	44.3%	42.4%	46.2%
15	Elective Theatre Utilisation - Capped touchtime	Dec 24	81.1%	85%		F	81.7%	79.4%	83.9%
16	Elective Recovery Plan : Day case activity performance	Dec 24	86.2%	100%	L	?	95.8%	86.4%	105.1%
17	Elective Recovery Plan : Inpatient activity performance	Dec 24	93.1%	100%		?	105.9%	80.7%	131.1%
18	2-hour urgent community response	Dec 24	79.3%	70%		P	82.7%	72.4%	93.0%

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

Summary icons key:



Our Performance Narrative : M9 December 24

Performance against the 4-hour care standard in A&E, for December 2024 remained below the 76% target at 68.3% which was a slight fall in month from 68.6%. Performance against the service, care standard and ambulance handovers over 60 minutes both improved in month but remain consistently off target. The hospital experienced OPEL 4 pressures for most of the month of December and was under scrutiny both from an ICB and Regional perspective. There was some improvement moving into the Christmas period. The G&A bed occupancy numbers were adjusted to include the Wrightington elective beds within the denominator and hence occupancy fell to 96.6%.

Virtual ward occupancy sat at 59.7% 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 maximise its use and reduced bed pressures on the acute site. In month, the NCTR was elevated at 115 against a target of 50 and work is underway to integrate the Health and Social Care Transfer of Care Hub and the Integrated Discharge Team and to streamline the discharge processes and to ensure that medically optimised patients are discharged in a timely way.

The cancer 62-day performance continues to exceed the 70% target at 79.7% and this is consistently monitored to ensure that patients are seen in a timely manner and cancer elective activity is protected from the pressures experienced in relation to urgent and emergency care. The cancer faster diagnosis standard was above the 77% target at 83.6%.

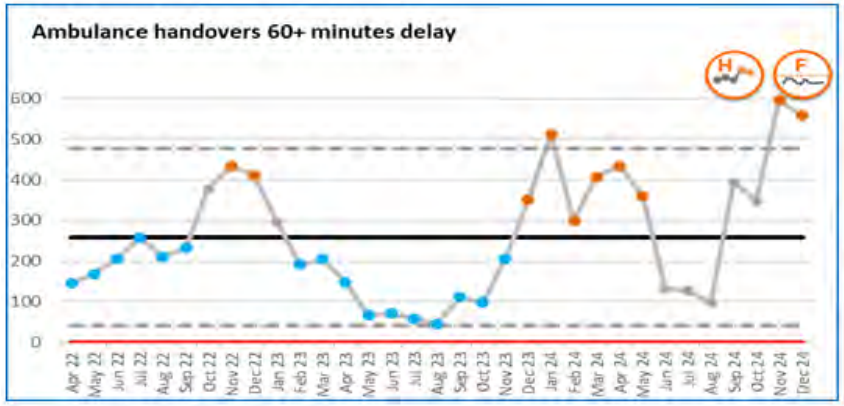
There were 252 patients who exceeded the 65 week wait, this was in the main due to a large number of patients waiting to be seen in dermatology and a smaller number of patients in gynaecology. There has been a number of actions taken to reduce the number of waiters in dermatology including bringing in a locum dermatologist, the use of About Health and Consultant Connect. Regular fortnightly meetings take place with the ICB Director of Performance. 52 week waits are being monitored and forecasts are being developed to identify specialties of concern so that mitigating actions can be taken to ensure that the number of 52 week waits does not increase.

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. There are however some risks emerging in relation to staff leaving the service to work for private providers with considerably escalated salaries.

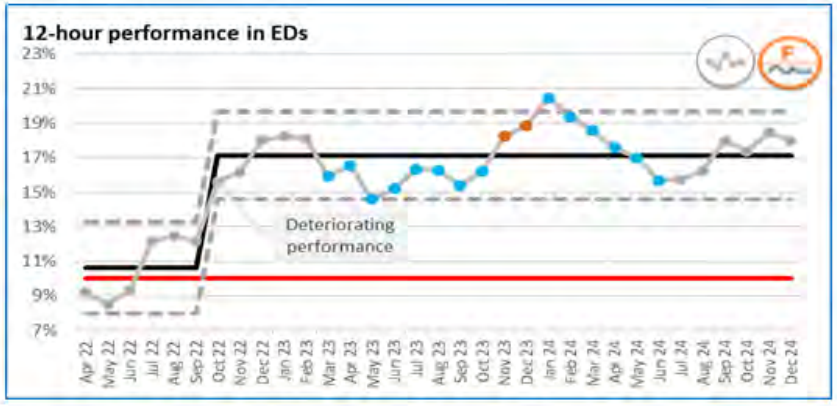
Work continues in relation to the capped touch time and the day case and inpatient activity performance.

The 2 hour urgent community response service continued to exceed the 70% target at 79.3% even with the Advanced Clinical Practitioner being located in the front door of A&E to support the Better Lives programme.

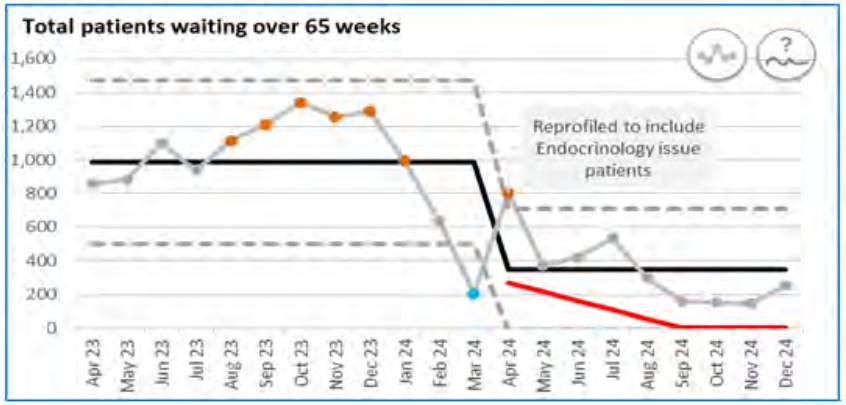
Our Performance Insight Report : M9 December 24



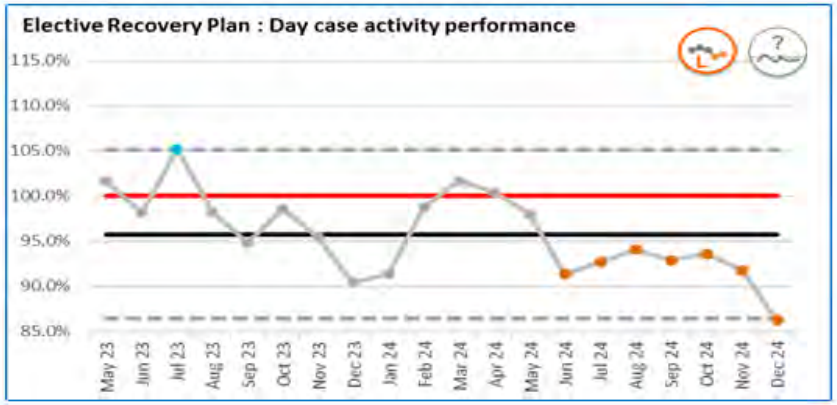
Dec-24
558
Variance Type
Concerning special cause variation point
Target
0
Target achievement
Metric is constantly failing the target



Dec-24
18.0%
Variance Type
Inconsistent performance compared to target
Target
10%
Target achievement
Metric is constantly failing the target



Dec-24
252
Variance Type
Inconsistent performance compared to target
Target
0
Target achievement
Inconsistent performance compared to target



Dec-24
86.2%
Variance Type
Concerning special cause variation point
Target
100%
Target achievement
Inconsistent performance compared to target

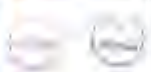
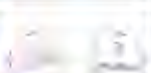
Summary:	Actions:	Assurance:
1. Ambulance handovers over 60 minutes decreased slightly in month. 2. 12-hour performance has improved marginally in month . 3. There was an increase in patients waiting beyond 65 weeks. 4. The day case activity performance fell further behind target.	1. Work is being undertaken internally and with NWAS when the A&E department is fully escalated and there are delays to ambulance handovers to support decision making around clinical prioritization and release of ambulance crews. 2. The BetterLives programme is now underway, and the CRT clinician is now in the front door of ED. 3. Close monitoring of long waiters and mutual aid and insourcing being actioned. 4. Review of all capacity at Wrightington to support better performance in relation to day case activity.	1. Delays are reducing as work is progressing. 2. Early indications from the pilot are seeing a positive impact as well as work to streamline discharge processes. 3. Scrutiny and focus and actions in place to reduce these to 0 as soon as possible. 4. Weekly meetings with the COO and DoF.

Our Finance Performance Overview : M9 December 24

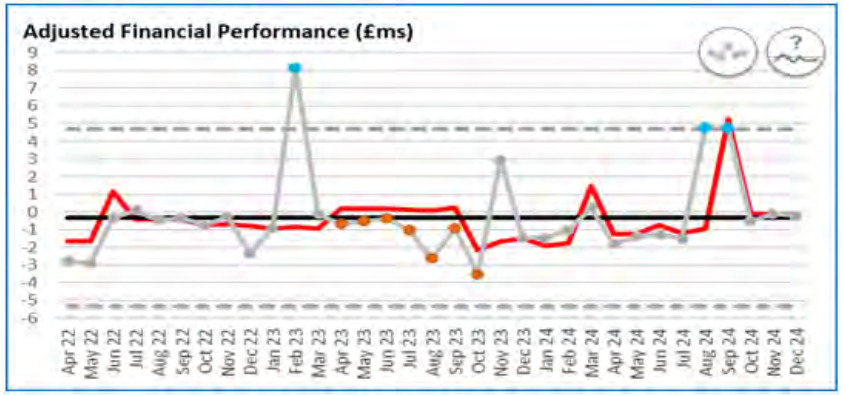
	Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
1	Surplus /Deficit (£ms)	Dec 24	-0.25	-0.13			-0.85	-7.27	5.56
2	Adjusted Financial Performance (£ms)	Dec 24	-0.23	-0.12			-0.32	-5.35	4.71
3	ERF Income (£ms)	Dec 24	8.98	9.88			10.00	7.68	12.32
4	Agency Expenditure (£ms)	Dec 24	0.66	0.66			0.79	0.49	1.09
5	Agency % of Total Pay	Dec 24	2.1%	3.2%			2.6%	1.6%	3.5%
6	Escalation (£ms)	Dec 24	0.48	0	L	F	0.58	0.43	0.74
7	Capital Expenditure (£ms)	Dec 24	1.57	1.75			1.48	0.73	2.23
8	Cash (£ms)	Dec 24	9.91	8.25			14.49	0.68	28.29
9	Cost Improvement Programme (CIP) (£ms)	Dec 24	2.42	2.28	H		2.26	1.74	2.79
10	Better Payment Practice Code (BPPC)	Dec 24	95.2%	95%			94.0%	90.4%	97.5%

Summary icons key:

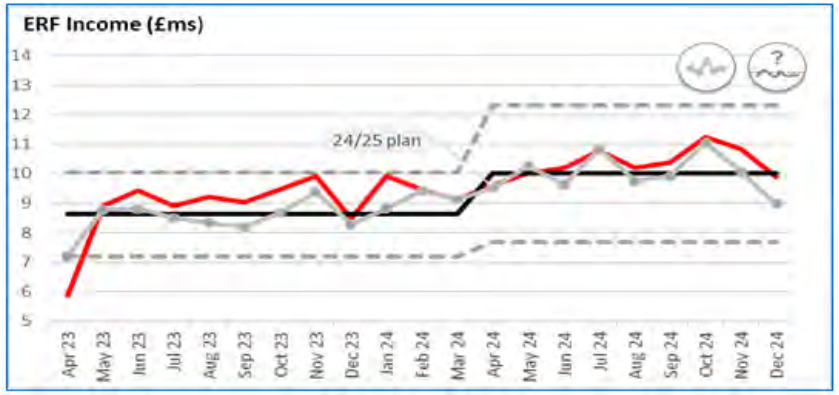
Our Finance Performance Narrative : M9 December 24

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Red		We are reporting an actual deficit of £0.2m for month 9 (December) and £3.4m year to date. The forecast provided to NHSE is to deliver the full year plan of £0.8m deficit, this requires an improvement on the current run rate of £1.2m per month for quarter 4, which looks increasingly challenging. This relies on delivery of the current ERF forecast, CIP plans and mid year tactical actions.
	Adjusted financial position: Achieve the financial plan for 2024/25.	Red		
ERF Income	Achieve the elective activity plan for 2024/25.	Amber		Elective activity is £0.8m behind plan in month 9 and £2.0m behind plan year to date. This includes Advice & Guidance Income of £1.1m 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 9, a marginal improvement from last month. This is below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure. We are currently at 2.1% of total pay spend in month and 1.9% YTD.
Escalation	Sustained reduction in escalation spend for 2024/25.	Green		Reported escalation costs for December was £0.5m, a slight increase from prior month. Additional doctors were used in month to cover escalated areas and outlier wards and this is expected to continue until the end of March. Additional doctors were also required to cover escalated ward at Wrightington during period 23rd Dec – 3rd Jan.
Capital expenditure	Achieve capital plan for 2024/25.	Green		Month 9 actual capital expenditure is £1.6m, which is £0.2m below plan due to the phasing of expenditure. We are forecasting to spend our CDEL envelope in full for 2024/25.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		There is a closing cash balance of £9.9m for December 2024 which is £1.7m above plan. There was a decrease of £1.3m in month which is less than the average cash run rate due to an increase in aged debt recovery in month along with other timing differences in the payment of invoices. The current cash run rate forecast indicates there will be sufficient cash balances for the remainder of the financial year. However, revenue cash support is expected to be required in quarter 1 of 2025/26.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red		In month 9, the Trust has delivered £2.4m CIP which was £0.1m favourable to plan. The YTD slippage has reduced to £0.1m due to the overperformance in recent months. 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 November is 94.4% by volume and 96.1% by value, which is a slight improvement to previous months.

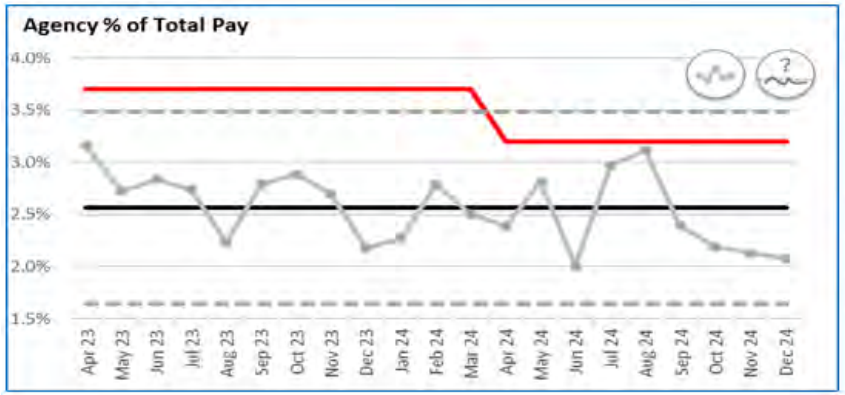
Our Finance Performance Insight Report : M9 December 24



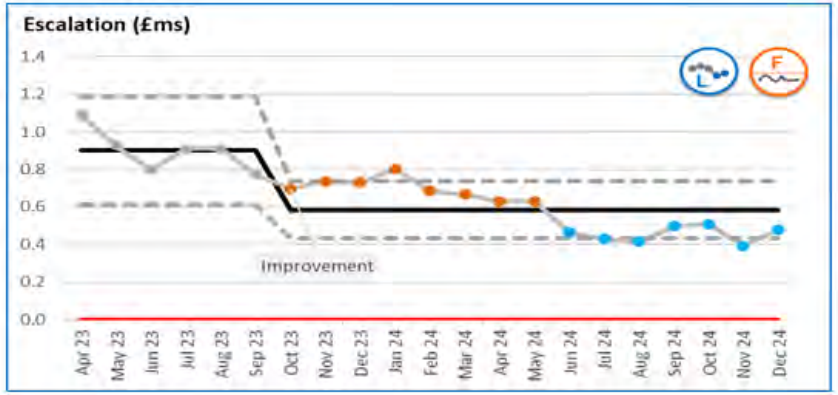
Dec-24
-0.23
Variance Type
Inconsistent performance compared to target
Target
-0.12
Target achievement
Inconsistent performance compared to target



Dec-24
8.98
Variance Type
Inconsistent performance compared to target
Target
9.88
Target achievement
Inconsistent performance compared to target



Dec-24
2.1%
Variance Type
Inconsistent performance compared to target
Target
3.2%
Target achievement
Inconsistent performance compared to target



Dec-24
0.48
Variance Type
Special cause improving variation
Target
0.00
Target achievement
Metric is constantly failing the target

Summary:	Actions:	Assurance:
1. Actual deficit of £0.2m in month 89 £3.4m YTD, including the non-recurrent deficit funding. This £0.1m adverse to plan in month and £2.8m adverse to plan YTD. 2. Elective activity is £0.8m behind plan in month and £2.0m year to date. Advice & Guidance income of £1.1m YTD has been included for diverted activity. 3. Agency expenditure is £0.7m in month 9, marginal improvement from last month. This is below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure. We are currently at 2.1% of total pay spend in month and 1.9% YTD. 4. Reported escalation costs for December was £0.5m, a slight increase from prior month. Additional doctors were used in month to cover escalated areas and outlier wards. Additional doctors were also required to cover the escalated ward at Wrightington.	1. The forecast provided to NHSE is to deliver the full year plan of £0.8m deficit, this requires an improvement on the current run rate of £1.2m per month for quarter 4, which looks increasingly challenging. This relies on delivery of the current ERF forecast, CIP plans and mid year tactical actions. 2. Specialist Services underperformance is predominantly due to lost theatre sessions in Trauma & Orthopaedics, and a recovery plan is in place. Other divisions also below plan in month, with plans to recover in remaining months of the year. 3. Grip and control measures on temporary spend remain in place. 4. The safe de-escalation of the acute site is being facilitated through the Better Lives transformation programme, supported by Newton Europe, and the internal discharge and flow programme.	1. Divisional Assurance Meetings, Finance Improvement Group, Executive Team Meeting, 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. Escalation is reviewed during weekly meetings and the Medicine Divisional Assurance Meeting.

Metrics where step changes have been added

Metric	Does seasonality apply?	Month of assessment	Check	Rationale	Reset limits?	From	Rationale	Icons	
								From	To
SHMI	n	M7	y	>6 points below the mean	y	Dec-23	Sustained improvement		
HSMR	n	M7	y	>6 points below the mean	y	Sep-23	Sustained improvement		
12-hour performance in EDs	y	M7	y	Oct 22 would have triggered an investigation	y	Oct-22	Deteriorating performance - division to advise		
G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI	y	M7	y	Jan 23 would have triggered an investigation	y	Jan-23	Deteriorating performance - division to advise		
Virtual ward patients	n	M7	y	Reflect capacity change	y	Apr-24	Reflect capacity change		
No Right to Reside Patients (excluding Discharges)	y	M7	y	Reflect change in recording	y	Apr-24	Reflect change in recording		
Total patients waiting over 65 weeks	n	M7	y	Reflect change in recording (Endoscopy)	y	Apr-24	Reflect change in recording (Endoscopy)		
Total patients waiting over 52 weeks	n	M7	y	Reflect change in recording (Endoscopy)	y	Apr-24	Reflect change in recording (Endoscopy)		
Percentage of patients waiting less than 6 weeks for diagnostic tests	n	M7	y	Reflect change in data content	y	May-24	Reflect change in data content		
Cancer faster diagnosis (FDS) standard performance	n	M7	y	>6 points above the mean	y	Jun-23	Improved performance		
Elective Theatre Utilisation - Capped touchtime	n	M7	y	>6 points above the mean	y	May-24	Investigate as unsure of reason		
Elective Recovery Plan : Inpatient activity performance	n	M7	y	Reflect new plan (24/25)	y	Apr-24	Reflect new plan (24/25)		
Appraisal	n	M7	y	Sustained improvement, above upper process limit	y	Apr-24	Improvement, redesign of appraisal form / proc		
Rate card adherence (Medical)	n	M7	y	Significant improvement variation	y	Aug-24	ECC rates aligned to WWL		
Vacancy rate	n	M7	y	>6 points above the mean	y	Sep-23	To reflect vacancy control panel being in place		
ERF Income	n	M7	y	To reflect 24/25 plan	y	Apr-24	24/25 plan		
Agency Expenditure (£'000s)	n	M8	y	Sustained improvement	y	Apr-23	Improved performance		
Escalation	y	M7	y	Sustained improvement	y	Oct-23	Improvement		
Capital Expenditure (£'000s)	n	M7	y	To reflect 24/25 plan	y	Apr-24	24/25 plan		
Cash (£'000s)	n	M7	y	To reflect 24/25 plan	y	Apr-24	24/25 plan		
Cost Improvement Programme (CIP) (£'000s)	n	M7	y	To reflect 24/25 plan	y	Apr-24	24/25 plan		

Change log

Ref	Metric	Change	Date	Requested by:
24/25 08	G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI	G&A Bed Occupancy - Acute Adult Inpatient Wards, RAEI changed to G&A Bed Occupancy - Acute Adult Inpatient Wards, WWL due to the inclusion of Wrightington bed stock in line with national guidance.	16/01/2025	Chief Operating Officer
24/25 07	Elective Theatre Utilisation - Capped touchtime	Alignment of the Theatre Utilisation metric with the national metric	12/11/2024	Data Analytics and Assurance
24/25 06	As appropriate	Metrics reviewed and step change added if appropriate.	12/11/2024	Data Analytics and Assurance
24/25 05	All Finance metrics	Finance metrics reported in £ms rather than £'000s to be consistent with the Trust Finance Report	16/09/2024	Director of Finance
24/25 04	2-hour Urgent Community Response	Reporting deadline moved to latest postion	18/08/2024	Community Division Director of Performance
24/25 03	Elective Recovery Plan - Inpatients & Day Cases Activity	Reported as at working day 1 in line with Finance figures	18/08/2024	Director of Finance
24/25 02	Escalation	Add new metric	16/07/2024	Director of Finance
24/25 01	ERF Income	Add new metric	16/07/2024	Director of Finance

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Thank you

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	15 January 2025
Chair:	Mary Moore

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

ALERT
• A report on progress with corporate objective (CO) 3 around improving diabetic care for the local population identified a co-hort of adolescent patients who are hard to engage and do not attend (or are not brought) to their appointments. A funding request for staff resource to support rectifying this was made this was redirected to the appropriate governance channels. • The divisional highlight report for medicine, quality impact assessment report, urgent and emergency care (UEC) and temporary escalation spaces (TES) reports all illustrated a consistent theme around the significant pressure that the trust is currently under. These brought to life the impact of pressures on staff and a poor patient experience. There was good assurance that despite pressures there was continued vigilance to identify safety issues and harm. (see Assurance) • The medicines management biannual report highlighted that the pharmacy team are beginning to see an impact following the GP Collective Action (industrial action by GP's), on certain groups, noting that those requiring ADHD medication are increasingly reliant on acute care for prescribing. This triangulates with Community Midwifery prescriptions requiring attendance to hospital for routine prescriptions , previously provided by GP practice. • A recommendation was noted through the Rainbow Ward staffing paper for consideration for the units uplift to be in line with the national recommendation of 5% which is currently being reviewed as a wider speciality roster piece of work by the Chief Nurse. This was redirected to the appropriate governance channels. • The safe nurse staffing report showed some areas with high levels of sickness, particularly Leigh theatres at 36.6%, albeit this is representative of small a small team.
ASSURE
• The urgent and emergency care report provided positive assurance on the vigilance around harm to staff and patients and poor patient experience evidenced. • The biannual quality impact assessment report evidenced scrutiny in respect of ensuring that cost improvement (CIP) is both effective and safe.
ADVISE
• A compelling patient story involving maternity care was provided and offered assurance

around how the various issues were dealt with, including the reconsideration of the initial complaint which was ultimately resolved with much more compassion and empathy.

- Work is ongoing to reform the ASPIRE accreditation programme to allow for better triangulation of data, staff ownership of the programme and a possible name change following consultation and engagement with staff to reshape it.
- The committee carried out its annual effectiveness review. Proposed changes will be discussed with the Chair and lead executives.
- The committee received the quarterly learning from deaths report.
- The action plan for the maternity SCORE survey (an externally led survey as part of the Maternity Leadership Programme) continues to be in development with external support secured.
- The consultant attendance audit triangulated with the staff story and the committee appreciated that consideration had been given to staffing the maternity ward with 24 hour consultants, which was found overall not to be feasible.
- The committee signed off that the CNST standards are on track and will be submitted for board sign off in February 2025.
- Feedback on the board assurance framework suggested that it would be helpful to include a trend indicator for the risks scores.
- **The committee received:**
  - The Clinical audit and effectiveness AAA
  - The CQC action plan update
  - The Patient Safety Group AAA
  - The Patient Experience AAA – triangulated with Medicines Management report
- **ED&I reflections were noted in respect of:**
  - The Patient story
  - The paper on progress with CO3
  - The medicine division's use of more lived experience partners, through complaints, to make improvements
  - The learning from deaths report

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The risks relating to the BAF were reviewed and no changes needed at this time.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	28 January 2025
Chair:	Julie Gill

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

ALERT

- The committee wishes to alert the Board to the issue with 'watch and wait' codes being incorrectly entered in to the Patient Administration System and the potential of patient harm caused by the incorrect closure of pathways as a result – this has been noted for drawing to the attention of the Quality and Safety Committee due to the overlap with the 'lost to follow up' work streams which it has been overseeing for several months.
- Urgent care performance sees WWL at 68% in terms of meeting the 4-hour treatment target versus the 78% national target and a deterioration of 1% compared to last month.
- In elective care WWL has reported 220 65-week wait breaches and 24 78-week breaches in December 2024.
- Ambulance handover time has also increased.
- The Committee noted both reputational and patient harm risks posed by the above.
- The trauma and orthopaedic team continue to underdeliver their elective activity.
- The year-end financial target is challenging and the impact on financial sustainability will be picked up as part of the planning process.

ASSURE

- The 'Getting it Right First Time' (GIRFT) team have visited WWL and following a review a set of priorities have been agreed in terms of workstreams to progress to improve performance and activity.
- A revised ward improvement programme will support the internal discharge and flow workstream, with revised governance processes now in place along with executive sponsorship through the Chief Nurse.
- The Executive Team continue to work to deliver the financial plan with mitigations to offset income loss and ongoing cost control.

ADVISE
▪ The Better Lives Programme was noted to be progressing well, with work to be done to identify where improvements in key indicators can be attributed to this. Admissions were noted to have been reduced by 4 patients per day which is the start of positive assurance here. ▪ WWL is working with the GIRFT team to identify areas of improvement for orthopaedic elective recovery, receiving weekly on-site input. ▪ It is likely WWL will need to draw down cash in April 2025. ▪ The Committee endorsed a business case for LED lighting following the receipt of £2.4m of additional external funding ▪ The cost improvement plan remains challenging for future years and the focus on recurring savings must continue.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ The corporate board assurance framework risks were considered and no changes to the scores were made.

Committee report

Report from:	People Committee
Date of meeting:	10 December 2024
Chair:	Mark Wilkinson

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

ALERT

- Enhanced bank rates paid to staff across the local and wider area have been brought in line with Agenda for Change rates and therefore reduced. The committee heard about how WWL will respond to the reaction from staff in relation to this and have implemented an escalation procedure should this be required to maintain patient safety.
- An increase in sickness rates across the trust was noted, as was the operational impact these are having. The committee further noted with concern that, at the time of reporting, only 29.3% of front-line staff had received a flu vaccination, although this remains comparatively good across the Greater Manchester system.

ASSURE

- The gender pay gap report was agreed for publication, the committee was assured by the work done over the past year to improve the position but did note that the current position is not reflective of where WWL wants to be.
- The People corporate objectives and programme of work was received with good progress noted.
- The People and Culture Strategy was approved and was noted as positive progress, with the new values and behaviours framework being endorsed. A refresh of the strategy will be undertaken in a year's time.
- The equality, diversity and inclusion annual report was approved for publication.
- Positive progress was noted around the workforce transformation work with Bolton NHS FT and the proposals to consider alignment of the trusts' corporate functions.
- The mutually agreed resignation scheme (MARS) was noted to be on track with a further update to be provided at the next meeting around the financial impact that this has had.
- The committee were assured in the oversight against the outcomes of internal audits.
- The surgery divisional report provided assurance in relation to local programmes of work that were being led by lead clinicians and representatives of the triumvirate.

Low turnover in the division was noted, providing assurance that the work being undertaken was having a positive impact.
ADVISE
• The committee noted significant changes to the mandatory training driven by national changes to the framework but took assurance from the work WWL has done thus far. • The committee received its first report on the pay bill and were able to appreciate the importance of including this within the usual plan of work. Normalised pay has been broadly static across the year. • The committee discussed noted a strong theme throughout the meeting around the importance of equality, diversity and inclusion considerations.
RISKS FOR ESCALATION
None identified.

Title of report:	Bi- Annual Nurse Staffing Review
Presented to:	Board of Directors
On:	05 February 2025
Item purpose:	Discussion
Presented by:	Kevin Parker-Evans Chief Nursing Officer
Prepared by:	Associate Chief Nurse- Safe Staffing Divisional Directors of Nursing & AHP's
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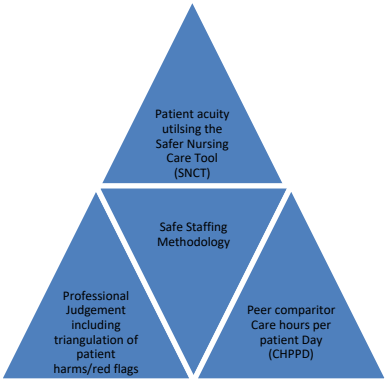
Executive summary

The Bi-Annual Staffing review is presented to provide the board with assurance that nursing establishments are sufficient to meet the needs of the patients in our care, and to meet patients' needs at times of peak demand.

It is mandated that all NHS organisations review staffing levels at least twice a year and the findings of the review to be shared with the Trust board and that decisions made following receipt of the report to be documented and to provide assurance of board level accountability and responsibility for staffing levels.

The review has been undertaken using the National Quality Board guidelines with respect to workforce under the developing workforce safeguards (2018) framework. The review is undertaken using the triangulated methodology:



The report outlines in detail the outputs of the methodology and recommendations. It is worth noting that during the review period (September 2024) the Trust was working in heightened operational pressures, meaning additional areas and escalation capacity were opened during the review period. This has a direct impact of the nurse staffing levels and the ability to report a true reflection of the nurse staffing levels. Additional escalation capacity had a direct impact on the following aspects of a nurse staffing review including and not inclusive of skill mix, redeployment of substantive staff, sickness, staff wellbeing/turnover.

The report identifies that overall, when staffing **core clinical areas** (excluding escalation capacity and the associated movement of staff) there is sufficient staffing levels to meet the needs of patients, there is the requirement for deeper reviews of some specialities and services to see how nursing establishment could be better used by supporting a more fluid workforce.

There are however several recommendations to further support the Safe Staffing review and further support a robust workforce planning mentality moving forward they are outlined as below:

- Acceleration of the Discharge and Flow Programme to reduce escalation capacity and occupancy to support the delivery of core nurse staffing levels across established areas.
- A capacity and demand review of core UEC (inc. SDEC) services and how staff are aligned to new models of working. Furthermore, investment in staff for Paediatric Emergency Care (PEC) is required to ensure the workforce is sufficient to meet the demands on the service.
- A peer review of head room allowance starting with speciality areas (ITU/ED/Theatres).
- A capacity and demand review of the higher dependency level bay within Winstanley ward with the consideration of a flexible seasonal variance staffing model.
- A capacity and demand review, supported by, a robust winter plan that has changes in specialties within its trajectory and therefore supports the acuity nuances in nursing staffing requirements i.e. Medical Outliers within the surgical footprint.
- A Band 6 skill mix review as requested by the Chief Nursing Officer.
- The embedded utilisation of Safe Care to ensure a live patient acuity nursing staffing review is being maintained.
- To further support professional judgement and granular level of establishments the Chief Nursing Officer has a full establishment review of all core wards and departments planned for February 202525.
- A detailed prospective workforce plan that uses 2024/2025 data to support planned recruitment events aligned to university graduation dates for registrants.
- A Quarterly Health Care Assistant workforce recruitment plan that supports a pool of health care assistants that can be aligned to vacancies in a timely manner and reduce recruitment time and reliance on temporary staffing.
- A programme of transformation aligned to nursing workforce that can support the review of roles, support blended ways of working to become more efficient, provide high quality care, provide clear succession plans and support with cost efficiencies that deliver the Trusts Financial sustainability plan.

The bi- annual staffing reviews intent is to provide assurance r.e the safe staffing levels and not be a hybrid approach to creating business cases. There are pipeline developments that will need workforce reviews and consideration as part of the planning process i.e. SAU development.

In summary the report provides assurance that **core established areas** are safely staffed in line with guidance. There is further to work to do to further support the fluidity of our nursing workforce to provide resilience and better forward planning of nursing workforce requirements.

Link to strategy and corporate objectives
Patients: To be widely recognised for delivering safe, personalised, and compassionate care, leading to excellent outcomes and patient experience.

People: To create an inclusive and people centred experience at work that enables our WWL family to flourish.

Performance: To consistently deliver efficient, effective, and equitable patient care.

Risks associated with this report and proposed mitigations

Financial implications

There is a risk to achieving the corporate objective of financial balance due to overspend on temporary staffing. The investment proposed will result in a reduction of spend already been incurred whilst addressing specific patient safety risks identified within the report.

Legal implications

There is a potential for an increase in litigation associated with harms that occur to patients whilst in our care.

People implications

Investment in the unregistered workforce provides an opportunity for the Trust to continue the ambition to be the employer of choice within the locality. Furthermore, this presents the opportunity to further develop the workforce to engage in cross boundary working within social care and the care home sector.

Equality, diversity and inclusion implications

There are no implications arising from this report.

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

Executive Team Meeting

Recommendation(s)

The Board of Directors are asked to note the assurance provided in the report with regards to the nursing staffing establishments and to approve the recommendations detailed within the report.

Biannual Nurse Staffing Review (September 2024)

1 Introduction

1.1 The purpose of this paper is to provide the Board is to provide assurance that nursing establishments are sufficient to meet the needs of the patients in our care, and to meet patient needs at times of peak demand.

1.2 This report will include reference to current funded establishments, national guidance, acuity and dependency measures and incidents of harm which have been triangulated to formulate the recommendations within this report.

1.3 This report covers adult inpatient areas and the Emergency Village; however, the report will take the opportunity to call out areas that will require further consideration as we move to make our services more sustainable.

1.4 The Maternity staffing review and associated recommendations will be reported separately to the Board as per the requirements for CNST and include recommendations for neonatal unit staffing as well as the paediatric inpatient ward and are therefore excluded from this report.

2 Background

2.1 Throughout 2012 and 2013[1][2][3][4][5] a series of reports were published describing the critical role of nurse staffing in the delivery of high-quality care and excellent outcomes for patients.

2.2 In 2013 it was nationally mandated that all NHS Organisations review staffing levels at least twice/year and for the findings of the review to be shared with the Trust Board and that decisions made following receipt of the report to Board be documented to provide assurance of Board level accountability and responsibility for staffing levels.

2.3 In November 2014 NHS England published 'Safer Staffing: A Guide to Care Contact Time[6]. This report outlines further requirements to provide assurance of staffing levels and the importance of the provision of nurse-to-patient direct care time.

2.4 Developing Workforce Safeguards 2018 states each Trust must demonstrate compliance with National Quality Board guidelines with respect to workforce, and for a declaration of safety in this

[1] NHS England (2012): *Compassion in Practice*
[2] The Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013): *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry.*
[3] Prof. Sir Bruce Keogh, NHS England (2013): *Review into the quality of care provided by 14 hospital trusts in England: overview report.*
[4] Don Berwick. Department of Health (2013): *A promise to learn, a commitment to act: improving the safety of patients in England.*
[5] Cavendish, C., Department of Health (2013): *The Cavendish Review: an independent review into healthcare assistants and support workers.*
[6] NHS England (2014): *Safer Staffing: A Guide to Care Contact Time.*

regard to be made within the Trust Annual Governance Statement. This should be jointly signed by the Chief Nurse and the Medical Director.

3 Methodology

3.1 Since 2011 WWL has undertaken adult nursing establishment review on a quarterly basis changing to bi-annual in line with National Guidance; March, and September utilising the Safer Nursing Care Tool™ (SNCT). This tool was developed in collaboration with the Association of United Kingdom Hospitals (AUKUH) utilising the research evidence undertaken by Keith Hurst[7]. The tool is recognised by the Quality Management Board (QMB)[8]. SNCT utilises methodology to determine the staffing required to deliver nursing care to patients within a given area dependent on actual individual patient levels of acuity and dependency. The tool also takes into consideration patient flow and nurse sensitive indicators (NSI's) in determining the appropriate level of care. Professional judgement is required to determine the skill mix of the staff employed within each area, and to assess the variability of staffing requirements which may be affected by changes in acuity and dependency levels of patients, and the environment that the patients are cared for (e.g., individual ward layout).

3.2 In January 2019 the Trust invested in SafeCare, a system that allows the measurement of the acuity and dependency needs of patients within inpatient areas to determine the hours of care required by the patient occupying the beds.

4 Safer Nursing Care Tool (SNCT)

4.1 The Trust utilises SNCT to determine the acuity and dependency of patients within our hospital. The tool incorporates agreed multipliers for adult and paediatric inpatient and assessment areas. Descriptions of the multipliers can be found at Table 1. Staff undertake assessment of the acuity and dependency needs of patients twice daily during their shift and this information, aligned with actual staffing levels on the wards, provides an indication of whether there is surplus or insufficient nursing time available to deliver care to the patients in each clinical area.

4.2 Professional judgement should be applied to the data provided by SNCT to ensure there is due consideration of environmental factors and skill mix, and triangulation quality outcomes and nurse sensitive to assist in the determination of the establishment required.

4.3 The Trust holds current licences to utilise the SNCT within adult inpatient areas, children and young people's inpatient areas, the emergency department (ED), and a Community Safe Nurse Staffing Tool (CSNCT). The Community Safe Nurse Staffing Tool is currently in beta testing prior to being finalised by the National Team. At the time of writing, a release date for the finalised tool has not been released. This report includes the findings of the ED Safe Staffing Tool from the data captured in September 2024.

[7] Hurst, K (2012): *Safer Nursing Care Tool Staffing Multipliers (2012) – Method and Results*

[8] Quality Management Board (2013): *How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.*

4.4 When establishment reviews are undertaken additional SNCT data is collected at 1500hrs across all participating areas for 30 consecutive days. This data is verified to provide assurance with regards to the accuracy of the assessment of the patients and to prevent gaming; gaming is the term used when the needs of the patients are scored higher than required.

4.5 There is a rolling programme of training for B7 and B6 clinical leaders to provide further assurance that staff are consistently scoring patients care needs correctly. Additionally, the Associate Chief Nurse for Safe Staffing has undertaken refresher training of the assessment of patients and delivery of training.

5 Quality Indicators

5.1 Data with respect to hours of time required based on acuity and dependency cannot be taken in isolation but must be considered alongside quality metrics, which provide an indication of outcomes and avoidable harms that occur within our clinical areas. These are reported monthly to the Trust Board within the performance report and included in the safe staffing reports received quarterly by Q&S. These metrics are CDT rates, number of falls, number of pressure ulcers, number of medicine administration errors and number of red flags reported, and these referred to as Nurse Sensitive Indicators (NSI's).

5.2 An increase in harms or red flags provides a trigger to senior nursing staff that staffing may either be inadequate for patient need or the skill mix may be incorrect resulting in delays/omissions of care.

6 Professional Judgement

6.1 Allied to the use of SNCT is the use of Professional Judgement (PJ) to confirm appropriate staffing levels. This is a bottom-up approach to the determination of staffing levels based on the judgement of experienced nurses to agree and determine the number and grade of staff required to provide care on a specific ward. PJ enables the consideration of the environment and skill mix/experience of staff to inform decisions about establishment setting. This is agreed with Divisional Directors of Nursing and includes the agreed allowance for the uplift of staff.

7.Skill Mix

7.1 The RCN[9] recommends a ratio of 65:35 registered nurses/unregistered staff in inpatient areas and 70/30 for assessment areas. Following nursing establishment review in 2017 the Trust Board agreed the minimum ratio for registered/unregistered staff was to be set at 55:45 and 65:35 within assessment areas.

7.2 The reduction in the ratio of registered nurses to unregistered nurses does affect the ability of the Trust to release staff to support the delivery of care during periods of operational pressures without reliance on temporary staffing to back fill. The reduction in the ratio of registered nurses

[9] RCN (2010): *Guidance on safe nurse staffing levels in the UK*

also impacts on the ability to provide oversight of patient care, and RN direct scrutiny, assessment and evaluation of care delivered to our patients.

8 Uplift

8.1 The RCN recommend that nursing establishments are uplifted by 23% to support study leave, annual, and sickness/absence; NHSI/SNCT recommend that the uplift in staffing is 22-25%. Trust Board agreed previously that the uplift would be set at 20% and this has remained unchanged. Across Greater Manchester the average uplift is 23%.

8.2 It is recognised that the Trust has undertaken a review of mandatory training requirements, supernumerary periods of time for staff new to post, and preceptorship packages for staff. It is recommended that further review of the uplift for staff is considered in 2025/26 as part of the biannual staffing review process, taking into consideration sickness targets, study leave and annual leave.

9 Supervisory Ward Leaders

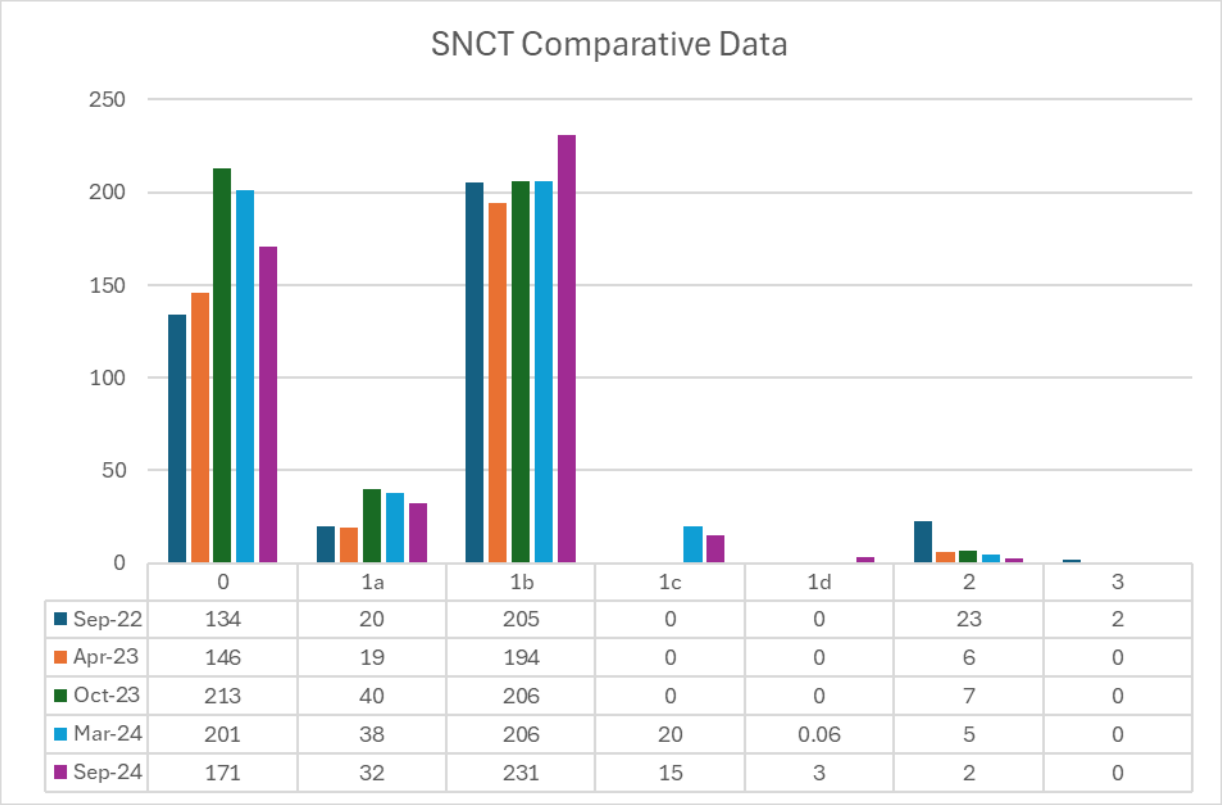
9.1 The Trust Board approved the funding of supervisory ward leaders in October 2021 as art of the strategy to improve local leadership and quality across inpatient areas.

10 Position Regarding Acuity and Dependency.

10.1 Comparison of acuity and dependency data is provided in Charts1.

10.2 When considering the categorisation of patients', it should be noted that patients in categories 1a, 2 and 3 should all be regarded as being acutely unwell. It would be expected that any patients assessed as Level 3 on an inpatient ward would be awaiting transfer to an ITU bed.

10.3 Level 2 patient needs are aligned to a requirement for either level 2 care, enhanced respiratory care, e.g. CPAP/BiPaP, or those patients who are acutely unwell requiring a lot of registered nurse input but for whom the ceiling of care is at ward level.



	0	1a	1b	1c	1d	2	3
Sep-22	134	20	205	0	0	23	2
Apr-23	146	19	194	0	0	6	0
Oct-23	213	40	206	0	0	7	0
Mar-24	201	38	206	20	0.06	5	0
Sep-24	171	32	231	15	3	2	0

Chart 1

10.4 Whilst level 1b patients do have greater dependency needs, registered nurses are still required to prescribe and assess the effectiveness of care delivered to our patient. Patients within this category may also have complex discharge needs, safeguarding needs and complex dressings that require registered nursing time and, therefore, it should not be assumed that all the care for these patients can be provided by unregistered staff. The data in chart 1 indicates that there has been an increase in the number of patients whose care needs are recorded at this level in September 2024. This triangulates with the capacity pressures experienced in month and the above recommended number of patients who remain in inpatient beds who are awaiting finalisation of discharge plans.

10.5 Level 1c patients are those patients who are receiving 1:1 care by staff paid for from ward budgets. Currently additional staffing is used to augment substantive staffing to provide this level of care. The data in Chart 1 demonstrates the ongoing progress to scrutinise the requirement for enhanced care across the Trust. The average number of patients receiving 1:1 care reduced by 5 patients/day from the previous report received.

11 Nurse Sensitive Indicators (NSI's)

11.1 NSI's are measures and indicators reflecting the structure, process and outcomes of nursing care. These measures help to reflect the impact of care that nurses working in inpatient services provide. In addition, they assist in determining the link between the care provided and funded staffing establishment within the ward. NSI data is reported monthly to Board within the Safe Staffing Report.

11.2 Strong visible leadership is key to the maintenance of high standards, avoidance of harms and continuous quality improvement. It is therefore recommended that the number of budgeted Band

6 staff within inpatient areas is standardised to ensure senior leadership presence throughout the 7- day, 24-hour continuum. This will also offer greater opportunity for staff progression and assist in recruitment and retention of staff.

11.3 Progress with ward assessment against standards of care has continued across adult inpatient areas and is regularly reported via quarterly Aspire reports to Quality and Safety Committee.

11.4 The Trust also receives quarterly reports detailing progress made with harm free care with specific focus on the reduction of falls and pressure ulcers acquired within our care.

11.5 For the purposes of this report NSI's will be captured alongside divisional information to support triangulation of information and provide the rationale for the recommendations with regards to staffing requirements.

.**12 Current Position, SNCT and Professional Judgement**

Division of Medicine

12.1 Data relating to the Division of Medicine can be found in Appendix 1.

12.2 Across the division of Medicine inpatient areas there has been significant use of temporary spend above the funded establishment, the main reasons for this being additional staff required to deliver enhanced care to patients, sickness and vacancy. Apart from ASU, Winstanley, CCU and Bryn Ward North, WTE used have been more than the funded WTE for the clinical area.

12.3 It should be noted that whilst the categorisation of patients utilising SNCT is of benefit, the tool is not effective in small bed bases which accounts for the significant discrepancy in SNCT recommended staffing on CCU. It should also be noted that the recommended staffing levels would be insufficient to staff the ward 24/7.

12.4 Appendix 1 Chart 4 provides detail of the acuity and dependency of the inpatients within the division and comparative data from the March 2024 SNCT data capture.

12.5 Throughout the data capture period it should be noted that on average there were 15 patients where the division advised the patient was receiving 1:1 care.

12.6 As previously mentioned within section 11 of the report NSI's are provide a helpful indication of nurse staffing risk factors. Appendix 1, chart 6 provides detail of the NSI indicators for the inpatient areas in the Division of Medicine that were reported during the data capture period.

12.7 When considering the data provided above the following points should be taken into consideration.

- There were 45 incidents reported, a reduction of 8 from the March report, and 61 nursing red flags during the data capture period, an increase of 43 red flags since the March report. Of the red flags reported 88.5% related to a shortfall in RN time.
- Thirty-five falls in total were reported across the division, with Lowton and MAU having the highest number of reported falls (16 in total).
- Drug administration errors were reported to have occurred on 2 of the 11 wards a reduction of 6 since the previous report received. There were no specific themes or trends.

12.8 There are no proposed increase/decrease to the establishment of the following areas: CCU, Pemberton, ASU, Shevington, Bryn Ward North and MAU, however the division has reviewed the

skill mix in these areas and made recommendations to the AFC WTE bandings of staff within the clinical area. The proposed skill mix requirements for each area can be found at Appendix 1

12.9 Astley Ward has the highest proportion of patients requiring 1:1 care of any of the medical inpatient wards and the highest number of patients at level 1b. There have been 3 falls reported in the area which all occurred on the day shift. The division recommend an increase of 5.38 WTE B2 staff (an additional HCA per shift throughout the 24-hour period) to ensure that there are sufficient staff to care for the dependency needs of their patients. This will also support the reduction in temporary spend associated with the 1:1 needs of the patients.

12.10 Lowton Ward has a higher bed base than MAU and a smaller establishment. Currently the clinical area is constantly short of hours required to deliver care to patients on SafeCare and this is reflected in the SNCT recommended staffing levels also. There were 7 falls reported in the 30-day data capture period. This area is also White on the Aspire accreditation. The division proposes an increase of 2.69 WTE B2 staff to provide an additional unregistered staff member overnight. There is a vacant B3 discharge assistant post on the ward and this funding could be used to offset some of the cost of the investment.

12.11 Winstanley Ward houses the Enhanced Respiratory Unit (ERU) with 7 beds. Patients within this area should be receiving non-invasive respiratory support and therefore the patients are categorised as level 2 patients. September data captured indicates that the demand for NIV and CPAP within ERU is an average of 2.43 patients' day/ whilst in March 2024 the demand was on average 2.14 patients/day. Data captured in April and October 2023, indicated the demand for level 2 care was on average 1.5/patients' day. SNCT suggests that the required staffing for the clinical area is 41.25 WTE staff against a funded establishment of 54 WTE. It is also of note that there have been mixed gender breaches associated with the ERU as these beds are being utilised to deliver care outside of the agreed criteria. For purposes of triangulation, it should be recognised that there has been low bed occupancy in critical care throughout the financial year, therefore consideration of the requirement for a bespoke ERU is required as these patients could be cared for by Critical Care staff thereby maximising use of staff in this specialist area supporting the ability to utilise staff to support peaks and troughs in activity and providing resilience within the workforce.

12.12 It is acknowledged that Ince Ward function has changed from being solely cardiology to being a combination of cardiology and general medicine. This ward is also currently assessed as White according to the Aspire accreditation. The reported harms in the area have all occurred at night. The division plan to move an unregistered staff member from days to nights to assist in the mitigation of risk. There are no other recommendations for establishment change in this area.

12.13 Although SDEC is not an inpatient area, the division have taken the opportunity to review attendance and staffing requirements for this area for completeness. It should be noted that 60-80% of patients admitted to SDEC required triage; triage is required within the first 15 minutes of presentation to the area. The clinical area is unable to support this KPI within the existing workforce and, therefore, consideration of how the service can be best supported with staffing across urgent and emergency care is required over the forthcoming year.

12.9 The Trust has utilised the ED SNCT for the first time and the data for the area can be found in Appendix 1 Charts 7-11. Unlike the inpatient areas data is captured over 12 days at 12 hourly intervals. This enables the information to be used to look at hourly occupancy and

acuity/dependency throughout a 24-hour period. UTC data was not captured during September but will be included in future reports. Furthermore, the Clinical Decision Ward (CDW) and ED Nurse staffing have merged due to the functionality of both areas coming directly under the Emergency Department, therefore patient being cared for in this area have been included within the ED data capture.

12.13 It should be noted that the department was in escalation at the time of the data capture, therefore patient numbers assessed include patients being cared for on the corridor area; this area not currently funded substantively and is a primary driver for the use of temporary staffing across the Adult ED area.

12.14 Annual attendances for adult ED have been reported at 100052 with PECCs annual attendances being 20037.

12.15 There are 6 descriptors of levels of care for the ED Department; broad details of the descriptors can be found in Appendix 1 Charts 10 and 11. The same descriptors are applicable to both Adult and Paediatric ED areas, however the multipliers for paediatric areas are slightly higher.

12.16 The Trust agreed a business case 2023 to increase the registered nurse to patient ratio in ED from1:5 to 1:4 in line with national guidance. The ED SNCT tool advocates a registered nurse proportion of 86.2%; the Trust actual proportion of funded registered staff is 86%.

12.17 The current RN position in ED is at the required establishment following national guidelines of a 1:4 nurse to patient ratio and correct resuscitation patient ratio to cubicle space. However, it should be noted that on average there are at least 12 patients awaiting inpatient beds across majors and therefore staffing for these patients could be flexed to that of an assessment area with the patients being nursed on a 1:6 ratio.

12.18 It has been noted that the number of breaches reported within UTC is increasing associated with an increase in patients being streamed directly to the area. The breaches are occurring as patients are waiting for treatments to be completed following medical review and the workforce within the area is insufficient to ensure that all patients are treated within 4 hours. Capacity pressures associated with escalation in ED is negating the ability to move staff to support. If the number of patients allocated to an RN with a decision to admit is reviewed, then there will be sufficient staff to flex to meet the requirement in UTC.

12.14 PECC funded establishment is 14.0 WTE staff. SNCT advises that the correct staffing for the volume of patients attending PECC should be 24.2 WTE. It can be seen from the chart in Appendix 1 Chart 8 that the Division has been utilising temporary staffing (average 12.8 WTE) to augment the staffing in the department, and therefore the substantive staff worked, and the temporary staffing used is in line with the SNCT advisable staffing levels. To meet the recommended staffing requirements, it is recommended that the establishment is increased by 5.38 WTE RSCN's, this will also address the registered nurse to patient ratio to promote safe, quality care.

Division of Surgery

12.15 The divisions funded WTE v SNCT recommended WTE can be found in Appendix 2 Chart 1.

12.16 Based on the nursing care needs across the surgical inpatient wards Orrell and Swinley wards are under-established to meet the needs of the patients. It should be noted that from April 2024

Langtree ward's funded establishment has been increased following the change of function of Bryn Ward and therefore this has now been rectified.

12.17 Langtree ward staff rostered and temporary staffing WTE is now in line with the funded establishment staffing. The suggested revised skill mix for the division can be found at Appendix 2 Chart 5.

12.18 Appendix 2 Chart 3 provides detail of the acuity and dependency needs of the patients within the division.

12.19 Orrell Ward admits predominantly surgical patients. Over the reporting period the ward has cared for several patients with increased acuity which has highlighted a shortfall in the staffing establishment for the clinical area. It is proposed that Orrell Ward use will be changing to a combined Surgical Assessment Unit (SAU) comprising 6 beds with the remaining 11 beds being utilised for surgical patients.

12.20 On average there were 3 patients a day receiving 1:1 care within the division which requires the greatest demand for this level of care was on Orrell Ward and this is reflected in the WTE temporary staffing required for the clinical area.

12.21 Swinley Ward has remained occupied by high numbers of medical outliers with an associated increase in the dependency of patients occupying the inpatient beds. It was noted in the June 2024 Bi-annual Staffing Review to Board that the plans to merge the Early Pregnancy Unit (EPU) on the Leigh site had not come to fruition and, in response to harms reported due the change in profile of patients in the area, the division has utilised temporary spend above funded establishment to mitigate the risk of harm to patients (Appendix 2 Chart 3). Consequently, SNCT has continued to reflect a need to increase the establishment for the clinical area.

12.21 When considering the data provided in Appendix 2 Chart 4 relating to the NSI the following points need to be taken into consideration.

- Nursing red flags are not frequently raised across any of the inpatient surgical wards, and the only type of red flag being raised were in relation to a shortfall in registered nurse time.
- Seven inpatient falls were reported in total across the inpatient areas, one of which resulted in moderate harm to the patient and was reported on Swinley Ward; this is an increase in the number of reported falls since the March 2024 data capture period. It was noted that there were no omissions in care.
- Three medication administration errors were reported all of which were no harm incidents.
- Ten pressure ulcers were reported across the inpatient wards which did not result in moderate or above harm to the patient; this is an increase from the 1 pressure ulcer reported in the March 2024 report. It should be noted that increased incident reporting can be attributed to increased attendance at Divisional Patient Safety Group, support from the governance team on how to report and increased education on identification of pressure damage. 80% of the pressure ulcers were reported across Langtree and Orrell Wards.
- Langtree ward has a higher proportion of medical outlying patients than the other 2 wards which drives the demand for nursing hours and for enhanced care.
- One CDT was recorded within the surgical division. The Division continues to work with the IPC team to implement learning points from the review of patients.

12.22 Appendix 2 Chart 5 provides detail of a proposed establishment and skill mix for the surgical inpatient areas.

Specialist Services Division

12.23 The data provided in Appendix 3 Chart 1 provides the funded v the SNCT recommended establishment and the acuity and dependency of the clinical area.

12.24 Appendix 3 Chart 3 provides detail of the acuity and dependency needs of the patients within the division.

12.25 JCW is a 16 bedded Private Patient facility which is comprised entirely of single rooms therefore the single room multipliers have been used to calculate the staffing required. The SNCT recommended aligns to the funded establishment, however it has been noted that rostered staffing is not aligned to activity. The division are proposing a change to the roster to align more closely staffing with demand and the revised staffing requirements can be found at Appendix 3 Chart 5.

12.26 Ward B is a 22 bedded inpatient area with a 50% split between bays and single rooms, therefore, the single room multipliers are applied when calculating staffing requirements in accordance with the SNCT methodology. It should be noted that there was a reduction in available beds associated with the agreed expansion and agree uplift in staffing of the Enhanced Care Unit (ECU), however the funded establishment for Ward B was not reduced at this time.

12.27 Ward A is a 28 bedded inpatient area with a 50/50 split of single rooms and bays and therefore the single room multipliers have been used when calculating staffing requirements. On average 22.2 beds were occupied during the data capture period. The SNCT recommended staffing is closely aligned to the funded establishment. As with the other two inpatient areas review of activity and bed occupancy has been undertaken and suggestions made to amend the roster demand template to reflect activity patterns.

12.28 Aspull Ward is a 28 bedded Trauma Orthopaedic Ward sited on the Royal Albert Edward site. SNCT data details that most of the patients in the clinical area require the assistance of 2 staff to support the patient care needs. The funded establishment for the area is slightly lower than the SNCT recommended staffing levels. It should be noted, however that there have been a considerable number of patient harms, red flags and complaints received relating to the quality of patient care, communication and visibility of the staff (Appendix3 Chart 4). There is a comprehensive quality improvement plan for the areas to address these concerns.

12.29 ECU is a perioperative unit caring for increased acuity patients post operatively. The patient to nursing ratio is 2:1. Occupancy can vary due to scheduling and staffing requirements will change dependant on patient needs. 6 beds are routinely staffed Monday to Thursday and 4 beds on a Friday. Weekend staffing is minimal which supports a deteriorating patient scenario to ensure an urgent clinical response to such incidences and where possible avoid unnecessary unplanned transfers to the acute site. The SNCT required establishment does not meet the requirements to staff the areas due to the size of the environment. It is therefore recommended that there are no changes to the current funded establishment levels.

Community Division

12.31 The data presented in Appendix 4 Chart 1 provides the funded v the SNCT recommended establishment.

12.32 The data indicates that in both areas the SNCT recommended establishment is higher than the current funded establishment.

12.33 The Community Assessment Unit (CAU) consists of 21 beds and the Jean Hayes Rehabilitation Unit (JHRU) has 24 beds. Both units have dedicated nursing and therapy resource. The therapy resource is involved in the delivery of direct care as part of their blended role working on the units.

12.34 Both units had 100% occupancy on average throughout the data capture period.

12.35 The data indicates that in both areas the SNCT recommended establishment is in line with the current funded establishment (once the additional 4.48 wte additional staffing for CAU is added to the establishment figure as part of 25/26 budget setting, the business case has already been approved). It should be noted that the 20% uplift for the additional HCA agreed has not been added to the staffing budget currently and therefore there will be a roster deficit when leave, sickness etc is taken resulting in a requirement for additional staff.

12.36 Due to the availability of community beds, we have seen a consistent higher acuity on Jean Hayes Reablement Unit which has increased the length of stay (Appendix 4 Chart 3). CAU, at times of Trust escalation, does see an increase in higher acuity patients being admitted to the unit. These patients often have higher levels of frailty and require more rehabilitation to facilitate their discharge home. There will be a focus over the coming months of ensuring that the unit delivers its proposed model of being a 72-hour short stay frailty unit with a co-located ambulatory care area. When this happens, it is expected that we will see a reduction in the number of level 1b patients on the unit, with more patients being assessed as Level 0 patients.

12.37 When considering the budgeted establishment against the worked and temporary staffing used CAU's worked and NHSP WTE are almost equal to the budgeted establishment for the area (Appendix 4 Chart 2).

12.38 NSI data for the 2 inpatient areas can be found in Appendix 4 Chart 4.

12.39 On CAU there were 5 reported falls over the course of the 30 days of data capture which is a reduction from the last census where 8 falls were reported. Previous reports have noted that the ward layout makes patient observation difficult and, because of the harms noted in previous reports, an additional Band 2 nurse is used on every shift throughout the 24-hour continuum so there is a nursing presence in each bay throughout all shifts. This resource has now been funded by the Trust, as stated at 12.36, and recruitment into these posts has commenced. These previously unfunded posts have been filled using NHSP Recruiting to these posts permanently will help develop consistent staffing which will help improve quality.

12.40 There is currently no recommendation to increase the staffing establishment within these two units within the community division. The hybrid staffing model currently in place on JHRU and the blending of roles results in some nursing' activities being undertaken by therapy staff alongside their therapeutic interventions. It is felt that the ongoing work to ensure the right patients are transferred to JHRU will mean more patients will be Care Level 0 and so the recommended SCNT level will align to the current funded establishment.

12.41 It is suggested that as both models of care on CAU and JHRU are adapted to ensure the right patients and cared for the on the units, the SCNT requirements will be aligned to the staffing establishments. Therefore, it is felt that the current staffing model is sufficient to meet the needs of the patients.

13 **Enhanced Observations**

13.1 NHSE recommends that staffing reviews take into consideration requirements for the delivery of enhanced care and as previously stated, this need to provide 1:1 and 2:1 care is now reflected in the categorisation of patient care within the SNCT tool.

13.2 Chart 1 in the main body of the report indicates that on average there were 15 patients/day who were in receipt of 1:1 care throughout September 2024. This a reduction from the average of 20 patients' day who were in receipt of 1:1 care in the March 2024 Biannual Staffing review. SNCT data also indicates that there was a slight increase in patients receiving 2:1 care in September 2024 than in March 2024; these patient's cares were being delivered on Shevington an Lowton Wards.

13.3 Current ward establishments do not contain any additional staff to support the delivery of enhanced care and temporary staffing is utilised to augment the workforce in these areas. The SNCT data suggests that an additional 52.47 WTE staff would have been required to meet the needs of our patient's. Analysis of the data from NHSP indicates 53.31 WTE staff worked under the booking code enhanced care during the data capture period.

13.4 The March 2024 review suggested that the Trust was an outlier in its use of enhanced care when benchmarked with other Trusts. The Associate Chief Nurse Safe Staffing has continued to monitor the Trust Demand for additional hours and benchmark demand against GM Trusts. This data now reflects that our demand is comparable or under that of similar sized organisations. The reduction in demand is aligned to workstreams to ensure staff are using least restrictive practice in the management of patients with complex needs, and the maintained focus on the appropriate use of additional staffing.

14 **Care Hours Per Patient Day (CHPPD)**

14.1 Care Hours Per Patient Day (CHPPD) is the metric recognised by NHS to benchmark staffing data (Appendix 5, Charts 1,2 &3). CHPPD includes total staff time spent on direct patient care and on activities such as preparing medicines, updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes student nurses and student midwives, and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight. When used in isolation, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective, or responsive. It should therefore be considered alongside measures of quality and safety and with the application of professional judgement.

14.2 The data is derived from planned and actual hours to be worked by registered and unregistered staff from e roster and divided by beds occupied at 23:59hrs.

14.3 The Trust overall CHPPD for September 2024 was 9.4. The GMICB provider median was 9.4 with the national provider median being 8.7.

14.4 Registered staff provided 5.1 hours of care on average/day which is the GMICB and national provider median suggesting that we are not an outlier in the care delivered by our registrants to our patients.

14.5 Unregistered staff provided 4.3 hours of care using the methodology advocated. This suggests that our patients receive more care from unregistered staff than the GMICB median (4.1) and the national median 3.5.

14.6 Details of overall CHPPD by ward can be found in Appendix 5, Chart 4.

15 Recommendations

15.1 The purpose of this report is to provide assurance that staffing levels within the Trust are safe and that there are sufficient staff to flex to the peaks and troughs of escalation, and to be responsive to patient needs. It should be noted that the Trust was in escalation at the time of the review resulting in high levels of outlying patients primarily on the surgical wards. The report has identified that there are sufficient staff within **cored funded areas** to meet these needs but identifies opportunity for further service and establishment review to provide greater resilience across the workforce.

15.2 The report highlights the high levels of temporary staffing being utilised by the Trust, particularly with regards to enhanced care and escalation, and that in some cases, the additional staff are not impacting on a reduction in avoidable harms, most notably falls which have increased from the previous report received.

15.3 Whilst the opportunity has been taken to skill mix on each of the inpatient wards at AFC bands 6, 3 and 2, the Chief Nursing Officer, in February 2025, as part of a wider workforce review and to support planning for winter staffing levels will revisit these proposals. This will include a capacity and demand review, supported by, a robust winter plan that has changes in specialties within its trajectory and therefore supports the acuity nuances in nursing staffing requirements i.e. Medical Outliers within the surgical footprint. This will also support professional judgement and granular level establishment setting across services.

15.4 This work will also support the development of a detailed prospective workforce plan that uses 2024/2025 data to support planned recruitment events aligned to university graduation dates for registrants.

15.5 The Division of Medicine presented a business case in 2024 requesting an increase in registered nurse staffing for the Paediatric Emergency Department and have been utilising temporary staffing to augment the workforce. The SNCT data indicates that this investment is required based on activity and acuity and dependency of children attending the department.

15.6 Within the Division of Medicine it is recommended that a service review of the Enhanced Respiratory Unit (ERU) is undertaken aligned to right patient, right care. This recommendation takes into consideration the underoccupancy of our Critical Care Unit and the skills held within this team to care for patients receiving respiratory support, and the mixed gender breaches that have occurred in both areas resulting from the inability to step people down from these areas when enhanced support is needed. It is recommended that the establishment on the ERU is reduced.

15.7 A review of staffing across Adult Urgent and Emergency Care areas is required to ensure that staff internal movement supports activity and demand and promotes delivery of care to patients in the right clinical area.

15.8 There are no recommendations to increase the establishment on the inpatient Community Wards, however it is noted that following investment in the B2 establishment on CAU, the headroom funding has not been allocated to the budget which will result in a requirement to backfill roster gaps with temporary staffing unless rectified.

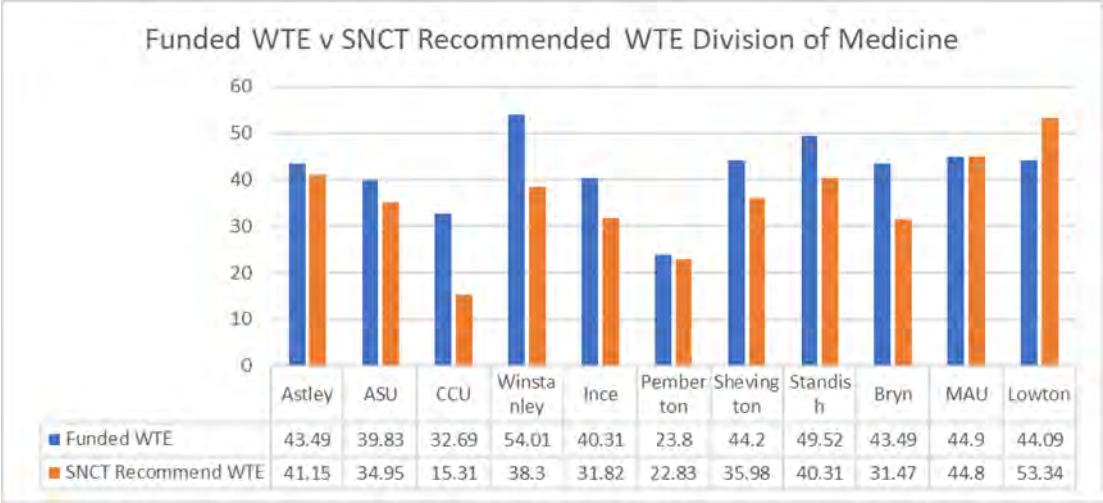
15.9 The Trust uplift for staffing remains at 20%. It is recommended that further review of the uplift for staff is considered in 2025/26 as part of the biannual staffing review process, taking into consideration sickness targets, study leave and annual leave.

15.10 It is recognised that further work is required to embed the use and ownership of SafeCare to support live assessment of patient acuity, deployment of staff in response to need and greater ownership at a divisional level.

15.11 A quarterly Health Care Assistant workforce recruitment plan that supports a pool of health care assistants that can be aligned to vacancies in a timely manner and reduce recruitment time and reliance on temporary staffing is to be developed.

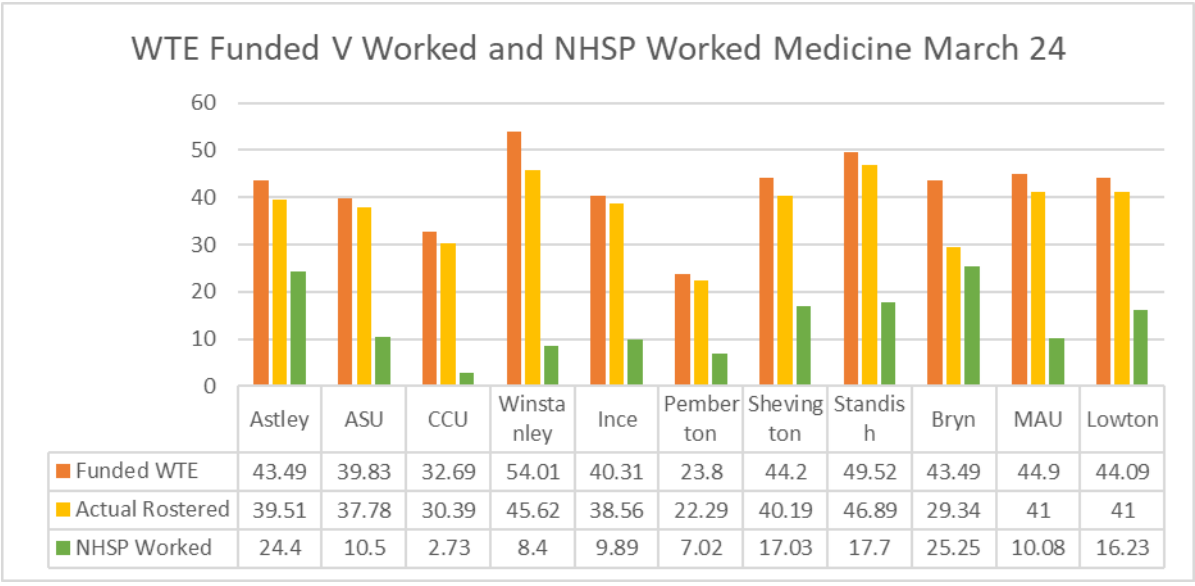
15.12 A programme of transformation will be developed aligned to nursing workforce that can support the review of roles, support blended ways of working to become more efficient, provide high quality care, clear succession plans, the efficiencies of which will support delivery of the Trusts Financial Sustainability Plan.

Appendix 1 Medicine



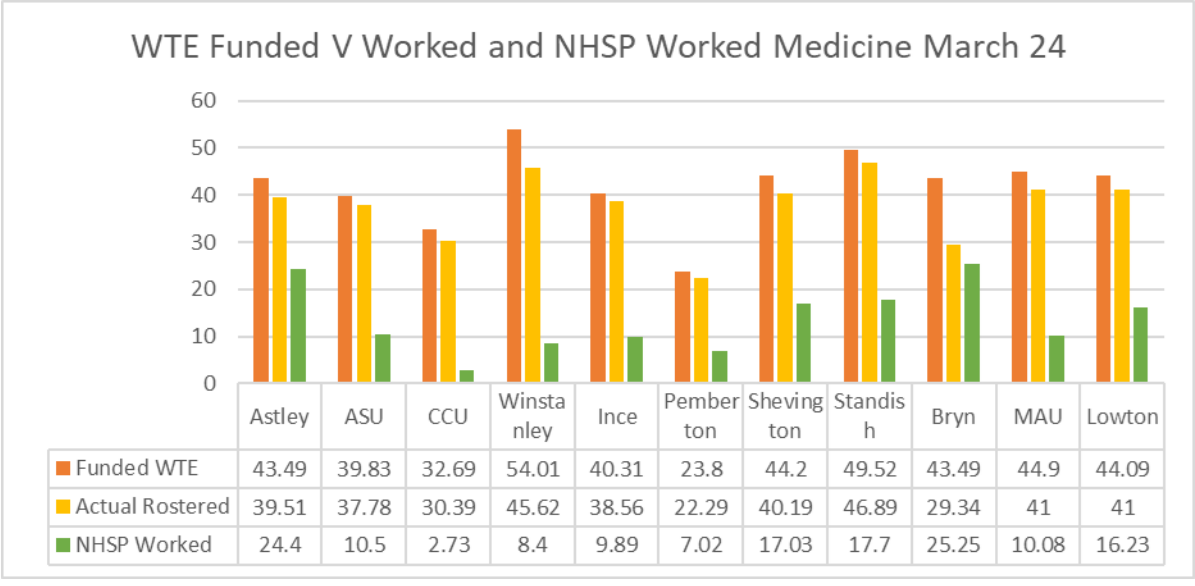
	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Funded WTE	43.49	39.83	32.69	54.01	40.31	23.8	44.2	49.52	43.49	44.9	44.09
SNCT Recommend WTE	41.15	34.95	15.31	38.3	31.82	22.83	35.98	40.31	31.47	44.8	53.34

Chart 1



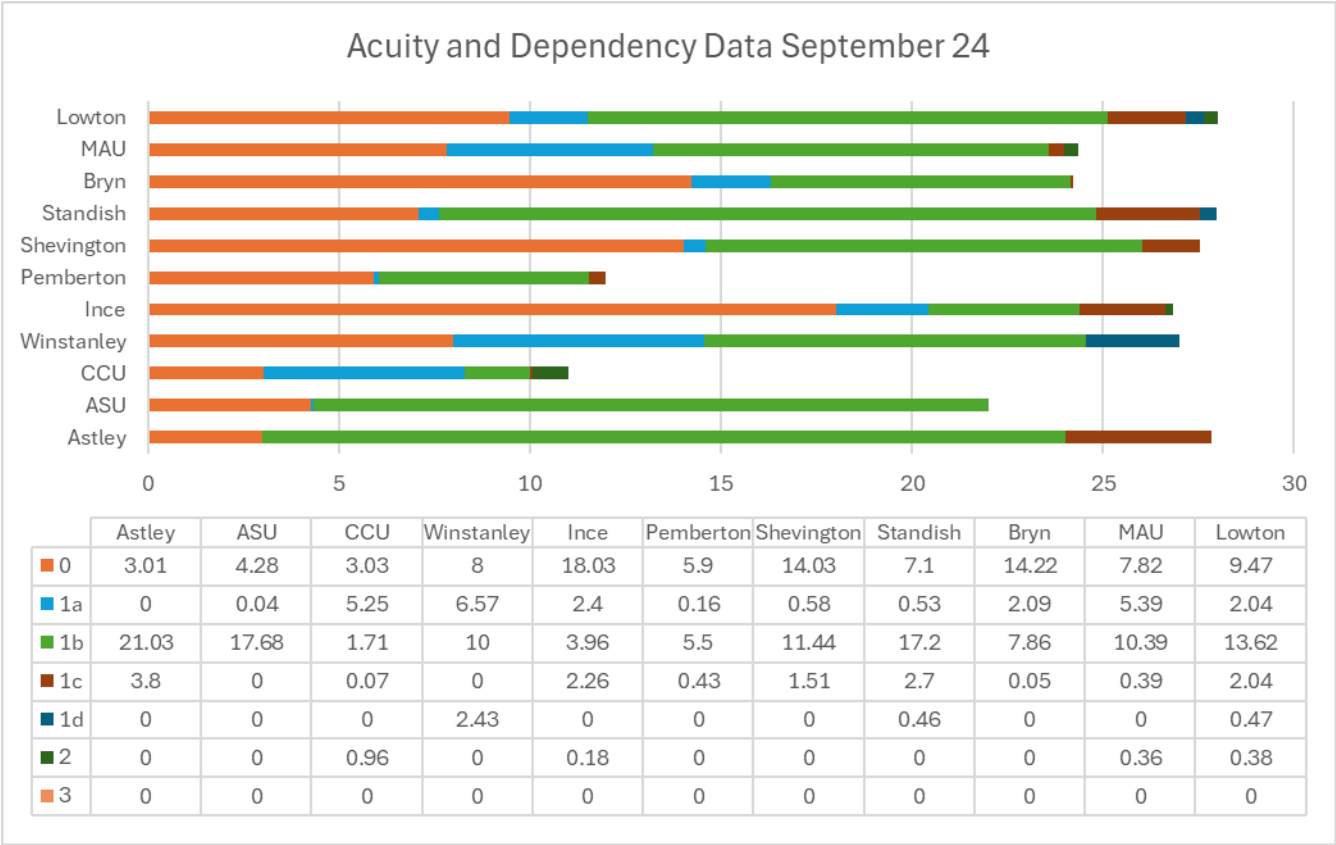
	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Funded WTE	43.49	39.83	32.69	54.01	40.31	23.8	44.2	49.52	43.49	44.9	44.09
Actual Rostered	39.51	37.78	30.39	45.62	38.56	22.29	40.19	46.89	29.34	41	41
NHSP Worked	24.4	10.5	2.73	8.4	9.89	7.02	17.03	17.7	25.25	10.08	16.23

Chart 2

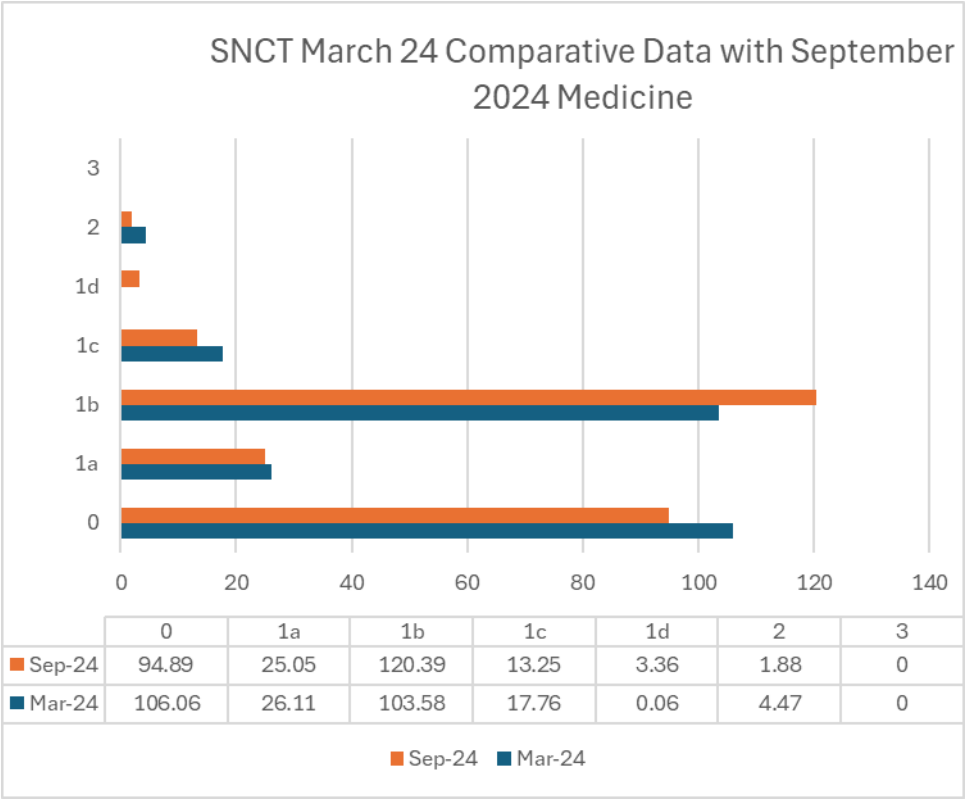


	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Funded WTE	43.49	39.83	32.69	54.01	40.31	23.8	44.2	49.52	43.49	44.9	44.09
Actual Rostered	39.51	37.78	30.39	45.62	38.56	22.29	40.19	46.89	29.34	41	41
NHSP Worked	24.4	10.5	2.73	8.4	9.89	7.02	17.03	17.7	25.25	10.08	16.23

Chart 3

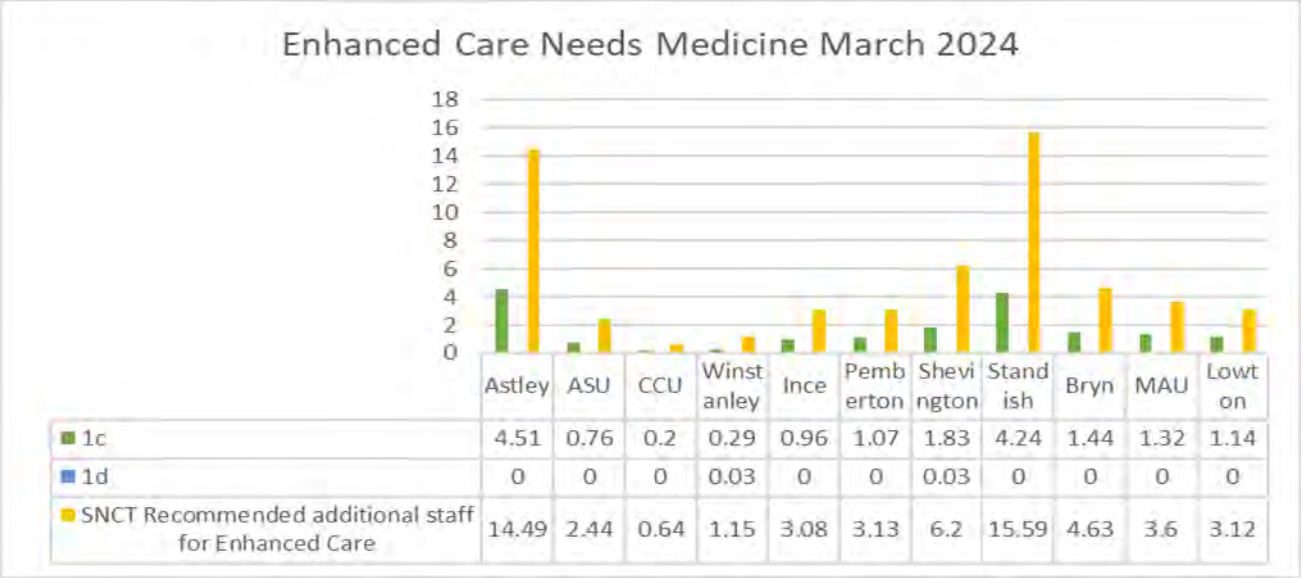


	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
0	3.01	4.28	3.03	8	18.03	5.9	14.03	7.1	14.22	7.82	9.47
1a	0	0.04	5.25	6.57	2.4	0.16	0.58	0.53	2.09	5.39	2.04
1b	21.03	17.68	1.71	10	3.96	5.5	11.44	17.2	7.86	10.39	13.62
1c	3.8	0	0.07	0	2.26	0.43	1.51	2.7	0.05	0.39	2.04
1d	0	0	0	2.43	0	0	0	0.46	0	0	0.47
2	0	0	0.96	0	0.18	0	0	0	0	0.36	0.38
3	0	0	0	0	0	0	0	0	0	0	0



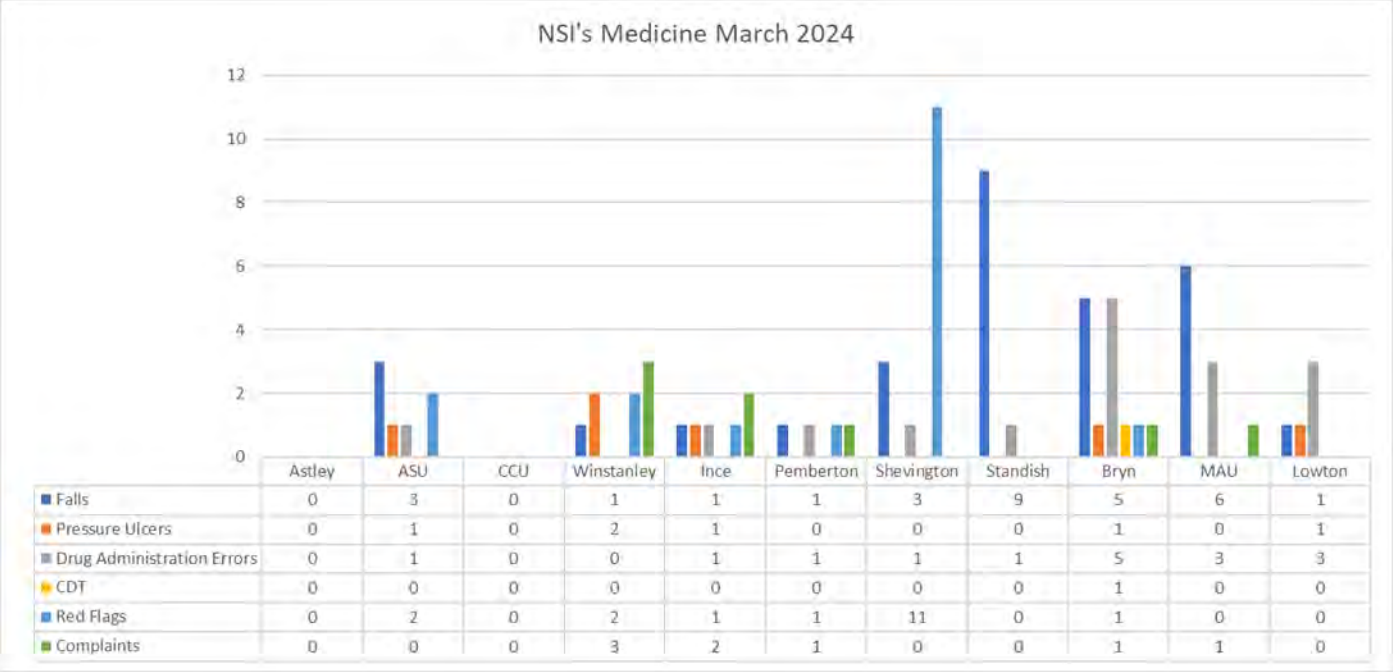
	0	1a	1b	1c	1d	2	3
Sep-24	94.89	25.05	120.39	13.25	3.36	1.88	0
Mar-24	106.06	26.11	103.58	17.76	0.06	4.47	0

Chart 4



	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
1c	4.51	0.76	0.2	0.29	0.96	1.07	1.83	4.24	1.44	1.32	1.14
1d	0	0	0	0.03	0	0	0.03	0	0	0	0
SNCT Recommended additional staff for Enhanced Care	14.49	2.44	0.64	1.15	3.08	3.13	6.2	15.59	4.63	3.6	3.12

Chart 5



	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	MAU	Lowton
Falls	0	3	0	1	1	1	3	9	5	6	1
Pressure Ulcers	0	1	0	2	1	0	0	0	1	0	1
Drug Administration Errors	0	1	0	0	1	1	1	1	5	3	3
CDT	0	0	0	0	0	0	0	0	1	0	0
Red Flags	0	2	0	2	1	1	11	0	1	0	0
Complaints	0	0	0	3	2	1	0	0	1	1	0

Chart 6

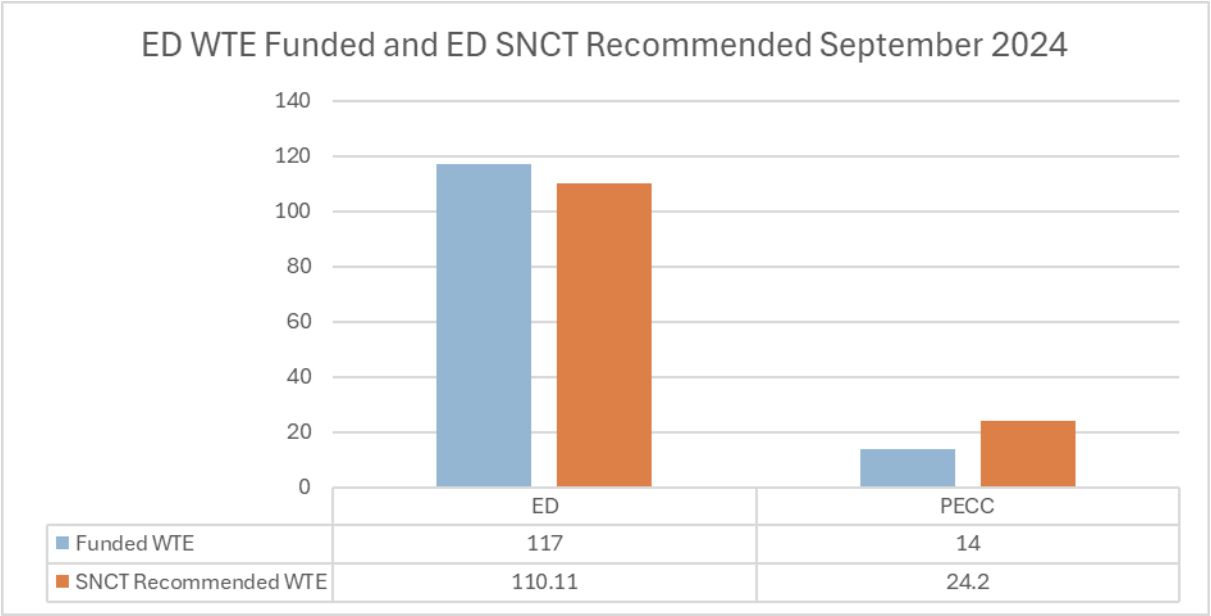


Chart 7

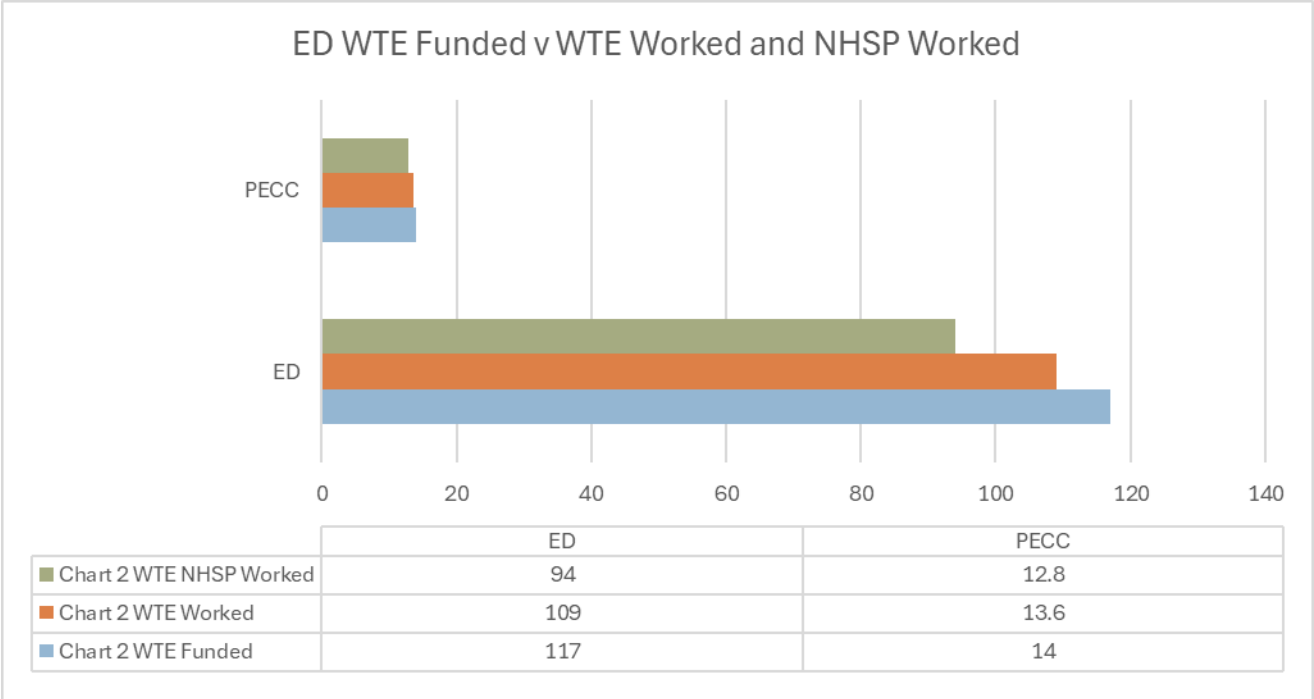
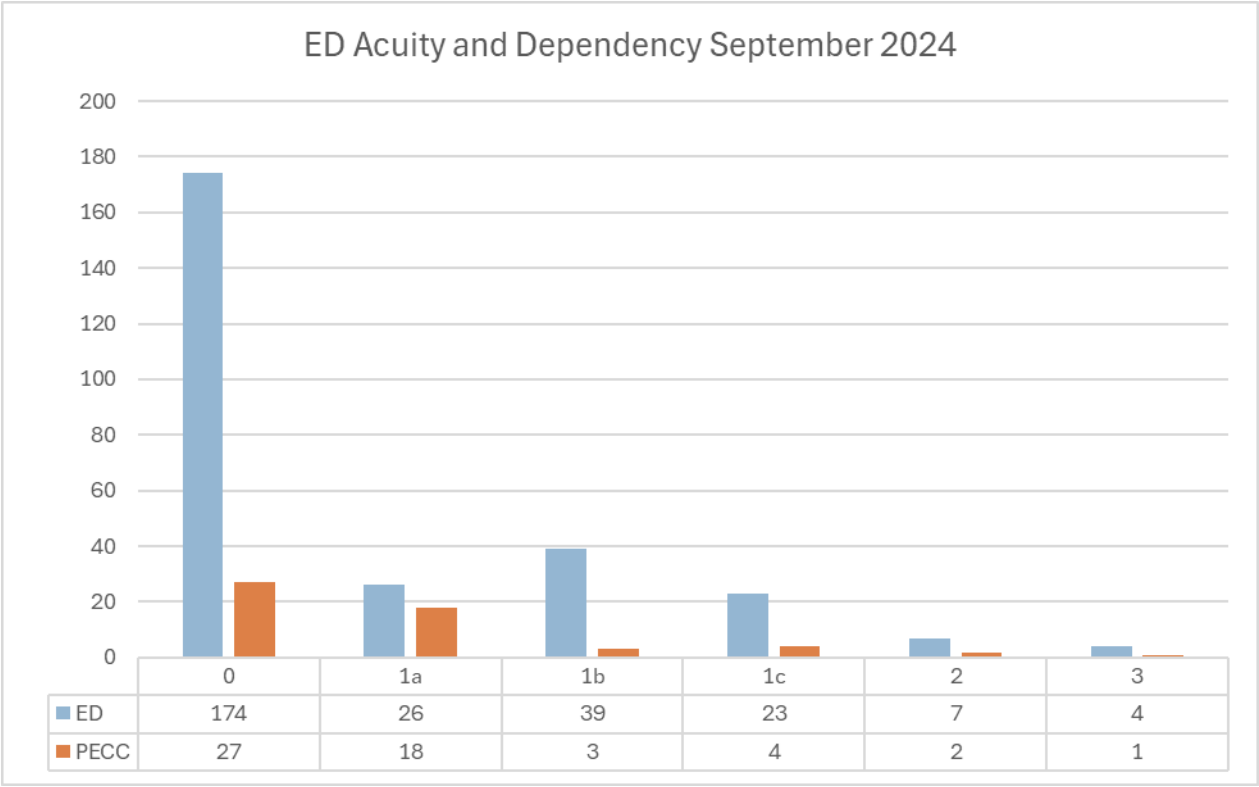
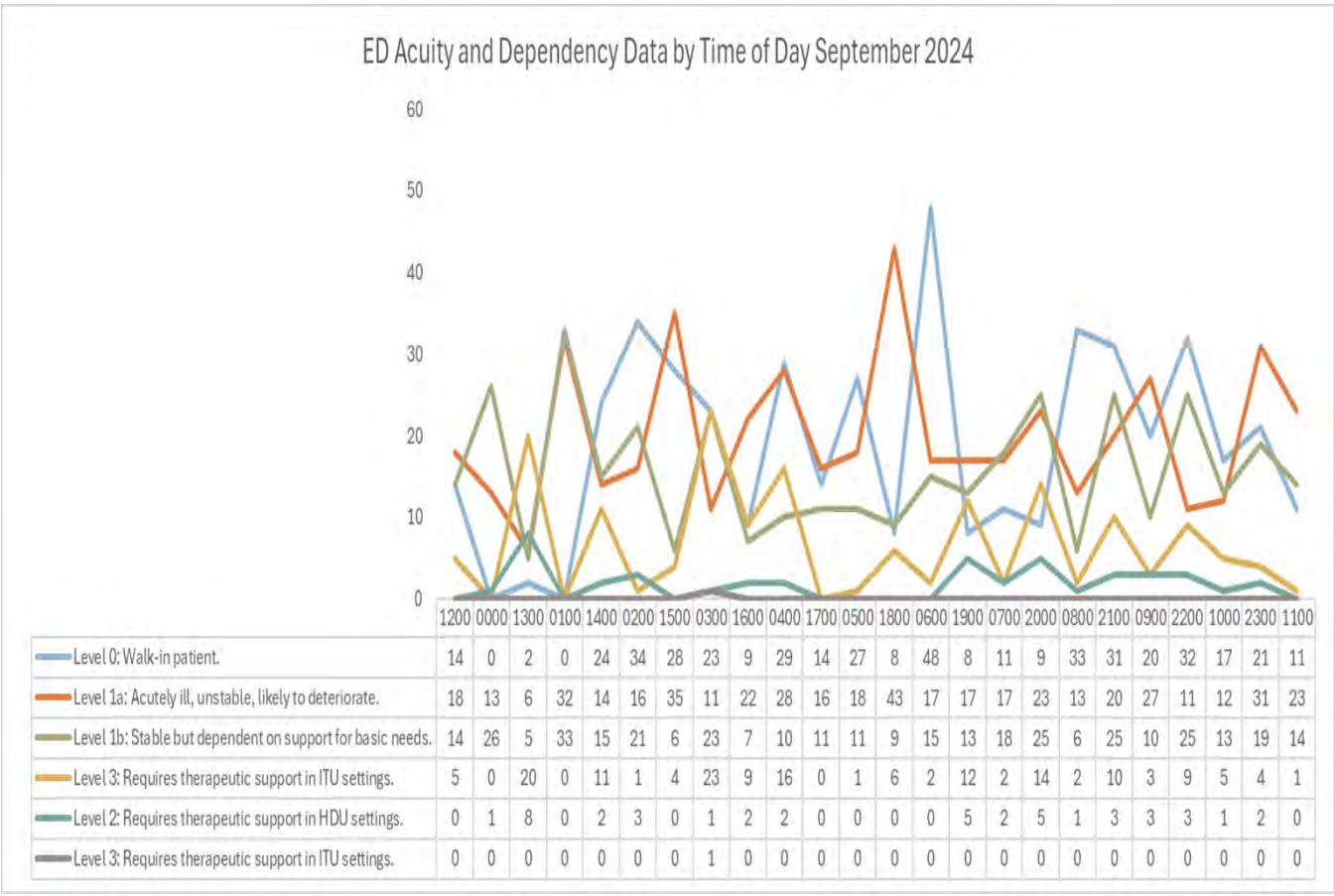


Chart 8



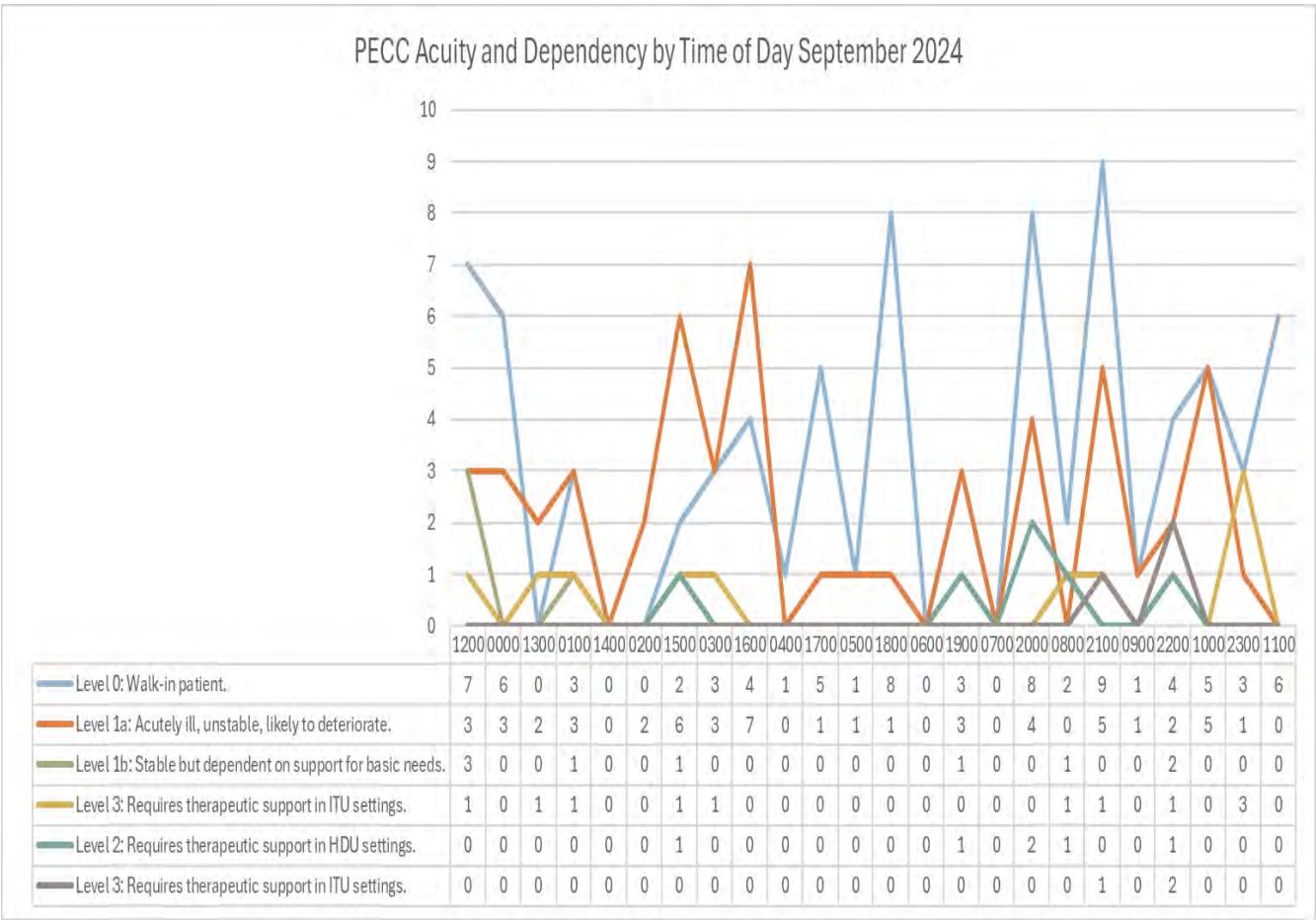
	0	1a	1b	1c	2	3
ED	174	26	39	23	7	4
PECC	27	18	3	4	2	1

Chart 9 ED A&D Average Daily Attendances ED



	1200	0000	1300	0100	1400	0200	1500	0300	1600	0400	1700	0500	1800	0600	1900	0700	2000	0800	2100	0900	2200	1000	2300	1100
Level 0: Walk-in patient.	14	0	2	0	24	34	28	23	9	29	14	27	8	48	8	11	9	33	31	20	32	17	21	11
Level 1a: Acutely ill, unstable, likely to deteriorate.	18	13	6	32	14	16	35	11	22	28	16	18	43	17	17	17	23	13	20	27	11	12	31	23
Level 1b: Stable but dependent on support for basic needs.	14	26	5	33	15	21	6	23	7	10	11	11	9	15	13	18	25	6	25	10	25	13	19	14
Level 3: Requires therapeutic support in ITU settings.	5	0	20	0	11	1	4	23	9	16	0	1	6	2	12	2	14	2	10	3	9	5	4	1
Level 2: Requires therapeutic support in HDU settings.	0	1	8	0	2	3	0	1	2	2	0	0	0	0	5	2	5	1	3	3	3	1	2	0
Level 3: Requires therapeutic support in ITU settings.	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

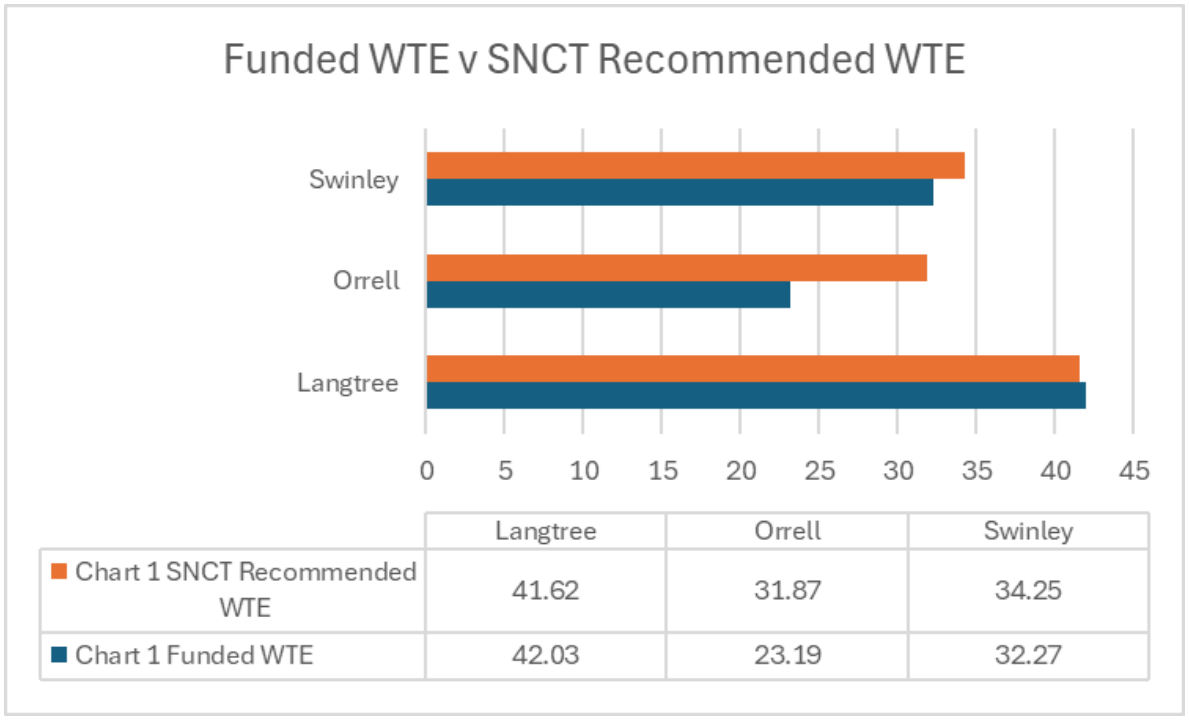
Chart 10 Adult ED A&D by time of day



	1200	0000	1300	0100	1400	0200	1500	0300	1600	0400	1700	0500	1800	0600	1900	0700	2000	0800	2100	0900	2200	1000	2300	1100
Level 0: Walk-in patient.	7	6	0	3	0	0	2	3	4	1	5	1	8	0	3	0	8	2	9	1	4	5	3	6
Level 1a: Acutely ill, unstable, likely to deteriorate.	3	3	2	3	0	2	6	3	7	0	1	1	1	0	3	0	4	0	5	1	2	5	1	0
Level 1b: Stable but dependent on support for basic needs.	3	0	0	1	0	0	1	0	0	0	0	0	0	0	1	0	0	1	0	0	2	0	0	0
Level 3: Requires therapeutic support in ITU settings.	1	0	1	1	0	0	1	1	0	0	0	0	0	0	0	0	0	1	1	0	1	0	3	0
Level 2: Requires therapeutic support in HDU settings.	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	2	1	0	0	1	0	0	0
Level 3: Requires therapeutic support in ITU settings.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0	0	0

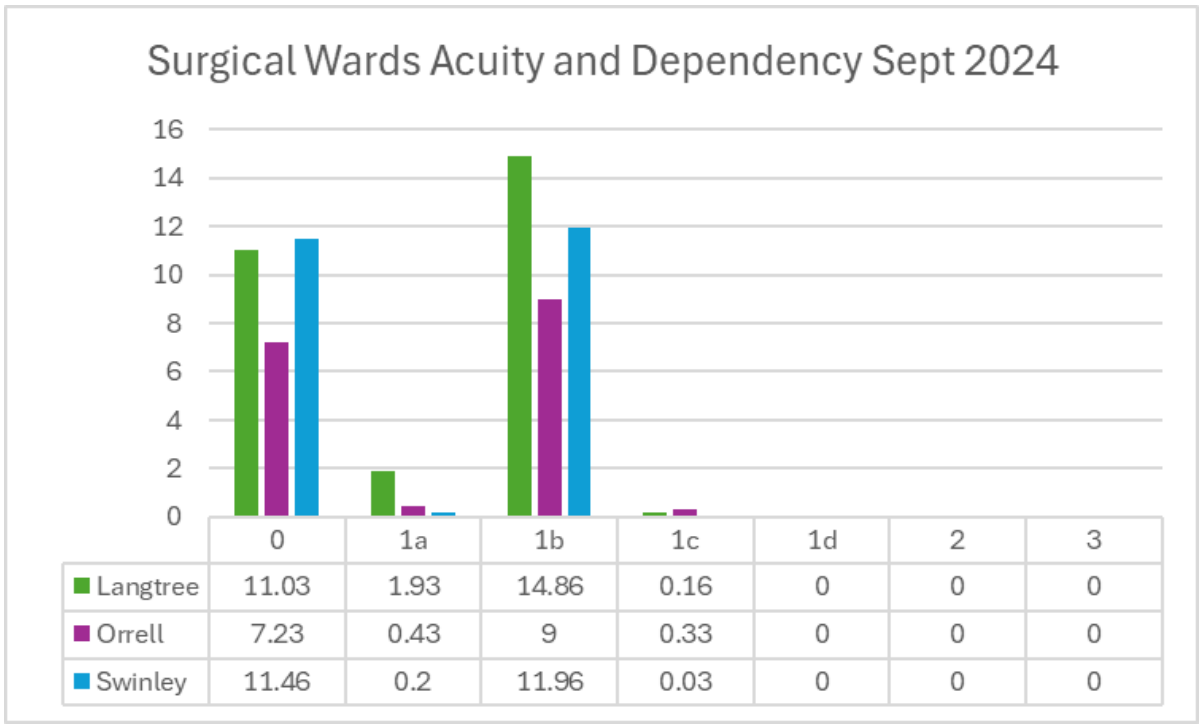
Chart 11 PECC A&D by time of Day

Appendix 2 Surgery



	Langtree	Orrell	Swinley
Chart 1 SNCT Recommended WTE	41.62	31.87	34.25
Chart 1 Funded WTE	42.03	23.19	32.27

Chart 1



	0	1a	1b	1c	1d	2	3
Langtree	11.03	1.93	14.86	0.16	0	0	0
Orrell	7.23	0.43	9	0.33	0	0	0
Swinley	11.46	0.2	11.96	0.03	0	0	0

Chart 2

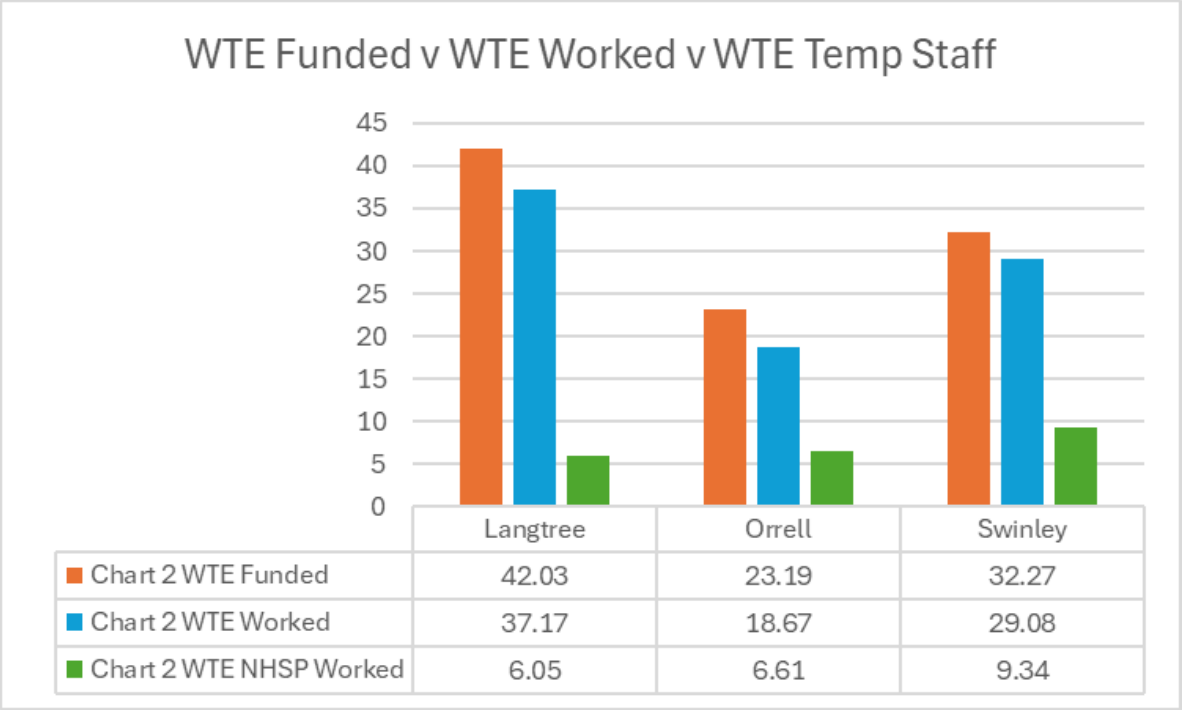


Chart 3

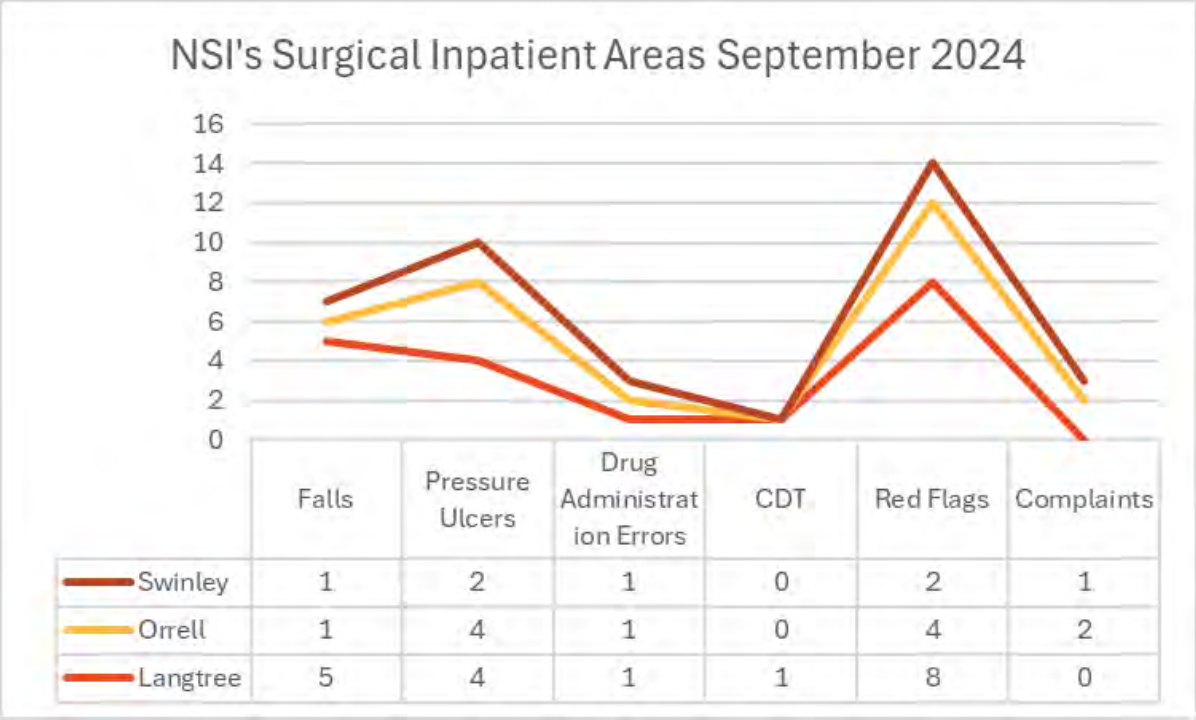
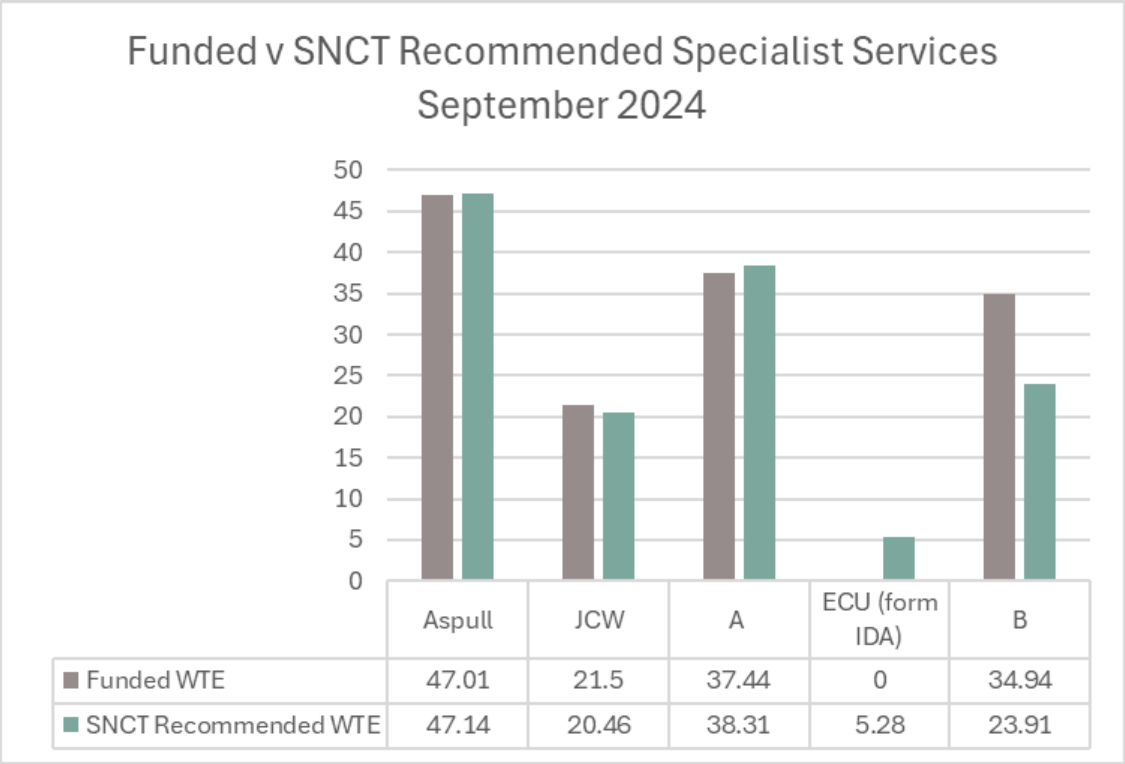


Chart 4

AFC Band	Langtree	Orrell	Swinley
	WTE RQD	WTE RQD	WTE RQD
Band 6	5.38	5.38	5.38
Band 5	18.82	10.75	13.42
Band 4	0.96	0	0.8
Band 3	5.38	5.38	5.38
Band 2	12.46	10.75	12.62
TOTAL	43	32.26	37.6

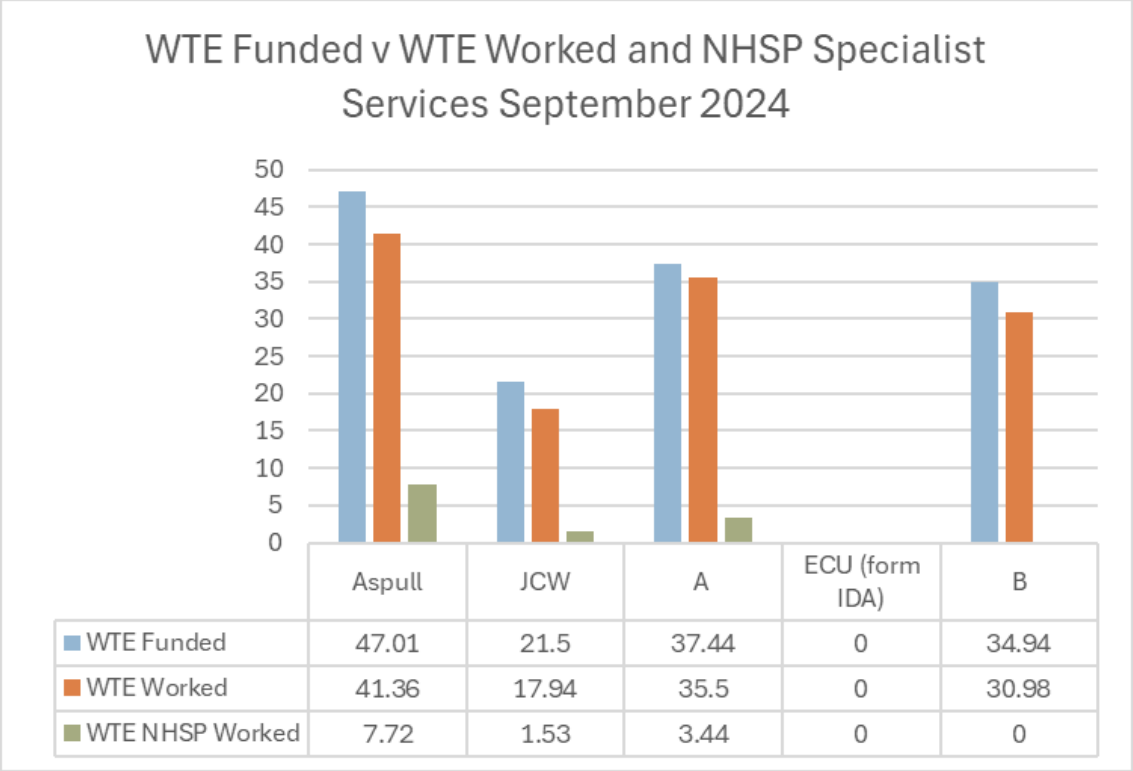
Chart 5 Suggested Revised WTE Required by AFC Band Per Inpatient Area Surgical Division

APPENDIX 3 Specialist Services



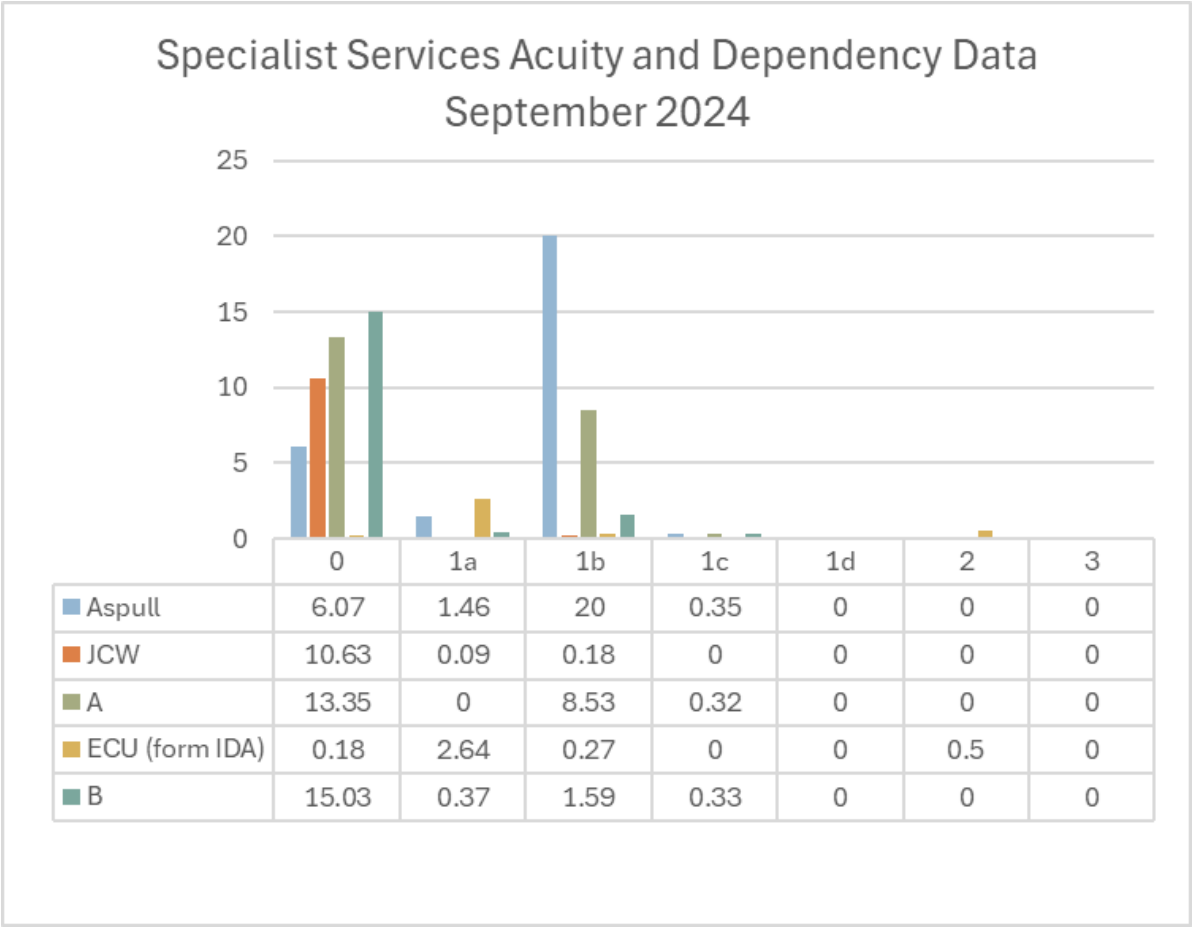
	Aspull	JCW	A	ECU (form IDA)	B
Funded WTE	47.01	21.5	37.44	0	34.94
SNCT Recommended WTE	47.14	20.46	38.31	5.28	23.91

Chart 1



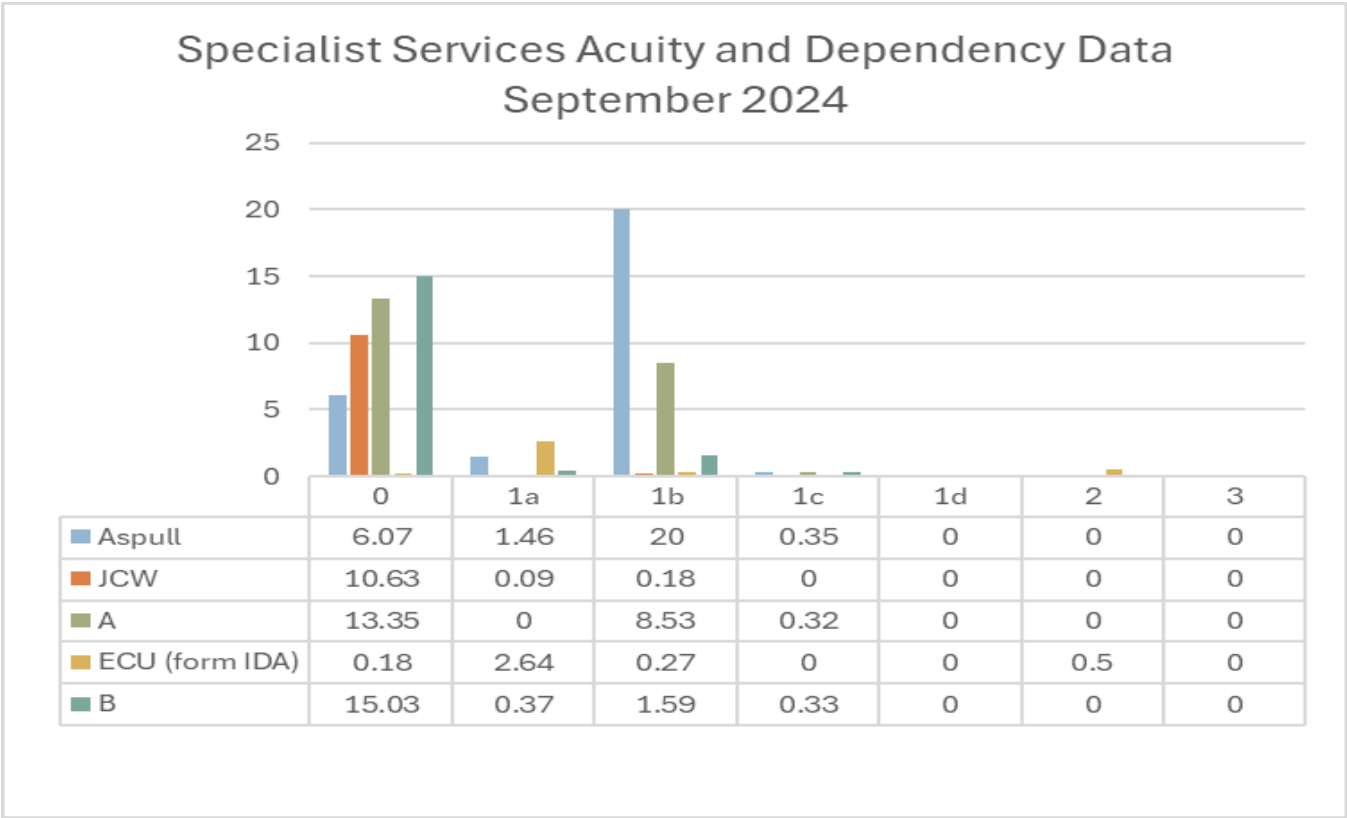
	Aspull	JCW	A	ECU (form IDA)	B
WTE Funded	47.01	21.5	37.44	0	34.94
WTE Worked	41.36	17.94	35.5	0	30.98
WTE NHSP Worked	7.72	1.53	3.44	0	0

Chart 2



	0	1a	1b	1c	1d	2	3
Aspull	6.07	1.46	20	0.35	0	0	0
JCW	10.63	0.09	0.18	0	0	0	0
A	13.35	0	8.53	0.32	0	0	0
ECU (form IDA)	0.18	2.64	0.27	0	0	0.5	0
B	15.03	0.37	1.59	0.33	0	0	0

Chart 3



	0	1a	1b	1c	1d	2	3
Aspull	6.07	1.46	20	0.35	0	0	0
JCW	10.63	0.09	0.18	0	0	0	0
A	13.35	0	8.53	0.32	0	0	0
ECU (form IDA)	0.18	2.64	0.27	0	0	0.5	0
B	15.03	0.37	1.59	0.33	0	0	0

Chart 4

AFC Band	Aspull	JCW	Ward A	Ward B
	WTE RQD	WTE RQD	WTE RQD	WTE RQD
Band 6	6.34	2.3	2.69	2.69
Band 5	18.82	9.41	16.13	14.21
Band 4	0	0	0	0
Band 3	10.75	5.38	4.99	4.99
Band 2	13.44	3.46	13.06	9.98
TOTAL	**49.35**	**20.55**	**36.87**	**31.87**

Chart 5 Suggested Revised Skill Mix and Staffing Requirements Specialist Services

Appendix 4 Community Services

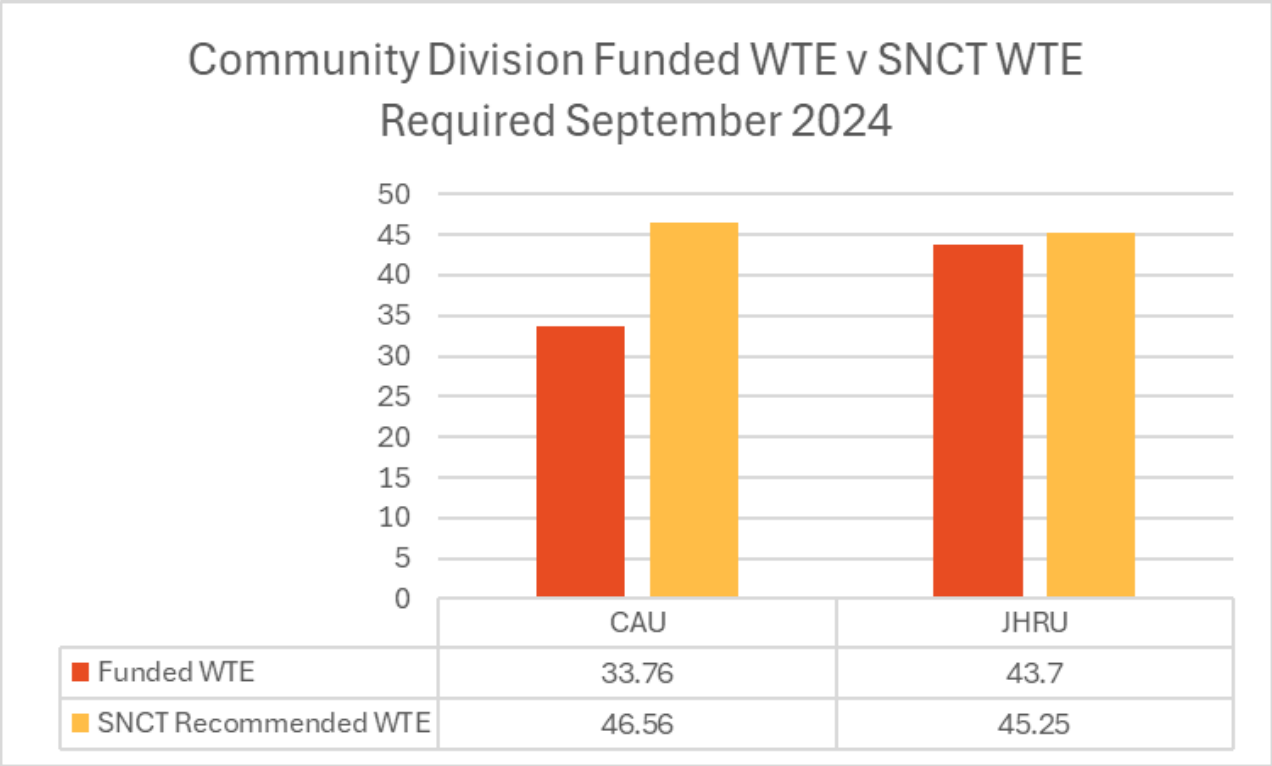


Chart 1

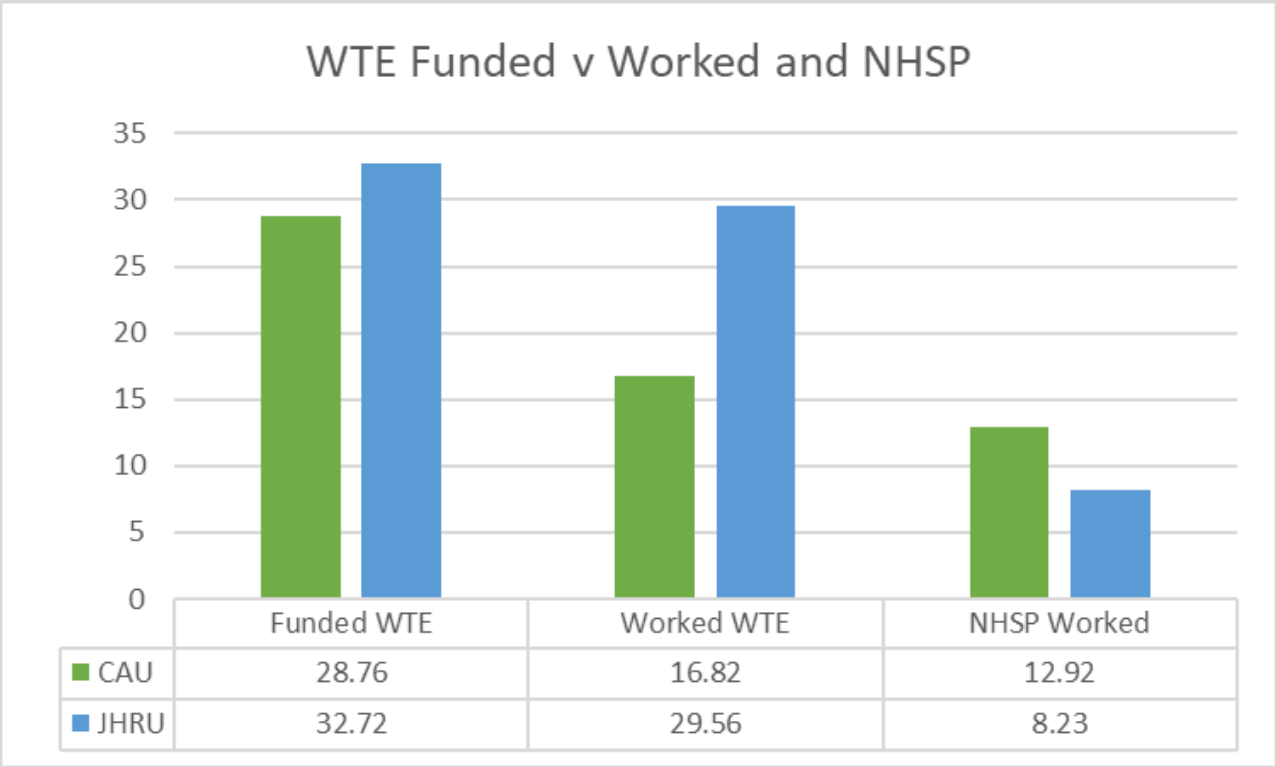


Chart 2

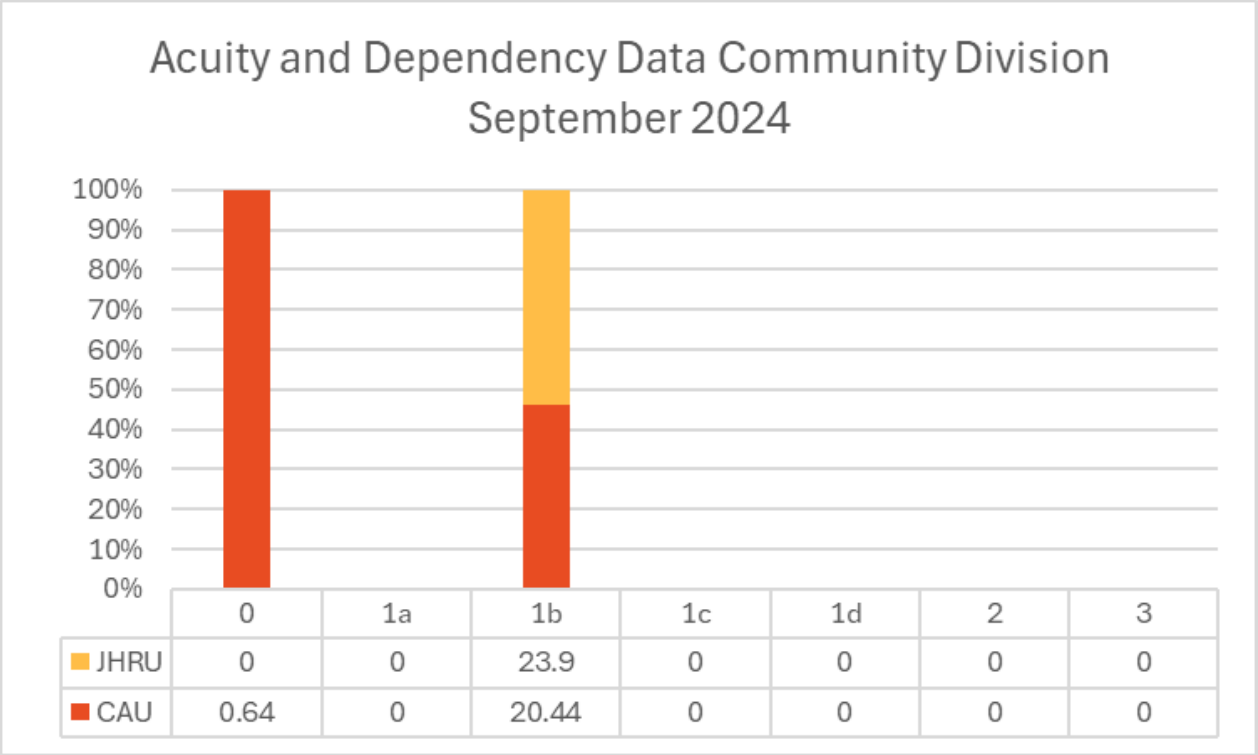


Chart 3

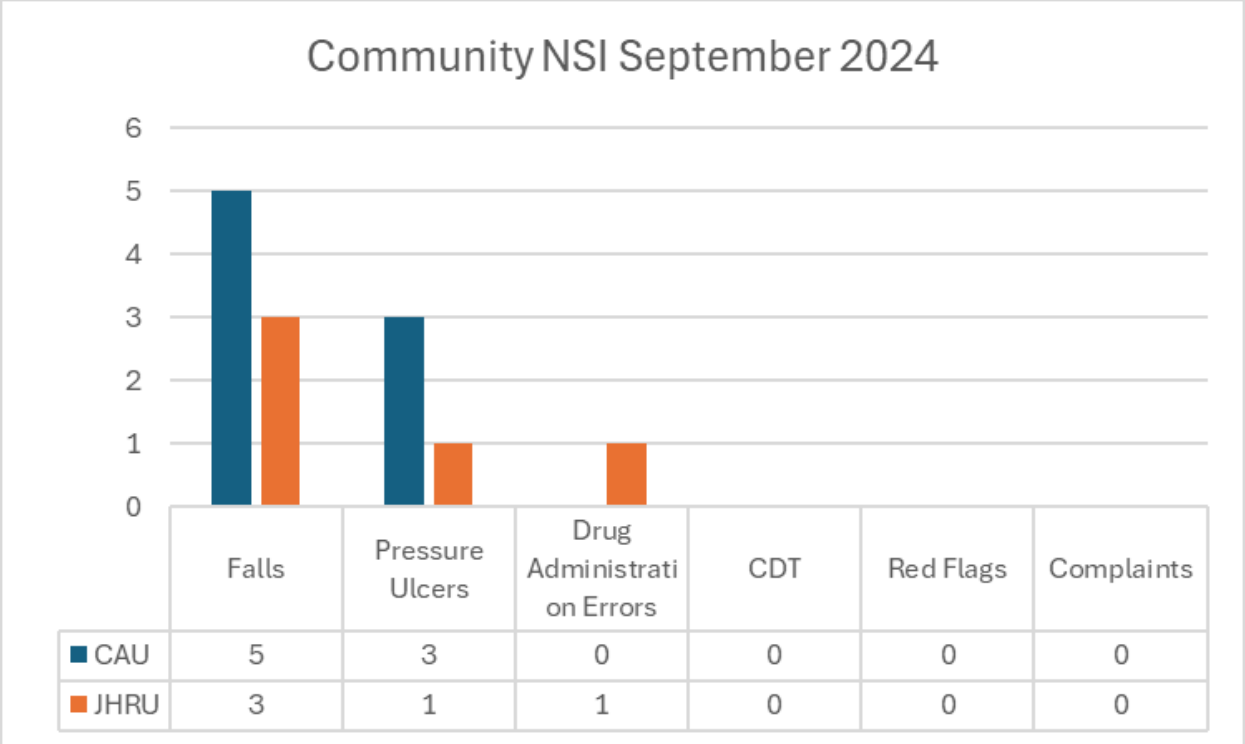


Chart 4

Appendix 5 Benchmark Data

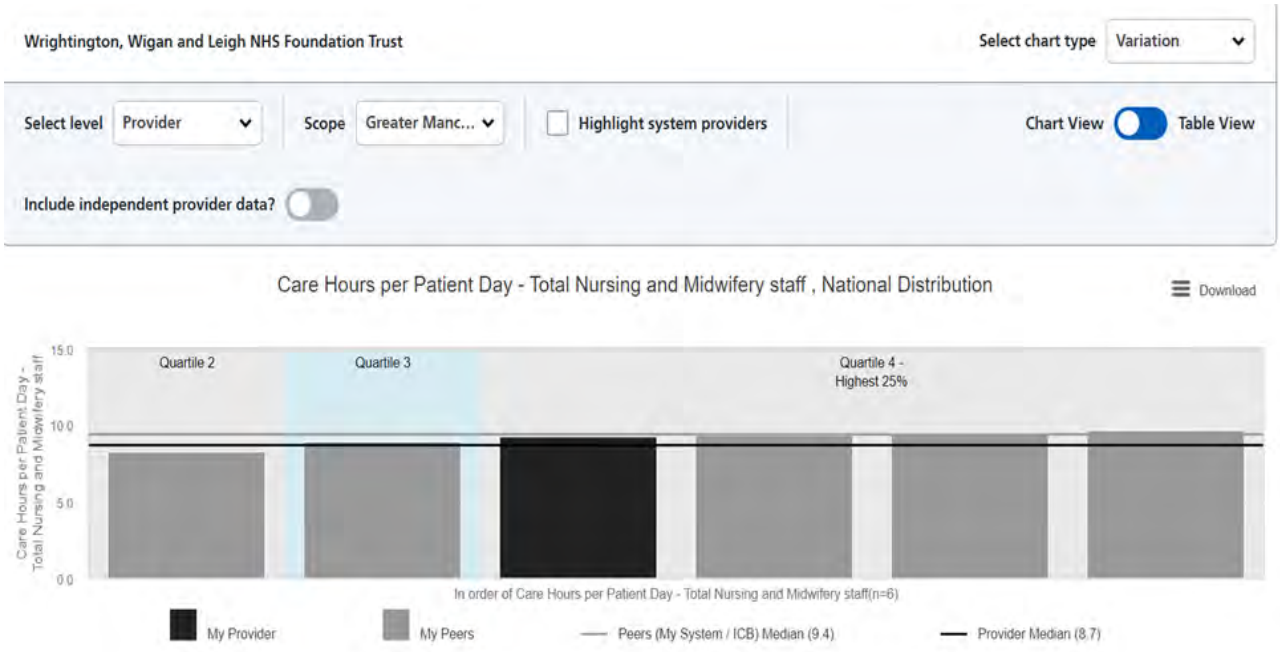


Chart 1 CHPPD V GM ICB (Data source Model Hospital August 2024)

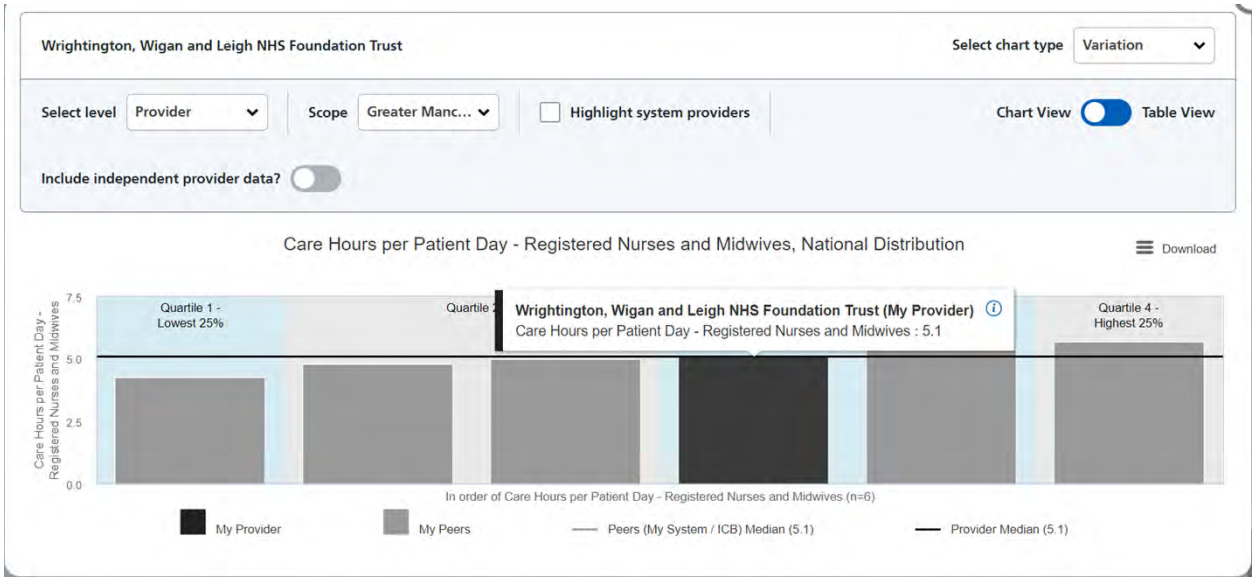


Chart 2 CHPPD Registered Staff v GMICB (Data source Model Hospital August 2024)

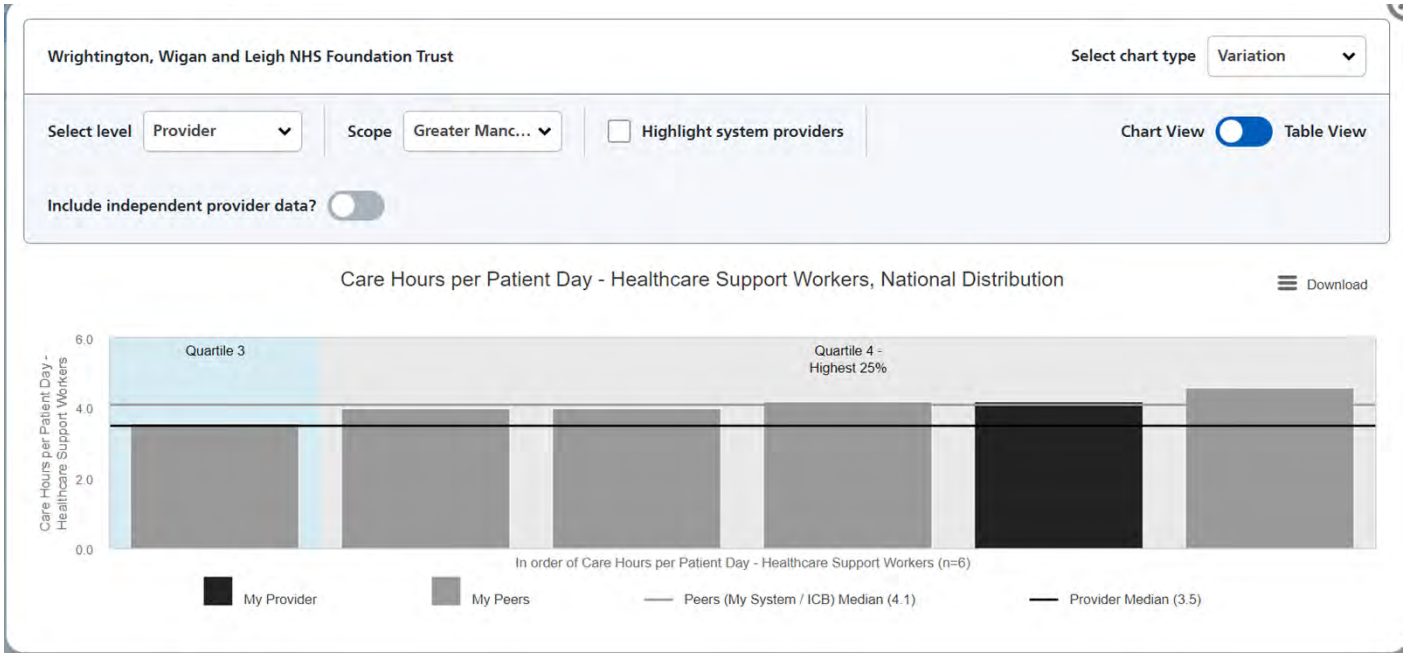
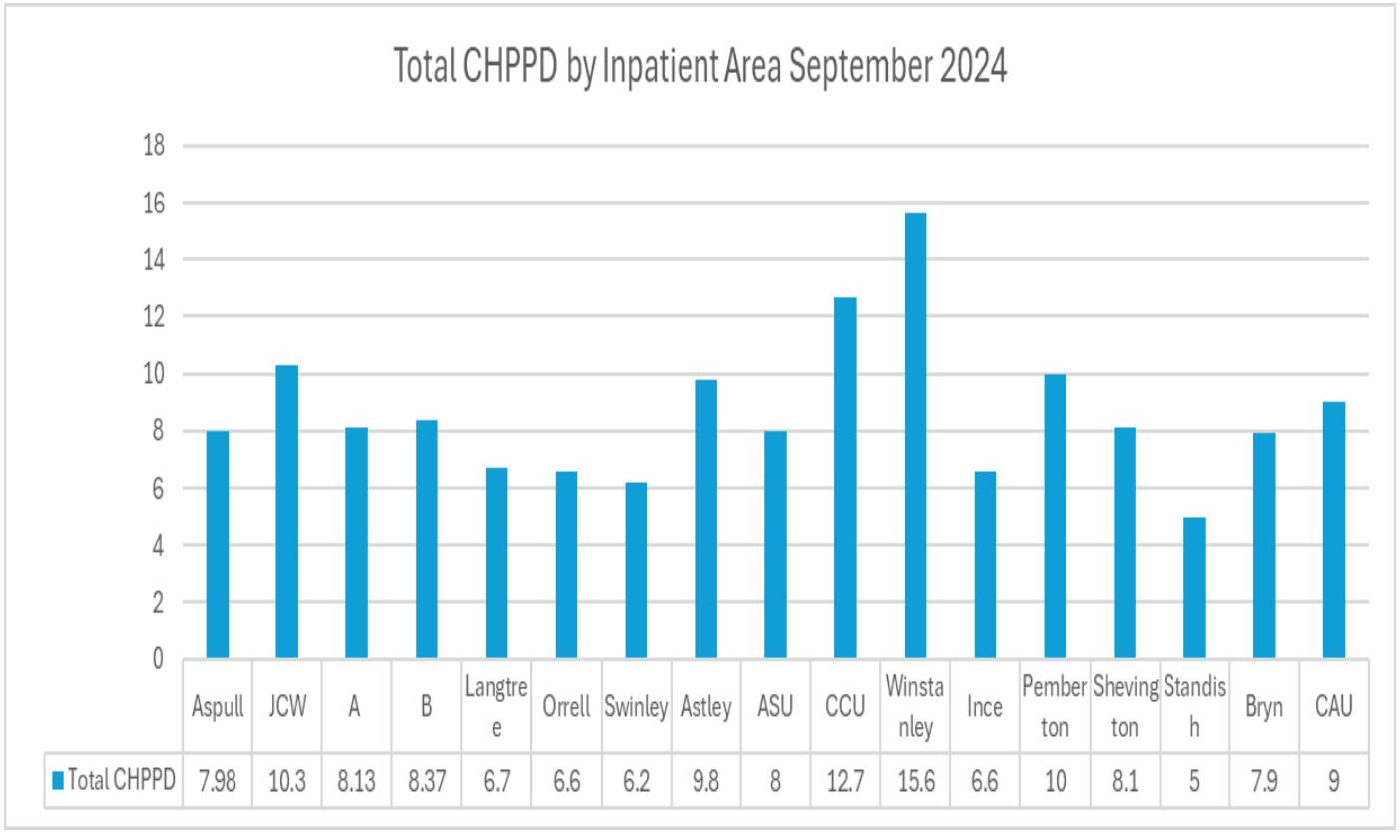


Chart 3 CHPPD Unregistered Staff V GMICB (Data source Model Hospital August 2024)



	Aspull	JCW	A	B	Langtree	Orrell	Swinley	Astley	ASU	CCU	Winstanley	Ince	Pemberton	Shevington	Standish	Bryn	CAU
Total CHPPD	7.98	10.3	8.13	8.37	6.7	6.6	6.2	9.8	8	12.7	15.6	6.6	10	8.1	5	7.9	9

Chart 4 CHPPD Combined per inpatient area September 2024

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Trust finance report for December 2024 (month 9)
Presented to:	Board of Directors
On:	5th February 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 9 (December 2024).

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 14 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.

The WWL Way

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 9th January 2025. The full finance report was presented to ETM on 23rd January 2025 and the Finance and Performance Committee on 28th January 2025 prior to Board.

Wider implications

There are no wider implications of this report.

Recommendation(s)

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Trust Finance Report

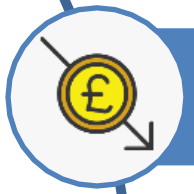
Month 9 – December 2024

Contents

Statistical Process Chart (SPC) Key

Key Financial Messages

For December 2024, the in-month position was a deficit of £0.2m, which is £0.1m adverse to plan. The YTD position is a deficit of £3.4m, which is £2.9m adverse to plan. The revenue position continues to trigger the red line ICB metric. A continued focus is required on the agreed tactical action plan, to deliver the financial plan for 2024/25. The improvement trajectory required is steeper, with an improvement of £1.2m per month needed for the last financial quarter to achieve this.



Divisional core CIP overachieved recurrently in month by £0.1m, however Transformation Schemes are significantly behind plan. The slippage YTD has reduced to £0.1m. The focus needs to remain on the delivery of recurrent savings to support our longer-term financial sustainability.

Divisional ERF performance is £0.8m below plan in month and £2.0m year to date. The Specialist Services division is below plan by £0.4m in month. Surgery and Medicine are also below plan in month by £0.2m respectively. Advice & Guidance has now been included in the divisional positions backdated to April 24.

The closing cash balance at the end of the month is £9.9m, which is a decrease of £1.3m from last month. The non-recurrent deficit funding (£9.7m 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.

Workforce in December is static at 6,993 WTE when compared to last month (-9 WTE). This remains 122 WTE above the workforce plan of 6,871 WTE. Pay expenditure is below plan £0.3m favourable in month (£2.4m adverse YTD). There has been a consecutive month-on-month reduction in temporary staffing WTE and expenditure on bank and agency, supported by the standardisation of NHSP bank rates from 1 December 2024.

Key Performance Indicators

Description	Performance Target	Performance	SPC Variation / Assurance	Explanation
Revenue financial plan	Surplus/deficit: Achieve the financial plan for 2024/25.	Red		We are reporting an actual deficit of £0.2m for month 9 (December) and £3.4m year to date. The forecast provided to NHSE is to deliver the full year plan of £0.8m deficit, this requires an improvement on the current run rate of £1.2m per month for quarter 4, which looks increasingly challenging. This relies on delivery of the current ERF forecast, CIP plans and mid year tactical actions.
	Adjusted financial position: Achieve the financial plan for 2024/25.	Red		
ERF Income	Achieve the elective activity plan for 2024/25.	Amber		Elective activity is £0.8m behind plan in month 9 and £2.0m behind plan year to date. This includes Advice & Guidance income of £1.1m 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 9, a marginal improvement from last month. This is below the NHSE agency ceiling, which is set at 3.2% of total pay expenditure. We are currently at 2.1% of total pay spend in month and 1.9% YTD.
Escalation	Sustained reduction in escalation spend for 2024/25.	Green		Reported escalation costs for December was £0.5m, a slight increase from prior month. Additional doctors were used in month to cover escalated areas and outlier wards and this is expected to continue until the end of March. Additional doctors were also required to cover escalated ward at Wrightington during period 23rd Dec – 3rd Jan.
Capital expenditure	Achieve capital plan for 2024/25.	Green		Month 9 actual capital expenditure is £1.6m, which is £0.2m below plan due to the phasing of expenditure. We are forecasting to spend our CDEL envelope in full for 2024/25.
Cash & liquidity	Ensure financial obligations can be met as they become due.	Amber		There is a closing cash balance of £9.9m for December 2024 which is £1.7m above plan. There was a decrease of £1.3m in month which is less than the average cash run rate due to an increase in aged debt recovery in month along with other timing differences in the payment of invoices. The current cash run rate forecast indicates there will be sufficient cash balances for the remainder of the financial year. However, revenue cash support is expected to be required in quarter 1 of 2025/26.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £27.3m, of which £19.1m is recurrent.	Red		In month 9, the Trust has delivered £2.4m CIP which was £0.1m favourable to plan. The YTD slippage has reduced to £0.1m due to the overperformance in recent months. 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 November is 94.4% by volume and 96.1% by value, which is a slight improvement to previous months.

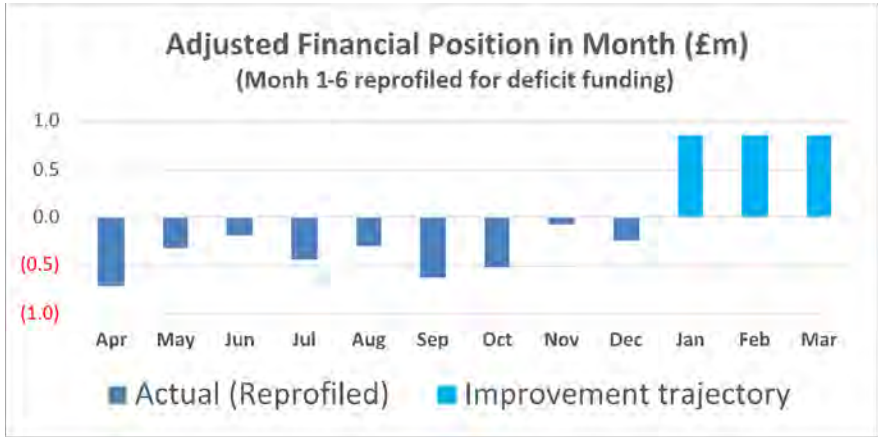
Financial Performance

Headlines

- Actual deficit of £0.2m in month 9**, £0.1m adverse to plan**.
- YTD is actual deficit of £3.4m, which **is £2.9m adverse to plan** including the non-recurrent deficit funding.
- We are forecasting to NHSE and GM ICB that we will deliver our revenue plan for the year. Whilst we have seen an improvement in the last 2 months this includes one-off items.
- It looks very challenging for quarter 4 to deliver the plan. Focus must remain on delivery of the tactical action plan.
- Clinical divisions are **£11.7m adverse to plan YTD,** including CIP delivery and ERF underperformance.

Improvement Trajectory to Deliver Revenue Plan

Based on the current run rate there needs to be a **£3.7m improvement** between month 10 and 12 to deliver the 2024/25 plan; an average of **£1.2m per month.**



Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Income	45,429	45,916	(487)	414,819	411,994	2,825	550,200
Pay	(31,771)	(32,150)	379	(291,651)	(289,249)	(2,401)	(385,714)
Non Pay	(11,721)	(11,838)	117	(108,861)	(104,811)	(4,049)	(140,768)
Financing / Technical	(2,188)	(2,060)	(128)	(17,762)	(18,544)	782	(24,725)
Surplus / Deficit	(251)	(132)	(119)	(3,454)	(611)	(2,844)	(1,008)
Adjusted Financial Performance *	(233)	(116)	(117)	(3,397)	(466)	(2,931)	(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	604	408	196	3,617	3,207	409
Surgery	247	215	32	4,248	1,936	2,313
Specialist Services	1,481	1,555	(74)	10,607	13,773	(3,166)
Community Services	600	572	28	5,109	5,148	(39)
Non Divisional Income	41,358	42,185	(827)	379,594	377,998	1,596
Finance	20	11	9	153	103	50
Digital Services	29	7	22	76	65	11
Dir of Strat & Planning	232	230	3	2,025	2,069	(44)
Chief Operating Officer	0	0	0	0	0	0
Human Resources	19	1	18	215	8	207
Medical Director	91	52	39	861	466	396
Estates & Facilities	400	459	(60)	3,932	4,135	(204)
Nurse Director	89	65	25	1,009	581	427
Trust Executive	8	26	(18)	38	231	(194)
GTEC	177	195	(18)	1,833	1,949	(116)
Corporate	73	(65)	139	1,501	323	1,178
Total	**45,429**	**45,916**	**(487)**	**414,819**	**411,994**	**2,825**

Headline

- Income is £0.5m adverse in month and £2.8m favourable YTD.

Medicine

- £0.2m favourable in month, £0.5m A&G income has been transferred from Non-Divisional Income backdated to month 1 and this is offset with an under achievement on ERF income of £0.2m.

Surgery

- Surgery's income is on plan in month due to £0.2m A&G income transferred from Non-Divisional Income backdated to month 1 and this is offset with an under achievement on ERF income of £0.2m.

Specialist Services

- £0.1m adverse in month due to £0.3m A&G income transferred from Non-Divisional Income and backdated to month 1. This is offset by an underperformance of £0.4m on ERF income.

Non-Divisional Income

- £0.8m adverse in month. £1.0m of the underperformance is due to the A&G income being transferred to the Divisions. This is offset by an ERF benefit relating to an under performance on LVA of £0.3m. Newton Europe income of £0.3m has been transferred to Corporate expenditure as the accounting treatment has been changed from gross to net.

Divisional ERF Activity and Income

Activity Plans

- The Trust has developed an internal elective plan for 2024/25, and this is being used to monitor the Divisions performance and for financial reporting.
- NHSE have released high-level provider ERF activity and financial targets for 2024/25.
- The Trust has followed the same methodology for the internal plan target value but have increased it by £7.3m FYE to include the internal business cases which are to be funded from an over performance on ERF.

ERF Performance

- In month 9 the Trust is £0.8m adverse 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 £0.4m adverse in month and £3.6m adverse YTD predominantly within Trauma & Orthopaedics, this is a result of not utilising all available theatre sessions.
- Surgery have underperformed against their plan by £0.2m in month and are £1.7m favourable YTD.
- Medicine are £0.2m adverse to plan in month and £0.1m YTD.
- Advice and Guidance income of £1.1m YTD has been included in the month 9 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	1,338	1,599	(261)	837	1,032	(195)	13,574	15,270	(1,696)	8,892	9,851	(959)
Medicine	Electives	51	26	25	95	41	55	380	246	134	525	387	138
Medicine	OP Proc New	111	187	(76)	34	64	(30)	1,191	1,785	(594)	401	616	(214)
Medicine	OP Proc FUP	521	346	175	90	69	21	5,723	3,304	2,419	1,025	658	366
Medicine	OPA New	1,719	2,158	(439)	431	525	(94)	20,485	20,609	(124)	5,103	5,018	85
Medicine	A&G				59		59				510		510
Medicine Total		**3,740**	**4,315**	**(575)**	**1,547**	**1,731**	**(184)**	**41,353**	**41,213**	**140**	**16,455**	**16,530**	**(74)**
Specialist Services	Day Cases	713	754	(41)	1,246	1,243	3	6,340	7,025	(685)	10,703	11,537	(833)
Specialist Services	Electives	349	397	(48)	2,532	2,882	(350)	3,240	3,663	(423)	23,486	26,611	(3,125)
Specialist Services	OP Proc New	728	806	(78)	109	133	(24)	8,280	7,698	582	1,311	1,271	40
Specialist Services	OP Proc FUP	1,131	1,017	114	157	139	18	12,042	9,709	2,333	1,643	1,331	312
Specialist Services	OPA New	2,722	3,086	(364)	564	634	(70)	27,856	29,475	(1,619)	5,692	6,053	(361)
Specialist Services	A&G				38		38				330		330
Specialist Services Total		**5,643**	**6,060**	**(417)**	**4,647**	**5,032**	**(385)**	**57,758**	**57,571**	**187**	**43,165**	**46,802**	**(3,637)**
Surgery	Day Cases	662	789	(127)	867	1,036	(170)	7,504	7,526	(22)	10,165	9,893	273
Surgery	Electives	102	114	(12)	413	437	(25)	1,598	1,085	513	4,532	4,176	356
Surgery	OP Proc New	1,523	1,601	(78)	314	341	(27)	16,239	15,285	954	3,373	3,255	118
Surgery	OP Proc FUP	2,977	2,891	86	557	537	21	30,079	27,613	2,466	5,846	5,125	721
Surgery	OPA New	3,740	3,859	(119)	730	765	(36)	37,099	36,855	244	7,363	7,309	54
Surgery	A&G				24		24				210		210
Surgery Total		**9,004**	**9,253**	**(249)**	**2,905**	**3,116**	**(211)**	**92,519**	**88,364**	**4,155**	**31,490**	**29,758**	**1,732**
Divisional ERF Totals		**18,387**	**19,628**	**(1,241)**	**9,098**	**9,879**	**(780)**	**191,630**	**187,148**	**4,482**	**91,110**	**93,090**	**(1,979)**

Overperformance

- Surgery £1.7m YTD

Underperformance

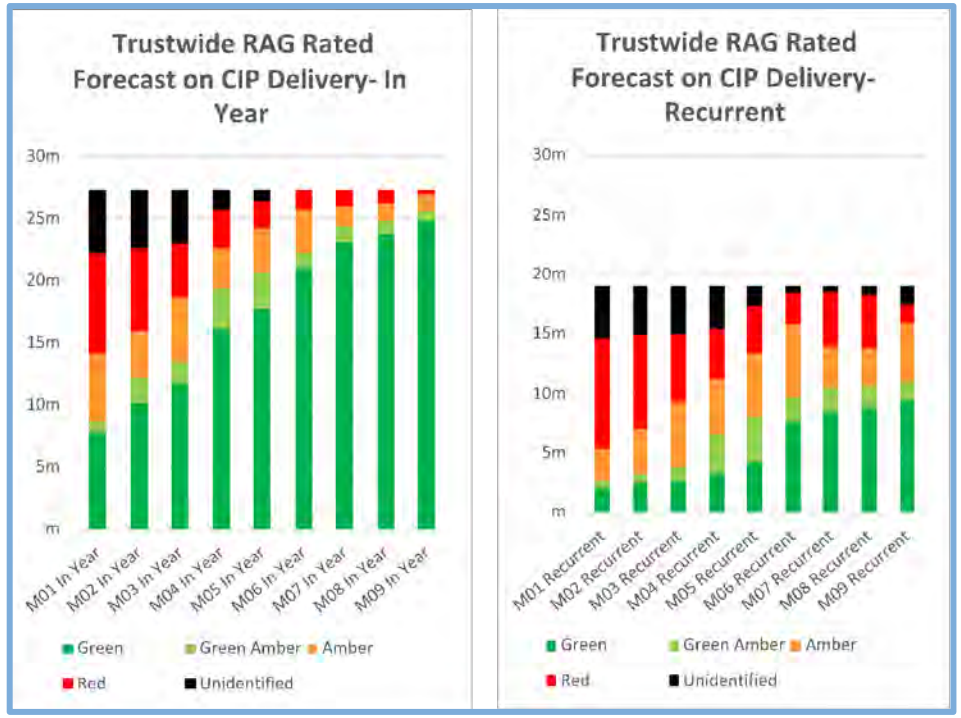
- Specialist Services £3.6m YTD
- Medicine £0.1m YTD

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 reduction in the recurrent amount identified from £18.2m to £17.5m.



December 2024 Reported Position

RAG	Value £'000
	-
	305
	1,320
	25,675
CIP Total	27,300

- £27.3m identified, £17.5m recurrent

November 2024 Reported Position

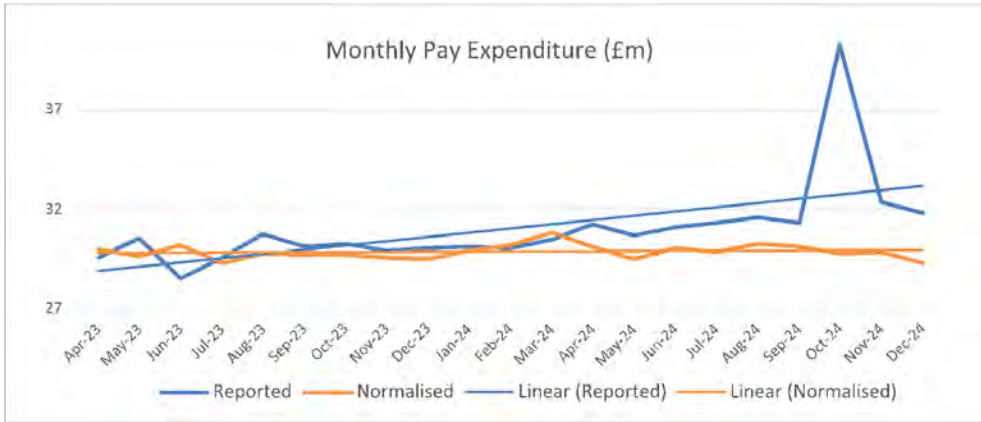
RAG	Value £'000
	-
	1,054
	1,404
	24,843
CIP Total	27,300

- £27.3m identified, £18.2m recurrent

Workforce

Pay expenditure

- The in-month pay expenditure is £31.8m which is £0.4m below plan in month, and £2.4m adverse to plan YTD.
- The normalised pay expenditure has reduced in Q3 24/25 but remains within the range seen since Q1 23/24. The Q3 monthly average is £29.6m (compared to the Q2 average of £30.0m).



Pay £0.4m below plan in month

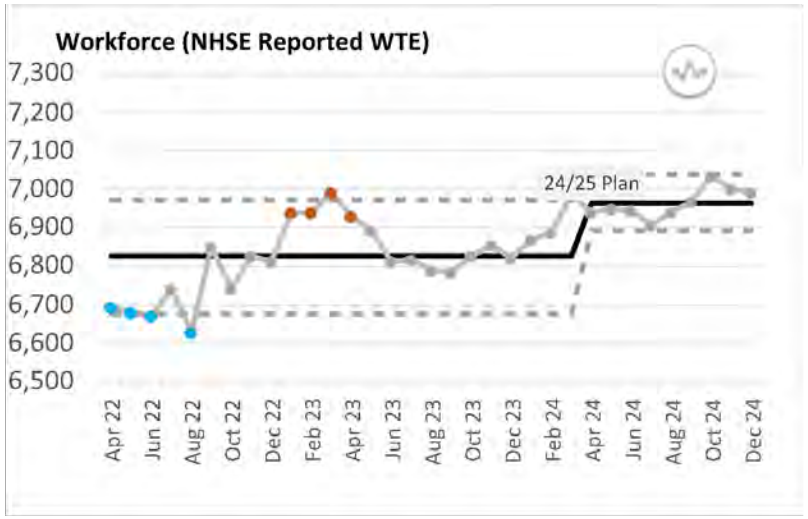
Normalised pay remains static

Normalised quarterly average

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

Workforce (WTE)

- Actual workforce 6,993 WTE in December. This is a slight decrease of 9 WTE from last month but remains 122 WTE above the workforce plan of 6,871 WTE.
- Substantive staffing has increased by 36 WTE with new starters across all divisions.
- Bank staffing has decreased by 39 WTE in Surgery (Theatres and wards), Medicine (nursing staff) and Specialist Services (reduced lists and Christmas closure)
- Agency has reduced by 9 WTE, largely found in Medicine, Community and Digital Services.



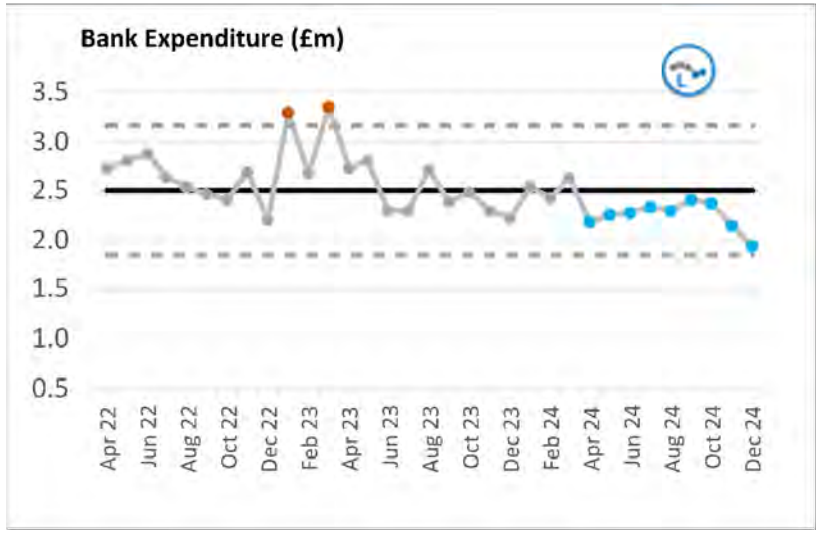
WTE above plan by 122 WTE

Reduction of 171 WTE required to get to the March plan (6,822 WTE).

Temporary Staffing

Bank expenditure

- Bank costs were £2.0m in December, a further £0.1m improvement from prior month. This can be seen across all divisions.
- Standardised bank rates based on AfC top of scale applied from 1st December 2024, removing the premium cost.
- Bank WTE reduced by 39 WTE compared to the prior month.
- The chart is showing a special cause improving variation.
- In month 9, Medicine (£1.1m) and Surgery (£0.4m) continue to be the biggest users.

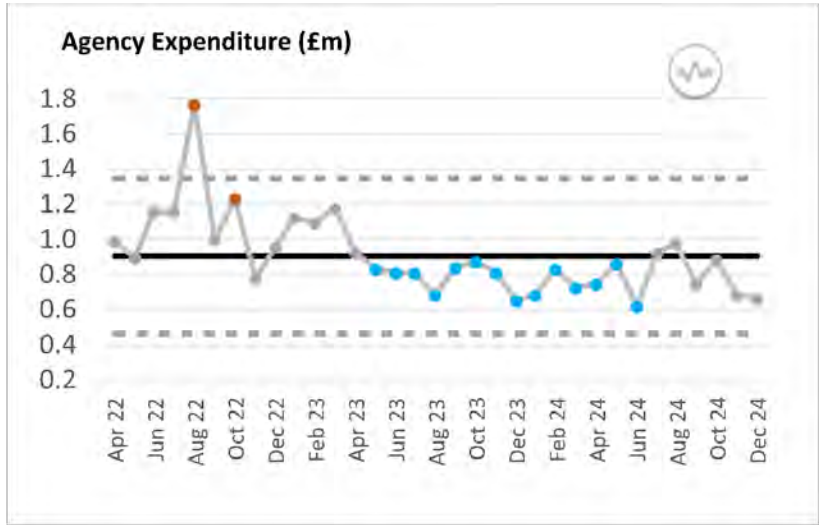


Bank expenditure reducing

Standardised rates implemented from December

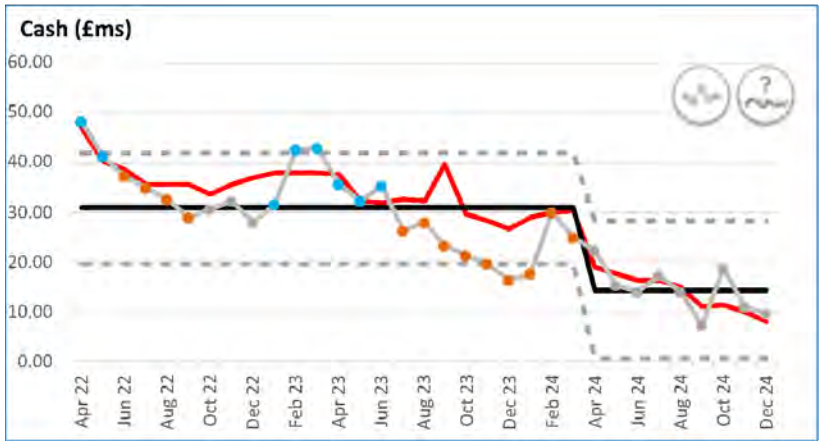
Agency expenditure

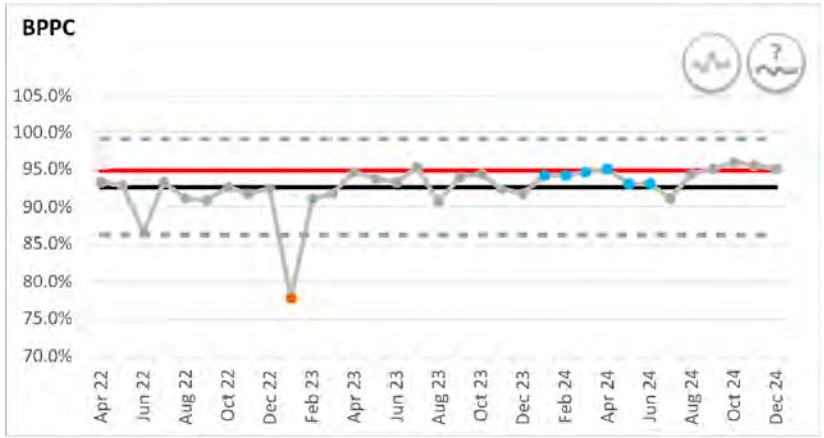
- Agency spend in month is £0.7m, a slight decrease from prior month, therefore the trend is showing common cause variation as this is still within the typical process limits.
- There was no material change in agency expenditure despite the standardisation of NHSP bank rates from 1st December 2024.
- Agency spend in month is 2.1% of the total pay spend, which is below the NHSE agency ceiling set at 3.2%
- Medicine (£0.4m) continues to have the highest level of agency within the Trust.



Below the NHSE agency ceiling, however scrutiny remains high

Cash and BPPC





Current cash position

- Closing cash at the end of December was £9.9m, a decrease of £1.3m from November, £0.6m relates to a delay in the November PDC drawdown along with other timing differences in the payment of invoices.
- The closing cash balance is £1.7m above the plan of £8.2m largely due to the provider deficit funding, pay award 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, £10.0m received to date with the remainder being phased over the year.
- As a result of this support the forecast indicates there will be sufficient cash balances for the remainder of the financial year. However, based on the current run rate cash support is forecast to be required in quarter 1 of 2025/26.

Better Payment Practice Code (BPPC)

- The in-month performance was 95.2% by volume and 97.9% by value.
- YTD performance 94.4% 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)	480	828	348	6,302	7,090	788	9,287	9,287	68%
Lease expenditure (IFRS16)	0	0	0	373	2,003	1,630	2,655	2,561	14%
Sub total internally funded	**480**	**828**	**348**	**6,675**	**9,093**	**2,418**	**11,942**	**11,848**	**56%**
National funding (PDC)									
Theatre 11, Wrightington	0	0	(0)	1,325	1,325	(0)	1,325	1,325	100%
Endoscopy	954	718	(236)	5,032	5,240	208	6,885	6,885	73%
RAAC Eradication Programme	139	118	(21)	283	354	71	711	711	40%
Nasogastro	0	89	89	0	178	178	267	267	0%
Sub total national funding	**1,093**	**925**	**(168)**	**6,640**	**7,097**	**457**	**9,188**	**9,188**	**72%**
Total capital programme	**1,573**	**1,753**	**180**	**13,314**	**16,190**	**2,875**	**21,130**	**21,036**	**63%**

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 £1.0m approved by NHSE in year:
  - £0.7m to eradicate Reinforced Autoclaved Aerated Concrete (RAAC)
  - £0.3m Trans Nasal Endoscopy equipment

Month 9 Headlines

- Capital expenditure is £0.2m behind plan in month and £2.9m below plan YTD.
- The YTD underspend is due to leases £1.6m, operational CDEL £0.8m and PDC £0.4m.
- Disposal of the asset under construction for the Surgical Training Academy (STA) generated a CDEL credit of £0.2m.

Operational CDEL

- £0.3m below plan in month and £0.8m behind plan YTD.
- Variance to plan largely due to underspend against Endoscopy and STA disposal.

PDC funded schemes

- £0.2m above plan in month and £0.5m below plan year to date, due to Endoscopy.

Lease Expenditure

- No planned lease expenditure in month. £1.6m below plan year to date.
- The endoscopy business case is seeking ETM and ICB approval in January.
- Lease expenditure will continue to trigger ICB red line metrics until expenditure is back on plan and this is not expected until March.
- Underspend on leases £0.1m offered to the ICB to support system overcommitment on leases.

Full Year Forecast Scenarios

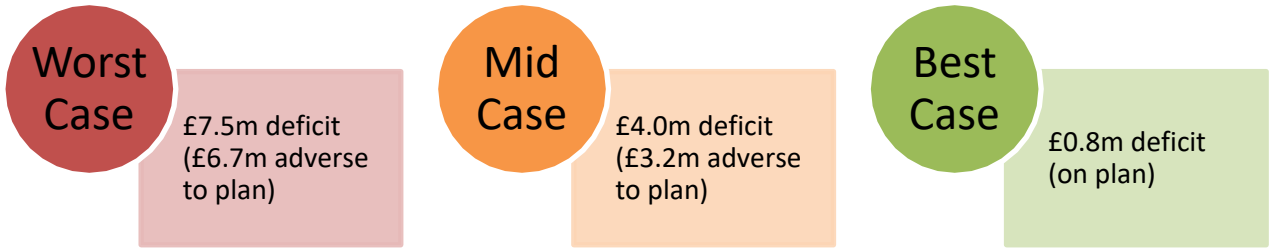
Bridge from straight line forecast to actual forecast. This sets out the assumption and improvement required to hit plan.

Straight line forecast £4.5m deficit	Remove non-recurrent items & phasing adjustments -£1.0m	ERF Forecast +£1.7m	Improvement required to deliver plan +£2.9m	Current forecast £0.8m deficit (as per plan)
•Extrapolated from £3.4m YTD deficit at month 9	•Non recurrent items, extrapolated impact -£2.0m: •Prior year income -£0.6m •Industrial action £0.1m •Non pay mitigations -£1.6m •Phasing adjustments £1.0m •Deficit funding phasing £0.4m •Other H2 adjustments £0.6m	•Requires ERF improvement on run rate of £2.1m, including £1.0m for Specialist Services as per their diviisonal forecast. •This includes the ERF stretch associated with the tactical actions (original plan £1.0m). •Assumes direct non pay expenditure of £0.4m.	•CIP improvement on run rate £0.1m (to deliver plan in full and recover YTD slippage). •Other tactical plan improvements in Q4 £2.8m (excluding ERF) with additional mitigations agreed to offset slippage.	•As submitted to NHSE •All other pressures to be mitigated within existing plan •Assumes no further industrial action

Key assumptions to achieve plan

- ERF improvement of £2.1m in Q4 compared to current run rate
- Deliver CIP plan in full through cash releasing savings
- Delivery of the mid year tactical action plan or equivalent mitigations to the same value
- Monthly run rate improvement of £1.2m required (from £0.4m YTD actual average deficit to £0.8m surplus per month)
- Ongoing discussions with system partners to support delivery of the best case

High level scenarios for full year forecast



Note: the scenarios are based on sensitivity modelling of a number of variables. The range reduces as we get closer to the year end and the position becomes more certain.

Risk Management and Mitigation

Revenue position

Recurrent CIP delivery: Recurrent CIP is below plan by £6.8m YTD which will impact on delivery of the Financial Sustainability Plan and timescale to return to a break-even position

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

Winter: The forecast assumes no unplanned increase in expenditure over winter, due to the Better Lives programme. (£0.5m planned in surgery)

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.

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

Local authority pay award: It is yet to be confirmed whether Wigan Council will support their element of the pay award. Discussions are ongoing at the time of writing.

Noviniti underwriting: £1.0m of costs have been underwritten to date, following approval at Trust Board to progress the scheme for the multi storey car park at Freckleton Street. This is a risk to the revenue position if financial close is not reached in year.

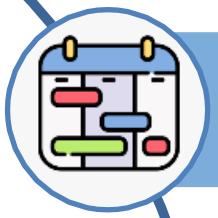
Annual leave accrual: This was released in full in 2023/24 in line with the Trust's policy. Following the annual accounts audit, a review of this has been requested for 2024/25.

Other

Cash: The non-recurrent deficit funding has mitigated the need for cash support in this financial year but the cash balance continues to decline. The revised cash forecast indicates external support would not be needed until Q1 2025/26 at the current run rate.

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 2025/26 planning round is progressing. A second submission is due to GM ICB on the 22nd January; with the final plan required by NHSE in March. At the time of writing, national planning guidance was yet to be released. Initial indications are a projected deficit worse than anticipated in the Financial Sustainability Plan for 2025/26, primarily due to delays in recurrent CIP delivery in 2024/25.

CIP plans for 2025/26 are being developed across the divisions, whilst we continue to ensure delivery of our 2024/25 CIP programme. The CIP target for 2025/26 is planned to be £25.2m, of which £19.6m is recurrent. Currently all transacted schemes 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.

As part of the mid year tactical actions, further non pay controls on discretionary expenditure have been introduced until the end of the financial year. The Chief Operating Officer will oversee orders within the following categories; provisions, hospitality, furniture & fittings, computer hardware, stationery, staff consultancy fees, and training expenses.

The Trust has been successful in a bid for national capital funding for LED lighting of £2.3m, to be spent by the end of the financial year.

Year 6 Maternity Incentive Scheme Compliance.

Wrightington Wigan. And Leigh Teaching Hospital NHS Foundation Trust		
Name of Person completing :		Cathy Stanford - Divisional Director of Midwifery and Child Health
Date completed:		January 2025
Date due to Trust Board for final Sign off of declaration form:		Board Sign Off 5TH February 2025
Do you submit your CNST progress to the Trust Board as per the Perinatal Quality Surveillance Model?:		Yes

Year 6 Maternity Incentive Scheme Compliance.

Executive Summary

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

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

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon on 3rd March 2025.**

The LMNS has had oversight and assurance by reviewing the evidence that WWL are meeting the ten safety actions leading up to the Board Declaration form submission on or before the 3rd March 2025.

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

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

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

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

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

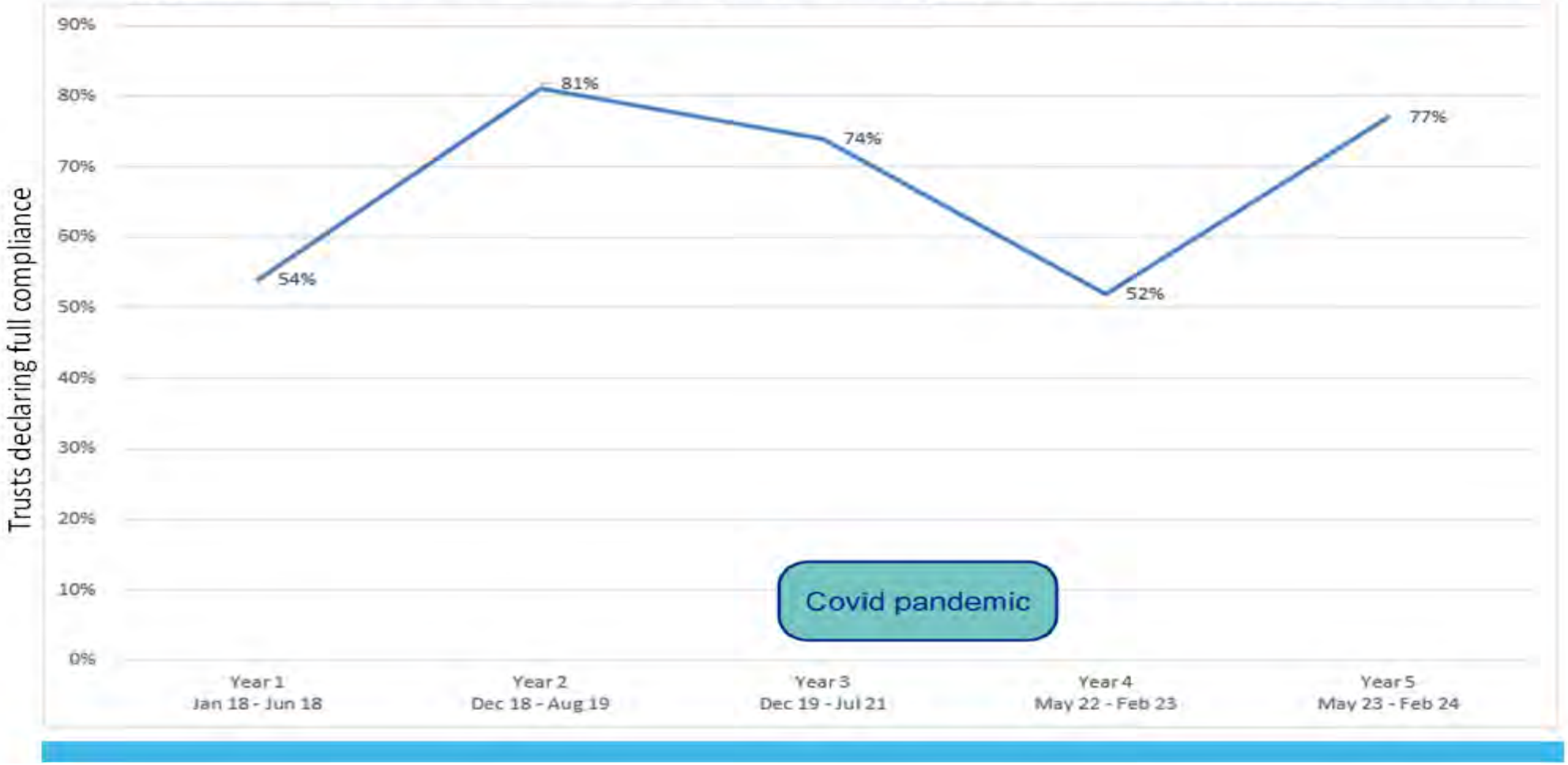
The Quadrumvirate request that the board note the evidence that has been submitted over the course of the year within the Maternity Board papers and review any subsequent and final documents within the February Board papers , predominantly evidence is within the Quarterly Perinatal Quality Surveillance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

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

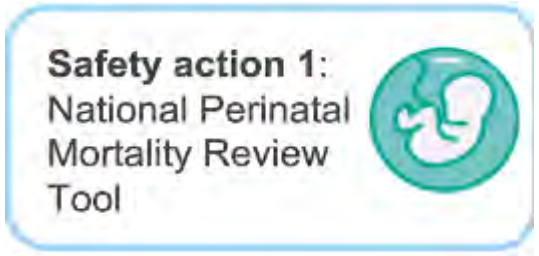
MIS full compliance MIS years* 1-5

NHS Resolution

*Although each iteration of the MIS is referred to as a 'year', these time periods have varied in response to external factors.



Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

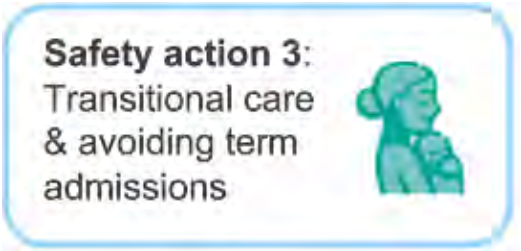


Requirements	Safety action requirements	Likely to be compliant for submission date? (Yes/ No /Not applicable)	Actions for compliance
A	**Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.	Yes	**Reported in Quarterly Perinatal Quality Surveillance Report and Monthly Perinatal Quality Surveillance Dashboard which is received at Trust Board, Quality and Safety Committee and Safety Champions Forum** **Q4 2023/2024, Submitted:** Trust Board 5TH June 2024. Quality and Safety Committee 10th July 2024 Safety Champions 24thMay 2024 **Q1 2024/2025 submitted:** Safety Champions 16th July 2024 Trust Board 7th August 2024 Quality and Safety Committee 10th July 2024 **Q2 2024/2025 Submitted:** Trust Board 4 December 2024 Quality and Safety Committee. 13th November 2024. Safety Champions 18th November 2024. **Q3 2024/2025Submitted:** Safety Champions 29th January 2025 Trust Board 5th February 2025
B	**Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	Yes	
C	**Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	Yes	
D	**Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	Yes	

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

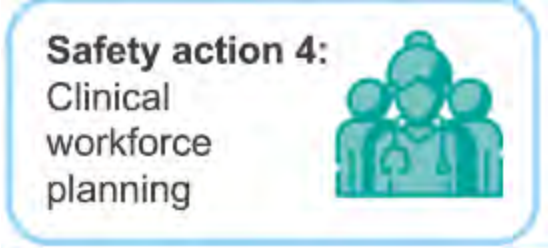
Requirement	Safety action requirements	Confident/ Requirement met? (Yes/ No /Not applicable)	Actions for compliance
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.			
1	Trust Boards to assure themselves that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

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



Requirements	Safety action requirements	Requirement likely to be met by Submission date? (completed /Yes/ No /Not applicable)	Actions for compliance
A	Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice.	Yes.	**ATAIN audits and presentations reported in Quarterly Perinatal Quality Surveillance Report which is received at Trust Board, Quality and Safety Committee and Safety Champions Forum as detailed below.** **Q4 2023/2024, Submitted:** Trust Board 5TH June 2024. Quality and Safety Committee 10th July 2024 Safety Champions 24thMay 2024 **Q1 2024/2025 submitted:** Safety Champions 16th July 2024 Trust Board 7th August 2024 Quality and Safety Committee 10th July 2024 **Q2 2024/2025 Submitted:** Trust Board 4 December 2024 Quality and Safety Committee. 13th November 2024. Safety Champions 18th November 2024. **Q3 2024/2025Submitted:** Safety Champions 29th January 2025 Trust Board 5th February 2025
	<u>Or</u> Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.	Yes.	
B	Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.	Yes.	

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



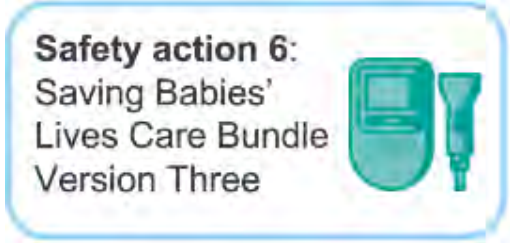
Requirements	Safety action requirements	Likely to be compliant by submission date? (Yes/ No /Not applicable)	Actions for compliance
a) Obstetric medical workforce			
1	NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums.	Yes	**In place and on track.** **Presented at:** Quality and Safety Committee. January 15, 2025. Safety Champions 29 January 2025
2	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.	Yes	**Presented at :** Quality and Safety Committee. January 15, 2025. Safety Champions 29 January 2025
3	Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.**While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**	Ongoing	**Action plan in place, presented at October Trust Board and February 5th, 2025**
4	Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes	**Ongoing audit in place . No issues identified.** **Presented at:** Quality and Safety Committee. January 15, 2025. Safety Champions 29 January 2025 Trust Board 5th February 2025

Requirements	Safety action requirements	Likely to be compliant by submission date? (Yes/ No /Not applicable)	Actions for compliance
b) Anaesthetic medical workforce			
1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes	**Evidence submitted to LMNS in January 2025**
c) Neonatal medical workforce			
1	The neonatal unit meets the relevant BAPM national standards of medical staffing. or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Ongoing	**Ongoing Action Plan submitted to LMNS/ NWNODN in January 2025, demonstrating improving compliance** **Updated Tier1 Action plan submitted to:** Trust Board 4 December 2024 Quality and Safety Committee. January 15, 2025. Safety Champions 29 January 2025 Trust Board 5th February 2025 **demonstrating improving compliance. (This is sufficient to declare compliance for this action)**
d) Neonatal nursing workforce			
1	The neonatal unit meets the BAPM neonatal nursing standards. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN.	Yes	**Annual staffing paper submitted to Trust Board in August 2024, outlining BAPM compliance with Nurse staffing**

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

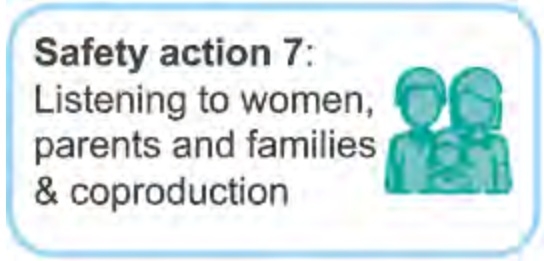
Requirements	Safety action requirements	Requirement met or likely to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.	Yes	**Birthrate + review undertaken and completed in March 2023** (next due Summer 25)
B	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	Yes	**Biannual staffing reports reflecting the findings of the Birthrate+ report submitted:** Quality and Safety Committee July 2024 January 2025 Trust Board June 2024 & 5th February 2025 **This includes the budgeted establishment and shortfall as recommended by Birthrate+**
C	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes	**Supernumerary Shift coordinator compliance and 1-2-1 care in labour reported monthly on maternity Dashboard which is submitted to Trust Board, Quality and Safety Committee and Safety Champions Forum. Additionally, compliance is reported in the Biannual Staffing reports submitted in June 2024 and February 2025.**
D	All women in active labour receive one-to-one midwifery care.	Yes	
E	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Yes	

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



Requirements	Safety action requirements	Requirement met or likely to be met for the submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.	Ongoing	**Quarterly monitoring from LMNS in place all actions remain on track to achieve with some exceeding the stretch targets. Paper submitted to Board in October following LMNS quarterly review. LMNS provides assurance upwards to the ICB**
B	Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes	**All six elements of Saving Babies Lives are compliant and submitted quarterly on the National implementation tool. LMNS Validation will be finalised January 2025 after quarterly reviews in 30/9/24 2/12/24**
C	*The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.	Yes	**In place and compliant**
D	Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	N/A	**Action confirmed by NHSR as n/a if LMNS oversight**

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

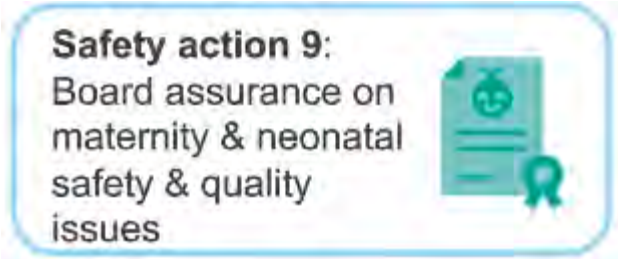


Requirements	Safety action requirements	Likely to meet requirement by submission date? (Yes/ No /Not applicable)	Actions for compliance
1	Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Engagement and listening to families. b) Strategic influence and decision-making. c) Infrastructure.	Ongoing	**Bimonthly meetings in place. Listening events scheduled throughout the year with families. Co production with MNVP embedded and in place. Fully funded Chair in place and supporting infrastructure.** **Evidence Submitted to LMNS January 2025**
2	Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	Ongoing	**Co produced annual Picker/CQC survey action plan tabled at MNVP in November 2024. November 2024 Safety Champions** **Submitted to LMNS January 2025.**

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

Requirements		Safety action requirements	Requirement likely to be met by submission date? (Yes/ No /Not applicable)	Actions for compliance
90% of attendance in each relevant staff group at:	1	Fetal monitoring training	Yes	Training needs analysis in place and agreed with all staff groups. Ongoing monitoring in place for all groups to ensure full compliance with all elements by 30 November 2024 as per Saving Babies Lives and CNST requirements. Any deviations from trajectory are escalated to Divisional and clinical leads for each speciality. Fully compliant for all staff groups Evidence Submitted to LMNS January 2025
	2	Multi-professional maternity emergencies training	Yes	
	3	Neonatal Life Support Training	Yes	

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



Requirements	Safety action requirements	Requirement likely to be met prior to submission date ? (Yes/ No /Not applicable)	Actions for compliance
A	**All Trust requirements of the PQSM must be fully embedded.** Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice. Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action	Yes	Quarterly Perinatal Quality Surveillance Reports submitted **Q4 2023/2024, Submitted:** Trust Board 5TH June 2024. Quality and Safety Committee 10th July 2024 Safety Champions 24thMay 2024 **Q1 2024/2025 submitted:** Safety Champions 16th July 2024 Trust Board 7th August 2024 Quality and Safety Committee 10th July 2024 **Q2 2024/2025 Submitted:** Trust Board 4 December 2024 Quality and Safety Committee. 13th November 2024. Safety Champions 18th November 2024. **Q3 2024/2025Submitted:** Safety Champions 29th January 2025 Trust Board 5th February 2025

Requirements Update provided to Quality and Safety Committee, Trust Board and Safety Champions	Safety action requirements	Requirement likely to be met prior to submission date ? (Yes/ No /Not applicable)	Actions for compliance
B	The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. **These discussions must include** • ongoing monitoring of services and trends over a longer time frame; • concerns raised by staff and service users; • progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). • Evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.	Yes	**Safety Progress and Performance Special Interest Group held Quarterly with LMNS and GMEC Trusts.** **Bimonthly Regional Safety Special Interest Group.** **LfPSE and PSII Incidents reported to Trust Board and Quality and Safety Committee in Quarterly Perinatal Quality Surveillance Reports as per Q4/Q1/Q2/Q3**
C	All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures. Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including • identifying and escalating safety and quality concerns and offering relevant support where required. **This will include:** • Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. • Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes	**Bimonthly safety Champions Forums in place and Bimonthly Non-Executive Director walkabouts.** **Quarterly Quadrumvirate and Safety Champions meetings held.** **Score Culture Survey competed and feedback sessions in place.** **Improvement plan developed with highlighted themes within areas.** **Update paper submitted :** Quality and Safety committee November 2024 Trust Board, December 2024 Safety Champions November 2024

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Safety action 10:
Maternity & Newborn Safety Investigations & Early Notification Scheme reporting

Requirement	Safety action requirements	Requirement likely to be met prior to submission date? (Yes/ No /Not applicable)	Actions for compliance
A	Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes	**Included in Quarterly Perinatal Quality Surveillance Reports :** **Q4 2023/2024, Submitted:** Trust Board 5TH June 2024. Quality and Safety Committee 10th July 2024 Safety Champions 24thMay 2024 **Q1 2024/2025 submitted:** Safety Champions 16th July 2024 Trust Board 7th August 2024 Quality and Safety Committee 10th July 2024 **Q2 2024/2025 Submitted:** Trust Board 4 December 2024 Quality and Safety Committee. 13th November 2024. Safety Champions 18th November 2024. **Q3 2024/2025Submitted:** Safety Champions 29th January 2025 Trust Board 5th February 2025
B	Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024.	Yes	
C	For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes	

Thank You.
Any Questions

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	MIS Safety Action 4 – Consultant Attendance
Presented to:	Trust Board
On:	5th February 2025
Item purpose:	Information
Presented by:	Kevin Parker-Evans – Chief Nurse and DIPC
Prepared by:	Gemma Weinberg Digital Midwife
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

Safety action 4 in the Maternity Incentive Scheme year 6 includes the attendance of the Consultant at specific events (SA4, Part 4). The data is collected monthly and is ongoing. The relevant time period for this safety action is from 2nd April 2024 to 30th November 2024. This report details the results of the audit from this time frame.

Link to strategy and corporate objectives

This is linked to finance and income strategies.

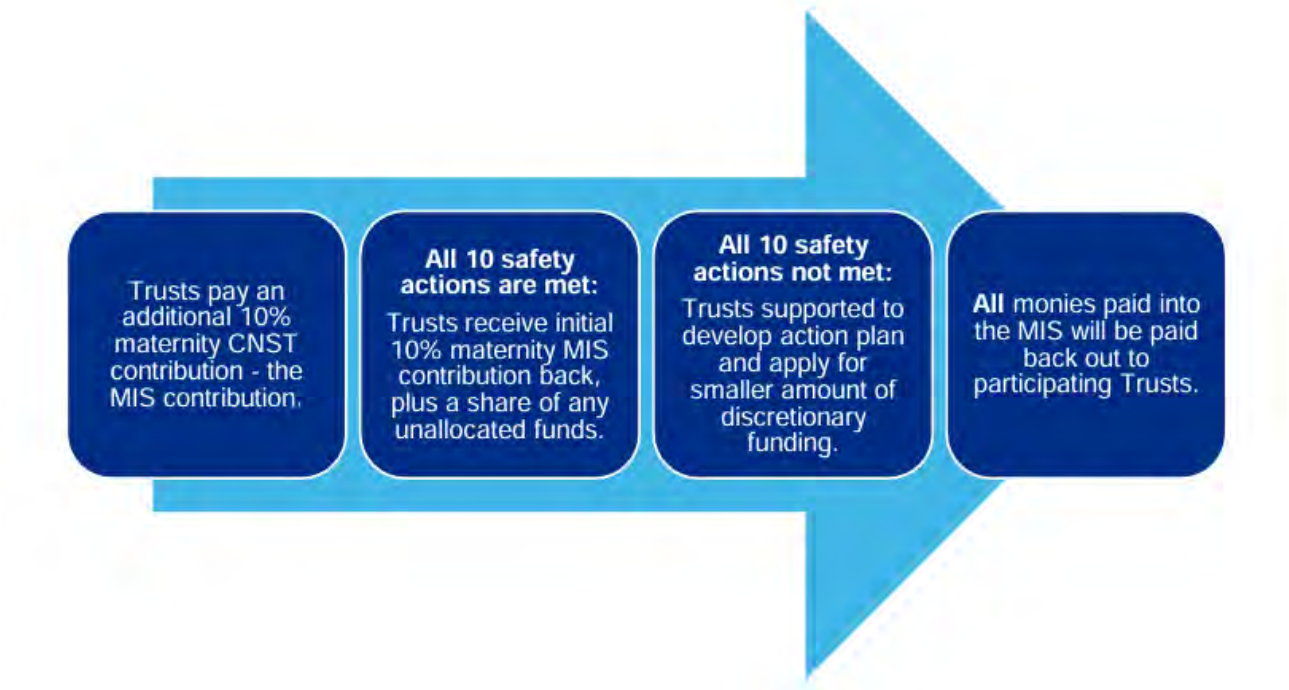
Risks associated with this report and proposed mitigations

There is a risk that all safety actions may not be met. Work continues throughout the time period to ensure that all actions are met to the required standard.

Financial implications

The NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions. The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). Members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund. Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such

a payment would be at a much lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution.



Legal implications

N/A

People implications

NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

Equality, diversity and inclusion implications

None

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

N/A

Recommendation(s)

The board are asked to consider the following report and its findings.

Report

The MIS requires that Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance. The obstetric attendance requirements are below:

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

The data is analysed monthly on a continuous basis to capture the necessary data.

Caesarean birth for major placenta praevia / abnormally invasive placenta

In the specified time period, there were 7 occasions where a woman needed a caesarean for placenta praevia. The consultant was in attendance for all 7 of these instances (100%).

Caesarean birth for women with a BMI >50

In the specified time period, there were 3 occasions where a woman needed a caesarean with a BMI of over 50. The consultant was in attendance for all 3 of these instances (100%).

Eclampsia

In the specified time period, there were 7 women who delivered with severe PET. The consultant was in attendance for 6 of these instances (85.71%). They were in theatre for 3 of the cases and present on the delivery suite for the other 3. Whilst the Consultant was not recorded as being in attendance for the final case, they did accept the transfer of the mother from another hospital and made the decision for Caesarean Section.

Maternal collapse e.g septic shock, massive abruption

In the specified time period, there were 3 women who delivered with sepsis. The consultant was in attendance in 2 of these instances (66.6%). There was no record in the hospital notes or on Euroking as to whether the Consultant was contacted or attended.

PPH >2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated

In the specified time period, there were 16 women who had an EBL of over 2000mls. The consultant was in attendance in 12 of these instances (75%). In one case the consultant reviewed the woman immediately afterwards in the ward round. In one case, the consultant was aware but there is no record of them attending. In the final 2 cases there is no evidence in the notes or on Euroking that the Consultant was called / attended. This figure has seen a slight improvement since the previous interim report presented.

Caesarean birth <28/40

There was one instance of Caesarean birth under 28 weeks in the reporting period and the consultant was in attendance in Theatre (100%)

4th Degree Tear

There was one instance of a 4th degree tear in the reporting period and the consultant was in attendance for the repair (100%).

Other

There were no instances of Premature twins (<30/40), 4th degree perineal tear repair or unexpected intrapartum stillbirth within the specified time period.

Shared learning and dissemination

In July of 2024, the labour ward lead was informed and will table at the next Consultant meeting to remind Consultants and Registrars to document discussions and attendance. The action plan for this is shown below.

Recommendations	Action	Lead	Timeframe	RAG rating	Evidence
1. All Consultants / Doctors to be informed of results of audit	Email labour ward lead consultant to inform of outcome of audit.	GW	August 24		Cons attendance email pdf.pdf
	Labour ward lead to take audit outcome to consultants meeting.	SD	August 24		
2. Documentation of attendance to be completed in MIS and mothers' intrapartum records for all RCOG required conditions for attendance	Labour ward lead to inform junior doctors of outcome of audit and remind them about the RCOG guidance. To reinforce importance of recording in the notes of consultant contact or attendance.	SD	August 24		SD cons attendance email.pdf
3. Share latest audit findings with all Consultants for onward cascade to all trainees.	Email to all Consultants	GW	December 24		

Conclusion

For the time period 2nd April 2024 to 30st November 2024 there were 35 instances where the Consultant should have been contacted to attend. The consultant was in attendance in 25 of these cases (83.33%). In the cases of PPH where the consultant was not shown as attending, the cases were managed well by senior registrars and there were no long-term adverse outcomes. This is an improvement on last year's figures, however further improvement of documentation of attendance is required.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	**Update for Maternity Incentive Scheme Safety Standard 4 Neonatal Workforce Compliance(December 2024 update)**
Presented to:	**Trust Board**
On:	**5th February 2025**
Presented by:	**Kevin Parker-Evans – Chief Nurse and DIPC**
Prepared by:	**Cathy Stanford Divisional Director of Midwifery and Child Health**
Contact details:	**T: 01942 773107 E: cathy.stanford@wwl.nhs.uk**

NWNODN Workforce Action Plan
2023/24 (year 5) 2024/25 (year 6) Update for Maternity Incentive Scheme Safety Standard 4 Neonatal Workforce Compliance (Actions 9 & 10 remain ongoing).

Complete	Partially complete/ Ongoing	Overdue	Not due

Recommendations	Action	Lead	Timeframe	Rag Rating	Comments and Evidence
9. **Review of AHP services and how they support and enhance the Neonatal workforce.**	**September 2021** Review options for shared roles with neighbouring units. (Recruit on a session basis for shared posts) Training and competency packages will be developed with support from the NWNODN. Recruit on a session basis as an option associated competencies, and training will be required Recruit to the following recommended posts. • Dietetics • Physiotherapy /OT • Speech and Language therapists • Psychologist. Job Descriptions to be developed	Cathy Stanford Divisional Director of Midwifery and Neonates	Ongoing		**October 2023 Update** Currently no funding for Additional AHP roles as recommended Will need to explore further funding for AHP roles as per recommendations. Currently compliant for Pharmacy support as designated senior paediatric pharmacist in post. Speech and Language and Dietetic support is on a request basis from WWL community Services. Physiotherapy is provided within the community following discharge from **November 2023 Update** Funding secured for part time Psychologist role to be shared with neighbouring unit, this is in addition to the existing pharmacist hours in place. Speech and language are available upon request. Physiotherapy is available in the community following discharge. Dietetic support remains difficult to achieve due to the training requirements of the existing Trust staff however the Neonatal service are actively pursuing this option with community service leads. **July 2024 Update Funding agreed to cover** 0.20 SALT. 0.20 Physio. 0.20 OT 0.20 Psychologist. Once in place this will significantly improve the onsite AHP presence within the Neonatal Unit. **Recommended Hours as per NWODN / BAPM** 0.20 SALT. 0.50 0.20 Physio. 0.70 0.20 OT 0.50 Psychologist 0.60

CS December 2024 Update

					Dietitian 0.22 Lead Neonatal Pharmacist already in place. Funding agreed with Community Division to provide AHP support. Awaiting team leader return from mat Leave and service will commence in early 2025. 0.20 SALT. 0.20 Physio. 0.20 OT 0.20 Psychologist. Once in place this will significantly improve the onsite AHP presence within the Neonatal Unit. However Dietetic support remains difficult to achieve due to the training requirements of the existing Trust staff however the Neonatal service are actively pursuing this option with community service leads to increase the dietetic presence on the NNU on a permanent basis.

10. **The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of medical staffing.** **(Safety Action 4. Maternity and Perinatal Incentive Scheme Year 6)**	• Rota Gaps for Tier I added to risk register. • Outline business case to be resubmitted for additional ANNP and/ or medical trainees • Recruitment of staff to commence training as ANNP **September 2021** • Full business case to be completed and sent for approval. • Recruitment and selection for substantive additional ANNP with allocated funds and additional Divisional Top-up	Christos Zipitis Divisional Medical Director Consultant paediatrician Cathy Stanford Divisional Director of Midwifery and Neonates			**<u>February 2022 Update</u>** Full rota cover remains an ongoing priority and vacant shifts are actively managed within the Division. There is an agreed plan within the Division to recruit to Advanced Neonatal Nurse Practitioners which will cover the shortfalls going forward and provide additional skilled senior support to the Neonatal unit. This is not an immediate solution as staff will need to be trained through accredited Training Programme which will take 2 years until completion. Year 3 Maternity Incentive Scheme (CNST) action plan and compliance paper agreed and supported by Trust Board Preliminary Outline Business Case.docx BC2022-046 - Advanced Neonatal Funding required for additional ANNP training programme once approval received. AB WWL NWNODN 2022 10 28.pdf **<u>October 2022 Update,</u>** Funding received from NWNODN to support the Tier 1 Rota Gap and provide Tier 1 cover 24/7. However, the current gap is not fully addressed by allocated funding. WWL Example Template Action Plan **<u>October 2023 Update</u>** Rota review currently being undertaken to include in-post ANNP to provide night cover alongside additional Clinical Fellows posts. Current Deanery trainee allocation is predominantly GP trainees who cannot provide cover for NNU Outline Business Case ANNP V03 13.0

October 2022 Update
Tier 1 neonatal cover –additional 3 new Clinical recruits, (long term staff grade locums) these will fill the Gaps from shortfall in allocated trainees and will allow for 1 SHO covering neonates 9 am to 9 pm weekdays and weekend and deliveries out of hours. Awaiting notification of places on January 2024 ANNP course for 2 existing members of staff as not been able to recruit to the fully funded ANNP post despite being out to recruitment several times . CNST requires that progress against the previously agreed actions in year 5 is demonstrated and clearly indicated if this is due to funding issues or lack of suitable trainees / recruitment.

October 2022 Update. Funding received from CCR to support the recruitment for an additional ANNP post. WWL will utilise any underspend to cover locum/agency gaps to help with safety until the additional ANNP post is recruited to. Overnight cover – there remains a shortfall as only one Tier 1 SHO covering both neonates and paediatrics.

October 2023 Update
Outline Business case completed to fund ANNP training and therefore increase the level of cover by an addition 2 x ANNP (Band 8a) to ensure compliance with a Tier 1 Rota 24/7 to cover the Neonatal Unit . Places requested for ANNP course for 2024

November 2023 Update
2 training places secured Interviews take place w/c 27/11/23 for January 2024 start date

Rota cover improved with dedicated SHO covering 9-9 7 days per week. Existing ANNP also able to cover some weekend or night shifts as duties allow, once trained (12 months) additional 2 ANNP will be able to provide a more robust rota cover. Rota templates have been developed which will require approval which are inclusive of ACP (to free up Rainbow Ward SHO to cover neonates) and ANNP.

August 2024 Update
2 ANNP now recruited and commenced training in January 2024. Will qualify in Jan 2025 and once period of consolidation will be able to contribute to the Tier 1 rota for NNU specific duties. Rota review currently being undertaken to include in-post ANNP to provide night cover alongside additional Clinical Fellows posts. Current Deanery trainee allocation is predominantly GP trainees who cannot provide **meaningful** cover for NNU" During the normal working times (Mon-Fri) when there are Consultants around (hot week), Tier 1 cover is less important as there is adequate senior input available during normal working hours.

December 2024 Update
Significant improvements will be in place with the introduction of a new rota which will include GP Trainees onto the night rota which will now allow for a designated Trainee to cover NNU for the 24-hour period. Also included will be the Advanced Neonatal Nurse Practitioners (ANNP'S) who will contribute to the rota to provide additional support after their 6-month period of consolidation post qualification. The existing 2 Paediatric Advanced Nurse practitioners will also contribute to the paediatric rota which additionally free's up trainee's cover for dedicated NNU cover.
This will be formalised in the new year; however, this will not come into place fully until possibly August 2025 to allow for the change over of paediatric trainees in order to not change the rota schedule part way through their placements. Additionally, the 2 newly qualified ANNP 's (Due to qualify in Jan 2025) will require time to consolidate their knowledge and skills. This will significantly improve compliance, and shortfalls should then only occur due to sickness and unavoidable absences.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Perinatal Quality Surveillance Full Report (Q3 2024-2025, Oct-Dec 24)
Presented to:	Trust Board
On:	5th February 2025
Presented by:	Kevin Parker-Evans Chief Nurse and DIPC
Prepared by:	Eve Broadhurst Head of Governance Maternity and Child Health for Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 822993 E: eve.broadhurst@wwl.nhs.uk

Executive summary

The Perinatal Quality Surveillance model incorporates the 5 principles outlined in NHSE/I document *Implementing a revised perinatal quality surveillance model* (2020) with a view to increasing oversight and perinatal quality at trust-board, local, regional, and national level, integrating perinatal clinical quality into the ICS structures, and providing clear lines of responsibility and accountability in addressing quality concerns at each level of the system.

The purpose of quarterly Perinatal Quality Surveillance report is to provide oversight and assurance to the Board that there are effective systems of clinical governance and monitoring of safety for Maternity and Neonatal services. It is a CNST requirement.

Incidents

There were 3 moderate or above harm incidents in maternity/obstetrics in Q3.

2 of the moderate harm incidents involved harm to staff in the course of their duties. None were RIDDOR reportable and have been managed in Division.

1 of the moderate harm incidents was 22+ week gestation twins born at WWL. Duty of Candour has been served and review of care is in progress.

There was a further incident from March 2023 which was reported in December 2024. This was in relation to photographs not being taken as planned following MTOP. This has been graded as moderate psychological harm and Duty of Candour has been served. Internal processes have been reviewed in Division and actions put in place. The team will meet with the family.

Exceptions

165 incidents are under investigation in obstetrics/maternity.
7 incidents are under investigation in neonatology.

All incidents are triaged in Division daily.
Ongoing support given to staff to complete within 10 days of incident.

Investigations

The report details all learning from approved investigations and actions will be monitored via Trust LfEG.

There have been no eligible MNSI cases for referral to NHS Resolution since 15.8.2023.

Screening Incidents Assessment forms (SIAFs) are now reported via the PQSR report (PSIRF national priority). 2 SIAFs were required in Q3. Both will be added to StEIS in January 2025 for monitoring. Both no harm.

Exceptions – 1 case awaiting cause of death before completion of PMRT. Inquest scheduled January 2025.

Feedback and complaints

In Q3 24/25, 5 formal complaints have been received for maternity services, which is higher than Q2. Of these 5 complaints, two were resolved informally as concerns due to the quick action of staff members.

0 complaints were received for neonatal services.

There is a downward trend in the number of formal complaints received over the rolling 12-month period in maternity services, with neonatal service complaints remaining very low.

A wealth of positive feedback has been collated from service users via the MNVP and the P&PE midwife and has been fed back to staff.

FFT response rates slightly decreased Q3 with a 95.7.% positive response rate. Themes from negative comments were related to parking and partners not being able to stay overnight during the induction process.

The CQC have released the national Picker survey results officially in December 24.
The results are incredibly positive for WWL.
97% of mothers felt that they were treated with respect and dignity
98% felt that they were treated with kindness and compassion during labour and birth
96% felt involved in decisions about their care during labour and birth.

No Exceptions.

SCORE survey

WWL Maternity and Neonatal services participated the SCORE staff survey to get a better understanding of team culture and engagement. 169 members of staff responded to the survey, giving a response rate of 54%. Analysis of the SCORE survey was undertaken in Q2.
An action plan is planned with support from external colleagues. There is no further update from last report.

Risks

The Risk Register has been included for maternity and neonatal services.

At the end of Q3 24/25,

0 risks under review.
0 risks awaiting approval
0 risk approved
0 risks closed

Exceptions – Work continues with low scoring risks. There are 6 risks scoring 6 or less which are under review to establish if can be tolerated or require further action.

Ockenden 2

Q3 has seen some progress against the Ockenden actions, and 3 outstanding actions remain.

MIAA Ockenden audit has been completed which concluded that we have provided *substantial assurance.*

Exceptions - 3 actions remain, all are in progress.

Maternity Incentive scheme

CNST MIS Year 6 was published on the 2nd of April 2024, and we are working closely with the LMNS for shared oversight and quality assurance. Evidence was submitted to the LMNS in Q3 for all 10 Safety Actions for preliminary QA before final submission. Initial feedback from the LMNS has been excellent. Final submission is 3 March 2025.

No exceptions

ATAIN

In Q2 24/25, the ATAIN MDT audit has shown the total number of term admissions to the NNU was 6.34% of total term live births, 2 admissions were excluded from the audit, they were expected admissions due to social issues. Unexpected term admissions to the NNU accounted for 5.97% of total term live births. This is an increase from Q1 24/25.

There is still work to be done with 7 (20 %) of total admissions being potentially avoidable which is a rise from Q1 24/24, and QI work is ongoing.

The findings and recommendations from audit are shared in the body of the report.
Preliminary areas of focus are 'cautious admissions' and need for robust processes to support junior staff with decision making to ensure appropriate transfer to the NNU, and the 'elective LSCS pathway' to avoid hurried admissions to either the NNU or the postnatal ward. There is also ongoing work with embedding the warm care bundle and the new neonatal resuscitation documentation.

No exceptions

Mortality and PMRT

There were 0 stillbirths in Q3 24/25.

There was 1 neonatal death following an unplanned breech birth at home. The birth was attended by NWAS. This case is under review and NWAS will support the PMRT.

Low numbers make thematic analysis difficult. However, all data is logged to allow analysis over time. We continue to monitor ethnic origin, social deprivation index, health indicators and learning for all mortalities. The full annual mortality report will accompany this paper.

Maternal age ≥30 years continues as a theme in Q3.

PMRT 100% compliant against MIS 6 Safety Action 1.

No exceptions

Saving Babies Lives 3

The report provides a full gap analysis of our progress against SBL 3 targets. The LMNS has reported significant assurance with 87% compliance (target 70%) in Q2. Work continues and the midwifery sonography service was commenced in Q3 to further support the SBL agenda.

No exceptions

GMEC LMNS Ambition

- Reduction in still births to a rate of 3.85 per 1000 registerable births in 2023/24
- Reduction in still births to a rate of 3.5 per 1000 registerable births in 2024/25
- Reduction of serious intrapartum brain injury to a rate of 1.0 per 1000 live births in 2023/24
- Reduction of serious intrapartum brain injury to a rate of 0.70 per 1000 live births in 2024/25

WWL measures its progress against the GMEC LMNS ambition. Over this rolling 12 period, stillbirth data has continued a steady decline. Data for the rate of HIE is positive and it is vital that we continue to monitor, learn and improve to sustain this figure.

The annual Mortality and PMRT Report will accompany this paper.

Mandatory training

Maternity mandatory training is compliant >90% in all staff groups.

No exceptions

Workforce/ Safe staffing

At the end of Q3, there are 4.65 WTE midwifery vacancies, and 2.74 WTE MSW vacancies.

2.68 WTE midwives have been recruited and will commence in post early Q1 25/26.

At the end of Q3 there are 0.80 WTE neonatal nursing vacancies and 0.64 Band 3 HCA vacancies.
The child health matron post is recruited to, and the post holder is expected to commence in late February 2025. 1 NNU Band 7 shift coordinator to commence in post in January 2025.

Staffing Red Flags

In Q3 2024/2025 there were 30 validated red flag events which is a significant increase when compared to previous data.

We maintained 100% compliance with supernumerary shift co-ordinator throughout Q3.

The significant increase in red flags for Q3 was due to delay between admission and commencing the induction of labour process (29 cases) due to staffing shortages caused by short term sickness. Escalation was in line with trust guidance and there was no harm reported. One red flag was 'recorded for delayed recognition of and action on abnormal vital signs', this was due to a delay in medicines administration due to electronic prescribing on HIS (this is not utilised in maternity).

Maternity Unit Diverts

In Q3 24/25 there were no maternity unit diverts.

GMEC benchmarking (latest available data on Tableau)

In Q2 24/25, WWL has performed worse than the GMEC average in all but 2 metrics - neonates with a diagnosis of HIE 2 & 3 at term ≥ 37 weeks and total early neonatal deaths.

*Note that current recommendations are that Trusts do not benchmark the rate of Emergency Caesarean Sections as it was recognised by Ockenden that the pressure for normality may compromise patient safety.

SPC charts (until end Q3 24/25)

The SPC charts below are a more up to date and useful tool to review our own progress and position against GMEC average over time.

In the last 12 months the parameters outside the GMEC mean are for term admissions to the NNU, 3rd degree tears and Apgars <7 at 5 minutes.

In line with the PSIRF, data is reviewed in Division to direct our focus for improvement work.
In Q3 an OASI working group was set up to tackle the rising trajectory of 3rd degree tears as despite initial improvements following the launch of OASI 2 in April 2024, rates are now rising. Rates of Apgars <7 at 5 have not significantly improved and an emerging theme from analysis is a link to induction of labour. It is a recommendation from this report that WWL liaise with the Royal Bolton Hospital as they have undertaken a piece of improvement work in relation to induction of labour.

ATAIN QI work has resulted in a downward trend in term admissions overall with the gap significantly closed between WWL rates of admission and the GMEC mean.

No exceptions

LMNS Outlier Assurance

No requests from the LMNS for data assurance were made in Q3.

No exceptions

Recommendations

It is requested that the Board of Directors and Executives review the contents of this paper to provide oversight and assurance that there are effective systems of clinical governance and monitoring of safety for Maternity and Neonatal services.

Maternity Perinatal Quality Surveillance Full Report

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

1. Obstetrics/Maternity Incidents occurring in Q3 – Severity (data pull 16/01/2025 - DATIX)

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
No Harm	62	67	48	64	71	45	57	67	48	49	55	66
Low	0	6	2	10	7	15	14	5	18	6	7	7
Moderate	0	0	0	0	1	0	0	0	0	0	1	2
Severe	0	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**62**	**73**	**50**	**74**	**79**	**60**	**71**	**72**	**66**	**55**	**63**	**75**

1.1 Neonatal Incidents occurring in Q3 – Severity (data pull 16/01/2025 – DATIX)

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
No Harm	3	18	21	42	26	8	3	4	12	7	14	12
Low	0	2	1	1	3	1	0	0	2	0	0	0
Moderate	0	1	1	0	0	0	0	0	0	0	0	0
Severe	0	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total	**3**	**21**	**23**	**43**	**29**	**9**	**3**	**4**	**14**	**7**	**14**	**12**

There were 3 moderate or above harm incidents in maternity/obstetrics in Q3.

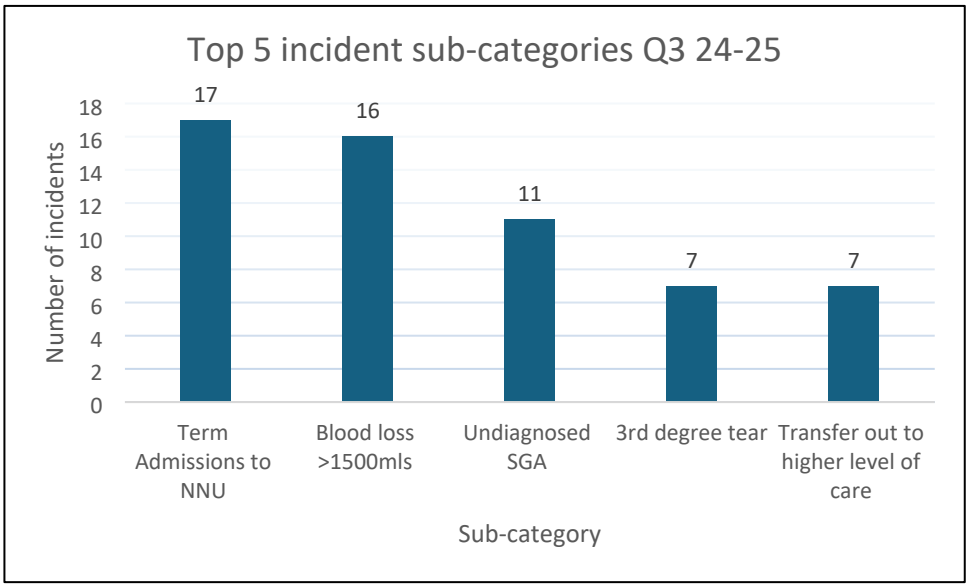
2 of the moderate harm incidents involved harm to staff in the course of their duties. None were RIDDOR reportable and have been managed in Division.

1 of the moderate harm incidents was 22+ week gestation twins born at WWL. Duty of Candour has been served and review of care is in progress.

There was a further incident from March 2023 which was reported in December 2024. This was in relation to photographs not being taken as planned following MTOP. This has been graded as moderate psychological harm and Duty of Candour has been served. Internal processes have been reviewed in Division and actions put in place.

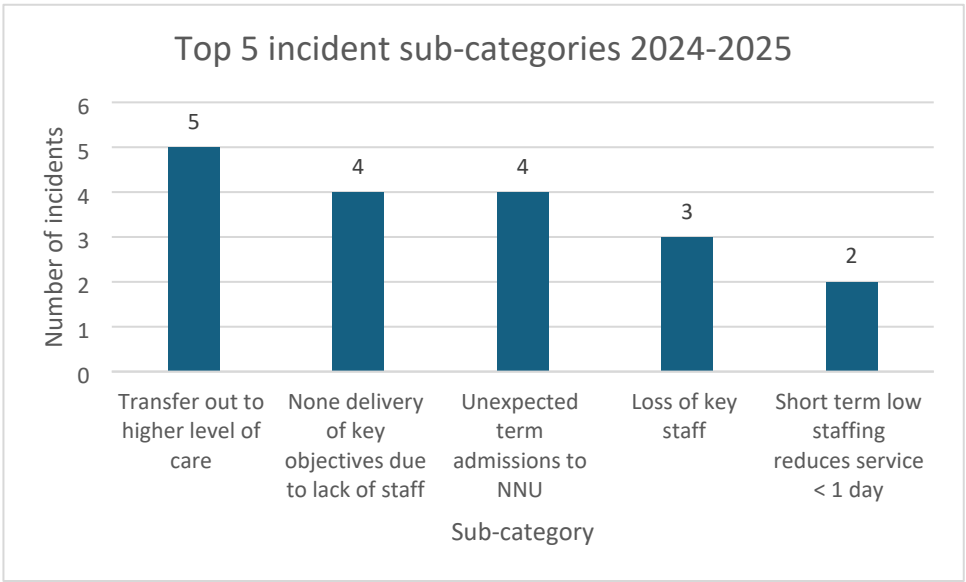
Exceptions
165 incidents are under investigation in obstetrics/maternity.
7 incidents are under investigation in neonatology.
All incidents are triaged in Division daily.
Ongoing support given to staff to complete within 10 days of incident.

1.2 Top 5 Reported Incident Sub-Categories Maternity– Q3 24/25 (data pull 16/01//2025 - DATIX)



Workstreams are in place for the review of term admissions to the NNU, Blod loss >1500mls, undiagnosed SGA and in Q3 a new workstream to look at the rising trajectory for 3rd degree tears was set-up.

1.3 Top 5 Reported Incident sub-categories Neonatology – Q2 24/25 (data pull 20/10/2024 DATIX)



Staffing continues to be the main reporting category with 1/3 of incidents reported relating to staffing deficits. All incidents reported were no/low harm.

1.4 Incidents reported to 'StEIS' and external agencies Q3 24/25

No incidents were logged on 'StEIS' in Q3.

No incidents met the MNSI referral criteria

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Incidents reported to 'StEIS'	0	0	1	2	0	1	1	0	0	0	0	0
MNSI referrals	0	0	0	0	0	0	1	0	0	0	0	0
Accepted MNSI referrals	0	0	0	0	0	0	0	0	0	0	0	0
Cases referred to NHSR	0	0	0	0	0	0	0	0	0	0	0	0
SIAFs (Antenatal and newborn screening)	-	-	-	-	-	-	0	0	0	1	0	1

2 Antenatal and Newborn Screening incidents were subject to SIAF in Q3. They will be logged on StEIS in January 2025 for monitoring purposes in line with the PSIRF national priorities.
1 incident related to none adherence to the Hepatitis B pathway in relation to surveillance bloods following birth, and 1 incident related to a delayed anomaly scan. Both incidents had a human factors element and pathways and fail-safes have been strengthened working alongside our Specialist Services colleagues and NHSE. Actions are monitored via DATIX and evidence will be submitted to NHSE.
Both incidents were no harm and professional Duty of Candour has been served.

1.5 MNSI overview

Cases to date	
Total referrals	25
Referrals / cases rejected	12
Total investigations to date	13
Total investigations completed	13
Current active cases	0
Exception reporting	0

No cases were referred to MNSI in Q3 24/25.
There are no open MNSI cases at the end of Q2 24/25.

The next MNSI QRM will be held on was held on the 31st January 2025.

1.6 MNSI /NHSR assurance Maternity Incentive Scheme Year 6 reporting period

There have been no eligible cases for referral to MNSI/NHS Resolution since 15/08/2023. MIS Year 6 was published on the 02/04/2024 and assurance data will continue to be provided as cases occur.

The MNSI/NHSR patient information leaflet has been updated in Q3 and ratified through usual governance processes. This will be sent to families with the formal Duty of Candour letter.

Advise, Resolve, Learn – MNSI / NHSR

MIS Year 6 reporting period 8.12.2023-30.11.2024

MNSI REF	Criteria	Date of incident	MNSI /NHSR Duty of Candour complete	Accepted / Rejected by MNSI	Details to legal for NHSR referral	NHSR REF
MI-037906	Therapeutic cooling	31.7.2024	NA – does not fit criteria	Rejected (congenital anomalies)	NA	NA

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

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

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

No Exceptions

1.7 Learning from completed investigations

In Q3 24/25, 2 completed investigations were approved at LfPSE. Action plans will be monitored via LfEG.

WEB number	Date	Incident	Investigation tool/s	Learning
WEB157774 StEIS 2024/3611	Mar 24	Unplanned Neonatal Transfer to Level 3 Unit (Death).	Detailed RR & Timeline. Expert independent review.	The plan for antenatal steroids was not re-visited and they were not given. Care on TC was fragmented between nursing and midwifery staff without clear handover of care / standardised processes of documentation. There were gaps in documentation of cares of baby on TC. There was opportunity for earlier paediatric review on TC in the context of a pre-term baby with jaundice and poor feeding. Normal observations may have given false reassurance to staff.

				There was an opportunity for administration of antibiotics 2.5 hours earlier. DIC was unlikely related to any omission in administration of Vitamin K. DIC may have been associated with sepsis / infection / toxic / immunological reactions. The aetiology of the DIC is not known and postmortem may support further understanding.
WEB161467 StEIS 2027/61467	May 24	Cooled baby – 35 weeks Suboptimal care of deteriorating patient	RR PSII	The baby was growth restricted (birth centile 0.4) and there was evidence that the baby's heart rate showed chronic hypoxia from admission. There is no standardised process of handover of care nationally between Trusts when women want to transfer care to another hospital. There was no clear communication in the records of the plan of care on transfer from Trust A (Derby Hospital) and the recent plan for twice weekly doppler scans was not easy to find and was missed. The last scan at Trust A was undertaken on Wednesday 15th May 2024 where a plan was re-made for twice weekly doppler scans. Trust A had increased doppler scans from once to twice weekly on the 9th May but were unable to accommodate at that point. The booking appointment with WWL was on Friday 17th May 2024. A doppler scan would have been due by Sunday 19th May. There is no scan service at the weekend. The earliest opportunity for doppler scan would have been on Monday 20th May which is the date the mother attended Maternity Triage with abdominal pain and birthed. A Cardiotocography (CTG) monitoring on the Day Assessment Unit could have

				been arranged to provide extra fetal surveillance had the need for twice weekly dopplers been realised. A CTG provides a snapshot view of fetal wellbeing by monitoring the heart rate for a period of time. However, in the absence of uterine activity and in the presence of normal fetal movements it is unlikely that a CTG would have made any significant difference to the outcome in this case. The cord gases reflected chronic hypoxia with metabolic acidosis which is consistent with the scan findings showing a small for gestational age fetus with raised umbilical artery doppler PI. Improvements were noted in relation to the importance of utilising the emergency call bell on Maternity Triage and using the 2222 emergency bleep. However, the time from admission on Maternity Triage to delivery of the baby was only 58 minutes and care was reasonable. Baby was cold on admission to the neonatal unit.

1.8 Investigation progress – overview of open investigations

At the end of Q3, 1 serious incident investigation is open.

WEB number	Date	Incident	Progress	Stage	Plan
PSIRF					
WEB156568 StEIS 2024/3444	Feb 24	Suspected co-sleeping death at home	RR presented at LfPSE	Police investigation completed.	Awaiting cause of death. Inquest scheduled in January 25. For joint PMRT with Bolton.

Exceptions

At end of Q3, 1 case awaiting cause of death before completion of PMRT. Inquest scheduled January 2025.

1.9 Triangulating data – Claims, Incidents, Complaints

NHS R attended the Safety Champions meeting in Q3 to discuss the new Scorecard with claims from 01/04/2014 to 31/03/2024 in detail.

On a quarterly basis, the Trust's Scorecard is reviewed alongside incident and complaint data and themes triangulated. In Q2 the themes identified were Fail/delay treatment and Psychiatric/Psychological. Actions are instigated based on the findings.

Claims scorecard 01/04/2014 - 31/03/2024

Top injuries by volume	Volume	Top injuries by value	Volume
Psychiatric/Psychological Dmge.	7	Brain Damage	2
Adtnl/unnecessary Operation(s)	6	Cerebral Palsy	1
Unnecessary Pain	3		
Loss Of Baby	4	Thrombosis/embolism	2
Fatality	3	Loss of baby	3
Top causes by volume.	**Volume**	**Top causes by value**	**Volume**
Fail / Delay Treatment	12	Fail To Make Resp To Abnrm FHR	1
Failure to perform tests	3	Fail To Act On Abnorm Test Res	2
Inappropriate treatment	3	Fail To Monitor 2nd Stg Labour	2
Fail/delay admitting to hosp.	2	Fail / Delay Treatment	12
Fail to act on abnorm test res	2	Failure To Supervise	1

Maternity Incentive Scheme - Safety Action 9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or Directorate) quality meeting.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Advise, Resolve, Learn

Triangulation Q3 2024-25

Inappropriate treatment –Twins 22+ weeks born in DGH - ? Opportunity for transfer sooner, twins not optimised and no counselling for family re same. Mum sent home following MTOP medication without information that may pass baby at home.
Psychiatric/Psychological – Lack of empathy referring to her baby as 'products of conception' following MTOP. Medical photographs not requested despite getting consent following MTOP. Woman felt disability not considered seriously in discussions re delivery choices.

Complaints Q3 2024-25 (5 formal complaints in Q3)

Communication - MW not prepared for appointment, lack of information and feeling dismissed in the antenatal period, lack of information regarding normal delivery, lack of information re what to expect at LSCS, lack of information of what to expect at home after MTOP medication, conflicting information re mode of delivery, conflicting information re discharge, midwife appointments not kept in postnatal period.
Values and behaviours –Lack of empathy in language used 'products of conception', concerns re postnatal depression and reflux dismissed by staff, disability considered in discussions re mode of delivery.
Patient care - Catheter care.
Clinical treatment – Cannulation injury

Learning Q3 2024-25

Signs of labour are not the same in very preterm pregnancies
Need to clarify if Actim Partus is suitable for use in women with old blood loss
Our language is extremely important and can cause harm.
Need failsafe to ensure medical imaging is not missed.
There is a need to strengthen mechanisms ofinformation giving in pregnancy

Incidents Q3 2024-2025 (4 moderate or above harm incidents)

2 involved harm to staff during the course of their duties.
1 was 22+ 6 twins born in DGH ? Opportunity for earlier transfer
1 was case of medical photographs not being requested despite consent being gained

Actions Q3 2024-5

Review medical illustration referral processes	By 31/03/2025 CP	
Strengthen mechanisms of information giving in pregnancy	By 30/09/2025 AL	
Clarify if Actim Partus is suitable following minimal/old brown blood loss PV	By 01/03/2025 AV	

2. Patient and staff experience Q3 24-25.

2.1 Patient and Public Engagement

A wealth of positive feedback has been collated from service users from ward visits, in-patient survey and the MNVP Thank you Thursday, and has been fed back to **51** individual midwifery and medical team members.

The P&PE midwife has visited 44 women in Q3 on the Maternity Ward who have had emergency procedures during their birth and a further 6 women whilst completing the WWL in-patient survey.

In Q3 24/25 there has been 100% positive feedback given about the care that had been received. Themes of positive feedback were values and behaviour, clinical treatment and good communication and support.

26% identified areas for improvement for the Maternity service, themes were communication, staff attitude, clinical treatment. These are feedback to individual Ward leaders to manage.

The P&PE midwife manages an overarching action plan based on service improvement feedback.

2.1.1 Examples of positive feedback received by the P&PE midwife from ward visits

Care amazing could not fault it. Community care was good.

Everyone has been lovely and explained what was happening.

Can't fault and praise staff enough. Really good and calm.

Explanations from doctors good. Everyone amazing.

Amazing staff, great care, nothing to improve

Pretty faultless, every member of staff incredible

Whole experience cannot fault. Good information. Explanation and support

Fantastic, brilliant care from everyone. Dad felt supported and included.

Amazing care with everything provided from IOL- ward.

Just THANK YOU

1st baby during Covid., no visitors alone but staff lovely. So different now was so lovely to see friendly staffs faces again.

Everyone exceptional, taken good care of us and thanks to them we are both well and fine. On top of their game.

Amazing, good explanations. Staff brilliant. Was anxious about coming in but was much better than she thought.

Amazing care. Husband cried when Dr Osman came in as he knew everything would be OK.

Everyone very good care. Doctor cared for them well and was reassuring. Midwife made them feel comfortable and helped her.

IUT Ormskirk. Great care, staff have done a lot, let partner stay due to anxiety.

Whole team amazing. Staff reassuring. Calm made a scary situation better.
Care brilliant, midwives personable, welcoming, reassuring to see the same staff postnatal as they had cared for her AN. TC brilliant staff presence in bay reassuring.

2.2 MNVP engagement

Walk the Patch visit was completed on 8th November 2024 by the MNVP Lead. 11 service users were spoken with during the visit (of these, 27% were non-white ethnic origin, 27% receiving transitional care).

Q3 Positive Feedback from MNVP Walk the Patch (Maternity Ward and Neonatal Unit)
Partners, when present, asked if they felt included in care and had information explained – all did
Repeated compliments about staff being personable, helpful and kind
'Felt supported' repeatedly used in feedback
1 service user chose to transfer to WWL due to previous poor experiences elsewhere
Lots of individuals singled out for praise – this was included in the Thank you Thursday.
Q3 Areas for improvement from the MNVP Walk the Patch (Maternity Ward and Neonatal Unit)
Parking has continued to be highlighted as an issue

Sometimes lack of explanations
'I wasn't expecting to have to ask for pain relief'
On Transitional care- can be a bit confusing who to ask for things. May have missed explanations as short staffed that day
IOL - delays reported. Some lack of communication about waiting times and when gels would be given
Dads surprised about not being able to stay overnight when baby is born in the evening
TLC – long waits reported
Hard to get hold of community midwives (antenatal)

15 Steps inspection for Maternity was completed on the 3rd December 24. A report was completed including positive feedback and with an Action plan attached.
Feedback was overall very positive from the inspection team of 6, informing that they had to be extremely fastidious to provide any actions.

2.3 Friends and Family Test source Envoy 17.01.24

	Responses	Positive
Antenatal	21	20
Birth	23	21
Postnatal Community	11	11
Postnatal Ward	87	84
Total	**142**	**136**

According to the Envoy system there has been a slight decrease in responses in Q3 as compared to Q2.

136 out of 142 comments were positive, giving an overall positive response rate of 95.7% which again is slightly lower than Q2. The remaining comments were mixed or negative feedback relating to parking and partner not being allowed to stay overnight

Work is underway to gather patient feedback specific to the Antenatal and Newborn Screening Service to inform service improvement.

2.4 National Picker Maternity Survey (Patient Survey)

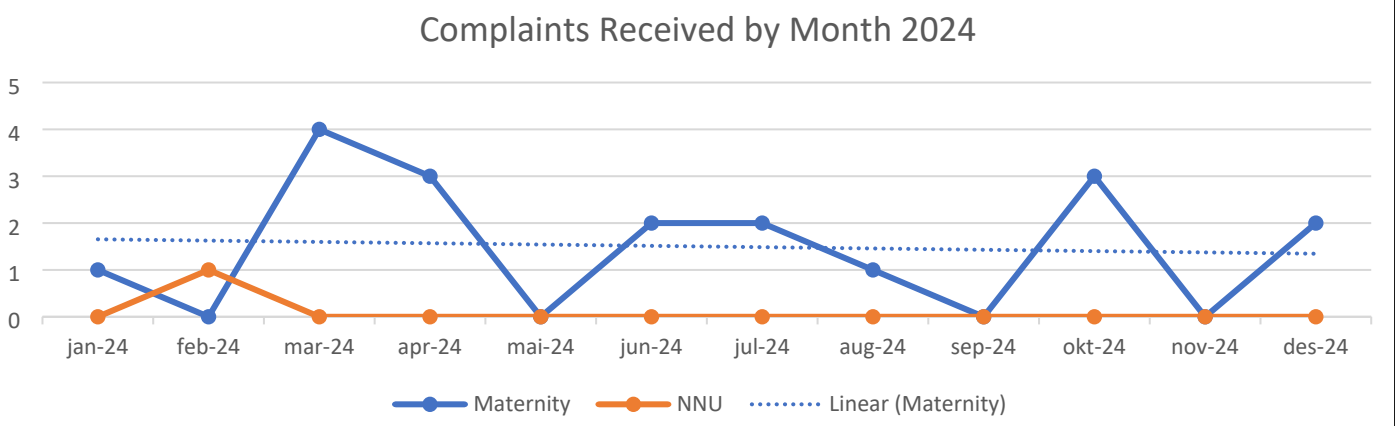
The results of the 2024 National Picker Maternity survey were received in Q2.
The CQC have released the national survey results officially in December 24.
The results are incredibly positive for WWL.

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

The MNVP lead and P&PE midwife are working together to produce the action plan for the survey. Remaining actions from the National Picker maternity survey action plan for 2023 have been carried forward onto the action plan for 2024.

2.5 Complaints

Formal Complaints	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24
Maternity	1	0	4	3	0	2	2	1	0	3	0	2
NNU	0	1	0	0	0	0	0	0	0	0	0	0



In Q3 24/25, 5 formal complaints have been received for maternity services, which is higher than the previous quarter. Of these 5 complaints, 2 were resolved informally as concerns due to the quick action of staff members.

0 complaints were received for neonatal services.

Themes from complaints

Q3	Oct	Nov	Dec	Total
Waiting Times	1	0	0	**1**
Communication	3	0	2	**5**
Clinical Treatment	1	0	1	**2**
Values and Behaviours	1	0	1	**2**
Patient Care	0	0	1	**1**

Waiting Times

- Concern raised around heavily pregnant women waiting in the waiting rooms due to clinics running behind.

Communication

- Concern raised around poor preparation prior to the midwife appointment, where the community midwife believed the patient was having a multiple pregnancy.
- Complaint raised frustration at a lack of information and understanding due to poor communication through the antenatal period and feeling dismissed due to being a first-time mum.
- Concern raised around receiving conflicting information from healthcare professionals regarding mode of delivery and birth of baby.
- Extensive concern raised regarding communication, including receiving conflicting information around discharge, ability for partner to stay on the ward, no information given re pulling the abdomen during Caesarean, and promises for visits not kept by the community midwife postnatally.

- Complaint raised around a lack of information on what to expect in a natural delivery, what to expect when taking medication to support in compassionate delivery at home, what to expect during a speculum examination, the language used when referring to "product of conception" and a lack of empathy.

Clinical Treatment

- Complaint raised around HELLP Syndrome.
- Complaint raised over injury caused by cannulation.

Values and Behaviours

- Concern raised around not feeling heard regarding wishes around mode of delivery and feeling as if her disability was not being treated seriously.
- Extensive concern raised about feeling treated like a teenager during discussions around future contraception, concerns around post-partum depression and reflux being dismissed.

Patient Care

- Extensive concern raised around poor catheter care following delivery.

No Exceptions

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q2 24/25

	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU	TARGET
July – September 2024	552	35 **(6.34%)**	33 **(5.97%)**	7 **(20%)**	**<4.6%**

In Q2, the total number of term admissions to the NNU was 6.34% of total term live births. This is an increase from Q1.

Unexpected term admissions to the NNU accounted for 5.97% of total term live births. This is an increase from Q1 and takes us above the target number of admissions.

There is still work to be done with 7 (20%) of total admissions being potentially avoidable.

Findings from Q2 audit

- Rates of term admissions to the NNU are on an overall downward trajectory
- The highest cause of admission in Q2 was respiratory distress (66.6%)
- Compliance around use of the NEWTT 2 tool was good
- 19 of the mothers in these cases (57.57%) underwent Induction of Labour.
- There were 7 women (21.21%) who were diagnosed with Diabetes (pre-existing or Gestational).
- There were 12 women who had a BMI of over 30 (36.36%)
- The Warm Care Bundle sticker is not used consistently, and hypothermia (below 36.5) was noted in 5 cases (15.15%)
- A further 9 cases (27.27%) did not have temperatures documented for the baby.
- DASH stickers were not completed in 21 cases (63.63%).
- Though the WARM sticker was present in 32 cases (96.96%), ambient temperature was not recorded on this sticker in 26 cases (78.78%)

- Antenatal education around colostrum harvesting was not discussed consistently and remains a point of learning.
- There is a new proforma for neonatal resuscitation which has been introduced at the end of Q2 to improve documentation and support further reviews.
- In Q2, 30.3% of admissions to the NNU were from ethnic minority backgrounds (this is a reduction from Q1).
- Reviews have identified deprivation categories 1 – 3 are the most frequent (54.54%)
- The majority of Unexpected Term Admissions to NNU were following Caesarean Section (75.75%)
- Emergency Caesarean Section babies accounted for almost half (45.45%) of admissions. While babies born by Elective Caesarean Section accounted for a further 30.33%.
- WWL currently follow "PEEP for 30": babies still continue to be admitted for Respiratory Distress. 11 babies (33.33%) were admitted to the Neonatal Unit before 30 minutes of life.
- 7 babies had a birth weight below the 10th centile (21.21%).

Recommendations

- Embed the Warm Care Bundle tool to improve thermoregulation of the newborn, as this quarter's findings indicate further work is required.
- The embedding of the newly approved scribe sheet for neonatal resuscitation.
- Continue efforts to support colostrum harvesting advice in the antenatal period, with the support of the Infant Feeding Specialist Midwives.

No exceptions

2.6 SCORE staff survey

The SCORE survey is a measure of culture and engagement in the workplace. 169 members of staff across maternity and neonatal services responded to the survey, giving a response rate of 54%.
Analysis of the SCORE survey was undertaken in Q2.
An action plan is being created with support from external experts. There has been no further progress made.

3. Risk register – Maternity and neonatal services

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

Under review	-	-	-	-
Awaiting approval	-	-	-	-
Approved	MAT	3772	Euroking System Error	20
	MAT	3802	Obstetrics/Gynaecology Tier 2 Staffing Shortages	12
	MAT	3605	Obstetricians and Gynaecologists on call rotas not allocating compensatory rest	12
	NEO	1977	Specialist AHP services should be available in all units for neurodevelopment and family integrated care	12
	MAT	4003	Inability to provide ultrasound scanning within 24 hours (SBL 3)	10

	MAT	3780	Maternity Ligature Risk	10
	MAT	3732	Entonox Risk	9
	MAT	1469	The risk of abduction from the maternity unit	8
	MAT	3756	Medical Devices Training	8
	MAT	3727	Euroking To PAS Error Risk	6
	MAT	3400	Screening for GBS at 36 weeks gestation in women with a history of GBS (group B beta-haemolytic streptococcus) infection	6
	NEO	1975	BAPM staffing guidelines - Staff shortages on the Neonatal unit	6
	MAT	140	Backflow of raw sewage due to blocked drains	4
	MAT	2459	Transportation and supply of Entonox (Nitrous oxide 50% and oxygen 50%) by Community Midwives for use at Homebirths	4
	MAT	3362	Midwifery Staffing Shortages	4

At the end of Q3 24/25,

0 risks **under review.**
0 risks **awaiting approval**
0 risk **approved**
0 risks **closed**

Exceptions

Work continues with low scoring risks. There are 6 risks scoring 6 or less which are under review to establish if can be tolerated or require further action.

4. Ockenden 2 progress update

Q3 Update		Local Actions			N/A	Trust Corp Action	National/ regional Action
		Red	Amber	Green			
EA1	Workforce planning and sustainability	0	1	7			3
EA2	Safe staffing	0	0	9			1
EA3	Escalation and accountability	0	0	5			
EA4	Clinical governance- leadership	0	0	6		1	
EA5	Clinical governance – incident investigation and complaints	0	0	7			
EA6	Learning from maternal deaths	0	0	2			1
EA7	Multidisciplinary training	0	1	6			
EA8	Complex antenatal care	0	0	4			1
EA9	Preterm birth	0	0	4			
EA10	Labour and birth	0	1	3	2		
EA11	Obstetric anaesthesia	0	0	7			1
EA12	Postnatal care	0	0	4			
EA13	Bereavement care	0	0	4			
EA14	Neonatal care	0	0	5			3
EA15	Supporting families	0	0	3			
	Total	0	3	76	2	1	10

There are a total of 15 immediate and essential actions and 92 sub actions from the Ockenden 2 report.
Where actions require national/regional input, an action plan has been put in place to ensure IEAs are mitigated within our capabilities in the interim.

Q3 24/25 has not seen progress against the actions and 3 remain outstanding.

The MIAA Ockenden 2 audit has been completed and the result was *substantial assurance given*.

Exceptions - 3 actions remain, all are in progress. All action leads have been asked to provide regular updates on their actions.

5. CNST - Maternity Incentive Scheme Year 6

The maternity incentive scheme (MIS) applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

MIS Year 6 was published on the 2nd of April 2024, and we are working closely with the LMNS for shared oversight and quality assurance. Evidence of compliance with all 10 Safety Actions was submitted to the LMNS in December 2024 with excellent initial feedback. The final submission date will be 3rd March 2025.

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	7	0	7
2	0	0	3	0	3
3	0	0	5	0	5
4	0	0	20	0	20
5	0	0	7	0	7
6	0	0	7	0	7
7	0	0	8	0	8
8	0	0	19	0	19
9	0	0	10	0	10
10	0	0	9	0	9
Total	0	0	95	0	95

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

No exceptions

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q2 24/25

	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU	TARGET
July – September 2024	552	35 (6.34%)	33 **(5.97%)**	7 (20%)	**<4.6%**

In Q2, the total number of term admissions to the NNU was 6.34% of total term live births. This is an increase from Q1.

Unexpected term admissions to the NNU accounted for 5.97% of total term live births. This is an increase from Q1 and takes us below the target number of admissions.

There is still work to be done with 7 (20%) of total admissions being potentially avoidable.

Findings from Q2 audit

- Rates of term admissions to the NNU are on an overall downward trajectory
- The highest cause of admission in Q2 was respiratory distress (66.6%)
- Compliance around use of the NEWTT 2 tool was good
- 19 of the mothers in these cases (57.57%) underwent Induction of Labour.
- There were 7 women (21.21%) who were diagnosed with Diabetes (pre-existing or Gestational).
- There were 12 women who had a BMI of over 30 (36.36%)
- The Warm Care Bundle sticker is not used consistently, and hypothermia (below 36.5) was noted in 5 cases (15.15%)
- A further 9 cases (27.27%) did not have temperatures documented for the baby.
- DASH stickers were not completed in 21 cases (63.63%).
- Though the WARM sticker was completed in 32 cases (96.96%), ambient temperature was not recorded on this sticker in 26 cases (78.78%)
- Antenatal education around colostrum harvesting was not discussed consistently and remains a point of learning.
- There is a new proforma for neonatal resuscitation which has been introduced at the end of Q2 to improve documentation and support further reviews.
- In Q2, 30.3% of admissions to the NNU were from ethnic minority backgrounds (this is a reduction from Q1).
- Reviews have identified deprivation categories 1 – 3 are the most frequent (54.54%)
- The majority of Unexpected Term Admissions to NNU were following Caesarean Section (75.75%)
- Emergency Caesarean Section babies accounted for almost half (45.45%) of admissions. While babies born by Elective Caesarean Section accounted for a further 30.33%.
- WWL currently follow “PEEP for 30”: babies still continue to be admitted for Respiratory Distress. 11 babies (33.33%) were admitted to the Neonatal Unit before 30 minutes of life.
- 7 babies had a birth weight below the 10th centile (21.21%).

Recommendations

- Embed the Warm Care Bundle tool to improve thermoregulation of the newborn, as audit findings indicate further work is required.
- Roll-out the newly approved scribe sheet for neonatal resuscitation.
- Continue efforts to support colostrum harvesting advice in the antenatal period, with the support of the Infant Feeding Specialist Midwives.
- Liaise with Royal Bolton Hospital / NHS Futures Platform for their initiatives in relation to Induction of Labour.

No exceptions

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

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Total births	**199**	**194**	**213**	**204**	**223**	**181**	**202**	**211**	**203**	**192**	**194**	**216**
Total Stillbirths	**1**	**1**	**0**	**1**	**0**	**0**	**1**	**1**	**2**	**0**	**0**	**0**
Stillbirths adjusted for MTOP	1	1	0	1	0	0	0	0	1	0	0	0
Total late fetal loss 22 – 23+6	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Neonatal Deaths	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Early neonatal deaths (0-7 days)	1	1	0	0	1	0	0	0	0	0	0	1
Neonatal deaths adjusted for MTOP	0	1	0	0	0	0	0	0	0	0	0	1
Total Maternal Deaths	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

7.1 Stillbirths

There were no stillbirths in Q3 2024.

7.2 Neonatal Deaths

There was 1 early neonatal death (within 1st week of life) in Q3 24/25.

2024	Type of NND	Gest	Ethnicity	Decile	Mat Age	BMI	Smoker	Diabetes	Birth centile	Care/Service delivery issues	PMRT grading
Dec	Early	33	White British	3	34	19	Yes	No	11.2	Unplanned home birth. Breech presentation. Attended by NWAS. Transferred to WWL. Under review	Await

Themes

Low numbers make thematic analysis difficult. However, all data is logged to allow analysis over time. We continue to monitor ethnic origin, social deprivation index, health indicators and learning for all mortalities. The full annual mortality report will accompany this paper.

Maternal age ≥30 years continues as a theme in Q3.

7.3 PMRT and MIS Year 6 compliance data source MBRRACE

In Q3 24/25, 0 cases were finalised at PMRT.

1 pre-meet was held with NWAS regarding the neonatal death in December 2024. NWAS will provide more details of the care they provided to inform the final PMRT. Full compliance with CNST MIS Year 6 Safety Action 1 has been achieved.

Case (date of death)	Standard 1 Notify all deaths within 7 working days	Standard 2 Seek parents' views of care: For at least 95% of all the deaths of babies	Standard 3a 95% of reviews to be started in 2 months of death	Standard 3b Minimum of 60% MDT reviews to be completed/published within 6 months
09/12/24	Met (1 day)	Met	Met	Due 09/06/25
26/09/24	Notification only	-	-	-
11/09/24	Met (1 day)	Met	Met	Due 11/03/25
30/08/24	Notification only	-	-	-
29/07/24	Notification only	-	-	-
06/04/24	Met (1 day)	Met	Met	Met
14/02/24	Met (2 days)	Met	Met	Met
10/02/24	Not eligible	-	-	-
07/02/24	Not eligible	-	-	-
21/01/24	Notification only	-	-	-
17/01/24	Met (3 days)	Met	Met	Met
27/12/23	Not eligible			

No exceptions

8. Saving Babies Lives (SBL) audit Q3

Element	RAG	Compliancy/ Improvement Plan
Element 1- reducing smoking in pregnancy		Latest available data for smoking cessation - CO @ booking 95%, meets SBL parameter of 95%. CO @ 36 weeks is 96%. Meets SBL parameter of 95%. CO at every antenatal appointment is 72% for 3 months data, current month is 84% with an improving trajectory. Under discussion with GM Smokefree group to set the quit date at the second visit to capture more women and allow incentives to be up taken. Regular teaching sessions of CO monitors are undertaken. Audit regularly undertaken. Trends, equity, and equality health status are used in all audits.
Element 2- risk assessment and surveillance for fetal growth restriction		Audit completed monthly. Number of babies detected in antenatal period is 74%. SBL parameter is 50%. All SFH and scan plotted correctly, Digital grow is now in full use. Scan accuracy no longer investigated as part of SGA Babies. Face to face training for SFH measurement and plotting, grow 2.0 digital plotting. Number of babies born <3rd centile and >37+6 weeks is 11% - SBL parameter is <70%. Babies born >3rd centile and <39 weeks is 18%. SBL parameter is <30% - all below stretch target parameters. Trends, equality, ethnicity all used in audits.
Element 3- Raising awareness of reduced fetal movements.		Audit shows Dawes Redman CTG 100%, above SBL parameter of 80%. Next working day scan is 70% which is below minimum of 90%. Moving forward improvement in documentation and next working day scan slot availability will improve percentages. New scanning facility in Triage commenced in September was withdrawn for a short period while an advertisement for a sonographer aide was placed on Trac. Re commenced on December 16th. Improvement on Q2 figures. IOL figures for RFM alone < 39+0 weeks gestation is 0%. Within SBL parameter of <3%.
Element 4- Effective fetal monitoring during labour		Number of staff with up-to-date training for CTG is 96%. SBL parameter is 80%. Number of audited records that had a risk assessment completed at onset of labour is 89%- SBL parameter is 90%. Maternal and fetal wellbeing hourly review is 88% - SBL parameter is 90%. Sample is a small cross section, and some did not receive a fresh eye within the second stage. Fresh eye review within the time frame and CTG categorisation with escalation is 97%. SBL parameter is 90%.
Element 5- Preterm Births.		All optimisation interventions Q3 are 67% - SBL parameter is >60%. Data is small sample of women in category, if some women don't receive a metric, factors affect percentages and can fluctuate results massively. Quick access preterm birth box utilised on delivery suite. Preterm birth clinic started in March 2024, dedicated access to consultant and Tv scanning. Trends are identified in audit and highlighted issues are addressed. December figures affect the quarter due to factors from 22+5-week twins and 33/40 breech BBA.
Element 6 – Diabetes in Pregnancy.		One stop clinic template implemented within SBL parameters, CGM is 100% above stretch target of 95%. HbA1C is @ 100%, above stretch target. All other parameters met.
SBL training Elements 1-6.		99% doctors and midwives compliant with element modules. Non-compliant staff contacted via e mail and face to face to address any ongoing issues with access, time allocation or learning challenges. GROW 2.0 training commenced, 183 members of staff trained by Q3 end. Above stretch targets in all categories.

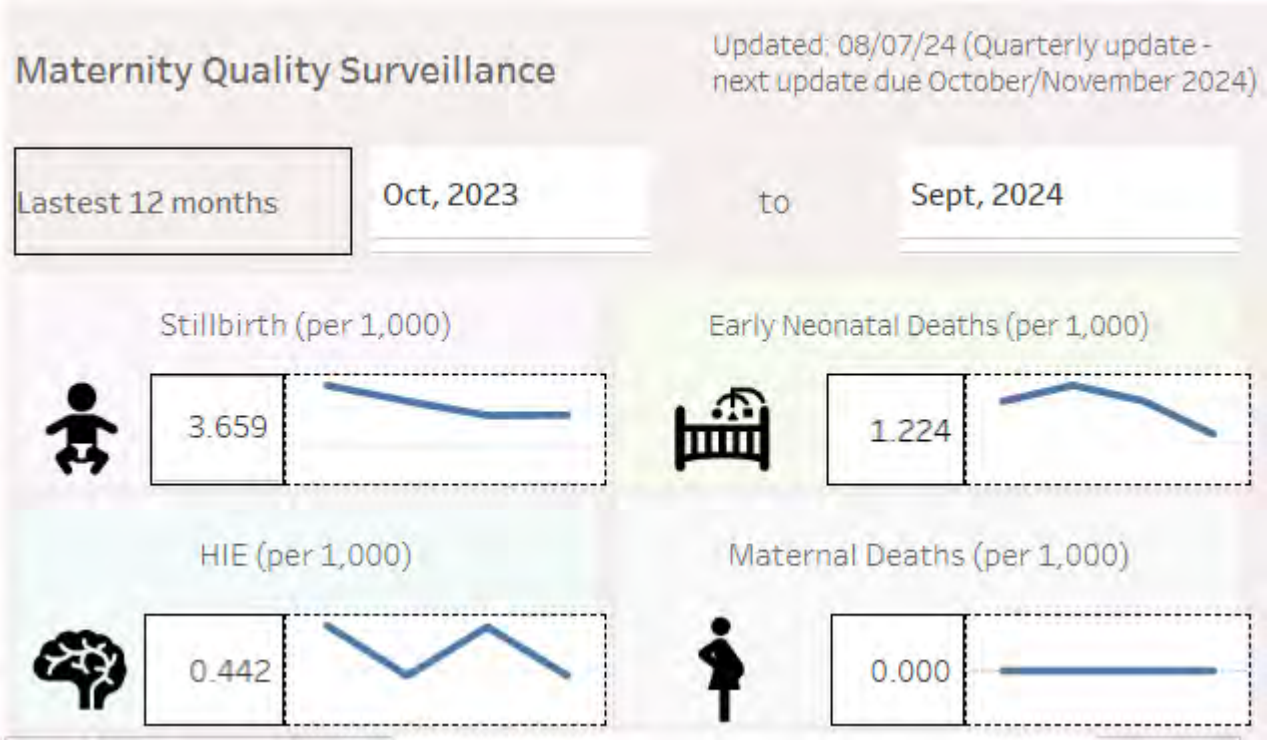
9 GMEC LMNS Ambition

• Reduction in stillbirths to a rate of 3.5 per 1000 registerable births in 2024/25

• Reduction of serious intrapartum brain injury to a rate of 0.70 per 1000 live births in 2024/25

9.1 WWL rates against GMEC ambition – October 2024 - September 2024

WWL measures its progress against the National and GMEC LMNS ambition. Over this rolling 12 period, stillbirth and early neonatal death data has continued a steady decline. Data for the rate of maternal deaths & HIE is positive and within national targets. It is vital that we continue to monitor, learn and improve to sustain this figure.



10. Mandatory Training Compliance Midwifery

	Number attended	Percentage of Staff	Rolling Percent
BLS	59	36%	97%
NLS	59	36%	97%
PROMPT	53	32%	93%
Fetal Physiology	49	30%	97%

In September 2024 the structure of mandatory training was updated. Midwives are now allocated 5 maternity training days per year, covering PROMPT, Fetal Physiology, Maternity Safety, Saving Babies Lives and specialist Services updates, ensuring all elements of MIS and the Core Competencies Framework 2 are covered.

No exceptions

10.1 Mandatory Training Compliance Other Specialities

	PROMPT		Fetal Physiology	
	Number attended	Rolling percentage	Number attended	Rolling percentage
Consultant Obstetrician	5	92%	1	100%
Obstetric Registrar	6	93%	3	95%
Anaesthetist	8	94%		

PROMPT & fetal physiology training is multidisciplinary with compulsory attendance from Midwives and Obstetricians. PROMPT is also compulsory for all Maternity support workers and Obstetric Anaesthetists.

Compliance with MIS Year 6 reporting period has been met and data submitted to the LMNS.

No exceptions

11. Workforce / Safe staffing

At the end of Q3, there are 4.65 WTE midwifery vacancies, and 2.74 WTE MSW vacancies.

2.68 WTE midwives have been recruited and will commence in post early Q1 25/26.

At the end of Q3 there are 0.80 WTE neonatal nursing vacancies and 0.64 Band 3 HCA vacancies.
The child health matron post is recruited to, and the post holder is expected to commence in late February 2025 . 1 NNU Band 7 shift coordinator to commence in post in January 2025

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

In Q3 2024/2025 there were 30 validated red flag events which is a significant increase when compared to previous data.

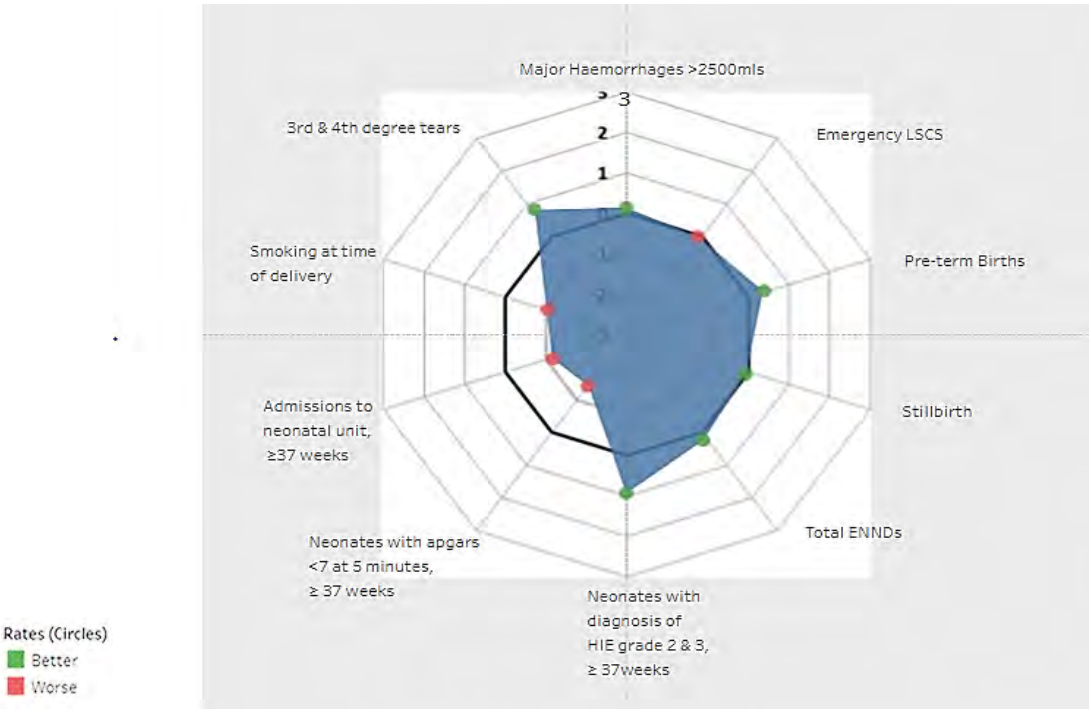
We maintained 100% compliance with supernumerary shift co-ordinator throughout Q3 and there were no maternity diverts.

The significant increase in red flags for Q3 was due to delay between admission and commencing the induction of labour process (29) due to staffing shortages caused by short term sickness. Escalation was in line with trust guidance and there was no harm reported. One red flag was ‘recorded for delayed recognition of and action on abnormal vital signs’, this was due to a delay in medicines administration due to electronic prescribing on HIS (this is not utilised in maternity).

11.2 Maternity Unit Diverts

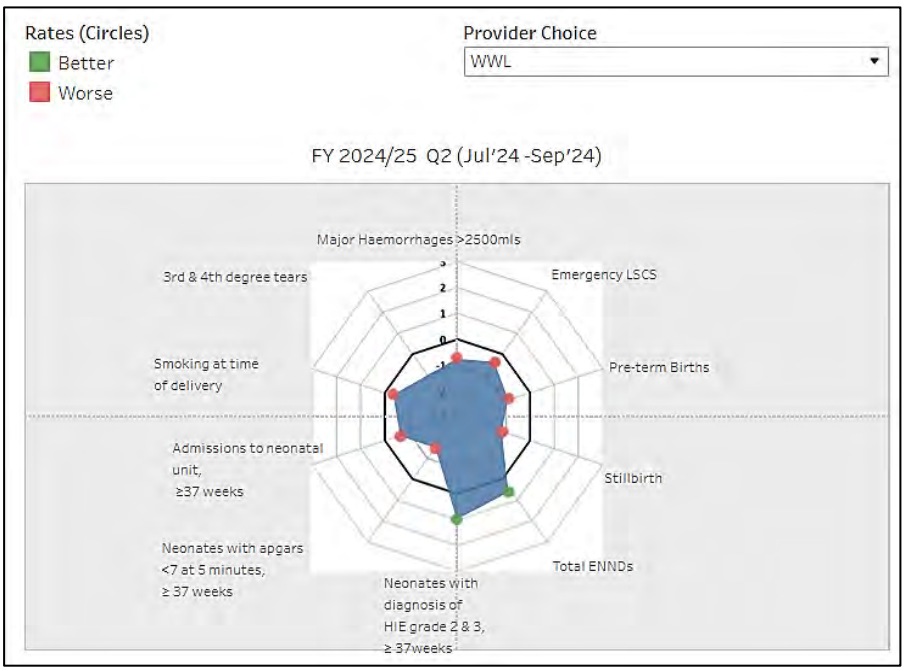
In Q3 24/25 there were no maternity unit diverts.

12. WWL data as compared to GMEC using spidergraph - rolling 12 months (Oct 23 – Sep 24)



Between October 23 and September 24, WWL performed better than GMEC average for rates of major obstetric haemorrhage >2500mls, 3rd and 4th degree tears, pre-term births, stillbirths, early neonatal deaths and neonates with confirmed diagnosis of HIE 2 & 3 at term.

12.1 WWL Data compared to GMEC average – spider graph Q2 24/25 Apr 24 - Jun 24



In Q2 24/25, WWL has performed worse than the GMEC average in all but 2 metrics - neonates with a diagnosis of HIE 2 & 3 at term ≥ 37 weeks and total early neonatal deaths.

Despite a rise in term admissions to the NNU in Q2, ATAIN QI work has resulted in a sustained downward trend in term admissions overall with the foot remaining firmly on the pedal as the improvement drive expands to support Transitional Care. An MDT working group to review PPH of more than 1.5 litres has commenced the review of cases in Q2 with a view to identifying areas for improvement to inform an overarching action plan. Q2 saw a rise in stillbirths however it is important to note that 3 of the stillbirths were MTOP due to detected fetal anomaly. No care issues have been identified and an emerging theme is staff are listening to and advocating for women's choice. An OASI working group has commenced in Q3 to explore the rising trajectory of 3rd degree tears.

*Note that current recommendations are that Trusts do not benchmark the rate of Emergency Caesarean Sections as it was recognised by Ockenden that the pressure for normality may compromise patient safety.

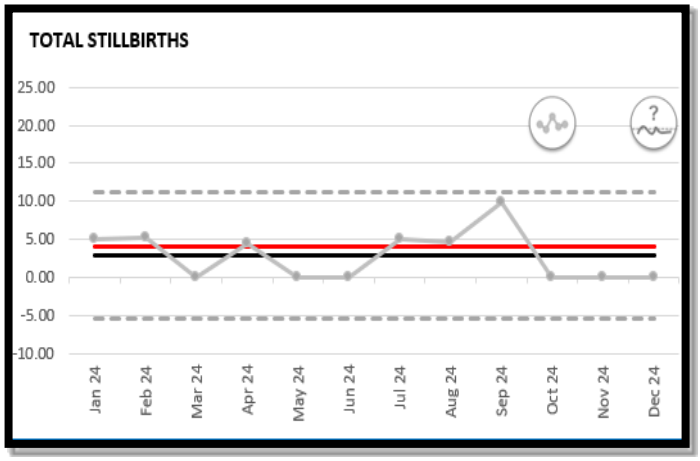
12.2 Statistical Process Control charts Q3 24/25

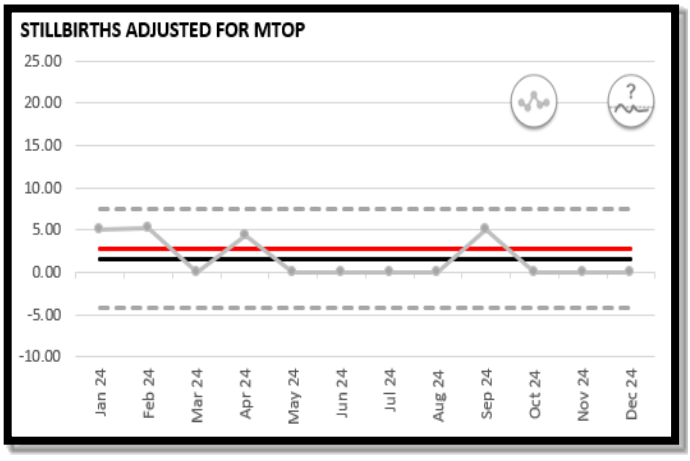
The SPC charts below are a more up to date and useful tool to review our own progress and position against GMEC average over time. The charts below give assurance of continued improvement and QI work continues in all areas and themes and trends monitored.

In the last 12 months the parameters outside the GMEC mean are for term admissions to the NNU, 3rd degree tears and Apgars <7 at 5 minutes.

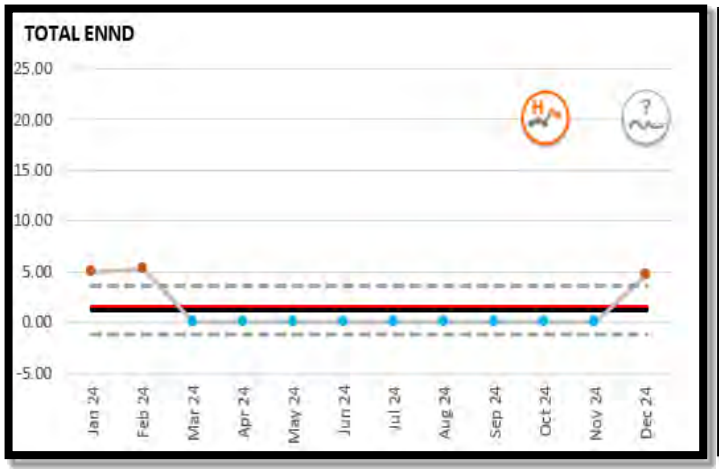
Themed analysis is underway to identify areas for improvement in relation to Apgars <7 at 5 minutes. Emerging themes are links to induction of labour. It is recommended that Maternity Serviced liaise with Royal Bolton Hospital as they have completed work around induction of labour.

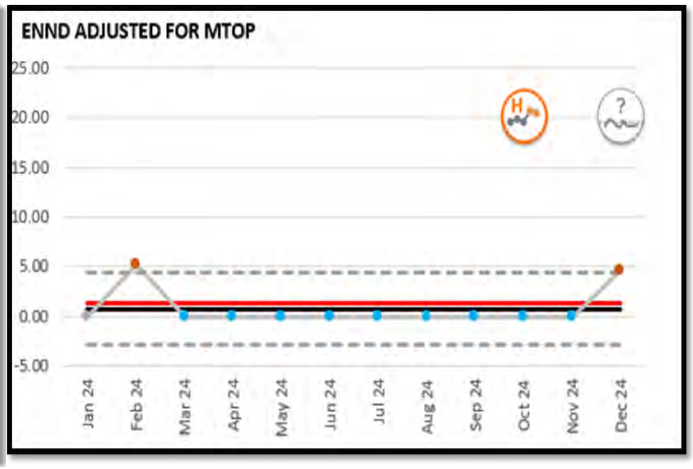
In line with PSIRF data and learning from incidents is reviewed to inform QI work and workstreams have been set up for PPH >1500mls, OASI (3rd and 4th degree tears) and LocSSIP. ATAIN reviews are undertaken weekly with an overarching QI action plan to drive improvement work and an overall downward trend in the number of admissions is noted.



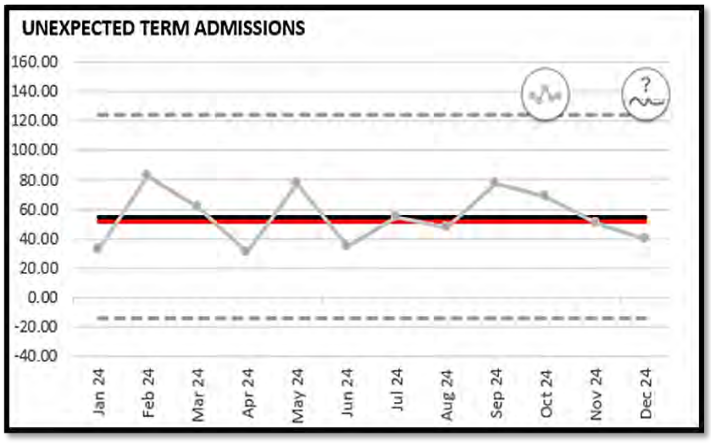


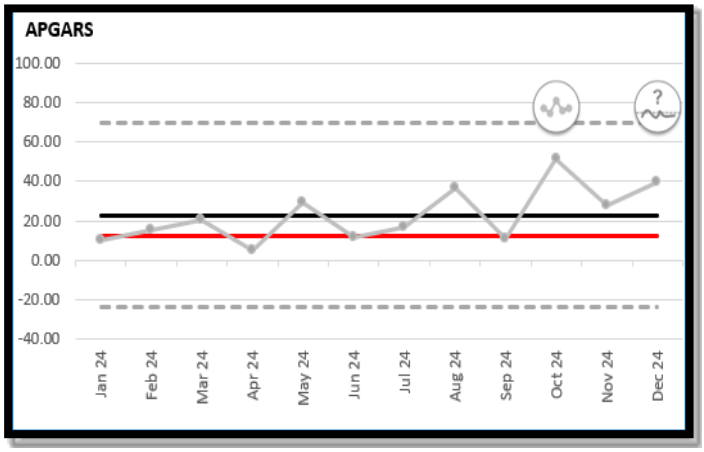
The first of the above two charts shows the total number of stillbirths. The second shows revised figures where medical termination of pregnancy (MTOP) is not included. All figures are shown as a rate per 1000.
There were 0 stillbirths in Q3.



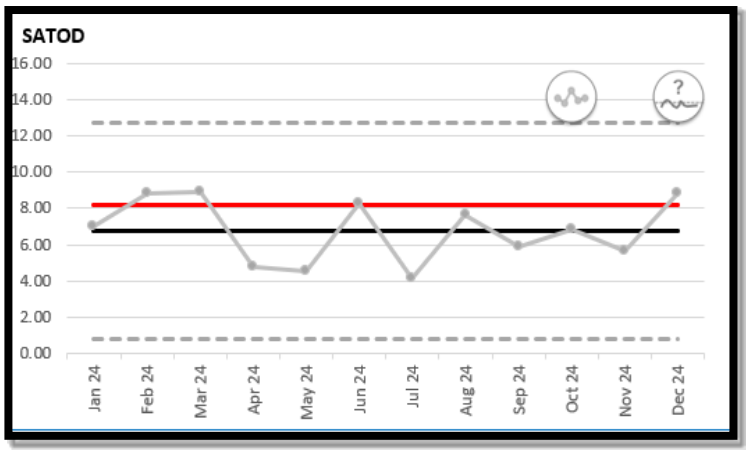


The first of the above two charts shows the total number of early neonatal deaths (ENND). ENND refers to deaths in the first week of life from 20 weeks. The second shows revised figures where MTOP is not included. The figures are shown as rate per 1000.
There was 1 ENND in Q3. This was an unplanned breech birth at home and was attended by NWAS. NWAS will support with PMRT.

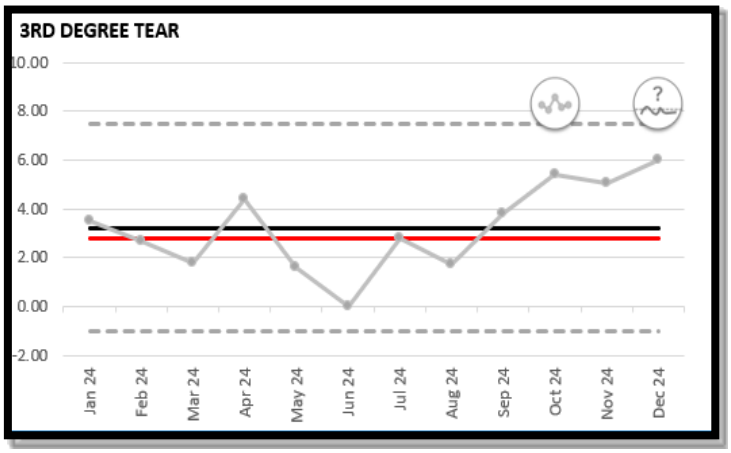




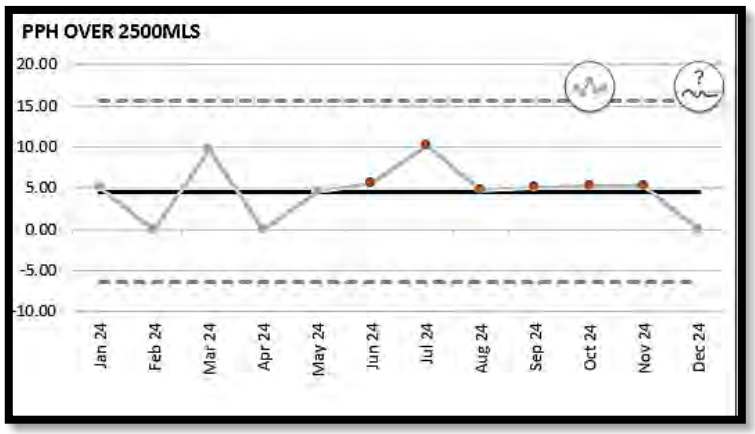
There has been an overall downward trend and significant progress to reduce the gap between WWL Term Admission to NNNU performance and the GMEC mean.
The Apgar score data is shown as a rate per 1000. Themed analysis is underway with a view to identifying learning to support improvement. Emerging themes are the correlation between induction of labour and Apgar scores <7 @5. This metric will continue to be monitored. We remain an outlier against the GMEC mean.



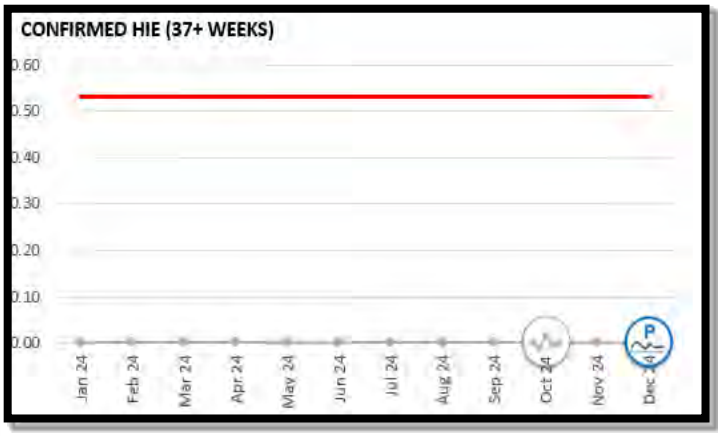
There has been a steady downward trajectory over this rolling 12-month period, with a slight spike in December. April, May and July saw the lowest figures in several years. All SBL 3 initiatives are on track. Smoking At Time of Delivery figures are shown as a %.



The OASI bundle was rolled out on 2 April to help improve outcomes. Initial findings saw a decrease in the number of tears however this has not been sustained. An OASI working group has been set up to explore progress with OASI & further QI work.



The WWL mean is in line with the GMEC mean in this rolling 12-month period. Recent systemic improvements have included bringing the WWL MOH protocol in line with GMEC and initiating the Pack System in Haematology. In Q3 2 women had a PPH >2500 mls.



There have been no babies with confirmed HIE 2/3 (37 weeks +) or meeting the MNSI investigation criteria since August 2023.

12.3 Outlier assurance data Q3 24/25

No data escalation assurance has been requested in Q3 24/25.

Summary

CNST MIS Year 6 criteria was published on the 2 April 2024 and WWL submitted the evidence against all 10 Safety Actions to the LMNS for preliminary QA. Initial feedback has been excellent. Final submission of compliance will be on the 3 March 2025.

In Q2 the LMNS have reported significant assurance of WWL progress against SBL3 targets with a compliance rate of 87% (target set at 70%). In Q3 the midwifery sonography service has started work with a view to supporting the SBL agenda.

In line with the PSIRF, data is reviewed in Division to direct our focus for improvement work. In Q3 an OASI working group was set up to tackle the rising trajectory of 3rd degree tears as despite initial improvements following the launch of OASI 2 in April 2024, rates are now rising. Rates of Apgars <7 at 5 have not significantly improved and an emerging theme from analysis is a link to induction of labour. It is a recommendation from this report that WWL liaise with the Royal Bolton Hospital as they have undertaken a piece of work in relation to induction of labour. ATAIN QI work has resulted in a sustained downward trend in term admissions overall with the gap significantly closed between WWL rates of admission and the GMEC mean.

An MDT working group to review PPH of more than 1.5 litres has commenced the review of cases in Q2 and have submitted their initial findings.

There were no data outlier responses requested by the LMNS in Q3.

Analysis of the Score Survey to explore team culture has taken place and an action plan is to be developed with external input in response. There has been no progression with this in Q3 and the DDOM will follow up.

No new areas for concern identified.

Agenda item: 26.5

Title of report:	Perinatal Mortality and PMRT
Presented to:	Board of Directors
On:	5th February 2025
Item purpose:	Information
Presented by:	Kevin Parker-Evans, Chief Nurse
Prepared by:	Eve Broadhurst, Head of Governance for Maternity and Child Health, on behalf of Cathy Stanford, Divisional Director of Maternity and Child Health

Executive Summary

The report outlines the national target set by the government in relation to halving the 2010 rates of stillbirth, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025, and aims to make sense of the shifting local, regional and national goal posts in order to make clear WWL's position at the end of 2024.

The report focuses on data outcomes from 2024 and identifies themes and trends in demographic and health status data and learning outcomes from care and service delivery, triangulating with data in relation to parent feedback.

The key messages from the report are;

- There were no late fetal losses (22-23+6 weeks' gestation) in 2024.

- The stillbirth rate in 2024 is 2.87 per 1000 registerable births. This is not in line with the local ambition (based on 2015 data) of 1.57 but is within the GMEC target for 24/25 and in sight of the national target of 2.6.

- The adjusted stillbirth rate (excluding MTOP) is 1.64 per 1000 registerable births. This is a significant improvement on 2023 rates and better than the GMEC mean. When adjusted to remove MTOP and fetal anomaly, the rate further improves to 1.23.

- The neonatal death rate in 2024 is 1.23 per 1000 births. This is not in line with the local ambition (based on 2015 data) of 0.52 but is better than both the GMEC mean and the national target of 1.5.

- The adjusted neonatal death rate (excluding MTOP) is 0.82 per 1000 registerable births which is an improvement on the adjusted early neonatal death rate in 2023 of 1.2 and is slightly better than the GMEC mean.

- The stillbirth rate as a result of MTOP or anomaly is 1.64 per 1000 registerable births which is a slight increase from the stillbirth rate as a result of MTOP or anomaly in 2023 of 1.61.

- The neonatal death rate as a result of MTOP is 0.4 per 1000 registerable births. 1 neonatal death was following MTOP for congenital anomaly (20+6 weeks gestation). This would account for 33% of the neonatal deaths at WWL which is in line with national data (MBRRACE, 2022).

- The serious intrapartum brain injury rate in 2024 was 0 per 1000 live births. This meets the local, regional and national ambition.

- The maternal death rate is 0 per 1000 maternities. This meets the local, regional and national ambition.

- WWL is 100% compliant with MBRRACE reporting requirements.

- WWL is 100% compliant with PMRT standards outlined in CNST Safety Action 1.

- A total of 4 stillbirth cases were eligible for the PMRT in 2024. 3 PMRT reviews have been completed and 1 is in progress. This is a reduction from 9 stillbirth cases eligible for the PMRT in 2023.

- A total of 1 neonatal death case was eligible for PMRT in 2024 (death in December 2024). The review is in progress. This is equal to the number of neonatal death cases eligible for the PMRT in 2023.

- To date in 2024 there have been no PMRT cases graded C or D which would indicate care or service delivery issues which may (C) or likely (D) have affected the outcome. Of the 2 outstanding PMRT cases awaiting final review, there was no immediate learning identified in relation to the care provided by WWL which would have affected the outcome.

- Incidental learning from review of mortalities has been themed as good care, wider-system learning (in relation to lack of pre-conception mental health care), documentation issues, communication issues, lack of senior review and inappropriate care plan.

- Themes for mothers who experienced a stillbirth as a result of MTOP or fetal anomaly were White British origin, maternal age ≥30 years and raised BMI. There were no strong themes identified in relation to social deprivation index, smoking or diabetes status. Half of the mothers were aged ≥30 years and had a raised BMI ≥30.

- Thematic analysis was not possible for neonatal death as a result of MTOP or congenital anomaly as there was only 1 case. Data is collated and will be reviewed over time to identify themes.

- Themes for mothers who had a stillbirth not as a result of an MTOP or fetal anomaly were predominantly White British origin, English-speaking, Decile 1 and 2 (postcodes associated with most socially deprived areas), age ≥ 30 years, raised BMI ≥30, and birth weight <10th centile. There were no strong themes identified in relation to smoking or diabetes status. 75% of mothers lived in

areas with a Decile 1 or 2 postcode, were aged ≥30 years and had a BMI ≥30 further compounding the risk.

- Thematic analysis was difficult for those mothers who had a neonatal death not as a result of MTOP or fetal anomaly due to the small numbers. Both women were aged ≥30 years.

- There are robust governance processes surrounding mortality review which are outlined in the report.

- 3 cases were reviewed via the PMRT and 2 are under view. External representation was facilitated in 2 cases. Causes of death were placental (2) and Triploid Syndrome (1).

- Learning from review informs an overarching action plan which is monitored via PMRT and the Clinical Cabinets.

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1. Introduction

The National Safety Ambition launched in November 2015, aimed to halve the 2010 rates of stillbirth, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025 with an interim ambition of a 20% reduction by 2020.

The original ambition was to halve these rates by 2030 but it was brought forward to 2025 in November 2017 following the provision of additional funding and support.

To meet the national ambition, it would require England and Wales to reduce its stillbirth rate to 2.6 stillbirths per 1,000 registerable births, the early neonatal death rate to 1.5 early neonatal deaths per 1,000 registerable births and the maternal death rate to 0.05 per 1,000 maternities (up to 42 days). There is no reliable data for rates of serious brain injury nationally before 2012. Data for the rate of serious brain injuries at term in England in 2012 would suggest a target rate around 1.62 per 1,000 live births by 2025 (National Data Analysis Unit, 2021).

Nationally, the 2020 stillbirth targets were met (rate 3.9 per 1,000 registerable births), however more recent data in 2022 and 2023 show an increased rate to 4.0 per 1,000 live births and it seems likely that a 50% reduction will not be met.

GMEC LMNS therefore re-set the regional stillbirth targets and outlined the serious intrapartum brain injury targets.

- Reduction in still births to a rate of 3.85 per 1,000 registerable births in 2023/24
- Reduction in still births to a rate of 3.5 per 1,000 registerable births in 2024/25
- Reduction in serious intrapartum brain injury to a rate of 1.0 per 1,000 live births by 2023/24
- Reduction of serious intrapartum brain injury to a rate of 0.7 per 1,000 live births in 2024/25

From a review of the Tableau system GM has set local targets based on a 50% reduction in each metric based on 2015 data by 2025.

To meet with the local ambition, it would require WWL to reduce the stillbirth rate to 1.57 per 1,000 registerable live births, the early neonatal death rate to 0.52 per 1,000 registerable births, the serious intrapartum brain injury at term rate to 0 per 1,000 registerable births and the maternal death rate to 0 per 1,000 maternities (up to 42 days). See Appendices 1 & 2 for progress against targets.

It should be noted that all the targets are based on total stillbirth rates and are not adjusted for stillbirths either as a result of medical termination of pregnancy (MTOP) or congenital anomaly.

The Perinatal Mortality Review Tool (PMRT) introduced in early 2018 supports standardised multi-disciplinary perinatal mortality reviews across NHS maternity and neonatal units in the UK. Reviews focus on the circumstances and care leading up to and surrounding baby deaths from 22 weeks' gestation onwards, including late fetal loss, stillbirths and neonatal deaths.

The NHS Long Term Plan (2019) also committed to improving how the NHS learns lessons when things go wrong. In particular it noted the role of the Healthcare Safety Investigation Branch (HSIB), now Maternity and Neonatal

Safety Investigations (MNSI), in reviewing all term stillbirths, early neonatal deaths and cases of severe injury following labour, as well as maternal deaths.

The report provides data and analysis of perinatal mortalities and PMRT outcomes in 2024.

2. Methodology

All stillbirths and early neonatal deaths (20 weeks onwards) are included in mortality rates.

Rates are also adjusted for both medical termination (MTOP) and MTOP and fetal anomaly where applicable.

All mortalities and cases of severe brain injury are reviewed via 72-hour review and learning is collated and themed, irrespective of gestation, cause of death or whether they are eligible for MBRRACE, PMRT or MNSI reporting.

All learning from both 72-hr review and the PMRT reports is tabled and informs an overarching action plan.

All learning identified from reviews is triangulated with the views of parents and tabulated to identify themes and trends and to inform an overarching action plan.

Themes are collated including ethnicity, English-speaking status, deprivation index, BMI, age, gestation, birth centile, smoking status, diabetes status and all care and service delivery learning outcomes.

2024 data will be the focus of this report, and reference to 2023 data will be included where relevant for comparison.

Data sources – DATIX, 72-hour reviews, PMRT reports, BadgerNet neonatal electronic patient record system, Maternity Dashboard, Perinatal Quality Surveillance Report, MBRRACE perinatal surveillance system.

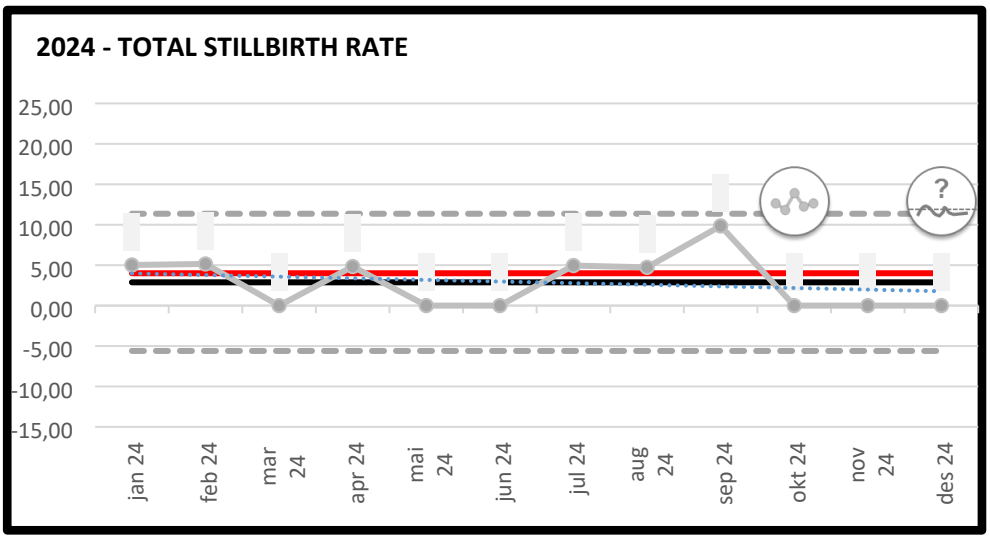
***There were no cases meeting the MNSI referral criteria in 2024 – no cases of confirmed HIE 2 or 3 at term, no intrapartum stillbirths at term, no early neonatal deaths at term and no maternal deaths.**

3 Late Fetal Loss, Stillbirth & Neonatal Death data

There were no late fetal losses (22 – 23+6 weeks gestation) in 2024, which is a reduction from 1 in 2023.

There was a total of 7 stillbirths in 2024. This is a reduction from 13 in 2023. There were 0 intrapartum stillbirths.

The total stillbirth rate per 1000 registerable births in 2024 is 2.87, which is an improvement on the total stillbirth rate per 1000 registerable births in 2023 of 5.23. While this rate does not yet meet the local ambition, it is lower than the GMEC LMNS ambition and is in sight of the national ambition rate of 2.6.

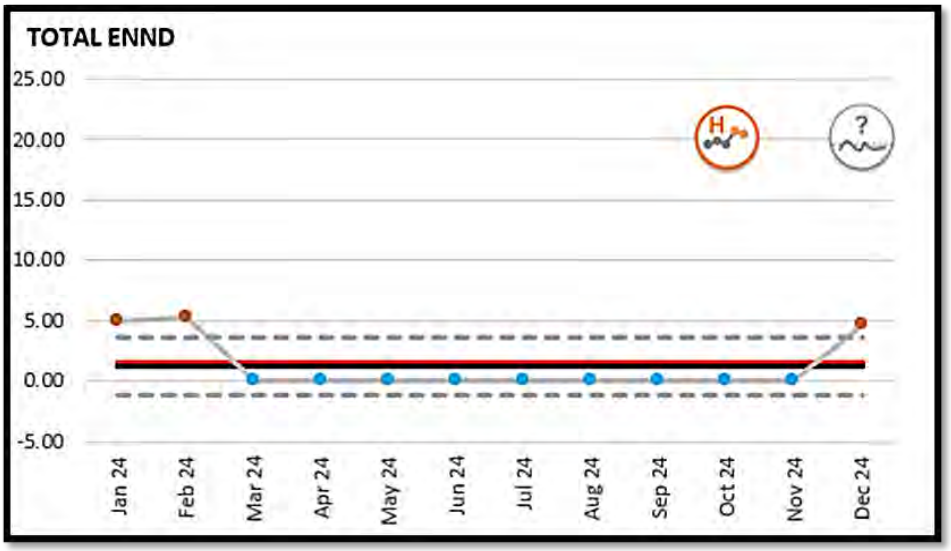


Red line = GMEC mean

Black line=WWL mean

There was a total of 4 early neonatal deaths at WWL in 2024. This is a reduction from 6 in 2023. As 1 of the deaths was before 20 weeks gestation this will not be eligible for MBRRACE reporting and will not be included in the early neonatal death rate data.

The early neonatal death rate per 1000 registerable births at WWL in 2024 is 1.23, which is an improvement on the neonatal death rate of 2.01 in 2023. While this rate does not yet meet the local ambition, it is slightly lower than the GMEC mean and lower than the national ambition rate of 1.5.



Red line = GMEC mean

Black line=WWL mean

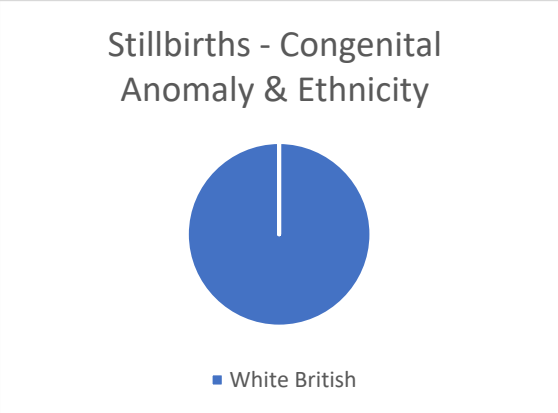
4 Congenital anomalies

4.1 Stillbirths and congenital anomaly

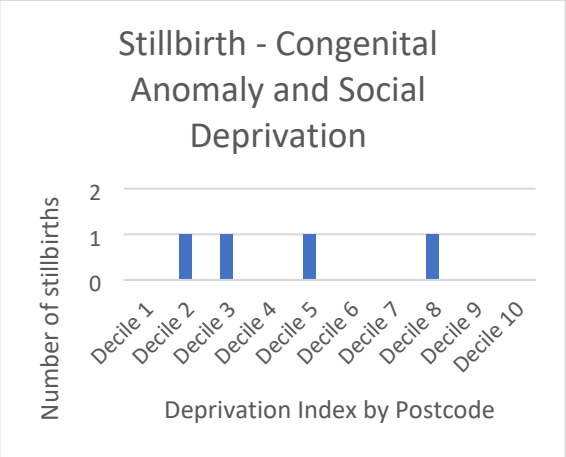
Of the 7 stillbirths, 4 were a result of fetal anomaly or MTOP due to fetal anomaly. The stillbirth rate as a result of MTOP or anomaly is **1.64** per 1,000 registerable births which is a slight increase from the stillbirth rate as a result of MTOP or anomaly in 2023 of 1.61.

4.2 Themes in cases of stillbirth as a result of MTOP or congenital anomaly.

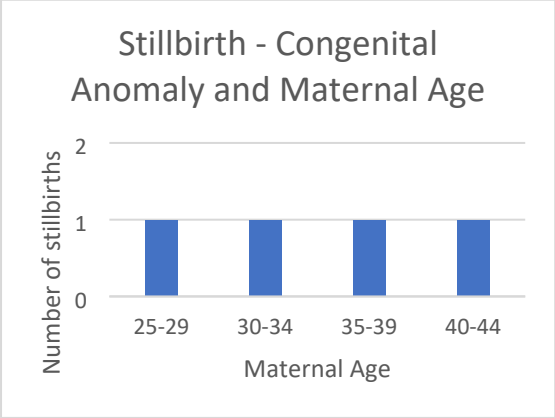
It is acknowledged that numbers are small, and that themed analysis is therefore difficult.



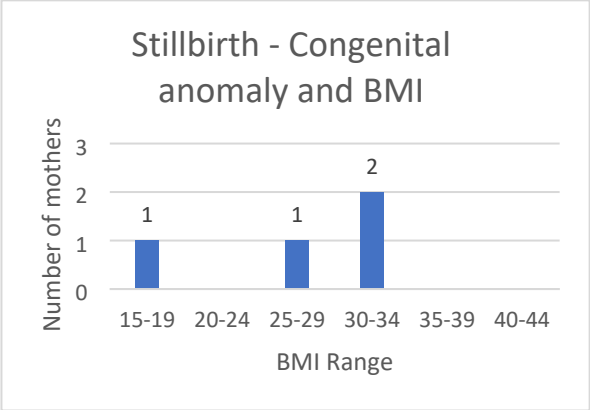
100% (4 of 4) of stillbirths of babies with known anomalies were of White British origin. There is no prevalent theme of stillbirth due to MTOP or fetal anomaly being associated with non-white British populations in either 2023 or 2024.



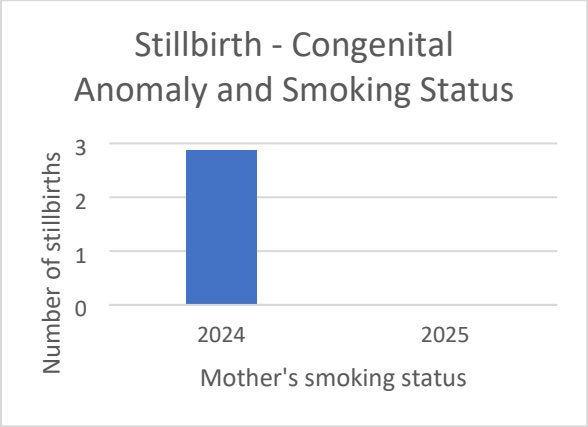
There is no strong correlation with stillbirth as a result of MTOP or fetal anomaly and any particular decile. This is stark contrast to 2023, where 100% of stillbirths due to congenital anomaly were associated with the lowest 2 deciles.



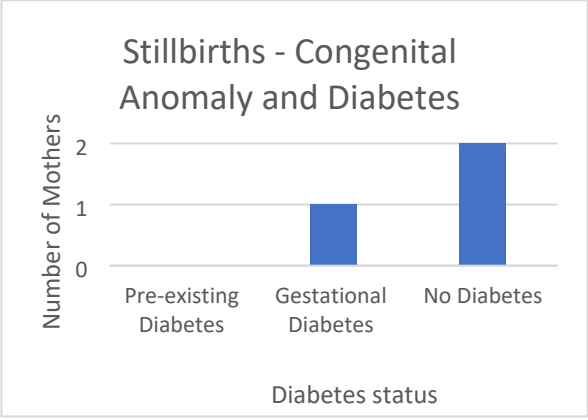
75% (3 of 4) of mothers were aged ≥ 30 years of age. This is an increase from 2023 where 50% of mothers who had a stillbirth as a result of MTOP or fetal anomaly were aged were ≥ 30.



75% (3 of 4) of mothers who had a stillbirth as a result of MTOP or fetal anomaly had a BMI of 29 or more, with 50% (2 of 4) having a BMI over 30. This is similar to 2023 findings, where 50% of mothers had a significantly raised BMI.



75% (3 of 4) mothers who had a stillbirth due to MTOP or fetal anomaly were none-smokers. Smoking has not been a persistent theme across 2023 or 2024.



75% (3 of 4) mothers who had a stillbirth due to MTOP or fetal anomaly were non-diabetic. Diabetes has not been a persistent theme across 2023 or 2024.

4.3 Neonatal Death and congenital anomaly

Of the 3 neonatal deaths in 2024 (excluding 1 non-reportable case), 1 was following MTOP for congenital anomaly (20+6 weeks gestation) giving a rate of 0.4 per 1000 registerable births which is a reduction from a rate of 0.8 in 2023. This would account for 33% of the neonatal deaths at WWL which is in line with national data. Nationally, congenital anomalies are the cause of 33% of neonatal deaths (MBRRACE 2022).

All neonates who are born at WWL who subsequently die in another hospital are monitored in Division and subject to joint PMRT.

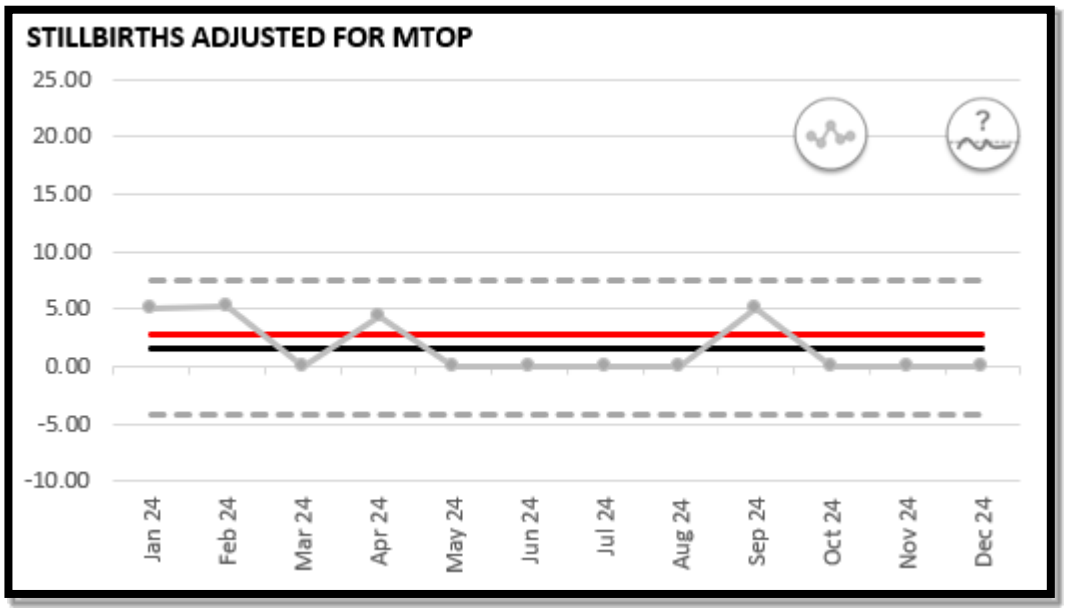
4.4 Themes in cases of neonatal death as a result of MTOP or congenital anomaly.

Themes cannot be drawn from 1 case. However, it is noted that the mother was of South-East Asian origin and was 41 years of age. Themes are logged by the Governance Team and continue to be monitored over time.

5 Stillbirth rates excluding abnormalities and MTOP.

5.1 Adjusted stillbirth rate for MTOP

There were 4 remaining stillbirths when the data was adjusted to remove stillbirths as a result of MTOP. The rate of stillbirths adjusted for MTOP is 1.64 per 1000 registerable births which is a significant improvement on the rates of stillbirth adjusted for MTOP in 2023 of 4.03 and better than the GMEC mean.



Red line = GMEC mean

Black line=WWL mean

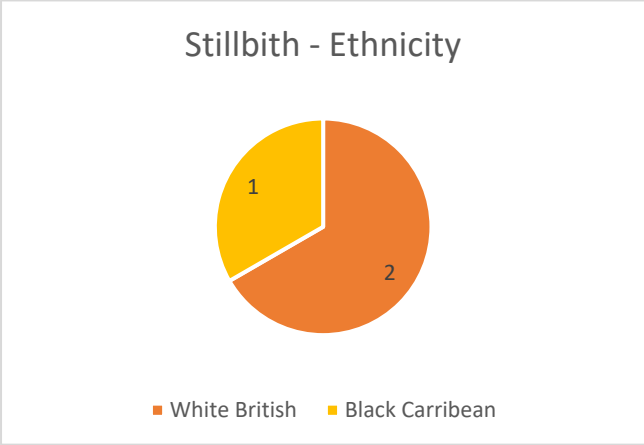
5.2 Adjusted stillbirth rate for MTOP and anomaly.

There were 3 remaining stillbirths at WWL when the data was adjusted to remove deaths as a result of fetal anomaly and MTOP. The adjusted rate of stillbirth per 1000 registerable births to exclude stillbirths as a

result of MTOP and fetal anomaly is 1.23. This is an improvement on the adjusted rate of stillbirth per 1000 registerable births in 2023 of 3.62.

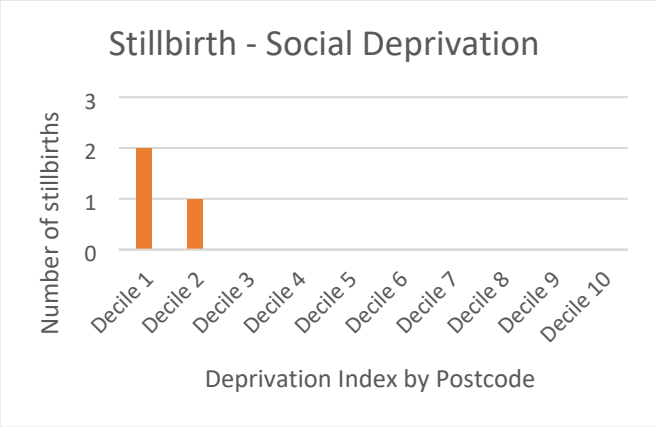
Data is not requested for submission via the Maternity Dashboard to exclude both MTOP and fetal anomaly, however this is collated by the Governance Team and will be reflected in the National MBRRACE report.

5.3 Themes from stillbirths excluding those as a result of MTOP or fetal anomaly.

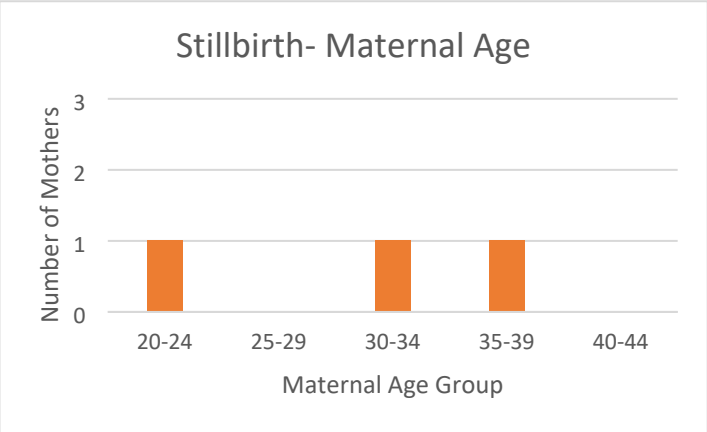


66% (2 of 3) of stillborn babies not as a result of MTOP or anomaly were of White British origin. In 2023 89% of mothers who had a stillbirth (not as a result of MTOP or anomaly) were of White British origin.

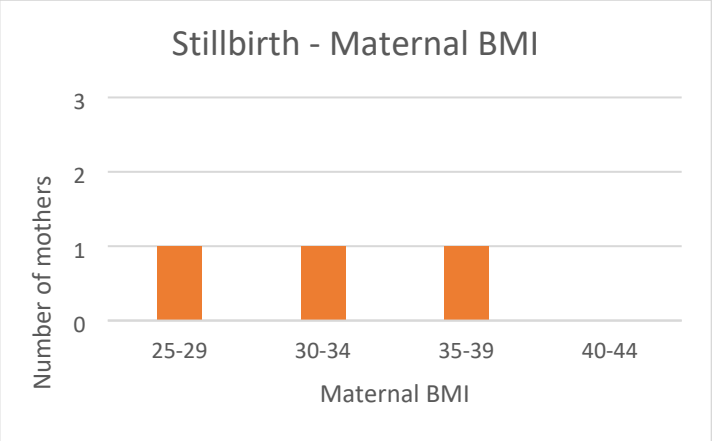
100% (3 of 3) of mothers who had a stillbirth (not as a result of MTOP or fetal anomaly) spoke English fluently. This reflects the findings of 2023.



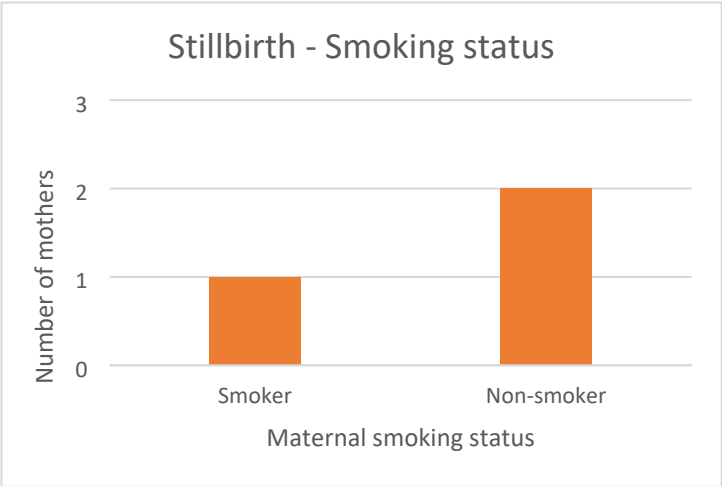
100% of mothers (3 of 3) who had a stillbirth not as a result of MTOP or fetal anomaly lived in the lowest 2 deciles. This is an increase from 2023 where 66% of mothers who had a stillbirth lived in the lowest 2 deciles.



66% (2 of 3) mothers who had a stillbirth not as a result of MTOP or fetal anomaly were ≥30 years of age. This is an increase on 2023 where 33% of mothers were ≥30 years of age.

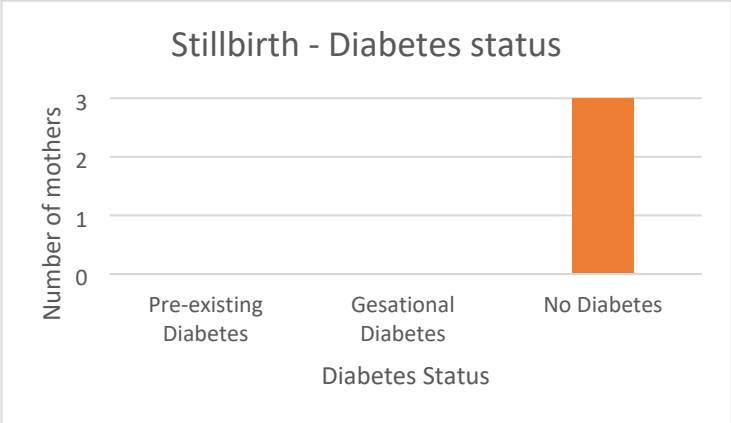


66% (2 of 3) mothers who had a stillbirth not a result of MTOP or fetal anomaly had a BMI ≥ 30. This is an increase on 2023 where 55% of mothers had a BMI ≥ 30.

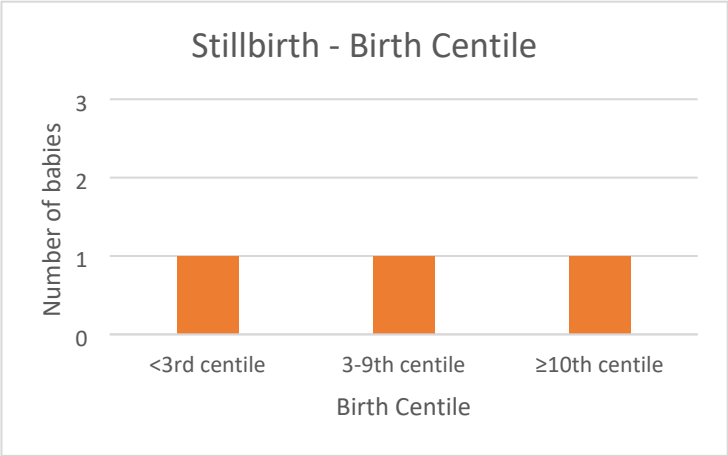


33% (1 of 3) of mothers who had a stillbirth not as a result of MTOP or fetal anomaly smoked cigarettes.

The mother who smoked during pregnancy received smoking cessation support and used an e-cigarette and smoked cigarettes. Smoking has not been a prevalent theme across 2023 (11%) or 2024.



0% (0 of 3) of those mothers who had a stillbirth not as a result of MTOP of fetal anomaly had diabetes. This reflects data outcomes in 2023.



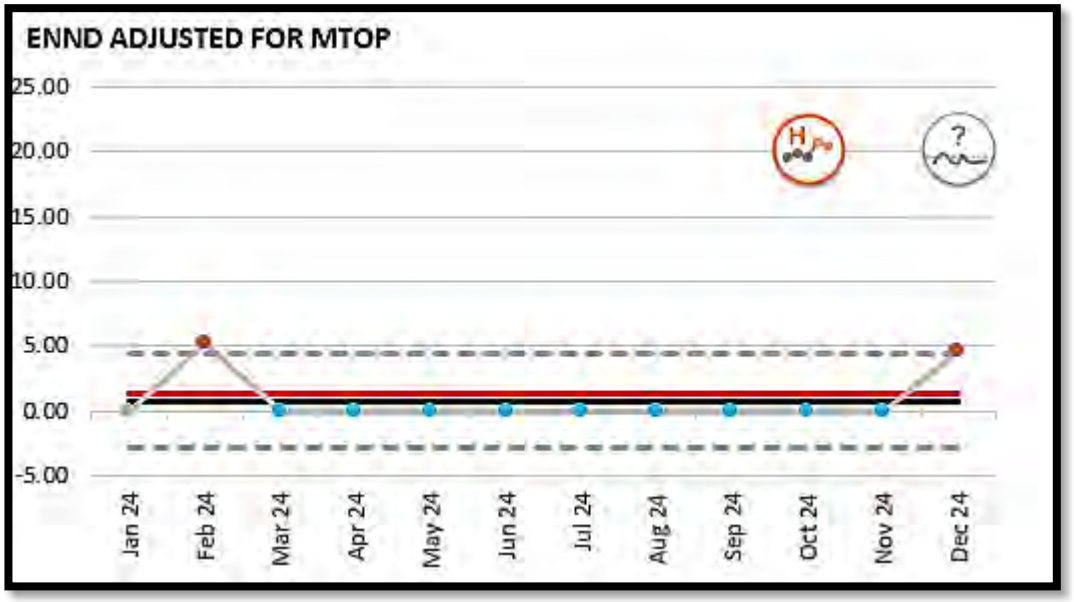
66% (2 of 3) of the babies without fetal anomaly who were stillborn had a birth weight below the 10th centile. This is an increase from 33% in 2023.

6 Early Neonatal Deaths excluding MTOP.

6.1 Adjusted early neonatal death rate for MTOP.

There was a total of 2 early neonatal deaths at WWL when the data was adjusted to remove deaths as a result of MTOP. 1 neonatal death at 20+6 weeks' gestation following MTOP has been removed from the data. This gives an adjusted early neonatal death rate of 0.82 per 1000 registerable births which is an

improvement on the adjusted early neonatal death rate in 2023 of 1.2 and is slightly better than the GMEC mean.



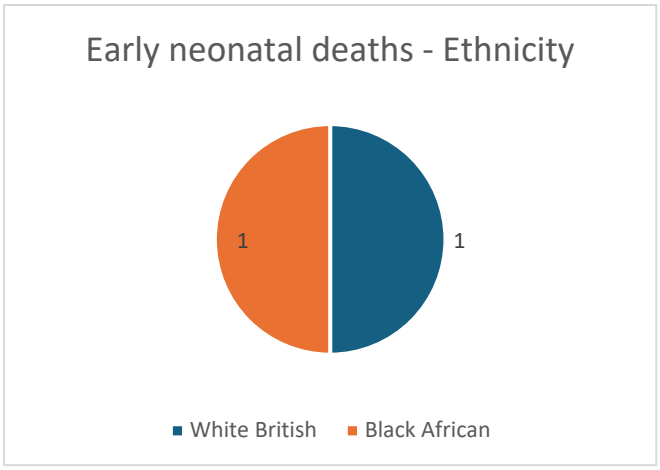
Red line = GMEC mean

Black line=WWL mean

There were 0 neonatal deaths as a result of fetal anomaly without MTOP.

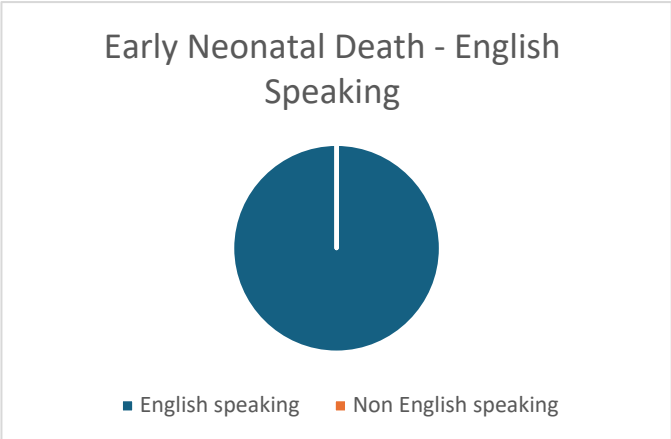
6.2 Themes from early neonatal deaths <u>excluding</u> those as a result of MTOP or anomaly.

It is acknowledged that numbers are small (2), and that themed analysis is therefore difficult. Note that data is logged for comparison over time. A visual representation for 2024 is provided.



50% (1 of 2) of women who had a neonatal death not as a result of MTOP or fetal anomaly were White British

50% (1 of 2) of women who had a neonatal death not as a result of MTOP or fetal anomaly were Black African.



100% (2 of 2) of women who had a neonatal death not as a result of MTOP or fetal anomaly spoke English fluently.

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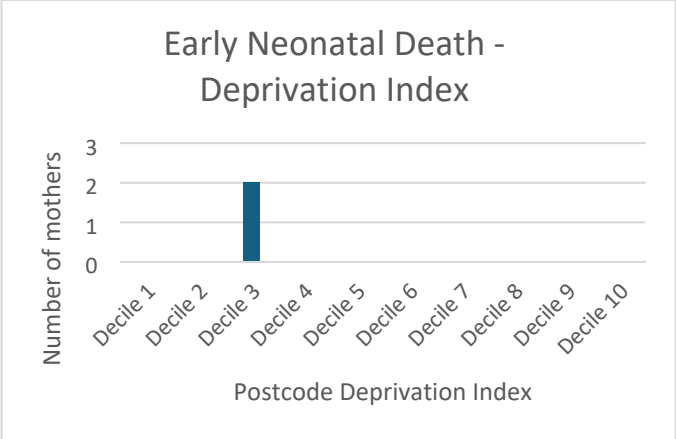
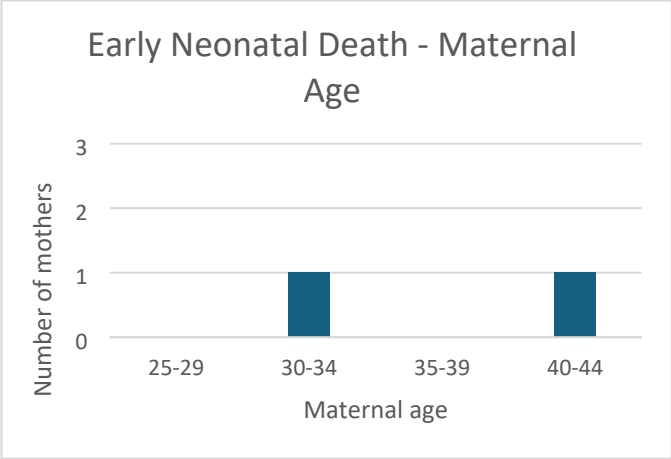
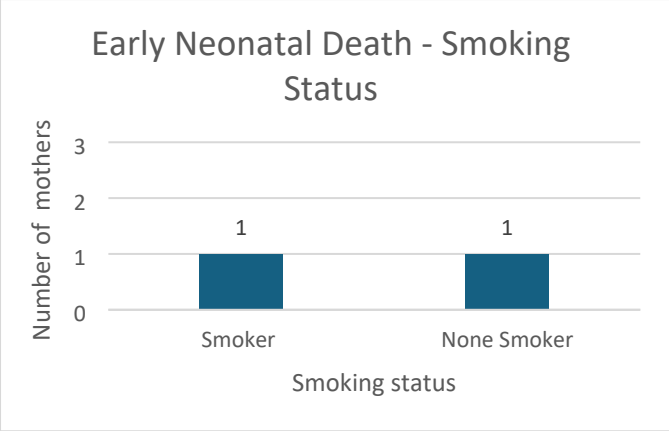


100% (2 of 2) of mothers who had an early neonatal death not associated with MTOP or fetal anomaly lived in an area with a decile 3 postcode

0% (0 of 2) of mothers lived in areas with the lowest 2 deciles.



100% (2 of 2) of mothers who had a neonatal death not associated with MTOP or fetal anomaly were ≥ 30 years of age.



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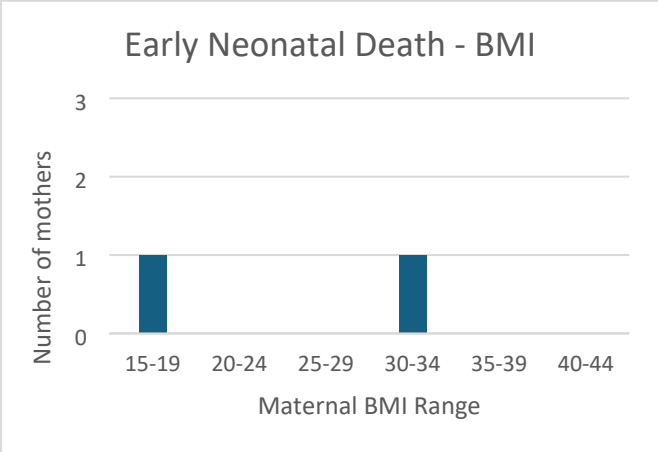
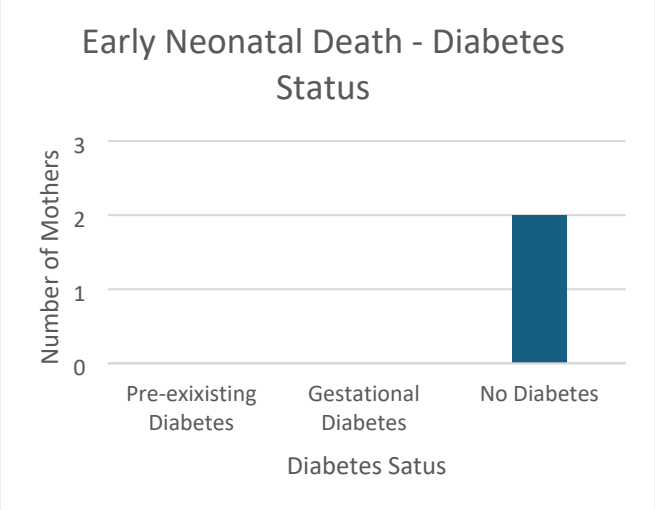
50% (1 of 2) of mothers who had a neonatal death not as a result of MTOP or fetal anomaly fetal anomaly smoked cigarettes.



50% (1 of 2) of mothers who had a neonatal death not as a result of MTOP or fetal anomaly fetal anomaly had a BMI ≥30



100% of mothers who had a stillbirth not associated with MTOP of fetal anomaly were none-diabetic.

7. MBRRACE reporting

Deaths to be reported to MBRRACE are:

Late fetal losses – the baby is delivered between 22 weeks+0 days and 23 weeks+6 days of gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

Stillbirths – the baby is delivered from 24 weeks+0 days gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.

Early neonatal deaths – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

Late neonatal deaths – death of a live born baby (born at 20 weeks+0 days gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.

All deaths at WWL in 2024 were reported to MBRRACE in line with national guidance and in compliance with CNST MIS Year 6 Safety Action 1.

8 PMRT

Of those cases reported to MBRRACE the PMRT has been designed to support the review of the care of the following babies:

All late fetal losses 22+0 to 23+6

All antepartum and intrapartum stillbirths

All neonatal deaths from birth at 22+0 to 28 days after birth.

8.1 Cases eligible for PMRT in 2024

A total of 4 stillbirth cases were eligible for the PMRT in 2024. 3 PMRT reviews have been completed and 1 is in progress.

This is a reduction from 9 stillbirth cases eligible for the PMRT in 2023.

A total of 1 neonatal death case was eligible for the PMRT in 2024 (death in December 2024). The review is in progress.

This is equal to the number of neonatal death cases eligible for the PMRT in 2023.

Reporting requirements are 100% compliant with CNST Safety Action 1 standards.

Case (date of death)	Standard 1 Notify all deaths within 7 working days	Standard 2 Seek parents' views of care: For at least 95% of all the deaths of babies	Standard 3a 95% of reviews to be started in 2 months of death	Standard 3b Minimum of 60% MDT reviews to be completed/published within 6 months
09/12/24	Met (1 day)	Met	Met	Due 09/06/25
26/09/24	Notification only	-	-	-
11/09/24	Met (1 day)	Met	Met	Due 11/03/25
30/08/24	Notification only	-	-	-
29/07/24	Notification only	-	-	-
06/04/24	Met (1 day)	Met	Met	Met
14/02/24	Met (2 days)	Met	Met	Met
10/02/24	Not eligible	-	-	-
07/02/24	Not eligible	-	-	-
21/01/24	Notification only	-	-	-
17/01/24	Met (3 days)	Met	Met	Met
27/12/23	Not eligible			

8.2 Grading of care

The PMRT MDT review group are asked to consider and grade the quality of care provided.

Four levels of grading of care are offered, A-D.

To date in 2024 there have been no cases graded C or D which would indicate care or service delivery issues which may (C) or likely (D) have affected the outcome.

Of the 2 outstanding PMRT cases there is no immediate learning identified in relation to the care provided by WWL which would have affected the outcome.

This echoes the grading of care via the PMRT in 2023.

Of the 3 completed PMRT reviews – 2 had an external panel member.

Causes of death were placental (2) Triploid Syndrome (1)

8.3 Incidental findings

All learning identified from reviews is collated and triangulated with the feedback from parents and tabulated to identify themes and trends and to inform an overarching action plan.

Theme	Occurrence
Good care	
No learning identified	4
Excellent communication between WWL and St Mary's to facilitate birth at WWL	1
Parents voiced no concerns with care	5
Parents specifically voiced praise for care by midwives on Triage and Delivery	1
Family's choices respected when planning timing of MTOP	3
3rd anomaly scan provided at mother's request as feeling anxious	1
Wider system learning	

No pre-conception care available for mental health	2
Documentation	
No clear plan of care documented for baby with anomaly	1
No clear plan for investigations required post birth for baby with anomaly	1
Communication	
Feedback re conflicting information re mode of delivery – fibroids/breech	1
Feedback re insensitive delivery of bad news when no FH on scan	1
Parents not informed until attended Birth Suite that baby may show signs of life	1
Lack of senior review	
Was not seen in Consultant ANC following dating scan	1
Inappropriate plan of care	
PlGF testing should be undertaken for any amount of proteinuria	1

9. MNSI Recommendations

There were no cases of stillbirth or neonatal death which met MNSI investigation criteria. This is a reduction from 1 case in 2023.

The were no cases of serious intrapartum brain injury in 2024 to report to MNSI. This is a reduction from 4 cases in 2023.

10. Governance

All mortalities and cases of serious intrapartum brain injury, irrespective of gestation or cause, are subject to incident reporting and 72-hour review.

All 72-hour reviews are presented at the weekly MDT Divisional Patients Safety Groups (PSG) which feeds into Trust Patient Safety Group and up to Trust Board.

Cases are escalated as appropriate to Trust Learning from Patient Safety Events Group (LfPSE) and actions are monitored via Trust Learning from Experience Group (LfEG).

The Maternity Incentive Scheme sets a timeline for notification, reporting and completion of PMRT reviews, including seeking parents' views, and this is monitored via the MBRRACE perinatal surveillance system and reported Floor to Board via the Perinatal Surveillance Report.

Mortality and Serious Brain Injury data is analysed monthly via the Maternity Dashboard and SPC charts by the MDT team in the Patient Safety Groups, Safety Champions, Clinical Cabinets and Divisional Quality and Effectiveness Group, to promote shared oversight.

Mortality data and PMRT outcomes are shared quarterly Floor to Board via the Perinatal Quality Surveillance Report.

The Trust works with the GMEC LMNS to share themes and learning at the GMEC LMNS Safety Significant Interest Group and the GMEC LMNS Perinatal Loss Significant Interest Group.

The LMNS analyses data across GMEC so that timely responses from Trusts can be sought if there are data anomalies.

Progress towards Saving Babies Lives (3) Care Bundle is also monitored, with quality assurance by the LMNS. Outcomes of the SBL3 audit are reported via the Perinatal Quality Surveillance Report.

Learning outcomes are shared via Comm Cell, the Governance Gazette, the Quality Bus, closed social media, the Perinatal Quality Surveillance Report and the new Annual Mortality report.

11. Discussion

Congenital fetal anomaly

WWL has seen a slight increase in the rate of stillbirths as a result of fetal anomaly in 2024. Nationally, congenital anomalies account for around 8.3% of the total number of stillbirths (MBRRACE, 2022). In comparison congenital anomalies accounted for 57% of the total number of stillbirths in 2024 at WWL. One potential reason for this discrepancy may be that MTOP took place after 24 weeks although anomalies were identified sooner. There were 3 MTOPs due to known anomaly, and 1 stillbirth at 30 weeks due to a known fetal anomaly. In all cases, the parents birth choices and decisions regarding timing of birth were respected and there were no delays.

The Royal College of Obstetricians and Gynaecologists (RCOG) recommend routine feticide with Potassium Chloride (KCl) from 21+6 weeks gestation if a decision is made to terminate a pregnancy for fetal anomaly. Although numbers are small and the rate of neonatal deaths following MTOP has reduced from 2023, again we have seen babies born before this gestation showing prolonged signs of life. This leads to the question as to whether there is a need to bring the gestation KCl is offered forward so that parents have a choice. The family were deeply upset when informed on the Birth Suite that their baby may show signs of life, therefore working within current RCOG recommendations, it is imperative that counselling is done at the earliest opportunity so that families have time to prepare.

Themes for mothers who experienced a stillbirth as a result of MTOP or fetal anomaly were predominantly of White British origin, maternal age ≥30 years and had a raised BMI. There were no strong themes identified in relation to the social deprivation index, smoking or diabetes status. Half of the mothers were aged ≥30 years *and* had a raised BMI ≥30.

Thematic analysis was not possible for neonatal death as a result of MTOP or congenital anomaly as there was only 1 case. South-east Asian origin and age >40 was noted. Data is collated and will be reviewed over time to identify themes.

The main learning outcome from review was good care, which respected family choice for investigations and timing of birth. There was learning about the need for counselling regarding the possibility of the baby showing signs of life at the earliest opportunity.

Stillbirth

WWL total stillbirth rate in 2024 is 2.87 per 1000 registerable births. This is not in line with the local ambition (based on 2015 data) of 1.57 but is within the GMEC target for 24/25 and in sight of the national target of 2.6 for 2025. When rates are adjusted for congenital anomaly and MTOP there is a significant reduction to 1.23 per 1000 registerable births.

Themes for mothers who had a stillbirth not as a result of an MTOP or fetal anomaly were predominantly of White British origin ($\downarrow$from 2023), English-speaking ($=$ to 2023), Decile 1 and 2 (postcodes associated with most socially deprived areas) ($\uparrow$from 2023), age ≥ 30 years ($\uparrow$from 2023), raised BMI ≥30 ($\uparrow$ from 2023), and birth weight <10th centile ($\uparrow$2023). 75% of mothers lived in areas with a Decile 1 or 2

postcode, were aged ≥30 years and had a BMI ≥30, further compounding the risk. There were no strong themes identified in relation to smoking or diabetes status.

The Wigan Borough is considered one of the most deprived local authorities in England using the Index of Multiple Deprivation (IMD) with one of the highest rates of obesity. The low number of stillbirths not as a result of MTOP or fetal anomaly (3) is testament to the skills of all our staff including the Saving Babies Lives Team, the enhanced teams and the sonography staff. WWL progress against SBL 3 targets is 87% (target 70%).

Fetal growth restriction accounts for a 7-fold increase in the risk of stillbirth (Perinatal Institute, 2018). SBL audits have also shown a link between SGA and low decile. The new midwifery sonography service commenced in December 2024 will further support the timely provision of third trimester growth scans in line with the SBL 3 Care Bundle.

Smoking at the time of delivery (SaTOD) rates are the lowest on record and 2024 has seen huge improvements in SaTOD data bringing us for the first time below the GMEC mean.

Raised BMI is a public health issue wider than the scope of maternity services, however local guidance recognises that women with a raised BMI are at increased risk of various pregnancy complications including stillbirth. It provides guidance to support women with a BMI >25-30 to self-refer to the Community Weight Management service where free Slimming World classes are available, and to offer women with a BMI of 30 or more a referral to the Specialist Weight Management service. The PMRT gathers data on folic acid, aspirin, diabetes screening (GTT) and scan pathways, however, does not reference care around weight management. This is something future local reviews should look at in light of this data to assess if any QI work can be initiated.

The main learning outcome from review was that PlGF testing should be undertaken for any amount of proteinuria as per regional guidance. There is a plan to discuss this in regional guidelines group as this would put pressure on the service. When triangulated with patient experience data there were examples of feedback of excellent care by the Birth Suite and Triage midwives and feedback regarding the need to break bad news with sensitivity and compassion.

Neonatal Death

The total neonatal death rate in 2024 is 1.23 per 1000 births. This is not in line with the local ambition (based on 2015 data) of 0.52 but is better than both the GMEC mean and the national target of 1.5. When the rate is adjusted for MTOP and congenital anomaly the rate further reduces to 0.82 which is an improvement on the adjusted early neonatal death rate in 2023 of 1.2 and is slightly better than the GMEC mean.

Thematic analysis was difficult for those mothers who had a neonatal death not as a result of MTOP or fetal anomaly due to the small numbers. Both women were aged ≥30 years.

There was no learning from review of the 2 neonatal and the parents expressed no concerns regarding their care.

12. Conclusion

WWL has seen improved rates of stillbirth and neonatal death in 2024 from 2023, both rates are within the GMEC ambition target for 2024/2025. The early neonatal death rate also meets the national ambition, and the stillbirth rate is in sight of the national ambition.

There were no cases of serious brain injury or maternal death in 2024 meeting both the local, regional and national targets. The last reported case to MNSI was in August 2023.

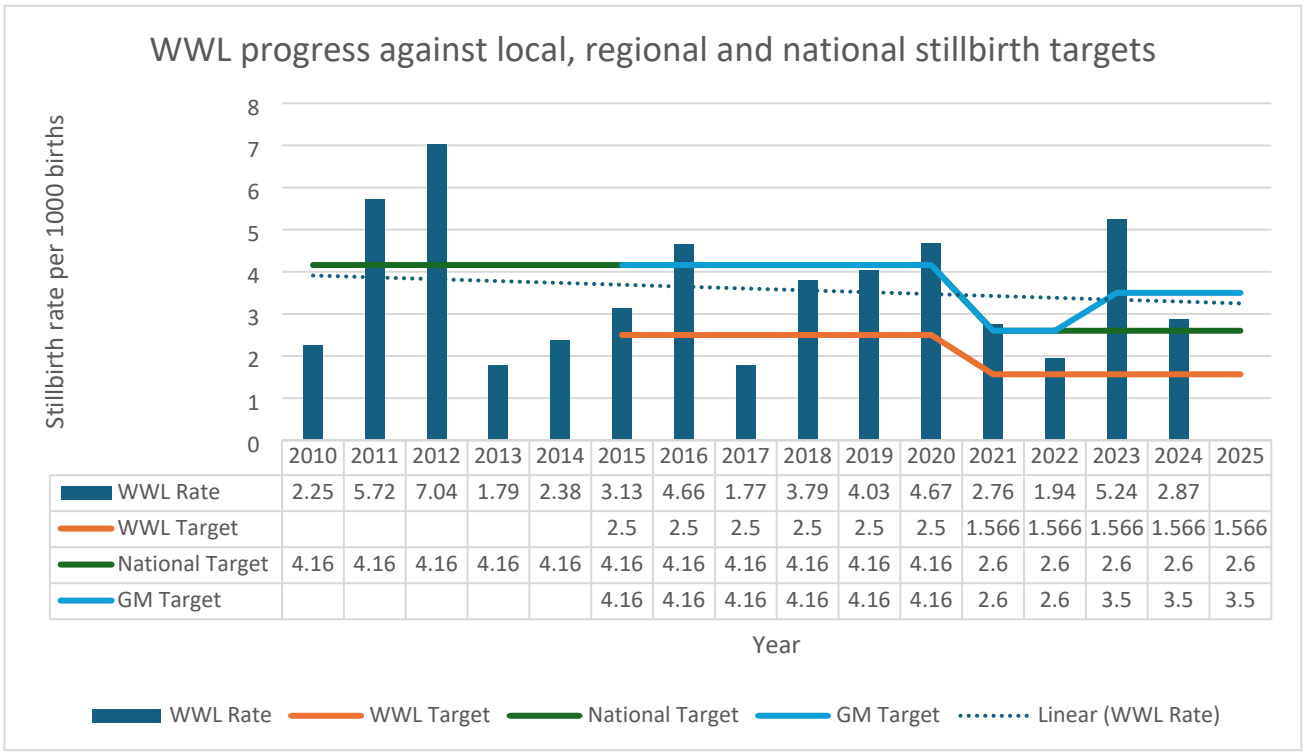
Progress against the SBL 3 care bundle continues with significant assurance given by the LMNS and above targets given.

Themes and trends will continue to be collated in Division and triangulated against patient experience to inform our learning and an overarching action plan is monitored through governance processes.

Appendix 1

WWL progress against local, regional and national targets.

Stillbirths

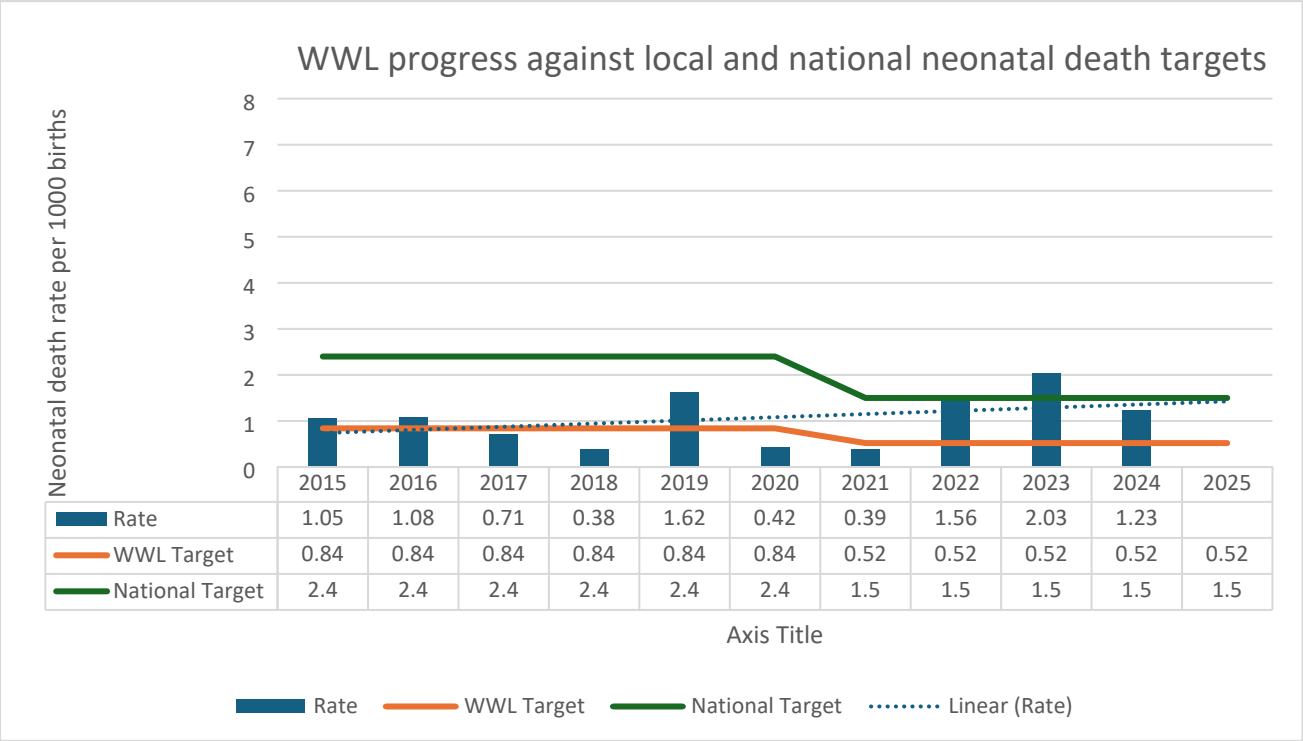


	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
WWL Rate	2.25	5.72	7.04	1.79	2.38	3.13	4.66	1.77	3.79	4.03	4.67	2.76	1.94	5.24	2.87	
WWL Target						2.5	2.5	2.5	2.5	2.5	2.5	1.566	1.566	1.566	1.566	1.566
National Target	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	2.6	2.6	2.6	2.6	2.6
GM Target						4.16	4.16	4.16	4.16	4.16	4.16	2.6	2.6	3.5	3.5	3.5

Appendix 2

WWL progress against local and national targets.

Neonatal deaths



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Rate	1.05	1.08	0.71	0.38	1.62	0.42	0.39	1.56	2.03	1.23	
WWL Target	0.84	0.84	0.84	0.84	0.84	0.84	0.52	0.52	0.52	0.52	0.52
National Target	2.4	2.4	2.4	2.4	2.4	2.4	1.5	1.5	1.5	1.5	1.5

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Midwifery 2nd Biannual Staffing review.2024/ 2025
Presented to:	Trust Board
On:	5 February 2025
Presented by:	Kevin Parker Evans Chief Nurse and DIPC
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	01942 773107 cathy.stanford@wwl.nhs.uk

Executive Summary

This is the second bi-annual report for 2024/25 which reviews Safe Midwifery Staffing levels

The report provides assurance of the following:

- Systematic, evidence-based process to calculate midwifery staffing establishment is complete.
- The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
- All women in active labour receive one-to-one midwifery care
- Submission of a midwifery staffing oversight report that covers staffing/safety issues to the board every 6 months during the Maternity (and Perinatal) Incentive Scheme Year Six reporting period.

Three Year Delivery Plan for Maternity and Neonatal Services update.

In March 2023 the **Three Year Delivery Plan for Maternity and Neonatal Services (2023) NHSE** was published**,** this sets out a series of actions for Trusts to make care safer, more personalised and more equitable for women, babies and families.

Services are being asked to concentrate on four high level themes, with theme 2 setting out three areas of action for maternity and neonatal staffing:

- continue to grow the workforce.
- valuing and retaining the workforce.

- investing in skills.

Ockenden

The final Ockenden Review published in March 2022 details a series of immediate recommendations for all NHS hospital trusts in England to meet, with the aim of providing assurance of maternity safety within each provider trust's maternity services.

NICE (2015) published guidance on safer midwifery staffing and identifies red flags where further action is required to ensure safety of women and babies. This maternity staffing report will highlight frequency of maternity safer staffing red flags and the reasons for the red flags.

Staffing levels and skill mix are key elements of a safe, effective, and high-quality service. In maternity, workforce planning is unique as each care 'episode' spans around 6-8 months, within both hospital and community settings, and involves a series of scheduled and unscheduled care which often involves unexpected inpatient admission as well as the birth itself. The activity within maternity services is dynamic and can rapidly change. It is therefore essential that there is adequate staffing in all areas to provide safe high-quality care by staff who have the requisite skills and knowledge.

Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers. The BR+ Acuity tool supports this, which is a safe staffing tool for delivery suite and Maternity ward activity.

The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from Quarter 4

Link to strategy

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

Risks associated with this report and proposed mitigations.

Detailed in the report body.

Financial implications

Cost implication of increased staffing requirements.

Legal implications

None identified.

People implications

Patient Safety and Staff wellbeing considerations

Wider implications

Trust Reputation and risk of regulatory requirements not being met.

Recommendations

The Board are requested to review the findings of the report, outlining the current establishment and existing vacancies in line with The Maternity Incentive Scheme Safety Action 5 and receive a biannual staffing report for maternity services.

The Board are requested to note the request for an additional uplift to be added to the baseline establishment to allow for the increased training needs to comply with Saving Babies Lives and The Maternity(and Perinatal) Incentive Fund Year 6/7 training requirements.

The final Ockenden Report also recommends that average sickness levels from the previous 3 years, maternity leave, and annual leave (inclusive of Trust Birthday Leave) is calculated within the uplift **.**

Maternity Safe Staffing for 2024/25

Report

In Q2 and Q3 period we have recruited 13.24 wte Midwives. In the same period there were 3.92 wte leavers. Recruitment within maternity services occurs predominately September to November each year following the third-year student midwives completing and qualifying.

Midwives	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec24
New Starters	0.0	2.0	5.76	4.48	0.0	1.0(pending)
Leavers	1.56	0.0	0.0	1.36	1.0	0.0

Recruitment.

Recruitment and retention continue to be a focus within the service and due to national and regional workforce challenges, all options are being explored to support the midwifery workforce.

In September 2024 twenty-five Student Midwives who have undertaken their training programme here at WWL were due to qualify and WWL employed 10.24wte of this cohort.

Midwife to Birth Ratio

This is report Monthly on the maternity Dashboard and remains fully compliant. Working s take into consideration births per months and Shift fill rate with Substantive and Bank shifts

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1:28	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**	**1:28**

Senior Leadership posts

Several senior posts have been recruited to ensure the correct senior leadership is in place across the service. These posts included:

- Additional Fetal Surveillance Midwife
- Additional Saving Babies Lives Midwife
- Triage Team Leader
- Intrapartum Matron
- Inpatient and Elective Pathway Matron
- Work force Lead
- Preceptorship Lead

All posts are now fully recruited to across the service.

Current Registered Midwife Vacancy Position (Staffing figures correct at 31.12.2024)

	Band 5/6	Band 7	Band 8a and above	Total
Clinical Vacancies	**5.11**	**1.26**	**0.0**	**6.37**
Upcoming vacancies in next 3 months	**2.36**	**0.0**	**0.0**	**2.36**

Additional Birthrate+ recommendations	**n/a**	
Additional uplift to 25%	**4.82**	**Not Currently funded**
Total proposed vacancies inclusive of additional uplift to 25%.	**13.55 (4.82 of which is unfunded and 2.36 upcoming vacancies, Jan - March)**	

Retention.

The Band 5 – 6 preceptorship program continues to be successful in maintaining our current staff with all progressing to Band 6 posts on completion of their preceptorship. 9 Band 5 Midwives have progressed to Band 6 in December 2024 having successfully completing their 18-month preceptorship programme.
Funding was received from NHSE&I to support Midwives and Midwifery support worker retention with a band 7 preceptorship Lead Midwife and a Band 4 Midwifery Support Worker (MSW's) in post, this funding is now recurrent.

The job purpose of these roles is to focus on recruitment and retention, providing a comprehensive preceptorship package, pastoral support through the recruitment process to in post as a newly qualified midwife and the upskilling of MSW's.

The RCM has raised awareness around the lack of experienced midwives and the challenges around their retention, therefore supportive development package for midwives progressing to Band 6 is in place as it has been recognised that the additional responsibilities can be a factor in high attrition rates if the support that has been in place during the preceptorship period is withdrawn.
To ensure the retention of all grades inclusive of band 7 and above, a developmental plan is in place to support their transition into the senior posts and allow for succession planning.

Enhanced continuity Community Teams

The roll out of enhanced continuity teams is linked to the 3 Year Delivery Plan for maternity and Neonatal Services to help improve outcomes for the most vulnerable mothers and babies. At present there are two enhanced Community Teams established which focus care on women at greatest risk of poor outcomes. Fern Team provide care to women and families from the most deprived neighbourhoods in deciles 1&2, as defined by the Indices of multiple Deprivation (IMD). They also provide care to all non-English speaking women.

Plans are also in place to ensure that all women from a Black, Asian, and Ethnic backgrounds regardless of deprivation decile are provided a level of enhance care within the current community teams. It is notable that the number of Black, Asian, or Mixed ethnicity women living within the Borough is increasing year on year and currently is approximately 16%

Staffing for the enhanced teams has come from within the current establishment as community teams caseloads have been adjusted. There are approximately 40% of women within the Borough that live in a postcode from the bottom deciles of deprivation i.e., Decile 1&2. However, postcode alone is not a reliable method of measuring deprivation, and these will be utilised in conjunction with other risk factors. Funding has been allocated via the LMNS

to support a continuity model of care and a pilot is to be commenced within Fern team to provide additional support and continuity, however at present this is non-recurrent.

Daisy Team.

Daisy team is the second enhanced care team which consists of 7 Midwives, 2 maternity Support workers and an admin assistant. Daisy team provide care to the most complex and vulnerable women within the Borough and hold a much-reduced caseload which is approximately 125 women per annum. Currently WWL receive partial funding from the local authority.

A full-service review was undertaken to establish the best way forward with enhanced care provision and best utilisation of Midwifery resources.

In order to expand enhanced care to a greater cohort of women, WWL are currently working with the local authority to agree KPI's linked to national, local, and regional objectives and working towards an integrated model of care which will include services from within the local authority and Health Visiting to provide a Family Safeguarding approach to this group of women and families.

Immunisation Team.

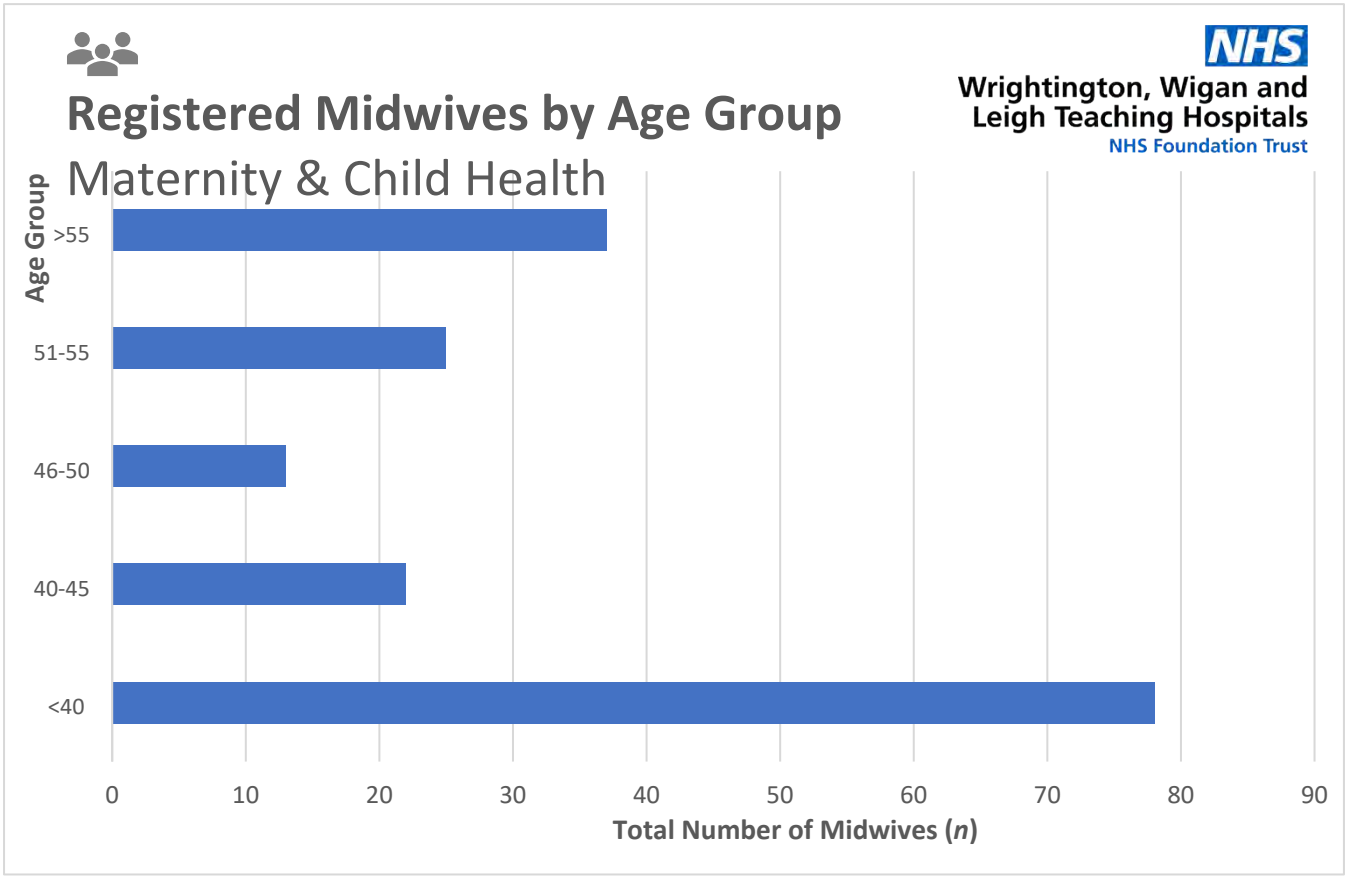
The Respiratory Syncytial Virus (RSV) programme was rolled out for pregnant women
from 1 September 2024. All pregnant women are offered a vaccine after they have reached 28 weeks gestation, to protect their babies against RSV.
RSV is a common virus which can cause a lung infection called bronchiolitis. In small babies this condition can make it difficult to breathe and to feed. Most cases can be managed at home but around 20,000 infants are admitted to hospital with bronchiolitis each year in England and significantly contribute to the paediatric winter pressures. Infants with severe bronchiolitis may need intensive care and the infection can be fatal. RSV is more likely to be serious in very young babies, those born prematurely, and those with conditions that affect their heart, breathing or immune system.
The staffing for this programme has been fully funded by NHSE with recurrent monies and Full budget will be received in the new financial year and the establishment adjusted to fully reflect this.

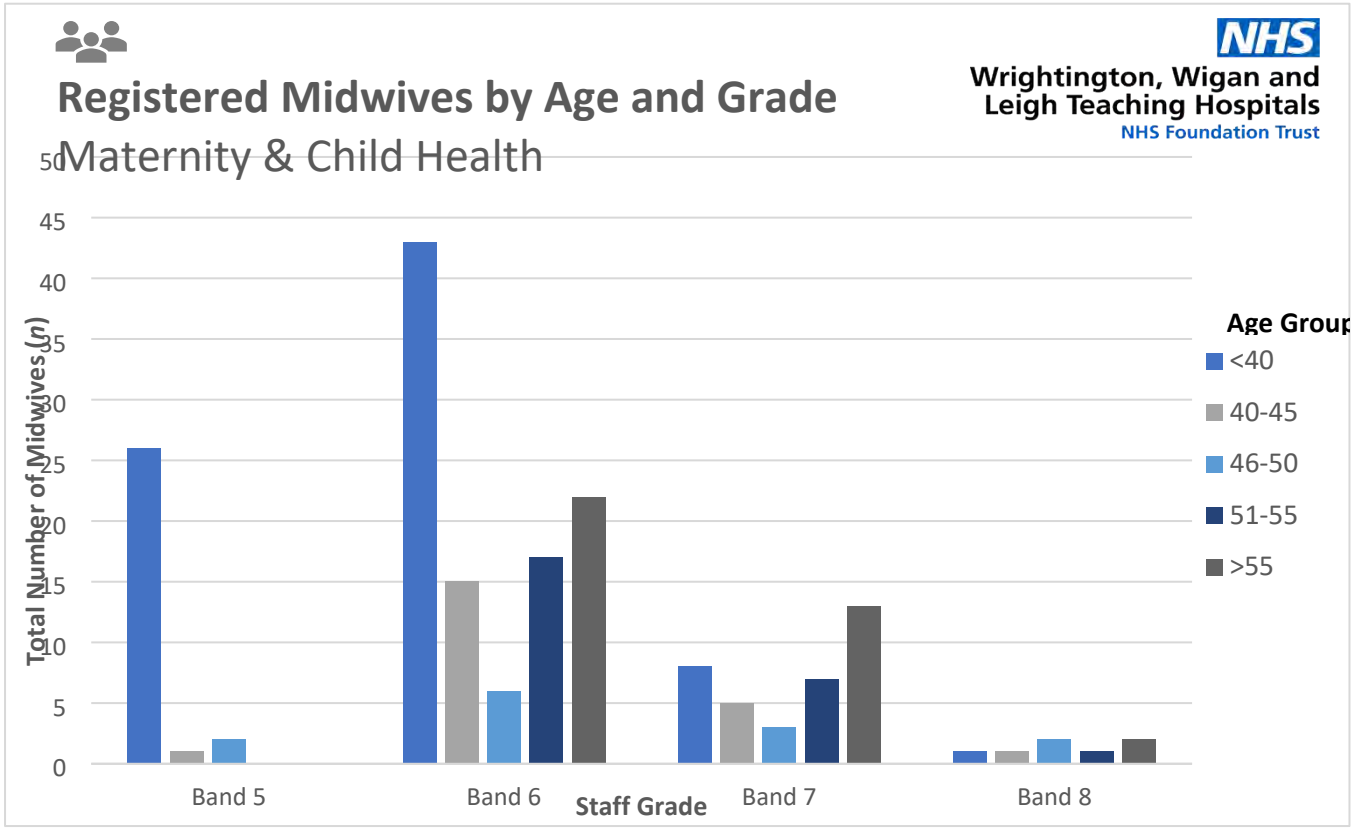
WWL have successfully rolled this out and seen a good uptake of the RSV vaccine with increased uptake of Flu and Pertussis which is also included within the service , additionally the offer of BCG to infants identified to be at risk for Tuberculosis will also be offered by the immunisation team on a daily/weekly basis which again should increase the uptake of this vaccine which is currently low across the Borough.

Workforce Profile

The age profile of the midwifery workforce has shifted again within the last 6 months with the biggest group of registered midwives (66%) being under 50.
Approximately 34% of the workforce is over 50, with this being more heavily weighted within the higher bands.
Regional and national workforce planning has seen a year-on-year increase in the numbers of student midwives

being recruited to Midwifery training programmes in response to the aging workforce and high attrition rates in some areas.





Sickness

The current overall sickness levels for maternity services has greatly improved and now is on average 4.5%.

All support measures are in place for staff wellbeing and staff are sign posted as appropriate to the wellbeing team and occupational Health services.

Professional Maternity Advocates are available for all staff to also support with wellbeing, along with robust adherence to the sickness processes with HR support. Roster management has been reviewed to ensure shift patterns are not too onerous and assurance that Roster rules are in place to support staff health and wellbeing.

Uplift to baseline staffing.

Training requirements for Midwives continues to increase significantly since the introduction of the Maternity Incentive Scheme and the Saving Babies Lives Care Bundle. Each Midwife needs a minimum of 5 days annually to be compliant with current requirements, this does not include the Trust mandated eLearning and any additional role specific modules such as NIPE (new-born and Infant Physical examination), Accredited Neonatal Life Support, Leadership and Critical Care, therefore it is requested that the uplift of 20% is increased to 25% which will incorporate training

needs but also the recommendations within the final Ockenden Report that average sickness levels from the previous 3 years, maternity leave and annual leave (inclusive of Trust Birthday Leave) is calculated within the uplift and meet the training requirements of the 3 Year plan.

An increase in uplift from 20% to 25% would increase the establishment by 4.82 wte. In addition, the shortfall in Birthrate+ recommended staffing which was agreed in principle in the last report has now been met from additional external funding however, in 2025 Birthrate+ is due to be repeated in line with National recommendations.

Therefore, the overall staffing shortfall including current vacancies and an agreement to uplift to 25% is 13.19 wte.

1:2:1 Care & Supernumerary Shift Coordinator

Evidence from an acuity tool (which may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation/escalation to cover any shortfalls

WWL utilises the Birthrate+ Acuity tool across the Maternity Floor.

The twice daily Safety Huddle monitors, among other things, the provision of 1:1 care in labour and the supernumerary status of the Delivery Suite Co-ordinator.

If there is an occasion when 1:1 care in labour is in jeopardy and/or the Delivery Suite Co-ordinator does not have supernumerary status this is promptly escalated to the Maternity manager on call. Mitigating action is then taken to address the issue and the corresponding Red Flag is uploaded to the Birthrate+ acuity tool as appropriate.

This data is also reviewed at the Maternity Clinical Governance monthly meetings and reported as part of the safer staffing reports, and additionally included within the Maternity Governance reporting to Trust Board and Quality and Safety Committee.

Red Flags

Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six-month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising.

In this period there has been 100% compliance with the provision of 1:1 care in labour and supernumerary Delivery Suite Co-ordinator status as per Maternity and Perinatal Incentive Scheme Year 6. ***There must be a rostered planned and an actual supernumerary shift coordinator at the start of every shift to ensure oversight of all birth activity within the unit. All women in active labour receive one-to -one midwifery care.***

RF1	Delayed or cancelled time critical activity
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
RF4	Delay in providing pain relief
RF5	Delay between presentation and triage
RF6	Full clinical examination not carried out when presenting in labour
RF7	Delay between admission for induction and beginning of process
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
RF10	Coordinator unable to maintain supernumerary status - providing 1:1 care
RF11	Coordinator unable to maintain supernumerary status - NOT providing 1:1 care

Midwifery red flags are reported Monthly in the Divisional Performance reviews, and Clinical Cabinet. Additionally, they are captured within the Quarterly Perinatal Quality Surveillance Reports which are submitted to Quality and Safety Committee, Safety Champions and Trust Board as well as Divisional and Directorate Governance Forums.

These are reported via the Birthrate Plus+ Acuity tool and validated monthly. The Maternity and Perinatal Incentive Scheme (CNST) requires that a Supernumerary Shift Coordinator be in place at the start of every shift, and that 1-2-1 care in labour is provided, this has remained predominantly compliant throughout the quarters and meets the CNST requirements.

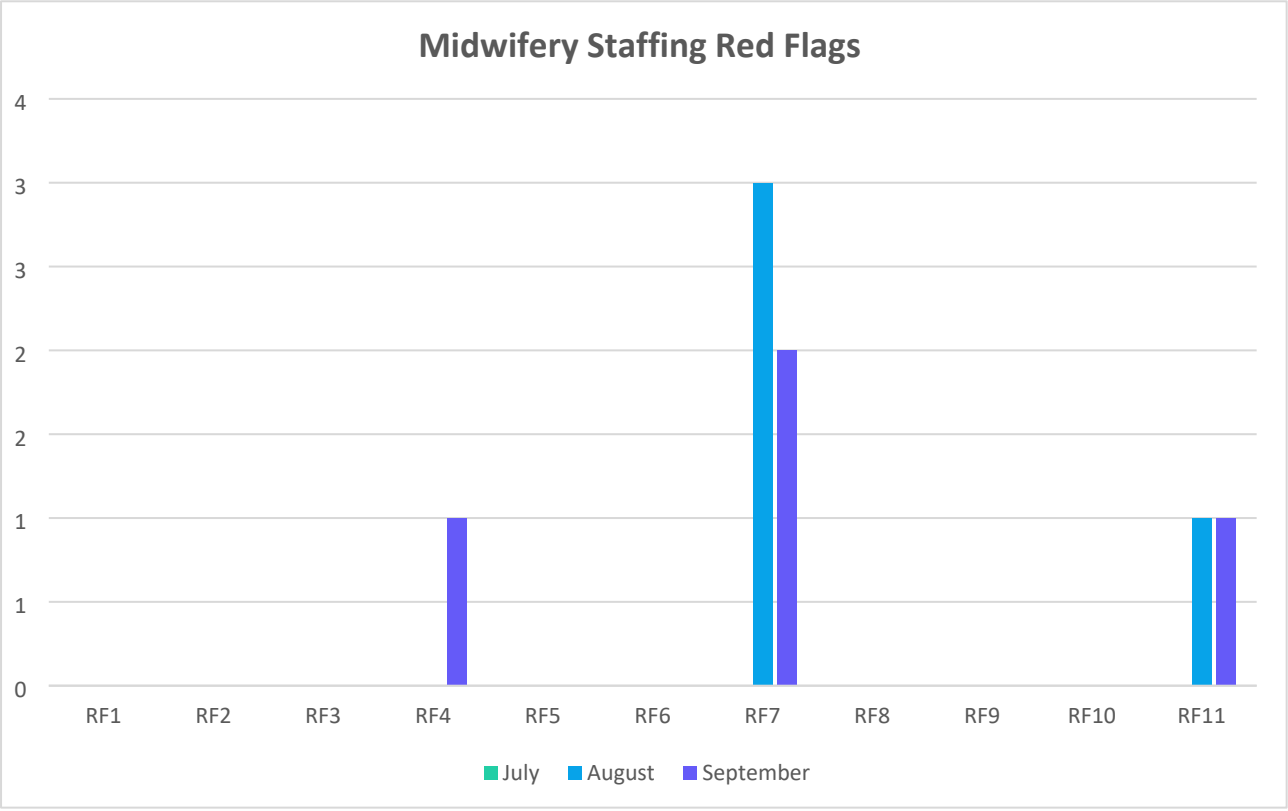
Q2 Red Flags

In Q2 2024/2025 there were 8 validated red flag events.

In July we reported 0 red flags which reflects a reduction in sickness levels, the uptake of bank shifts and reduced activity and acuity.

The contributing factors for the red flags in August and September are largely around short-term sickness and high levels of acuity. The key theme identified are delays in induction of labour being commenced, safety maintained all appropriate monitoring was followed. We had 1 red flag for a delay in pain relief, this was a woman awaiting an epidural, acuity and activity was the reason for the delay and simultaneous emergency care ongoing, no harm caused alternative analgesia was utilised in the interim

1 red flag was reported due to the shift coordinator not supernumerary; this was reflected in the requirement of the on-call manager on site, appropriate escalation was followed, no harm was caused, coordinator had full oversight provided care to postnatal woman who required minimal support. From analysis of the red flag events, it is evident that the appropriate escalation was followed, and safety maintained, no harm was caused.

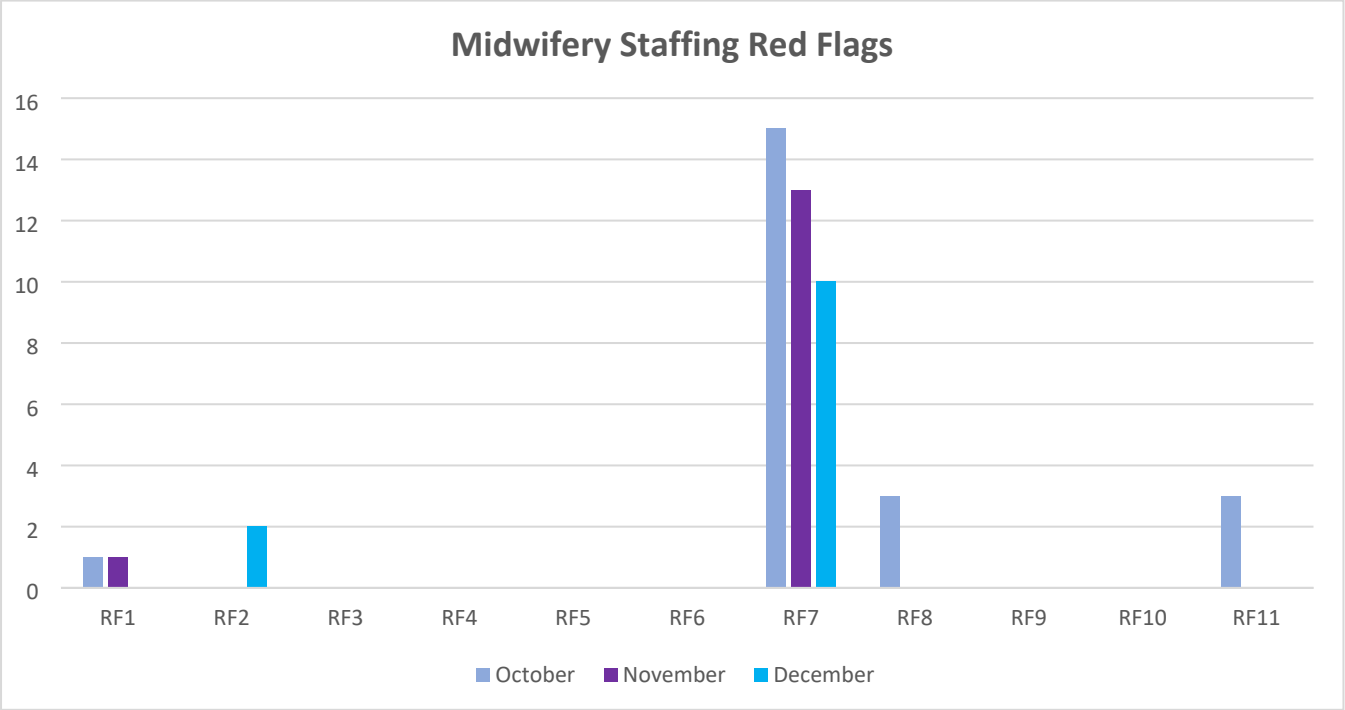


Q3 Red Flags

October was a particularly busy period within maternity services with significantly increased births. In October and December 100% 1:1 care in labour was provided, in November it was reported as 97.4% of 1:1 care in labour on the maternity dashboard, however, no red flags were submitted during Q3 on the acuity tool.

100% compliance with supernumerary shift co-ordinator was maintained throughout Q3 and there were no maternity diverts.

The contributing factors for the significant increase in red flags for Q3 was predominantly due to delay between admission and commencing the induction process (94%), there was no harm reported, and the delays were to maintain safety across the maternity service.



Escalation policy

The maternity service follows the agreed Greater Manchester and Eastern Cheshire Maternity Escalation Procedures leading to a Temporary Divert Policy, which includes mitigation and escalation for managing any shortfalls in staffing.

A maternity SitRep is completed daily and shared with maternity managers. A GM wide electronic SipRep is also in place to be completed daily and will include the status from all GM Maternity units and monitored through the Local Maternity System (LMNS) in conjunction with NWAS.

This is supported by the Birthrate+ acuity tool across the maternity floor which was purchased to support the real time reporting of acuity and activity and identifies where staff are required to provide assurance that the correct staffing levels are in place against activity and acuity.

Birthrate+

The 2023 BirthRate Plus® report recommended that management or specialist midwife roles should not be included in the clinical numbers. The report noted that within WWL management and specialist roles the clinical specialist midwives have both a clinical and non-clinical role. It is a local decision of senior midwifery management as to the % contribution to the clinical staffing. The remaining % is included in the non-clinical roles. Currently there are 13.17wte Specialist Midwives of which 2.47wte are allocated to the clinical total. The remaining 10.70wte are included in the additional wte.

A skill mix of 90/10 is applied so that 10% of the clinical wte are suitably qualified MSWs (Band 3s), working in postnatal services in the ward and on community. It is a local decision by the senior midwifery management team as to an appropriate skill mix for this area of care.

We continue to review maternity services to ensure the appropriate level of manager and specialist midwives are not included in the midwifery numbers, however during periods of escalation managers and specialist midwives are required and continue to work clinically to support safe care provision.

Since the last Birthrate+ report of March 2023 there has been additional funding received for Saving babies Midwifery roles, Recruitment and Retention, Preceptorship, Third Trimester Scanning and Bereavement which has increased the overall head count, as highlighted in the table below.

Specialist Roles

Role.	**Band**	**WTE**	**Funding Linked to :**
Infant Feeding Lead /Infant Feeding Midwife	7/6	1.80	Core
Fetal Surveillance Midwife.	7	1.0	SBL
Smoking Cessation Lead Midwife	7	1.0	SBL
Saving babies Lives Lead Midwife	7	1.0	SBL
Diabetes Specialist Midwife	7	1.0	SBL
Pre-Term Birth Midwife(SBL)	7	0.60	SBL
Bereavement Midwife	7	1.60	Ockenden
Antenatal / Newborn Screening	7	1.20	Core
Perinatal Mental Health Midwife and Lead	7/6	2.0	Ockenden
Practice Education Facilitator (PEF)	7	0.80	Core. **Unfunded**
Practice Educators	7	2.0	Core.
Preceptorship Lead	7	0.80	Ockenden
Third Trimester Scanning Midwife	7	0.32	SBL
Patient , Public & Staff Engagement Lead	7	0.60	Ockenden
Total		**15.72**	
Funded Establishment		**14.92**	

Senior Management Team

Role	Band	WTE	**Funding Linked to :**
Divisional Director of Midwifery	8d	1.0	Core
Deputy Divisional Director of Midwifery	8c	1.0	Core
Head Of Governance	8b	1.0	Core

Community Matron	8a	1.0	Core
Specialist / SBL / Fetal Surveillance Matron	8a	1.0	Core
Inpatient, ANC and Elective Pathway Matron	8a	1.0	Core
Intrapartum and Triage Matron	8a	1.0	Core
Digital Midwife	7	1.0	Ockenden
Governance and Risk Midwife	7	1.0	Ockenden
Quality and Safety Midwife	7	1.0	Ockenden
Workforce Lead	7	1.0	Ockenden
Consultant Midwife	8b	**0.0**	Ockenden
Advanced Midwife Practitioner	8a	**0.0**	
Total		**11.0**	**7.55%**
Funded Establishment		**11.0**	

In Q2 and Q3 the number of specialist and managerial midwife roles in post accounted for 17.68% of the current budgeted workforce.

However, recurrent funding streams have been made available from Ockenden and Saving Babies Lives since the initial Birthrate+ report in 2023 which has mandated the recruitment to these posts.

Clinical Roles

Area	Band	Budget	Actual	Vacancy
Delivery Suite	7	6.24	6.08	**0.16**
	6	31.42	18.69	**1.69**
	5		11.04	
	4	5.38	0	**1.54**
	3		3.84	
Mat Ward	7	0	0	**0**
	6	20.37	12.12	**1.05**
	5		7.2	
	4	8.83	0	**0.79**
	3		8.04	
Triage/DAU	7	0.5	0.5	**0**
	6	8.83	8.44	**0.39**
	5		0	
	4	5.38	0	**0.26**
	3		5.12	

ANC	7	0.5	0.5	**0**
	6	7.69	5.60	**1.09**
	5		1	
	4	4.86	0	**0.26**
	3		4.6	
Community - Wigan	7	0.5	0.5	**0**
	6	8.6	6.53	**1.11**
	5		0.96	
	4	1	0	**0**
	3		1	
Community - Ashton	7	0.5	0.5	**0**
	6	7	5.31	**0.09**
	5		1.6	
	4	1	0	**0.2**
	3		0.8	
Community - Leigh	7	0.5	0.5	**0**
	6	7	6.23	**-0.19**
	5		0.96	
	4	1	0	**0**
	3		1	
Fern	7	0.5	0.5	**0**
	6	9	7.2	**-0.12**
	5		1.92	
	4	1	0	**-0.6**
	3		1.6	
Daisy	7	1.5	0.4	**1.1**
	6	5	5	**0**
	5		0	
	4	1.88	1	**0.33**
	3		0.55	

	Band	Budget	Actual	Vacancy
Immunisation Team	**7**	0	0	0
	6	3.30	3.08	0.22
	5		0	
	4	0	0	0
	3		0	

	Band	Budget	Actual	Vacancy	Pending	Actual Vacancy
Total	7	**10.74**	**9.48**	**1.26**	0	**1.26**
	6	**104.91**	**75.12**	**5.11**	0	**5.11**
	5		**24.68**			
	4	**30.33**	**1**	**2.78**	0	**2.78**
	3		**26.55**			

***Band 5 Posts are rotational during the preceptorship period and will be allocated to all areas in the service. They are included within the overall contracted actual WTE.**

Title of report:	Freedom to Speak Up Q3 Board Report
Presented to:	Board of Directors
On:	05 February 2025
Item purpose:	Information
Presented by:	Selina Morgan, Freedom to Speak Up Guardian
Prepared by:	Selina Morgan, Freedom to Speak Up Guardian
Contact details:	T: 07826860276 E-mail: Selina.morgan@wwl.nhs.uk

Executive summary

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

- Assurance on Freedom to Speak Up (FTSU) Guardian approach and activity throughout Quarter 3.
- An update on FTSU developments Including the evolving FTSU Champion Network.
- An overview of FTSU casework, themes and trends.

Key points for noting include:

- There were 34 cases in Q3, an increase from the previous quarter.
- Attitudes and behaviours was the predominant theme in Q3.
- 79% of staff raised their concern anonymously.
- Where required, there is senior leader involvement to ensure progress towards Board responsibilities.
- There is continuing and planned FTSU awareness raising work, with mutual collaboration with other areas of the Trust, including Staff Side and Steps4Wellness.
- Casework indicates more complex cases, however positive resolution of FTSU concerns.

Link to strategy and corporate objectives

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

- To improve the quality of care for our patients

Everyone within the organisation should feel safe, comfortable and confident to speak up and by adopting our organisational values to create the right environment, by doing this we improve health and care outcomes for the population we serve and staff experience.

Risks associated with this report and proposed mitigations

There is a risk to the quality and safety of patient care, and to staff engagement and productivity, if staff do not feel able to speak up regarding their concerns.

Financial implications

There are no financial implications

Legal implications

There are no legal implications

People implications

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

Equality, diversity and inclusion implications

It is important a wide range of staff are encouraged to speak up. The Freedom to Speak Up Guardian now reports protected characteristics to the NGO (National Guardian Office).

1. INTRODUCTION

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

- Assurance on Freedom to Speak Up (FTSU) Guardian approach and activity throughout Quarter 3.
- An update on FTSU developments Including the evolving FTSU Champion Network.
- An overview of FTSU casework, themes and trends.

2. APPROACH AND ACTIVITIES

Proactive awareness raising development work completed since the last FTSU Board report includes:

- Continued attendance to various team meetings to raise awareness and importance
- Attendance at the SWAP Programme where the FTSU Guardian presented to 14 work experience colleagues on 16/01/25.
- Inclusion of speaking up in Trust-wide communications
- Robust Development of the FTSU Dashboard
- MIAA Audit of Freedom to Speak Up service report due week commencing 27th Jan 2025.

3. FTSU CHAMPIONS

- 29 FTSU Champions chosen from a wide range of professional backgrounds within the Trust have completed the FTSU e-learning modules Speak Up and Listen Up and 18 of the Champions have completed the aligned FTSU training programme.
- According to the FTSU Guardian survey 2023, only 21% of Trusts have over twenty Champions. However, there is no upper limit, and Champions continue to be appointed and trained on a rolling basis.
- FTSU Champions have access to Quarterly drop-in sessions, to allow for greater flexibility alongside their substantive roles.

4. CASEWORK THEMES AND TRENDS

4.1 Case Numbers:

- There were 34 cases brought to the FTSU Guardian in Quarter 3, an increase of 14 cases from Quarter 2.
- There were 20 cases brought to the FTSU Guardian in Quarter 2. This is a slight decrease (of 9 cases) from Quarter 1. The summer season of Q2 meant a significant number of staff on annual leave, which may be the reason for this.

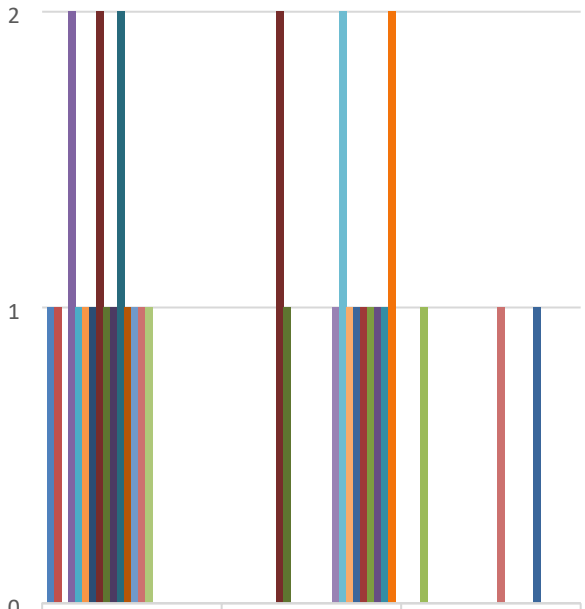
4.2 The themes of FTSU concerns in Q3 are shown below:

Theme	**Q3 2024**		
(**Bold**= Reportable to NGO)	Oct	Nov	Dec
Inappropriate Attitudes / Behaviours	5	2	2

Bullying / Harassment	1	1	
Worker Safety / Wellbeing	2	3	
Patient Quality / Safety			
Disadvantageous / Demeaning Treatment or Detriment			
Persons Capability			
Leadership and Management	7	6	
Policy and Procedure	2	1	
Service Change			1
Discrimination		1	
Racial Discrimination			
Improvement Suggestion			

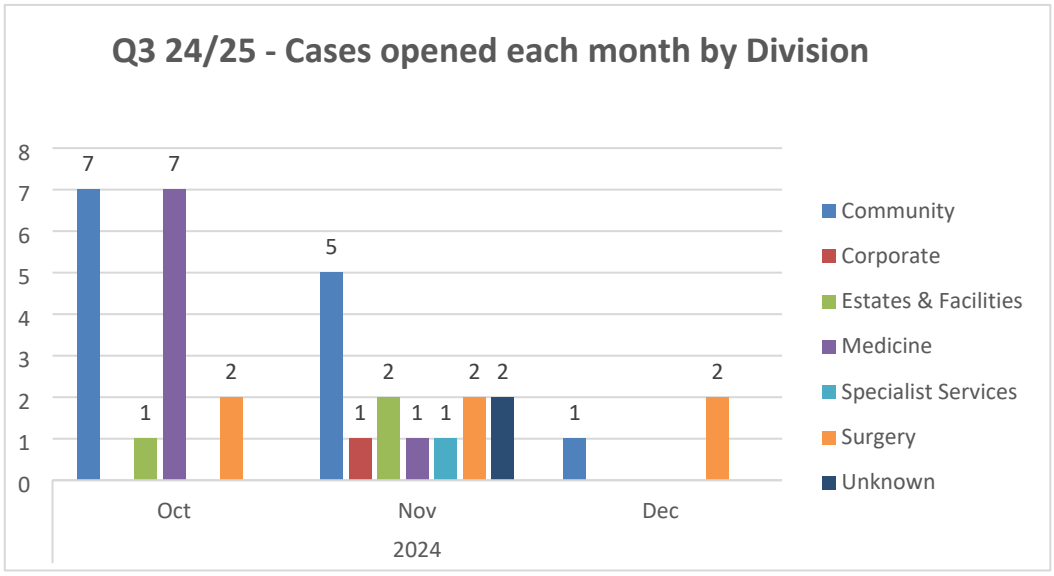
4.3 Cases reported each month by service area

Q3 24/25 - Cases opened each month by service Area



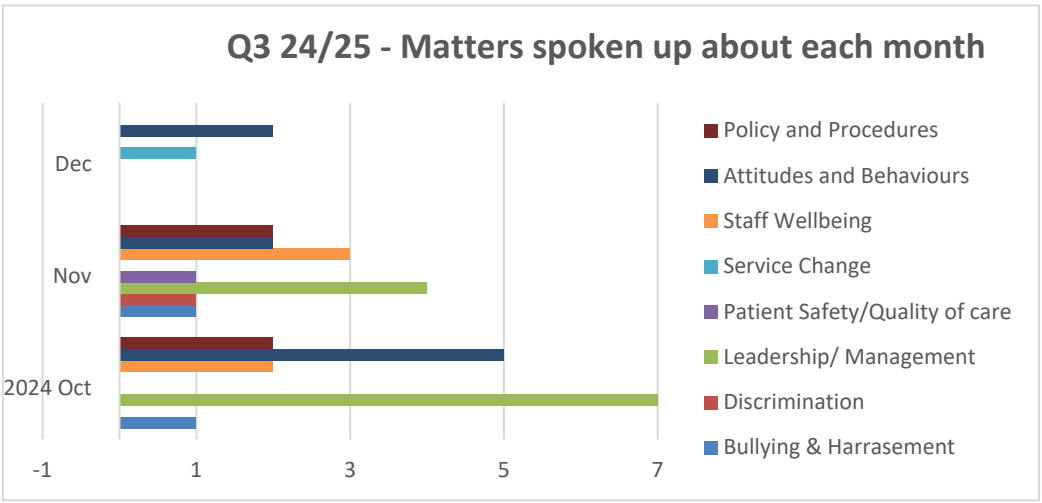
	Oct 2024	Nov	Dec
Pharmacy	1		
IPC	1		
ICU			1
B Ward	2		
A&E	1		
Admin	1		
CIC team/ Families Safeguarding	1		
CAU	2	2	
Podiatry	1	1	
Gastroenterology	1		
Medical Education Dept	2		
Porters	1		
COPD Oxygen	1		
Dietetics	1		1
Lowton Ward	1		
Ward A&B		1	
Med Electronics		2	
GP Out of Hours		1	
Maternity		1	1
Occupational Health		1	
Paediatric		1	
Palliative Care		1	
Ophthalmology		1	
Unknown		2	

4.4 Cases reported each month by Division



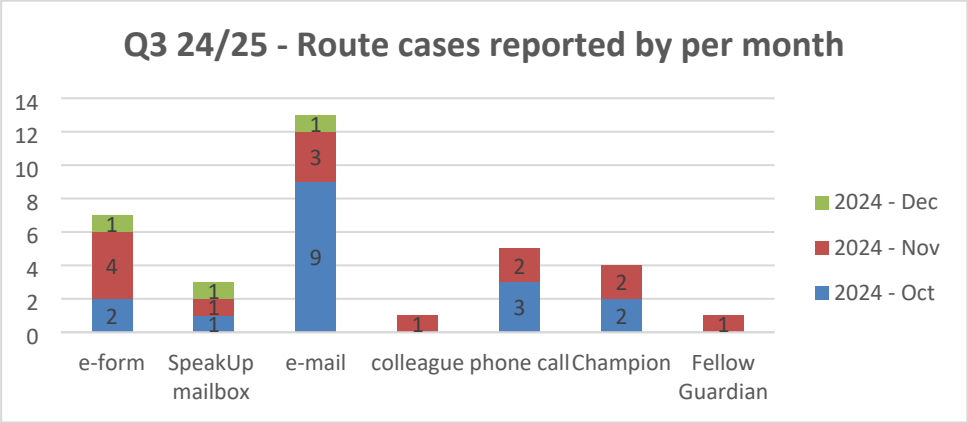
There have been cases in Q3 where OD involvement has been sought and independent service reviews commissioned. On these occasions work has involved engaging with staff within the division on what is working well, what needs improving and a focus on improving communication styles.

4.5 Matters Spoken Up about



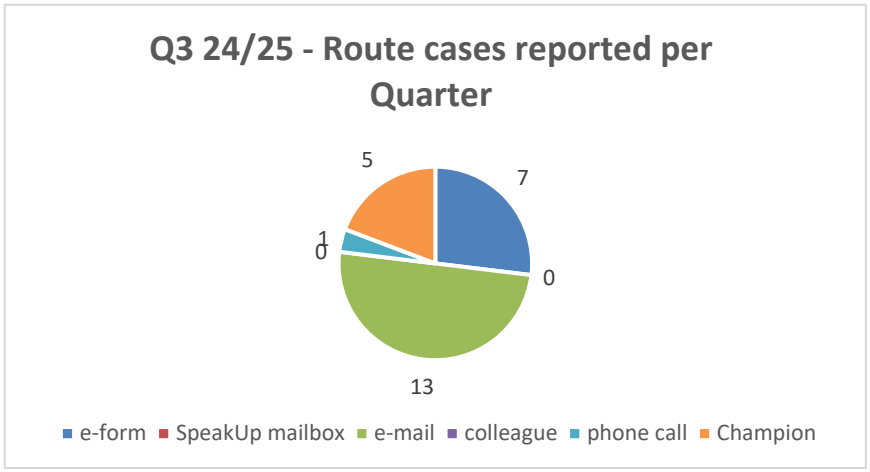
Attitudes and Behaviours was the predominant theme throughout Quarter 3, followed very closely by Leadership and Management, this category does not always mean Line Management, however management in general and this information is detailed in the FTSU Guardians tracker on the individual cases reported.

4.6 Route staff are using to report concerns



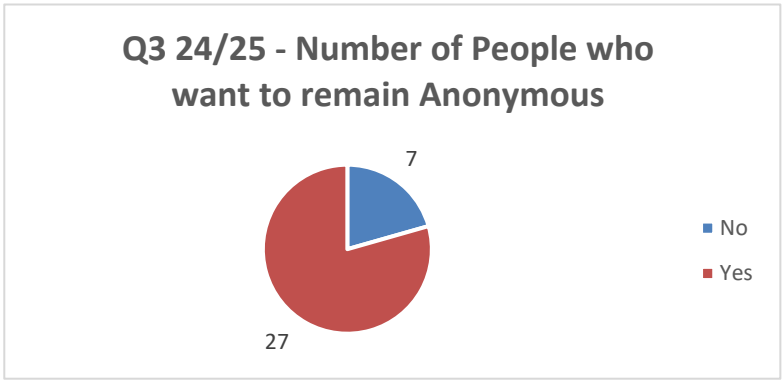
More staff continue to use different routes to speak up and raise their concerns other than just the Speak Up mailbox. This highlights confidence in the process and assurance of response.

4.7 Route reported per Quarter 3



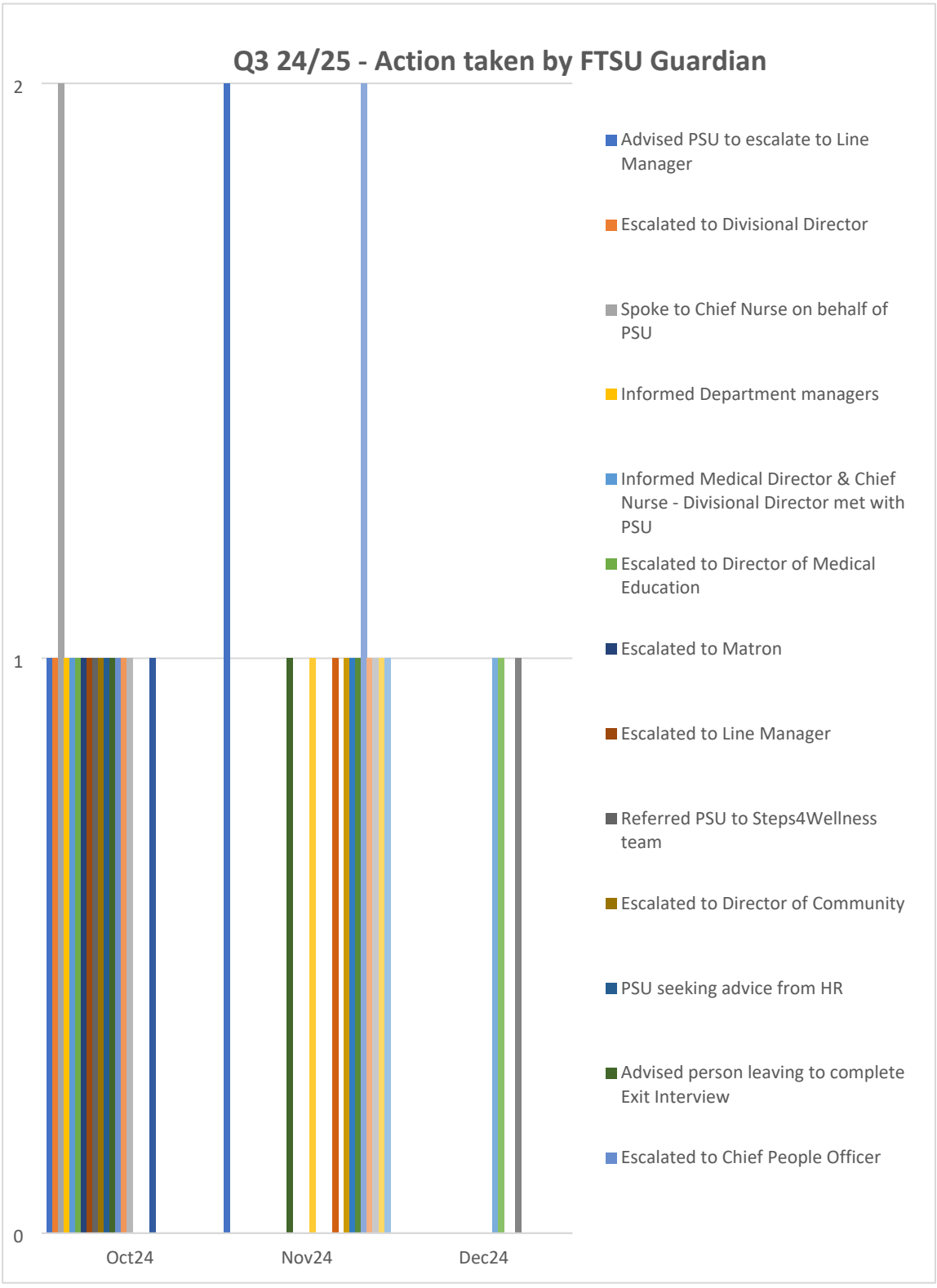
Within Quarter 3 e-mail was the primary form of contact for those wishing to use the Freedom to Speak Up route.

4.8 Number of staff who want to remain anonymous



27 out of the 34 staff that raised a concern in Quarter 3 did not want their identity revealed. This is 79.41% of staff in Quarter 3 wanting to remain anonymous. It is important that anonymous concerns are taken seriously. Often staff want to remain anonymous due to fear of reprisals and victimisation. This could be a sign the culture where the individual works requires investigation.

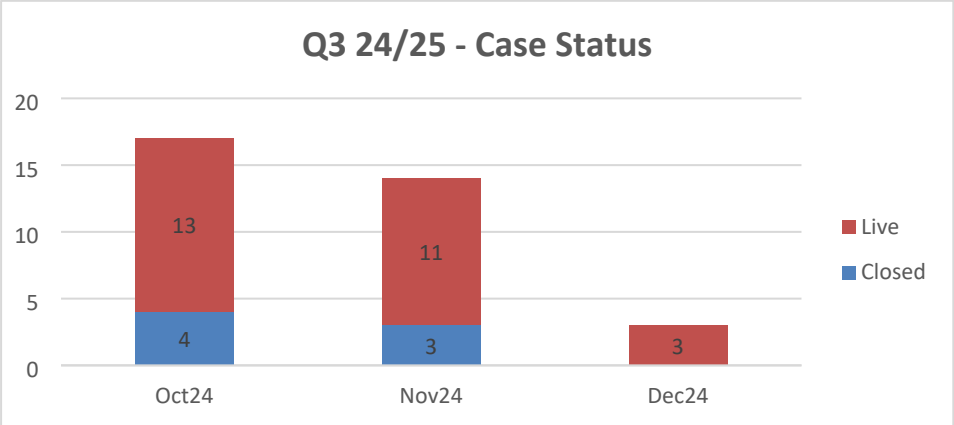
4.9 Action taken by FTSU Guardian



Cases have become more complex, and the role of the Guardian is not only to offer support and guidance, but to signpost and to work with relevant colleagues across the Trust to ensure resolution and a positive outcome. The FTSU Guardian will always advise the PSU (Person Speaking Up) to speak to their Line Manager in the first instance, this can resolve the issue more quickly, however in some cases this is not always possible.

Each case is individual and therefore very different meaning different avenues to resolve each case needs to be explored. The FTSU Guardian will only escalate to a Divisional or Senior leader with the PSU consent.

4.10 Cases Closed



Cases are only closed when the PSU is happy with the outcome and has seen an improvement in the matter raised. The FTSU Guardian will check in with both parties to monitor progress, ensure resolution is on track and advise on anything further. The more complex the case, the more time it takes to close. Where there are cases regarding the same or similar concerns and external or commissioned support is required, cases could take months to complete.

5. NEXT STEPS

- Continue to grow Champion Network
- Continue with triangulation work between Staff Side and Staff Experience/OD Team to resolve cases, improve culture and staff experience
- Schedule Management/Senior Leadership FTSU drop-in sessions to commence March 2025

6. RECOMMENDATIONS

The Board is recommended to note the content of this report.

Title of report:	Health Inequalities Update
Presented to:	Board of Directors
On:	05/02/25
Presented by:	Richard Mundon, Director of Strategy and Planning
Prepared by:	Michelle Cooper, Principal Data Analyst, DAA
Contact details:	BI PerformanceReport@wwl.nhs.uk

Executive summary

This paper provides an update to the Health Inequalities paper presented to Board in May 2024. The finding of the reports, produced in 2023 and 2024, have been reviewed against current data with similar findings. The 2 main themes identified, deprivation and age remain key factors within the analyses.

Patients in the most deprived areas continue to wait longer for elective treatment. Outpatient DNA rates, although having reduced from 10.4% in 22/23 to 8.3%, the rate remains highest in quintile 1 in the borough (20% most deprived areas); double for those in quintile 5 (20% least deprived areas). Patients in the most deprived areas remain more likely to be an A&E regular attender. Focused work at a local community level has not yet reduced A&E rates.

Children remain more likely to wait longer for elective treatment. Patients aged 80+ have the highest number of patients on the waiting list per head of Wigan population. DNA rates remain high in the 0-17 year age groups and males aged 20-54 years. A&E attendance rates and A&E frequent attenders remain highest amongst the patients aged 65+ cohort. As age increases, the rate of readmission increases.

Work has continued to embed protected characteristics into core apps and into local trust reporting. A DNA predictor tool has been developed and is in place; a further iteration is planned to make this even more effective. The text reminder service which has been implemented to positively affect DNA rates will be extended to 2 reminders for all appointments, again evidenced to reduced DNA rates.

An Endoscopy waiting times insight report was produced showing that being from a non 'White British' background, a more deprived area, being in a younger age band and being female are all factors linked to waiting longer for Endoscopy treatment.

To provide assurance around the data used to understand inequality a project was completed to assess and recommend improvements regarding ethnicity recording. The recommendations are currently being implemented across highlighted areas and systems.

WWL and the council continue to collaborate at the Integrated Delivery Board to progress focused work to reduce health inequalities. Collaborative analyses between WWL and Wigan Council continues to support decision making. For example, a joint piece of insight was completed to inform geographical placement of community based respiratory services.

Link to strategy

To reduce inequalities in the services which we provide to improve the quality of care for all our patients.

Risks associated with this report and proposed mitigations

There are no current risks associated with the report.

Financial implications

There are no current financial implications associated with the report.

Legal implications

There are no current legal implications for the trust.

People implications

The report identifies health inequalities and actions being taken to embed a culture of learning and improvement for equity as a Trust; continuing to adapt ways of working to include equity into everything we do so it becomes business as usual.

Wider implications

There are no wider implications.

Recommendation(s)

The Board are requested to receive the report, note the content and to provide any feedback that will support the continuation of key work to address health inequalities, including visible leadership and advocacy to staff, encouraging them to grow their understanding of health inequalities.

Report:

1.0 Purpose of this report

Following the paper presented to board in May 2024 which summarised where the Trust is in terms of identifying and addressing health inequalities in the local community, this paper provides an update on the current position, what actions have been taken and next steps.

The Trust Board are asked to note the paper and provide any feedback that will support the continuation of key work to address health inequalities, including visible leadership and advocacy to staff, encouraging them to grow their understanding of health inequalities.

"Our aim is for every patient to receive the same high quality of care, regardless of where they live, what health condition they are experiencing, or any other personal characteristic that may affect their experience of accessing health care services." (WWL Equality, Diversity, and Inclusion Strategy 2022-2026)

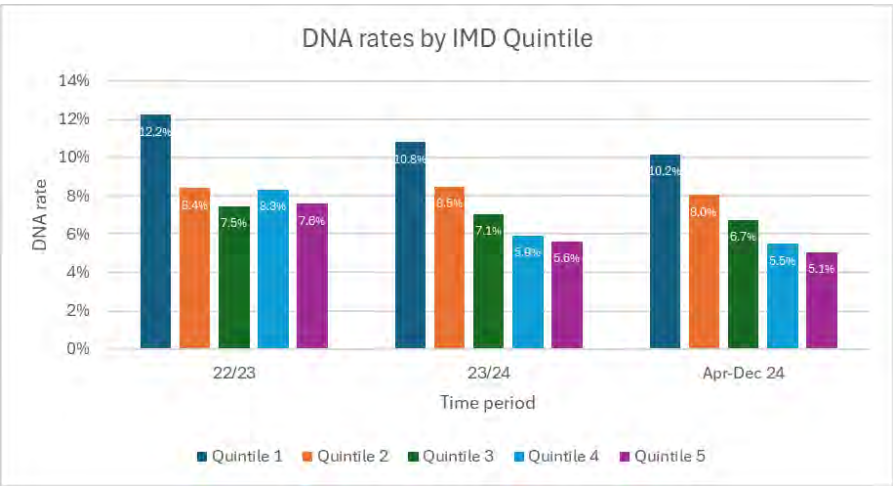
2.0 Assessment of position

Three insight papers were produced during 2023 to inform the organisation of health inequalities currently experienced by the population we serve, as well as understanding health inequalities in the treatment provided by WWL, specifically around: waiting lists, outpatient DNA's, A&E attendances, and emergency admissions. The findings of the papers in 2023 which analysed 22/23 data have been compared to performance for 23/24 and Apr-Dec 2024.
Age, sex, and ethnicity are protected characteristics which were purposefully considered for the analysis; these characteristics are now embedded in on demand reporting. Analysis by IMD deprivation score was also included.
A further insight paper was produced on Endoscopy waiting times in June 24.

Although key themes can be observed from the data insights, it must be recognised that patient characteristics are not homogenous, and tangible actions across specific groups may well present complexities at both a local and system level. Two key themes were identified across the original insights, and these have been compared to recent data.

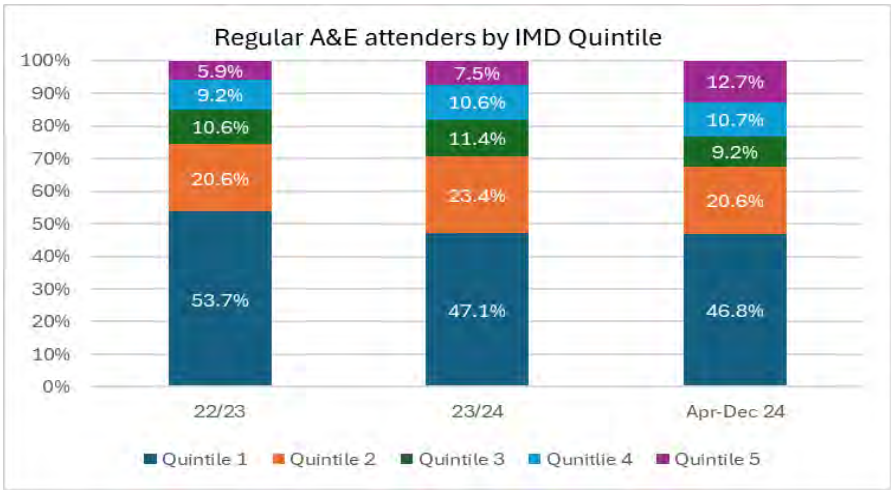
Theme A - Deprivation

- Patients' resident in the most deprived areas were found in the initial report to make up over a third of the total RTT waiting list and more likely to wait 18 weeks+ compared to patients living in lesser deprived areas. This is still the case compared with April - November 24. For those who have had to wait more than one year for treatment this has increased rapidly both locally and nationally, but more so in the most deprived areas of Wigan, whereby patients are twice as likely to wait over a year for treatment compared people who live in the most affluent areas (data period Apr-23-Sep-23); this is still the case for recent data (Apr 24 – Nov 24).
- Outpatient DNA rates continue to be highest for those living in the most deprived areas, as deprivation reduces so does the DNA rate. During Apr 22- Mar 23, the DNA rate for patient's resident in quintile 1 (20% most deprived areas) was nearly twice as high as for those resident in quintile 5 (20% least deprived areas, the same was found for the period Apr 23 – Mar 24, and during Apr – Dec 24 the DNA rate in quintile 1 (20% most deprived) was twice as high as those resident in quintile 5 (20% least deprived).



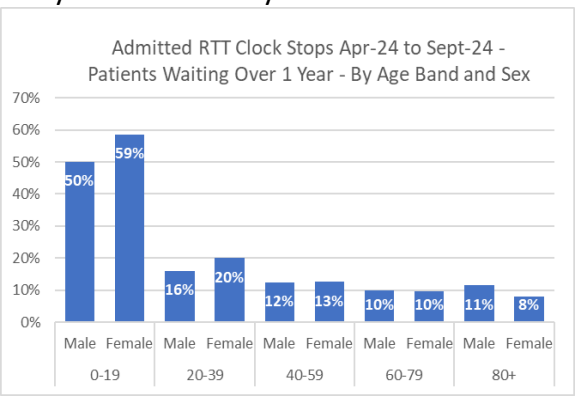
The overall DNA rate for the Wigan residents at WWL has reduced from 10.4% in 22/23 to 8.9% in 23/24 and 8.3% in Apr-Dec 24.

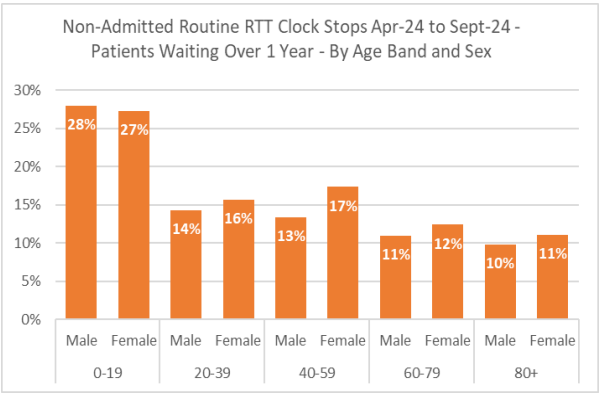
- Patients living in the most deprived areas were found more likely to be an A&E regular attender, with the most deprived quintile equating to 53.7% of regular attenders (data period Apr-22-Mar-23); data for the last 21 months shows quintile 1 still equates to the highest number of regular attenders although the proportion is not quite as high, Apr 23 – Mar 24, quintile 1 having 47.1% or regular attenders and April – Dec 24 quintile 1, 46.9%.



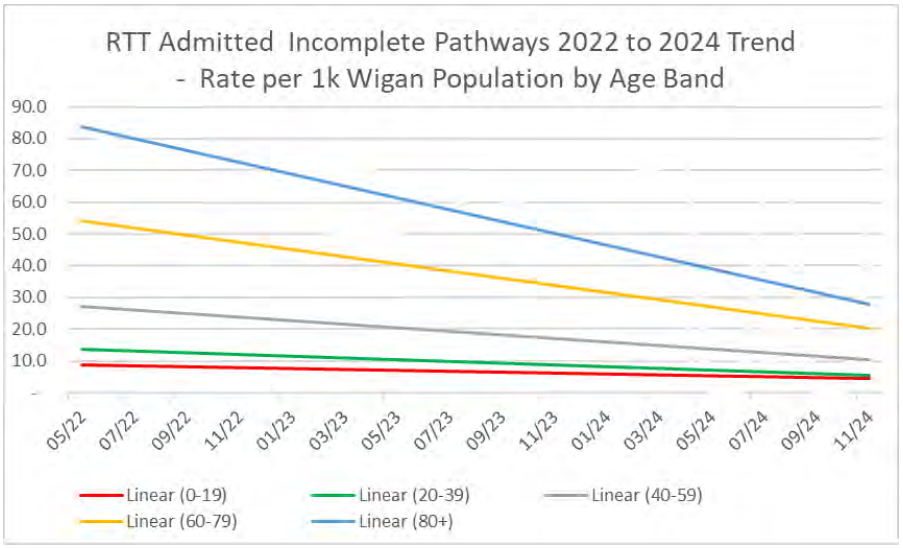
Theme B - Age

- Children remain more likely to wait over 1 year for outpatient treatment and 3 times more likely to wait over 1 year for admitted treatment.

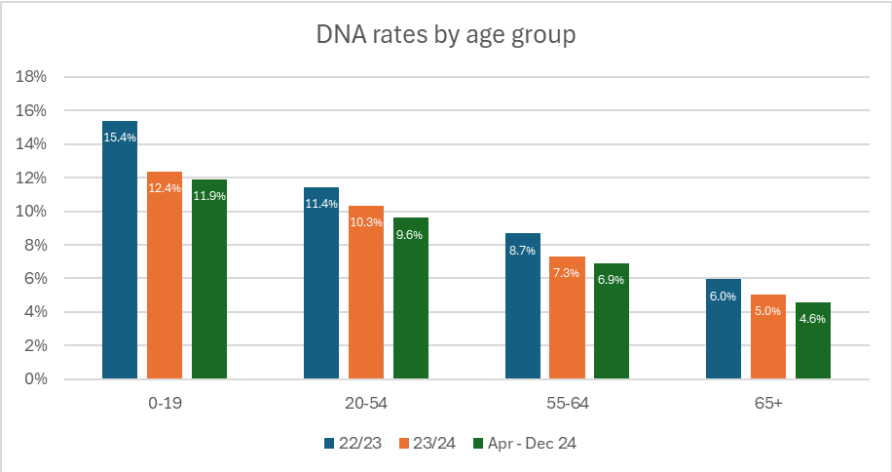




- Our waiting times are reducing but no particular age group have been disproportionately impacted, each age group relatively seeing a reduction at a similar rate from their baselines
- During Apr-Sep 23, long waiting times were evident in Community Paediatrics caused by the significant backlog, where over two thirds of patients seen waited over 1 year, this has not improved during the same period Apr – Sep 24 with a similar position, 67% of children waiting over a year to be seen. During Apr-Sep 24, 62% of patients who waited over 1 year for ENT admission were children.
    - Capital investment approved with GM to invest in dedicated Paediatric surgical days at the Leigh Surgical Hub.
    - WWL are fully engaged in the wider GM work that is developing a pan GM model for Community Paediatrics. We also continue to make improvements in the service through the Clinical Services redesign transformation programme.
- Patients aged 80+ have the highest number of patients on the waiting list per 1,000 head of Wigan population and the highest rate of 18 weeks waits per 1,000 population. Although the rates are decreasing, the theme for patients aged 80+ is still evident during the period Apr-Sep 24.



- DNA rates remain highest amongst younger age groups, specifically those aged 0 to 19 and males aged 20 to 54 years. As age increases, the rate of DNA was shown to reduce for the data period Apr-22-Mar-23, a similar pattern occurred in Apr 23 – Mar 24, and for the period Apr – Dec 24 for higher DNA rates amongst patients aged 0-19 and males aged 20-54 years, although the proportions were not as marked.



- Oral Health - Wigan Borough Joint Strategic Needs Assessment (JSNA) Population Health Summary[2] for 2024 identified that the rate of WWL admissions for tooth decay in children was significantly higher than the Greater Manchester, North West and England average. During Apr-Sep 24, 62% of children seen (128), waited over 1 year for admission.
- A&E Attendance rates are highest amongst older age groups, and the percentage of patients defined as an A&E frequent attender were the highest amongst the 65 years + cohort, (data period Apr-22-Mar-23); this was found to be the same for Apr 23- Mar 24 and April – December 24.
- JSNA[2] emergency admissions data for 2021-2022 showed that Wigan has the highest rate of hospital admissions for falls in older people nationally, in the JSNA 2024, Wigan Borough no longer has the highest rate across Greater Manchester and the North West for this measure.
- As age increases, the rate of readmission also increases. During 2022/23 21.8% of patients aged 75 years and above were readmitted into hospital within 30 days of discharge; the figure for 23/24 was 23.4% and 22.1% for Apr-Sep 24

3.0 Areas of Progress

- ✓ Embedding protected characteristics into local trust reporting; the DAA Team include a health inequalities lens into reports where data supports
- ✓ A consistent approach for reporting protected characteristics within Qlik functionality has been actioned to core apps.
- ✓ Local DNA deep dive – to investigate a range of influences on the Trusts DNA rate using a combination of Data Analysis and Data Science techniques. It was identified that a major factor determining whether an appointment is likely to be attended or not, is the historic DNA rate of each individual patient.
- ✓ DNA predictor developed and in place. Tool allows users to identify and target patients who are most likely to DNA an outpatient appointment. Patients are sent a text reminder prior to their appointment; we have seen a reduction in DNA rates for Wigan residents from 10.4% in 22/23 to 8.9% in 23/24 and 8.3% in Apr-Dec 24.
- ✓ DAA completed a project to assess and recommend improvements regarding Ethnicity recording. The project highlighted a lack of consistent approach to the recording of patient ethnicity data across the trust and a subsequent variance in data completeness across our different services. Recommendations from the project include:
    - o exploring potential system changes for mandatory fields and screen prompts

- identified the need for a standard operating procedure (SOP) for the consistent capture of patient ethnicity and supporting staff in its use
- providing communications to highlight the importance of capturing this information to both staff and patients
- providing supporting materials to ensure staff feel more confident

✓ An Endoscopy waiting times insight report was produced during 2024. Improving the accurate capturing of ethnicity data is an area the trust is currently actively working towards improving, but endoscopy data is much more complete than many of the trust's other datasets so was included. The insight report found being from a non 'White British' background, coming from a more deprived area, being in a younger age band, and being female are all factors linked to waiting longer for endoscopic treatment. It further demonstrates that one of the factors is that a higher DNA rate appears to be associated with patients from more deprived areas, from younger age bands (specifically younger men), and from non 'White British' backgrounds.

✓ We continue to make improvements in community paediatrics service through the Clinical Services redesign transformation programme.

✓

✓ Community engagement – start small, scale up. To gain a holistic understanding of the issues impacting inequity of access in healthcare, the Integrated Delivery Board agreed that one specific community/neighbourhood would be the initial focus to develop and test an approach to addressing inequalities at a system level. Improvement opportunities/ learning would be then scaled up across neighbourhoods/localities where appropriate. This area identified was Scholes area in Central Wigan. For the 4 years 2019-2023 there was a rate of 14.73 attendances per patient in the population, moving this time period forward 1 year, 2020-2024, the rate has increased slightly to 15.79.

✓ Integrated Delivery Board, jointly chaired by the Director of Public Health, Wigan Council and Chief Executive, WWL, continue to meet monthly to progress focused work to reduce inequalities.

✓ Health and Wellbeing Board Partnership Development session held September 24 to focus on 'Prevention' and to reflect the proactive work taking place and sharing key enabling work required.

✓ Collaborative analyses between WWL and Wigan Council completed to identify high need areas to support community based respiratory care to improve care and reduce duplication for patients.

✓ There are a number of People projects related to equality and diversity in the workplace in place including
- EDI Champions
- Equality Impact Assessment process for patient services
- Zero tolerance to racial prejudice

✓ The Quality Impact Assessment process continues to be overseen by a monthly panel chaired by the Chief Nurse and Medical Director. The QIA process advises it should run alongside Equality Impact Assessments, so equality considerations are an integral part of service redesign and development.

4.0 N**ext Steps**

- Embed a culture of learning and improvement for equity as a Trust; continuing to adapt ways of working to include equity into everything we do so it becomes business as usual.
- Creating links between the EDI Group and Patient Experience Team.

- To build on the success that the current text reminder service has had on improving DNAs, the Trust is implementing an extension to the current text reminder service so that every patient will receive 2 reminders prior to every appointment.
- Further iteration of DNA Predictor Tool to identify patients still at high risk of DNA for additional interventions to maximise impact.
- Implement recommendations to improve the recording of ethnicity so analysis can be undertaken to identify any inequalities.
- Improve the recording for patients with learning disabilities, autism and neurodiversity so analysis can be undertaken to identify any inequalities.
- Building on the success of the outpatient text reminders to reduce DNA rates, exploring the possibility of extending this to other services for example, Endoscopy.
- Delivery of local BI plan:
    - Agree equity data priorities for 2024/25 and recommendations for wider collaborative inequalities measurement and reporting, and increasing scope of what the trust can analyse beyond deprivation, ethnicity, age and gender
    - Continue to work collaboratively with Edgehill University to support the incorporation of Health Inequalities throughout its undergraduate medical program; local Wigan data provided to support the training.
- Build on the analyses undertaken to identify suitable clinic locations for community respiratory clinics.
- Full engagement with the wider GM work that is developing a pan GM model for Community Paediatrics
- Dedicated Paediatric surgical days at the Leigh Surgical Hub following capital investment approved with GM.

5.0 Reference

1. 2024/25 priorities and operational planning guidance: NHS England » 2024/25 priorities and operational planning guidance [Accessed on 14/01/2025]

2. Wigan Borough Joint Strategic Needs Assessment Population Health Summary: Appendix B - Joint Strategic Needs Assessment.pdf [Accessed on 16/1/25)

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard and Optimisation Report
Presented to:	Board of Directors
On:	5th February 2025
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 December dashboard has highlighted that there are three areas for increased observation. Delay in category 2 CS, Apgars and 3rd / 4th degree tears. An OASI audit is underway, and the governance team is looking into the Apgars. 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 December 2024 dashboard and overview of indicators as outlined below.

Report

December 2024 Exception report - Maternity
Summary

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

- There were seven validated midwifery red flags reported in December. 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 November.
- 1:1 care is at 100% in December which is an improvement on November's figures.
- There were 2 Maternity complaints received in December, but the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

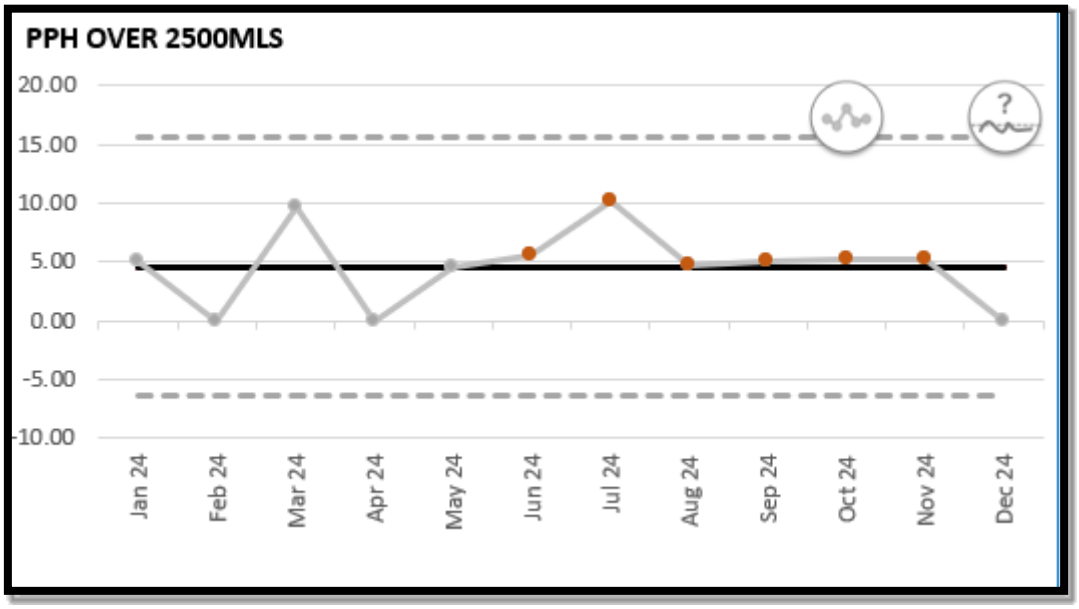
PSII Commissioned Incidents

There were no PSII Commissioned incidents reported in December.

Green

Category 1 Caesarean Sections with no Delay in Knife to Skin (%). This metric rose into red levels in July and August. Category 1 Caesarean sections should have an interval of no more than 30 minutes between decision and knife to skin. December figures show a drop into green levels. 1 woman out of 14 had an interval of more than 30 minutes.

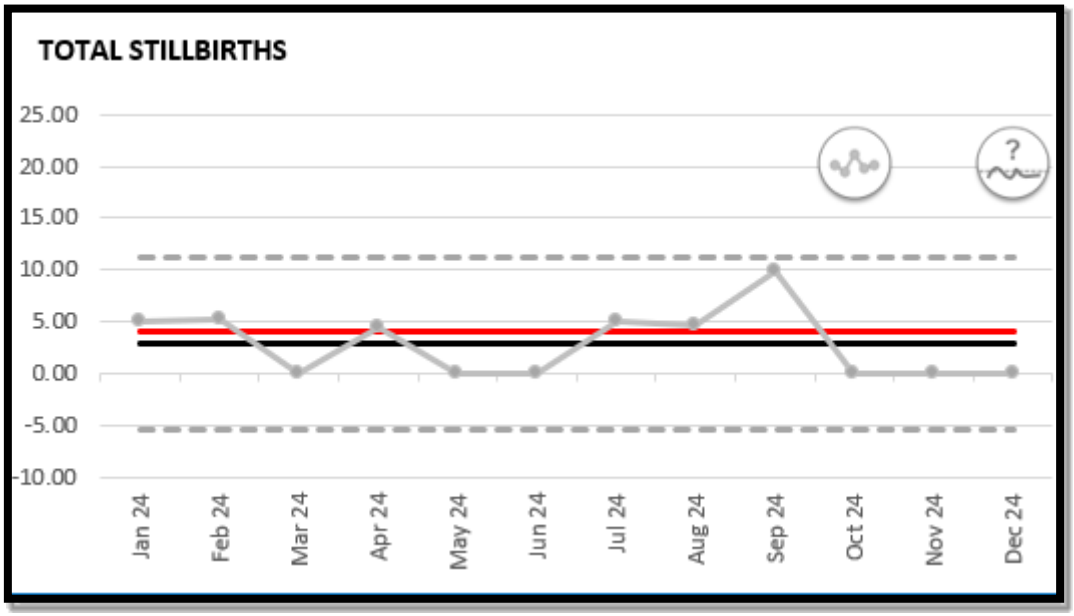
PPH over 2500mls (rate per 1000). There were no women who had a PPH of over 2500mls in December. The below SPC chart shows how WWL compare with GM (red line). The figures for this metric are recorded as rate per 1000.



The number of mothers who have opted to breastfeed (%) – May saw the highest figure since it started being recorded on the dashboard. November saw a slight dip in this metric, but higher levels have been seen in December. Work continues to improve this metric.

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

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



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

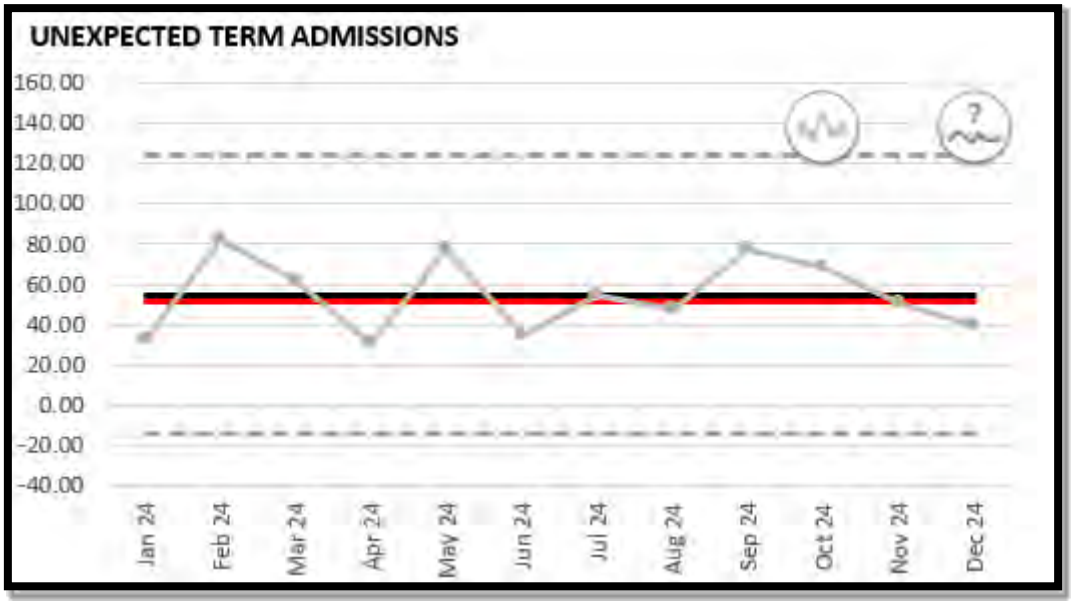
Women readmitted within 28 days of Delivery (rate per 1000). There were 2 maternal readmissions to the obstetric unit in December. The admissions were for a blood patch and for a wound infection. No omissions in care were noted. There was also an admission for medical reasons (gallbladder) but as this was not a readmission for obstetric reasons this does not apply for this metric.

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

Women booked by 12+6 weeks (%) This saw a drop into amber levels in January but the months following have seen the metric return to normal levels and have remained green for 11 months. Wigan remains one of the highest performers in GM for this metric.

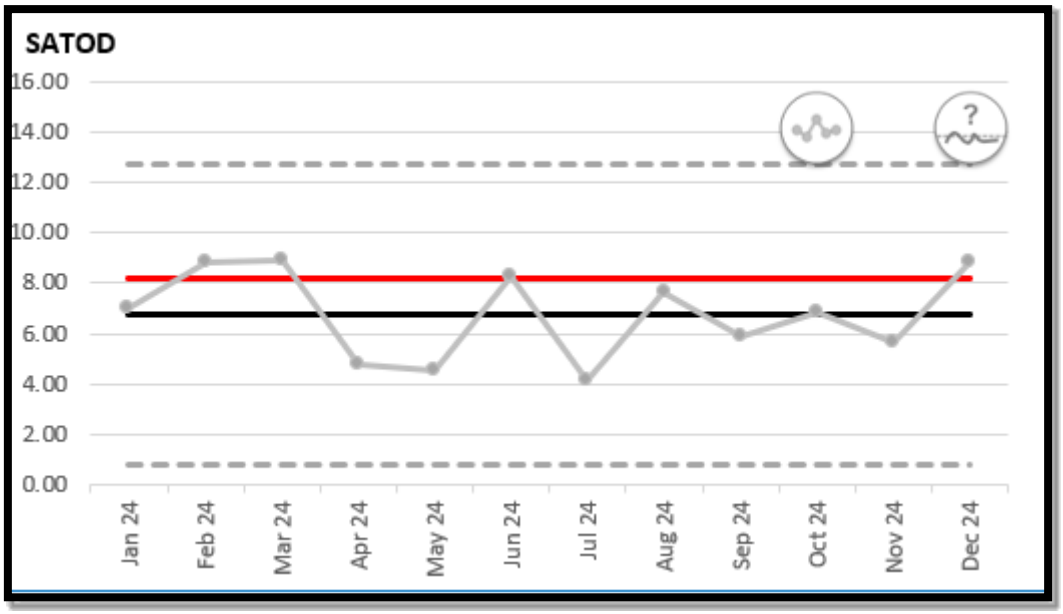
Skin to skin contact (%) This metric saw a small dip in April, but it has seen a return to normal levels since. Work continues to improve this metric.

Term admissions to NNU (rate per 1000). This metric sees a drop in December. This figure is recorded as rate per 1000 and equates to 7 babies in December. 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).



Amber

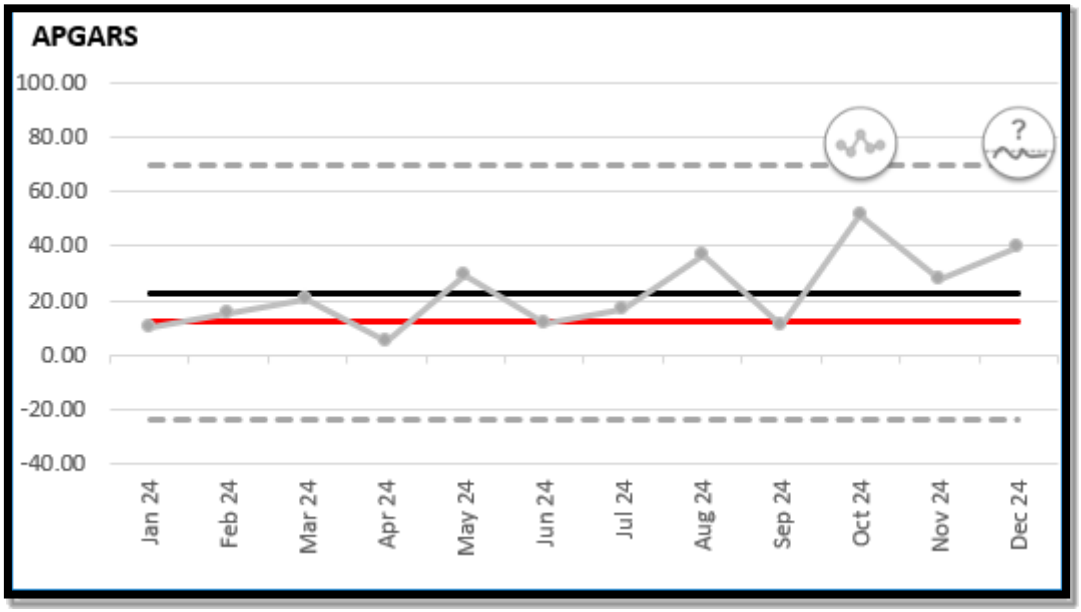
Smoking at the time of Delivery (SATOD) (%). This metric has seen a significant improvement. In April, May, and July the figures were at the lowest recorded on these dashboards. This figure has seen a slight increase in December into amber levels after being green since March 2024. Work continues to promote and encourage smoking cessation throughout pregnancy. The below SPC chart shows our % SATOD rates in comparison to GM (red line).



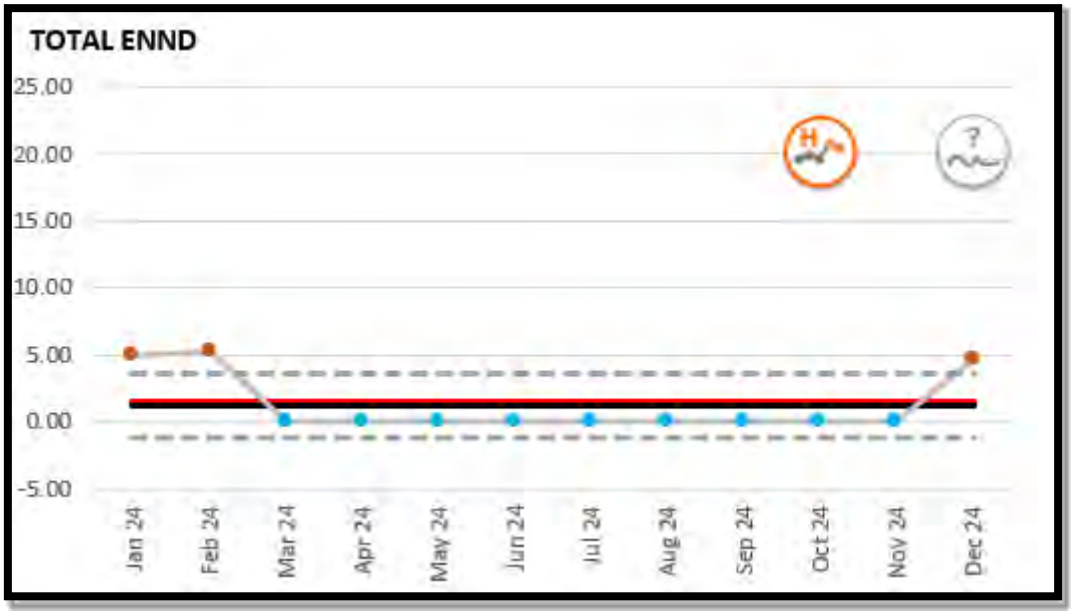
Booked by 9+6 – This parameter is a relatively new addition to the GM data. The aim is to work towards booking all women before 10 weeks of pregnancy. Whilst our figures are in amber levels, they have seen significant improvement since the start of 2024. The chart below shows how WWL is performing in 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.

Red

All infants with Apgar's less than 7 (rate per 1000). This metric saw a slight increase in December and remains red. The rate per 1000 in December equates to 57 babies. All cases are fully investigated by the governance team. The below SPC chart shows how our figures compare to the GM average (red line).

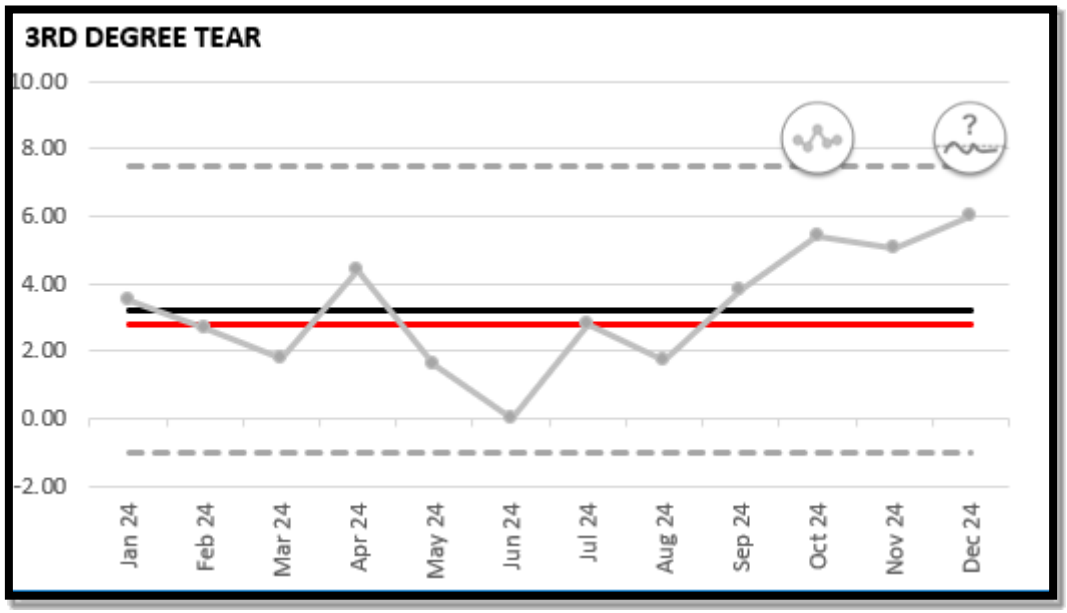


Number of Neonatal Deaths (rate per 1000). The figure is recorded as a rate per 1000. There was one ENND in December. This lady had a BBA at 33 weeks and the baby sadly died in A&E. The below SPC chart shows how WWL compare with GM (red line).



Category 2 Caesarean Sections with no Delay in Knife to Skin (%). Category 2 Caesarean sections should have an interval of no more than 75 minutes between decision and knife to skin. In December there were 6 women out of 24 who had an interval time of more than 75 mins. These intervals ranged from 77 minutes to almost 3 hours.

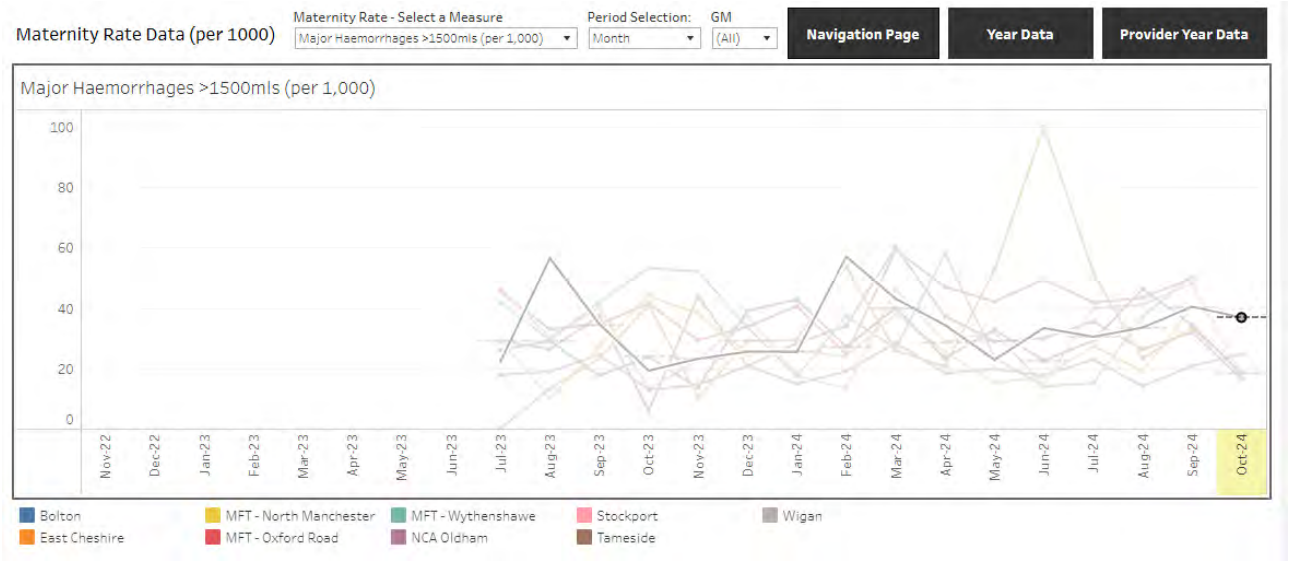
3rd / 4th degree tear (%). The figure is recorded as a rate per 1000. There were 7 women who had a 3rd degree tear December. The below SPC chart shows how we compare to the rest of GM for this metric. An audit has been started to look at why the levels for this metric are rising.



Other areas not RAG rated

PPH 1500mls – 2500mls – The figure shown on the dashboard is shown as a rate. The rate in December equates to 6 women. The chart below shows how WWL is performing in relation to the rest of GM. As this

is not currently one of the key parameters assessed by GM there is no GM average to be able to provide an SPC chart. WWL are currently participating in a nation PPH study called OBSUK. It is hoped that the data from this study may help to reduce the PPH figure nationally in the future.



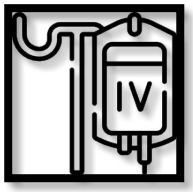
Conclusion

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

Optimisation Metrics - December

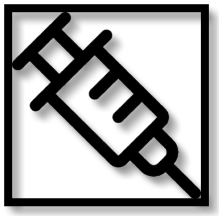
The below relates to 5 mothers who delivered 6 babies.

- There were 2 babies (twins) not born in an appropriate care setting due to rapid delivery.
- 2 babies born < 30 weeks gestation.
- 4 babies born < 34 weeks gestation.

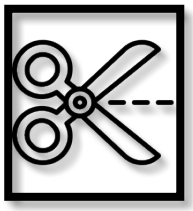


There were 2 deliveries under 30 weeks (twins) in December and the mother did not receive MgSO4 due to rapid delivery.

17% of babies received steroids within 7 days of delivery (< 34 weeks).



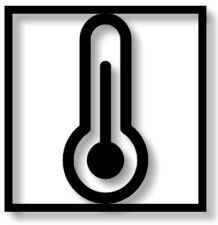
- 1 mother received a full course of steroids in the week before delivery.
- 1 mothers received a partial course
- 3 mothers (4 babies) did not receive steroids. This was due to being precipitate deliveries and one being a BBA.



50% received optimal cord management (< 34 weeks).

- 3 babies received delayed cord clamping at delivery.
- 3 babies did not receive delayed cord clamping at delivery. This was due to 1 being a BBA and 2 being 22+5 weeks (twins).

50% of babies had a Normothermic Temperature (36.5-37.5C) on admission to NNU, measured within one hour of birth (< 34 weeks).

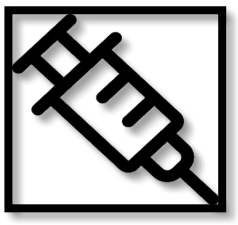


- 3 babies had a normothermic temperature taken within an hour of birth.
- 3 babies did not have a normothermic temperature recorded within an hour of birth. This was due to 1 being a BBA and 2 being 22+5 weeks

33% of babies received maternal breast milk (EBM) within 24 hours of birth (< 34 weeks).

- 2 babies received EBM within 24 hours of birth.
- 4 babies did not receive EBM within 24 hours of birth (x1 ENND, X2 transferred out, x1 maternal choice)

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



- 1 mother received intrapartum antibiotics.
- 1 mother was N/A
- 3 mothers did not receive intrapartum antibiotics (BBA and precipitate deliveries)

Safety Dashboard 2024

Maternity

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 Q1	Q2	Q3	YTD	Trend
Activity					254	231	217	242	232	236	255	219	229	272	221	218	702	710	703	711	
		Above 80%	Below 50%														57.88%	56.82%	66.07%	68.99%	
						90.04%	92.52%	93.61%	91.27%	93.56%	94.12%	93.15%	93.89%	91.18%	90.95%	93.12%	90.38%	92.81%	93.72%	91.75%	
	Registerable births				199	194	213	207	222	180	202	211	203	192	194	216	606	609	616	602	
	Planned home births (as % of all births)				0.00%	0.51%	0.46%	1.93%	1.80%	1.11%	0.50%	1.42%	1.48%	0.52%	0.52%	1.39%	0.32%	1.61%	1.13%	0.81%	
	Unplanned home births (as % all births) – BBA				3.01%	0.00%	0.00%	0.00%	0.00%	0.56%	0.50%	0.47%	0.49%	0.52%	0.52%	0.93%	1.00%	0.19%	0.49%	0.65%	
	NVD (as % of total births)				51.20%	47.93%	43.19%	42.03%	49.10%	48.33%	42.08%	48.82%	44.83%	35.42%	32.99%	45.37%	47.44%	46.49%	45.24	37.93%	
	Instrumental deliveries (as % of total births)				7.53%	8.76%	10.33%	12.56%	6.31%	5.00%	10.89%	6.16%	6.90%	12.50%	7.73%	8.80%	8.87%	7.96%	7.98%	9.68%	
	Total number of Caesarean Sections (all categories – as % of total births)				41.70%	43.29%	46.01%	44.93%	44.59%	46.67%	47.03%	44.08%	46.31%	52.08%	59.28%	45.83%	43.67%	45.39%	45.80%	52.40%	
	Robson Group 1: Nulliparas; single cephalic term pregnancy; spontaneous labour				2	4	10	4	6	4	2	9	7	7	5	9	16	14	18	21	
	Robson Group 2a: Nulliparas; single cephalic term pregnancy; induced labour				22	16	23	24	25	19	17	18	19	17	23	16	61	68	54	56	
	Robson Group 2b: Nulliparas; single cephalic term pregnancy; planned CS				8	8	10	12	11	12	10	12	11	21	21	19	26	35	33	61	
	Robson Group 3: Multiparas without uterine scar; single cephalic term pregnancy; spontaneous labour				0	0	0	0	1	5	1	1	1	5	2	0	0	6	3	7	
	Robson Group 4a: Multiparas without uterine scar; single cephalic term pregnancy; induced labour				4	7	10	2	7	3	4	4	7	6	8	5	21	12	15	19	
	Robson Group 4b: Multiparas without uterine scar; single cephalic term pregnancy; planned CS				4	9	6	8	7	8	9	6	6	4	5	4	19	23	21	13	
	Robson Group 5: Multiparas with a scarred uterus; single cephalic term pregnancy				25	24	19	25	24	22	30	25	17	23	28	29	68	71	72	80	
	Robson Group 6: Nulliparas; single breech pregnancy				5	9	7	4	5	2	1	5	6	1	4	5	21	11	12	10	
	Robson Group 7: Multiparas; single breech pregnancy (including women with a scarred uterus)				4	3	2	6	1	3	2	1	5	4	6	2	9	10	8	12	
	Robson Group 8: All women with a multiple pregnancy (including women with a scarred uterus)				2	0	5	3	4	0	8	2	8	1	4	4	7	7	18	9	
	Robson Group 9: All women with a single oblique or transverse pregnancy (including women with a scarred uterus)				0	1	0	0	2	2	3	0	0	1	0	2	1	4	3	3	
	Robson Group 10: All women with a single cephalic preterm pregnancy (including women with a scarred uterus)				7	3	6	5	6	4	8	10	7	10	9	4	16	15	25	23	
	Number successful VBAC				3	3	2	3	3	0	1	5	4	2	4	4	8	6	10	10	
	% of Category 1 Caesarean Sections with no Delay in Knife to Skin (over 30 minutes) – as % total cat 1 CS	Above 90%	Below 80.9%		90.90%	100.00%	61.11%	90%		91.66%	77.77%	64.28%	100%	93.30%		92.30%	84.00%	88.00%	80.68%		
	% of Category 2 Caesarean Sections with no Delay in Knife to Skin (over 75 minutes) – as % total cat 2 CS	Above 90%	Below 80.9%				64.10%		75%	76.19%	72.72%		66.66%			75.00%	78.83%	79.43%	75.35%		
	Number of Caesarean Section at Full Dilatation				3	3	8	5	2	6	5	1	4	6	4	5	14	13	10	15	
	IOL (as % of all women delivered – excluding pre labour SROM)	Under 35.9%	Above 40%				42.72%	34.78%		42.78%	42.08%			35.42%		32.80%	40.36%	39.07%	39.00%	35.11%	
															3	1	3	5	0	4	

	Number of women induced for Suspected SGA				14	14	16	6	13	14	9	10	5	8	5	9	44	33	24	22	
	Number of In-utero transfers in from other units				4	4	4	5	4	4	4	2	7	3	4	0	12	13	13	7	
	Number of In-utero transfers out to other units				0	2	0	1	2	0	1	1	2	2	1	5	2	3	4	8	
	Average Postnatal Length of Stay				1.7	1.7	1.8	1.7	1.8	1.5	1.5	1.6	1.8	1.9	1.7	1.6	1.73	1.66	1.63	1.73	
Maternal Morbidity	3rd and 4th degree tears (as % vaginal births)	Under 2.5%	Above 3.5%				1.75%	4.42%	1.63%	0.00%		1.72%	3.81%	5.43%	5.06%	5.98%	2.64%	2.02%	2.78%	5.49%	
	Of which 4th degree tears (number)				0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	
	PPH 1500 – 2500 mls (Rate per 1000)				25.12	56.99	43.06	34.13	22.83	33.33	20.3	33.17	40.4	31.25	46.39	27.8	41.72	30.09	31.29	35.14	
	Number of women with a PPH 1500 - 2500mls				5	11	9	7	5	6	6	7	8	6	9	6	25	18	21	21	
	PPH > 2500mls (Rate per 1000)	Under 4	Above 6			0	9.56	0			10.1					0	4.85	3.35	6.62	3.46	
	Number of Women Requiring Level 2 Critical Care				1			1	1	1	2	1	1	0	1	0		3			
	Number of Women Requiring Level 3 Critical Care				0			0	0	0	0	0	0	0	0	0		0	.		
	Number of Blood Transfusions > 4 Units				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Number of Maternal deaths				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of women re-admitted within 28 days of delivery (Rate per 1000)				15.22	15.46	4.78	19.6	18.26	22.22	10.3	14.35	5.05	10.41		9.4	11.82	20.02	9.9	17.02	
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis (Number)				0	0	1	2	1	1	1	0	0	0	1	0	1	4	1	1	
al Morbidity and Mortality	Total stillbirths (as rate per 1000)				5.02	5.15	0	4.83	0	0	4.95	4.73	9.85	0	0	0	3.39	1.61	6.51	0	
	Stillbirths (excluding MTOP as rate per 1000)					5.15	0	4.83	0	0	0	0	4.93	0	0	0	3.39	1.61	0	0	
	Number of stillbirths (excluding MTOP)				1	1	0	1	0	0	0	0	1	0	0	0	2	0.33	0	0	
	Early neonatal deaths (as rate per 1000)				5.02	5.15	0	0	0	0	0	0	0	0	0	4.6	3.39	0	0	1.53	
	Early neonatal deaths (excluding MTOP as rate per 1000)				0.00	5.15	0	0	0	0	0	0	0	0	0	4.6	1.72	0	0	1.53	
	Number of Early Neonatal Deaths (excluding MTOP)				0	1	0	0	0	0	0	0	0	0	0	1	1	0	0	1	
	Number of babies born below 37 weeks				14	12	19	9	14	9	19	19	21	17	13	17	45	32	59	47	
	Shoulder Dystocia (as % of total births)				1.51%	1.0%	0.93%	1%	0.45%	2%	1%	0.47%	1%	2%	0.5%	0%	1.16%	1%	1%	1%	
	Number of singleton babies born under 27 weeks				0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%	0%	
	Number of multiple babies born under 28 weeks gestation				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of above babies where transfers out not facilitated				0	0	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	
	Number of women delivered under 34 weeks (livebirth)				2	4	4	1	3	0	2	2	5	5	4	4	10	4	9	13	
	% of Mothers who delivered under 34 weeks who received a complete course of AN steroids				50%	50.00%	50%	100%	33%	N/A	100%	100%	60%	80%	25%	25%	50.00%	67%	87%	43%	
	% of Mothers who delivered under 34 weeks who received AN Magnesium Sulphate				100%	75%	75%	100%	100%	N/A	N/A	50%	80%	100%	50%	50%	83.00%	100%	65%	67%	
	Number of women delivered under 30 weeks (livebirth)				1	1	1	1	0	0	0	0	2	2	0	0	3	0.33	0.66	0.66	

Neonat	% of Mothers who delivered under 30 weeks who received AN Magnesium Sulphate				100%	0.00%	100.00%	100.00%	N/A	N/A	N/A	N/A	50.00%	100.00%	N/A	N/A	67.00%	100.00%	50.00%	100.00%
	% of Mothers who delivered under 30 weeks who received a complete course of AN steroids				0%	0.00%	100.00%	100.00%	N/A	N/A	N/A	N/A	100%	100.00%	N/A	N/A	33.00%	100.00%	100%	100.00%
	Number of mothers who delivered under 34 weeks who received a partial dose of steroids				1	1	2	N/A	1	N/A	N/A	N/A	1	1	2	1	4	1	1	4
	Number of mothers delivered under 34 weeks who did not receive any course of steroids and omissions in care noted				0	0	0	N/A	0	N/A	N/A	N/A	0	0	0	0	0	0	0	0
	% of babies who had delayed cord clamping (% of total births)				84.85%	89.7%	88.73%	89%	91.44%	93.89%	92%	88%	88%	86%	87.63%	91%	87.76%	91%	89	88
	% of babies born <37 weeks whose mother received intrapartum IV Antibiotics (% of births under 37 weeks)				7.14%	16.7%	3.09%	2%	43.75%	2.92%	63.1%	68.42%	60%	52.94%	50.28%	3%	8.96%	16%	63.8	35.45
	Neonates with Apgars <7 at 5 minutes (>_37 weeks gestation) - Rate per 1000	Under 15	Above 21					5.08	28.99	11.70		36.84	11.05	51.42	27.93	35.53	17.38	15.25	21.49	38.29
	Term Admissions to NNU (births >_ 37 weeks gestation) - Rate per 1000				32.79	82.4		30.46	77.29	35.09		47.37	77.35	68.57	50.28	35.53	59.01	47.61	59.77	51.49
	Number of babies re-admitted with 28 days of birth				13	16	14	13	18	13	18	16	15	12	33	14	43	44	49	59
	Number of babies born < 3rd centile				14	15	12	9	9	14	14	14	4	7	7	9	41	32	32	23
	Number of babies born < 3rd centile >_ 38 weeks				7	6	7	6	4	8	3	6	2	4	1	0	20	18	11	5
Public Health	% women smoking at time of booking (as % of total bookings)				5.12%	11.7%	8.41%	7.23%	7.42%	9.44%	9.02%	10.05%	5.68%	5.51%	6.79%	9.63%	8.41%	8.03%	8.25%	7.31%
	% women smoking at time of delivery (as % of total births)				7.04%			4.41%	4.50%	8.33%	4.06%	7.58%	5.91%	6.77%	5.67%		8.24%	5.75%	5.85%	7.08%
	Babies in Skin-to-Skin within 1 hour of birth				82.91%	75.26%	78.4%		82.43%	81.11%	80.20%	75.36%	74.88%	75.52%	79.50%	81.48%	78.86%	79.00%	76.81%	78.83%
	Percentage of Women Initiating Breastfeeding				60.80%			60%	66.67%			59.72%	59.61%	65.63%		59.26%	57.40%	61.00%	57.27%	60.87%
	Number of women who report that they are drinking alcohol at booking				0	1	0	0	1	0	0	0	0	1	0	0	1	0.33	0	1
Workforce	1:1 Care in Labour (as % all births - excluding El CS and BBA)				100%	100%	100%	99.5%	100%	100%	100%	100%	99.08%	100%	97.40%	100%	100.00%	99.80%	100%	99.00%
	Percentage of shifts where shift Co-ordinator able to remain supernumerary				100%	100%	100%	98.33%	100%	100%	100%	98.38%	98.33%	100%	100%	100	100.00%	99.44%	99.00%	100.00%
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	1	1	0	1	1	0	0	0	0	0	0.66	0.66	0
	Number of vacancies				7.63	6.17	6.31	8.13	8.91	7.07	7.93	7.62	8.58	2.5	0.74	2.74	6.7	8.03	8.04	1.99
	Midwife : Birth Ratio				1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28	1.28
	Prospective Consultant hours on Delivery Suite				60	60	60	60	60	60	60	60	60	60	60	60	180	180	180	180
	Number of Midwifery Red Flags Reported				0	3	5	5	8	1	0	5	4	9	13	7	8	14	10	29
Incidents	Number of incidents reported				78	75	55	70	86	64	75	76	66	59	64	71	208	220	217	
	Number of MNSI Investigations				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of PSII Comissioned Incidents reported				1	0	0	1	0	1	1	0	0	0	0	0	1	0.66	1	
	Number of Complaints received in the month				1	0	4	3	0	2	4	1	0	3	0	2	5	5	1.66	
	Number of Letters of Claim Received in the month				0	0	0	0	0	0	1	1	0	1	1	0	0	0	0.66	
	HIE 2 &3 > 37 weeks (rate per 1000)				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Safety Dashboard 2024

Neonatal

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

		Goal	Red Flag	Measure	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 Q1	Q2	Q3	Q4	YTD	Trend
Safety	% of Shifts Staffed to BAPM	100.00%	< 90%	Badger		84.21	48.39	58.33														
							48.39	46.67														
	Unit Closed Due to Capacity	0	≥ 1	Datix		1	1		3													
	Unit Closed Due to BAPM/Staffing	0	≥ 1	Datix				1					1		1							
Admissions	Number of Births from Maternity				199	194	213	207	222	180	202	211	203	192	194	216						
	Admissions Under 27 Weeks to NNU	< 1	≥ 1	Badger	0	0	0	0	0	0	0	0	0	0	0							
	Admissions 27+1 – 34 Weeks to NNU			Badger	2	7	7	1	2	0	2	0	5	5	3	3						
	Total Admissions to Neonatal Unit			Badger	23	25	32	20	31	12	19	23	29	22	17	19						
	Transitional Care Admissions: 34 – 36+6			Badger	2	4	0	2	1	2	5	1	4	3	6	2						
	Transitional Care Admissions: 37+			Badger	4	8	6	8	7	5	4	5	7	7	8	5						
	Total TC Admissions			Badger	6	12	6	10	8	7	9	6	11	10	14	7						
	Number of unexpected Term Admissions to NNU				6	15	12	6	16	6	10	9	14	12	9	7						
	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)				3.27%	8.24%		3.46%	7.29%	3.50%		4.74%	7.77%	6.25%								
	Unexpected Term Admissions to NNU (*as % of Total Admissions*)			Badger/ NWNODN	26.08%	60%	37.50%	30%	50%	50%	52.60%	39.13%	48.20%	54.54%	52.90%	36.8%						
AP	Mothers Eligible for AN Steroids (*< 34 Weeks*)			NNAP/ NWNODN	2	4	4	1	3	0	2	2	5	5	3	4						
	% of Mothers Who Received Full Course of Antenatal Steroids				50%	25%	50%	100%	33.33%	N/A	100%	100%										
	Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*)			NNAP/ NWNODN	1	1	1	1	0	0	0	0	2	2	0	1						
	% of Mothers Receiving Antenatal $MgSO_4$				100%	0.00%	100%	100%	N/A	N/A	N/A	N/A	50%	100%	N/A							
				NNAP/ NWNODN	2	5	7	1	3	0	2	2	5	5	7	5						
	% of Babies Receiving Delayed Cord Clamping	≥ 85%	< 73%	NNAP/ NWNODN	50.00%		71.42%	100%	100%	N/A	100%	50%	60%	80%								
	Babies Eligible for Temperature on Admission (*< 32 Weeks*)				2	5	7	1	3	0	2	2	5	5	3	5						
	% of Babies With Temperature Within First Hour of Admission (*< 32 Weeks*)				100%	80%	71.40%	100%	100%	N/A	100%	100%	60%	100%	100%	80%						
	% of Babies With Temperature on Admission of 36.5°C – 37.5°C (*< 32 Weeks*)				100%	80%	71.40%	100%	100%	N/A	100%	100%	60%	100%	100%	60%						
	Babies Eligible for Senior Review				18	17	28	15	27	10	18	20	27	21	15	13						

		Goal	Red Flag	Measure	2024 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NN	Number of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	18	17	28	12	25	10	16	19	26	19	12	10
	% of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	100%	100%	100%	80%	92.59%	100%	88.88%	95%	96%	90.47%	80%	76.9%
	Total Ward Rounds Where Parents Present			NNAP/ NWNODN	17	20	31	15	25	258	77	60	113	150	64	119
	% of Ward Rounds Where Parents Present			NNAP/ NWNODN	100.00%	100.00%	100.00%	100.00%	96.20%	75.70%	85.60%	87.00%	76.40%	76.10%	78.00%	69.20%
	% of Eligible Babies Reciving Retinopathy Screening (*ROP*)			NNAP/ NWNODN	100.00%	100.00%	100.00%	0.00%	60.00%	100.00%	0.00%	N/A	3.00%	100.00%	N/A	1.00%
	% of Babies With Central Line Blood Infections			NNAP/ NWNODN	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.0%	0.00%	0.00%	0.00%
	Babies Eligible for Follow-Up At 2 Years			NNAP/ NWNODN	1	2	0	0	2	0	1	1	3	1	2	3
	% of Babies Receiving Follow-Up At 2 Years			NNAP/ NWNODN	0.00%	50.00%	N/A	N/A	50.00%	N/A	0.00%	0.00%	66.66%	100.00%	100.00%	100.00%
Incidents	Number of Incidents Reported			Datix	5	28	27	39	32	9	3	6	14	10	19	11
	Number of Network Exception Reports			NWNODN	1	1	1	0	0	1	1	1	1	1	1	1
	Number of Concise Investigations	0	≥ 1	Datix	0	0	0	0	0	0	0	0	0	0	0	0
	Number of StEIS Reported Incidents	0	≥ 1	Datix	0	1	0	0	0	0	0	0	0	0	0	0
	Number of Complaints	< 2	≥ 2	Datix	0	1	0	0	0	0	0	0	0	0	0	0
	Number of Letters of Claim Received	0	≥ 1	Datix	0	0	0	0	0	0	0	0	0	0	0	0
Breastfeeding	% of Mothers Expressing Breast Milk in First 24 Hours Following Baby's Admission to NNU			Unicef/ NWNODN	26.10%	20.00%	21.90%	5.00%	9.40%	25.00%	10.50%	14.80%	24.10%	40.90%	29.40%	31.60%
	% of Babies Receiving Human Milk in First 24 Hours Following Admission to Neonatal Unit			Unicef/ NWNODN	17.40%	16.00%	15.60%	10.00%	9.40%	25.00%	0.00%	11.10%	31.00%	40.90%	17.60%	26.30%
	% of Babies Receiving Human Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	7.70%	53.10%	33.30%	55.20%	65.40%	17.60%	60.00%	60.00%	43.50%	44.40%	30.00%
	% of Mothers Expressing Breast Milk on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	7.70%	0.00%	0.00%	0.00%	53.80%	0.00%	15.00%	33.30%	39.10%	16.70%	20.00%
	% of Mothers Breastfeeding on Discharge from Neonatal Unit			Unicef/ NWNODN	14.30%	3.80%	50.00%	26.70%	27.60%	38.50%	17.60%	45.00%	40.00%	34.80%	38.90%	30.00%
	Number of Babies Eligible to Receive Breast Milk in the First Two Days of Life (*< 34 Weeks*)			NNAP/ NWNODN	2	5	7	1	3	0	2	2	5	5	4	4
	% of Babies < 34 Weeks Receiving Breast Milk in First Two Days of Life			NNAP/ NWNODN	100.00%	40.00%	71.40%	100.00%	100.00%	N/A	0.00%	50.00%	60.00%	80.00%	75.00%	50.00%
	Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14			NNAP/ NWNODN	2	1	7	1	5	4	0	1	0	3	3	4
	% of Babies < 34 Weeks Receiving Breast Milk at Day 14			NNAP/ NWNODN	50.00%	100.00%	85.70%	100.00%	80.00%	100.00%	N/A	100.00%	N/A	100.00%	100.00%	75.00%
	Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge			NNAP/ NWNODN	4	3	8	1	8	6	3	1	6	4	3	6
	% of Babies < 34 Weeks Receiving Breast Milk at Discharge			NNAP/ NWNODN	50.00%	66.70%	75.00%	100.00%	75.00%	100.00%	0.00%	100.00%	66.70%	50.00%	100.00%	33.30%

					2024												2024					
		Goal	Red Flag	Measure	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	Trend
Activity	Care Days ICU (*HRG1*)			Badger	4	4	20	7	5	1	2	8	11	19	10	13						
	Care Days HDU (*HRG2*)			Badger	46	54	96	106	124	56	15	54	57	39	94	72						
	Care Days SC (*HRG3, HRG4, HRG5, and code9*)			Badger	181	183	202	216	219	146	85	81	165	131	117	165						
	Cot Capacity ICU %			Badger	12.90%	13.79%	64.50%	23.30%	16.10%	3.33%	6.45%	25.80%	36.66%	61.29%	33.33%	41.93%						
	Cot Capacity HDU %			Badger	49.46%	62.06%	103.22%	117.77%	133.33%	62.22%	16.10%	58.06%	63.33%	41.93%	104.40%	77.41%						
	Cot Capacity SC %			Badger	58.37%	63.10%	65.16%	72.00%	70.64%	48.66%	27.41%	26.12%	55.00%	42.25%	39.00%	53.22%						
	Overall Cot Capacity %			Badger	53.22%	59.35%	73.27%	78.33%	80.18%	48.33%	23.50%	32.94%	55.47%	43.54%	52.61%	57.60%						
	Care Days TC (*HRG3*)			Badger	0	0	0	0	0	0	0	0	3	1	0	2						
	Care Days TC (*HRG4*)			Badger	27	42	31	57	46	34	44	30	73	49	57	37						
	Care Days TC (*HRG5*)			Badger	0	0	2	0	0	2	0	0	0	0	3	1						
	Care Days TC (*code 9*)			Badger	0	2	2	4	0	0	4	0	1	1	8	1						
	Total TC Care Days			Badger	27	44	35	31	46	36	48	30	77	51	68	41						
	Overall TC Cot Capacity %			Badger	21.77%	37.93%	26.12%	50.80%	37.09%	30.00%	38.71%	24.19%	64.16%	41.13%	56.67%	33.06%						
Training	NLS Accrediated	≥ 70%	< 70%	WWL	86.80%	86.10%	86.10%	86.10%	86.10%	94.87%	94.87%	97.30%	95.00%	95.00%	97.30%	97.40%						
	NLS In-House	≥ 90%	< 90%	WWL	97.60%	95.10%	95.10%	95.10%	95.10%	90.00%	90.00%	90.00%	90.00%	90.00%	97.10%	97.60%						
	Qualified In Speciality of Intensive Neonates	≥ 70%	< 70%	WWL	92.10%	94.90%	94.90%	94.90%	94.90%	88.88%	88.88%	88.88%	86.70%	86.70%	87.00%	87.00%						
	Family Intergrated Care	≥ 85%	< 85%	WWL	100.00%	100.00%	88.40%	88.40%	88.40%	88.40%	88.40%	88.40%	88.40%	88.40%	98.10%	98.10%						
	Unicef BFI	100%	< 80%	WWL	100.00%	97.80%	95.70%	95.70%	100.00%	100.00%	100.00%	100.00%	95.00%	95.00%	98.10%	98.10%						
	Perinatal Mental Health	≥ 80%	< 80%	HEE	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.00%	100.00%	100.00%	100.00%						

Safety Dashboard 2024

Optimisation

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

	2024											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of singleton babies born under 27 weeks or < 800g	0	1	0	0	0	0	0	0	0	0	0	0
Number of multiple babies born under 28 weeks gestation	0	0	0	0	0	0	0	0	0	0	0	2
% of babies <30/40 gestation whose mothers received MgS04	100.00%	0.00%	100.00%	100.00%	100.00%	N/A	N/A	N/A	50.00%	100.00%	N/A	0.00%
% of babies <34/40 gestation whose mothers received Antenatal Steroids within 7 days of delivery	50.00%	60.00%	57.00%	100.00%	33.33%	N/A	100.00%	0.00%	60.00%	80.00%	25.00%	17.00%
% of Babies Receiving Delayed Cord Clamping	50.00%	66.60%	71.00%	100.00%	100.00%	N/A	100.00%	50.00%	60.00%	80.00%	100.00%	50.00%
% of babies <34/40 gestation who had a Normothermic Temperature (36.5-37.5C) On admission to NNU measured within one hour of birth	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	100.00%	100.00%	50.00%
% of babies <34/40 gestation who received Maternal Breast Milk (EBM) Within 24 hrs of birth	100.00%	80.00%	71.00%	100.00%	100.00%	N/A	0.00%	100.00%	60.00%	80.00%	75.00%	33.00%
% of babies <34/40 gestation whose mothers received Intrapartum Antibiotics >4 hrs prior to delivery	N/A	66.66%	0.00%	N/A	100% X1 N/A and X2 had full course	N/A	100% x1 N/A and x1 full course	N/A	60.00%	100.00%	N/A	20.00%

2024						
Q1	Q2	Q3	Q4	YTD	Trend

Maternity Perinatal Quality Surveillance Dashboard 2024

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

CQC Maternity Rating – Last assessed 2023

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

		Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Cardiotocograph (CTG) training and competency assessment	Midwives	10 (98.7 % compliant)	14 (98% compliant)	8 (96.3 % compliant)	5 (97 % compliant)	19 (97 % compliant)	12 (95.2% compliant)	13 (98% compliant)	(98.7% compliant)	21 (95% compliant)	19 (94% compliant)	(92% compliant)	12 (97% compliant)
	Consultants	1 (90% compliant)	1 (83% compliant)	2 (92.8% compliant)	2 (85.7% compliant)	0 (78 % compliant)	1 (84% compliant)	1 (100% compliant)	(100% compliant)	0 (92% Complaint)	1 (100% Complaint)	(96% Complaint)	0 (100% Complaint)
	Registrars	1 (86% compliant)	2 (100% compliant)	1 (88% compliant)	1 (90% compliant)	1 (100 % compliant)	1 (83% compliant)	2 (100% compliant)	(100% compliant)	2 (100% compliant)	1 (95% compliant)	(93% compliant)	0 (95% compliant)
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives	0 (0%) (85% compliant) **PROMPT cancelled due to doctors strike**	14 (8.9%) (87% compliant)	21 (13%) (82% compliant)	11 (6.7%) (86.5% compliant)	13 (7.8%) (95% compliant)	17 (10.8%) (89% compliant)	9 (5.5%) (97% compliant)	No PROMPT training took place in August	18 (10.9%) (90% compliant)	17 (93% compliant)	18 (93% compliant)	13 (93% compliant)
	MSW	0 (0%) (86% compliant) **PROMPT cancelled due to doctors strike**	4 (11%) (89% compliant)	4 (11%) (89% compliant)	3 (8.6%) (94% compliant)	4 (10.8%) (94% compliant)	3 (8.8%) (94% compliant)	4 (10.8%) (91% compliant)		2 (15.8%) (94% compliant)	3 (91% compliant)	3 (91% compliant)	4 (89% compliant)
	Obstetric Consultants	0 (0%) (69% compliant) **PROMPT cancelled due to doctors strike**	1 (7.7%) (61.5% compliant)	2 (18%) (77% compliant)	1 (7.7%) (84% compliant)	1 (7.7%) (100% compliant)	0 (100% compliant)	1 (6.6%) (100% compliant)		0 (0%) (100% compliant)	3 (100% compliant)	3 (100% compliant)	0 (92% compliant)
	Obstetrics Registrars	0 (0%) (92% compliant) (1 now on LTS) **PROMPT cancelled due to doctors strike**	1 (7%) (86% compliant) (1 now on LTS)	2 (17%) (67% compliant) (1 now on LTS)	1 (7%) (84.6% compliant) (1 now on LTS)	0 (79% compliant)	1 (7%) (84.6% compliant) (1 now on LTS)	1 (16.6%) (84.6% compliant) (1 now on LTS)		3 (15.7%) (100% complaint)	3 (90.9% complaint)	3 (90.9% complaint)	0 (93% complaint)
	Anaesthetists	0 (0%) (88% compliant) **PROMPT cancelled due to doctors strike**	3 (15%) (90% compliant)	2 (15%) (80% compliant)	0 (15%) (88% compliant)	2 (6.8%) (94% compliant)	1 (3%) (77% compliant)	1 (5.5%) (95% compliant)		0 (0%) (94% compliant)	8 (94% compliant)	3 (91% compliant)	3 (94% compliant)
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)		60	60	60	60	60	60	60	60	60	60	60	60
1:1 care in labour		100%	100%	100%	99%	100%	100%	100%	100%	99%	100%	97%	100%
Maternity Red Flags reported (>3)		0	3	5	5	8	1	0	5	4	8	13	7
Diverts: Number of occasions unit unable to accept admissions(>1)		0	0	0	1	1	0	1	1	0	0	0	0
Supernumeray Shift Co-ordinator		100%	100%	100%	98%	100%	100%	100%	98%	98%	100%	100%	100%
The number of incidents logged graded as moderate or above (>5)		0	1	1	2	1	0	3	0	0	0	1	4
All cases eligible for referral to MNSI.		0	0	0	0	0	0	1	0	0	0	0	0
Number of Datix submitted when shift co-ordinator not supernumerary*		0	0	0	1	0	0	0	1	1	0	0	0

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust	0	0	0	0	0	0	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0
Progress in achievement of CNST 10	Progress with standards OnTrack	Progress with standards OnTrack	Awaiting the publication of CNST Year 6 (standards from Year 5 maintained)	Publication of CNST Year 6 (Review of standards underway)	Progress with standards On Track	Review of all standards underway	Evidence collection for all standards underway	Evidence collection for all standards underway	Evidence collection for all standards underway	Evidence collection for all standards underway	Evidence collection for all standards underway	All evidence has been collected and ready for submission
Number of StEIS Reportable Incidents**	0	0 (1 NN)	0	0	0	1	0	0	0	0	0	0
Number of Stillbirths	1	1	0	1	0	0	1	1	2	0	0	0
Number of Early Neonatal Deaths * **	1	1	0	0	0	0	0	0	0	0	0	1
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0

* acuity app from November 2023
** date reported to StEIS
*** before 7 days

Maternity Perinatal Quality Surveillance Dashboard December 2024

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

CQC Maternity Rating – Last assessed 2023

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

December - Exception report

Neonatal Deaths	CNST	Maternity Red Flags reported
There was 1 early neonatal death in December 2024 This is a joint PMRT investigation with NWAS	All evidence has been collected and ready for submission	There were 7 red flags validaated for December 2024, all were "Delay between admission for induction and beginning of process"
Supernumerary Shift coordinator	**1:1 care in labour**	**All cases eligible for referral to MNSI**
The shift coordinator remained supernumary throughout December 2024. No Red Flags submitted	100 % of women received 1:1 care in labour (excluding BBA)	There were 0 case eligible for referral to MNSI

Cardiotocograph (CTG) training	Practical Obstetric Multi-Professional Training (PROMPT)
Overall compliance for fetal physiology in December is % Midwife = 93 % rolling compliance Obstetric Consultant = 100% rolling compliance Obstetric Registrar = 95% rolling compliance	Midwives – 13 attended (7.8%) rolling 93% MSW – 4 attended (10.5%) rolling 89% Obsteteric Consultants – 0 attended (0%) rolling 92% Obsteteric Registrars – 0 attended (0%) rolling 93% Anaesthetists – 3 attended (17.6%) rolling 94%

Feedback	
Service User Voice Feedback	**Staff Feedback from Frontline Champions & Walkabouts (Bi-Monthly)**
WWL Maternity Instagram Page "Some amazing people here! Will, the most entertaining and amazing surgeon for my elective section and Hannah was just the best midwife I could have asked for to help me during and after. The best experience to support me after a scary emergency section with my first. Hope you all had a lovely Christmas and new year When you were able to celebrate XX"	15 Steps for Maternity The MNVP lead undertook a walkabout on the 3rd December 2024 with the ICB, Dad Matters and Voices for Choices Postive feed back was received comments include Areas are very bright, calm, warm and quiet and felt well maintained. The unit felt more welcoming and less clinical. Particular highlights the Myro-doodles – they have a big visual impact, allow theming (the butterflies - bereavement suite) also serve as directional aids. Braille included on signage. All staff we met were friendly and welcoming. All areas were very clean and tidy. A 15 steps action plan has been developed to address issues raised including visiting times, information for diverse groups, use of the birthing pool and parking.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	LED Lighting – National Energy Efficiency Fund
Presented to:	Board of Directors
On:	05 February 2025
Item purpose:	Information
Presented by:	Richard Mundon
Prepared by:	Environmental and Sustainability Manager
Contact details:	Josh.balmer@wwl.nhs.uk

Executive summary

Please find attached the Trust Annual Sustainability report for 23/24, for information. Board should be aware that since the '23/'24 reporting period, the Trust has been successful in its application for a grant from the National Energy Efficiency Fund. Information on the NEEF bid is included within this cover sheet.

The Trust has been successful in securing National Energy Efficiency Funding to the value of £2,362,000 to support Internet of Things enabled LED Lighting installs at Leigh infirmary, Wrightington Hospital, Hindley Health Centre, Golborne Clinic and Tyldesley Clinic. Public Dividend Capital (PDC) will be made available to the Trust for the financial year 2024/25. Memorandums of Understanding have been received and signed and orders have been placed for materials.

The Trust shall be required to submit monthly progress reports to NHS England to ensure delivery of the scheme's benefit in accordance with MOUs.

A breakdown of the funding awarded for each site can be found below.

Site	Award total inc. VAT (£)
Leigh Infirmary	854,220
Wrightington Hospital	1,305,434
Hindley Health Centre	71,456
Golborne Clinic	65,679
Tyldesley Clinic	65,506

The install is currently underway and is intended to be installed and commissioned by 29th March 2025. Please see Appendix A – Install Plan.

The install will realise a recurrent CIP of approximately £316,000 based on the current electricity tariff of 23.19p/kWh. Electricity spend reduction will be realised from the commissioning date and the CIP will be realised within the 2025/26 financial year.

Link to strategy and corporate objectives

This report is linked to the Net Zero Strategy, Green Plan and Corporate Objective C16. LED lighting is a technology that supports reduced electricity consumption and therefore a lower carbon footprint. Carbon footprints form one of the base measures of our environmental performance.

Risks associated with this report and proposed mitigations

There is a risk that the install plan may slip and not meet its install deadline. NHSE have accepted that fact that deadlines are tight and there may be delays. We have confirmed that we will endeavour to meet the EOFY deadline and keep them informed of any delays. This will not impact the funding allocated but may have a small impact upon CIP.

Financial implications

Reduction in energy spend. Recurrent CIP of c.£316,000.

Legal implications

None

People implications

The light fixtures will be more adaptable to changes in the patient environment. They should provide an overall more comfortable patient experience.

Equality, diversity and inclusion implications

None

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

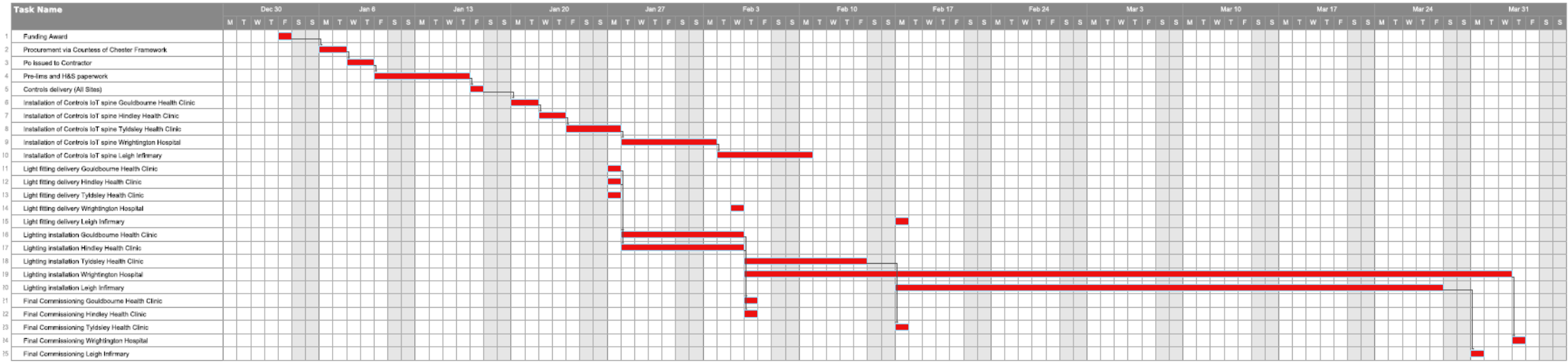
None

Recommendation(s)

The Board of Directors are asked to receive and note the contents of the Annual Sustainability Reports.

Appendices

Appendix 1 – Install Plan



Title of report:	Annual sustainability report 2023/24
Presented to:	Board
On:	05 February 2025
Item purpose:	Information
Presented by:	N/A Consent agenda
Prepared by:	Environmental and Sustainability Manager
Contact details:	Josh.balmer@wwl.nhs.uk

Report

Summary of progress on delivery of the Green Plan

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

NHS Carbon Footprint

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

There has been a 5% decrease in total emissions compared to the 2019/20 baseline. Most areas have seen a decrease in emissions since the baseline year, but the effect of this is nearly cancelled out by the 21% increase in natural gas emissions since the 2019/20 FY. Reduced electricity usage accounts for a 1,750 tCO_2e decrease in emissions since the baseline year, the single largest contributor to the overall decrease in emissions. This is largely attributed to efficiencies generated at a national level. Business Travel has seen the highest fall in emissions relative to the total in the baseline year, mainly down to the lack of international and Long-Haul flights in this year's data. Water usage and treatment has seen the highest proportional increase. However, it should be noted that this emissions category has seen large fluctuation since the baseline year and accounts for a small percentage of the overall footprint.

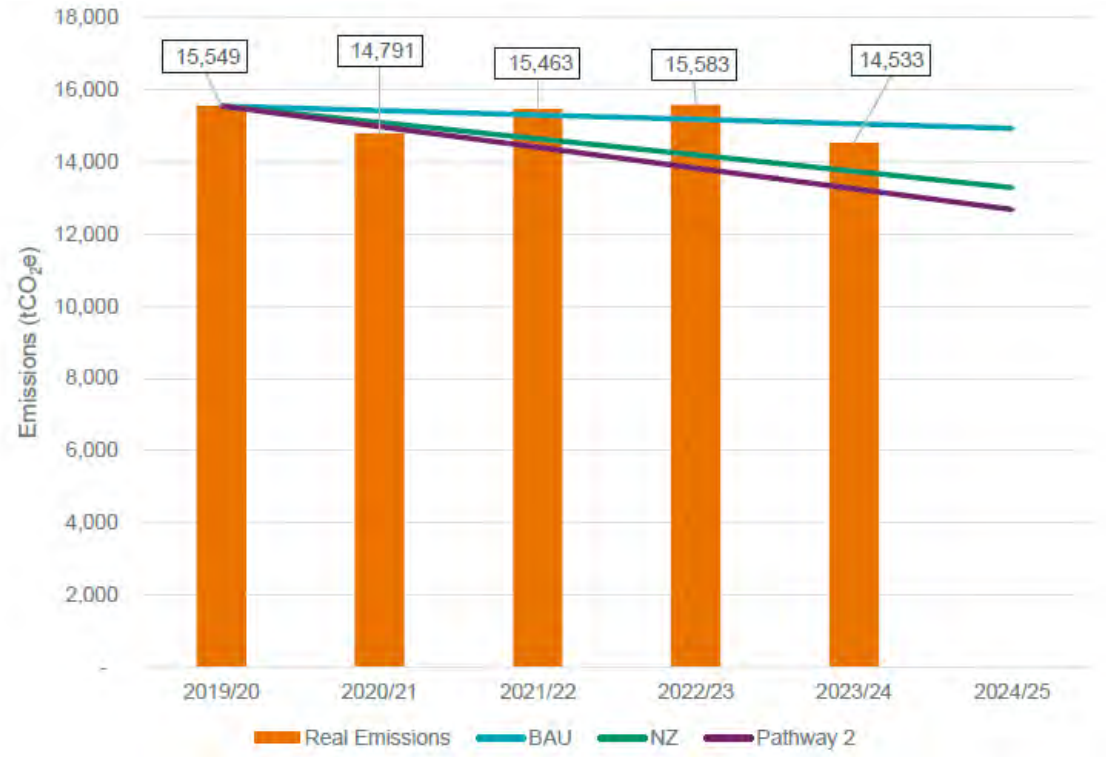


Figure 1 - Real Emissions Performance comparison with Business as Usual, Net Zero and Pathway 2

Carbon footprint by site type (including transport) is presented in Figure 2. The emissions associated with Clinical site types accounted for 97% of the overall 23/24 NHS Carbon Footprint. The next highest emitting category was transport, accounting for 1% of the total tCO_2e. Natural gas consumption is the largest contributor to the clinical sites' carbon emissions, accounting for 76% of the 12,118 tCO_2e total.

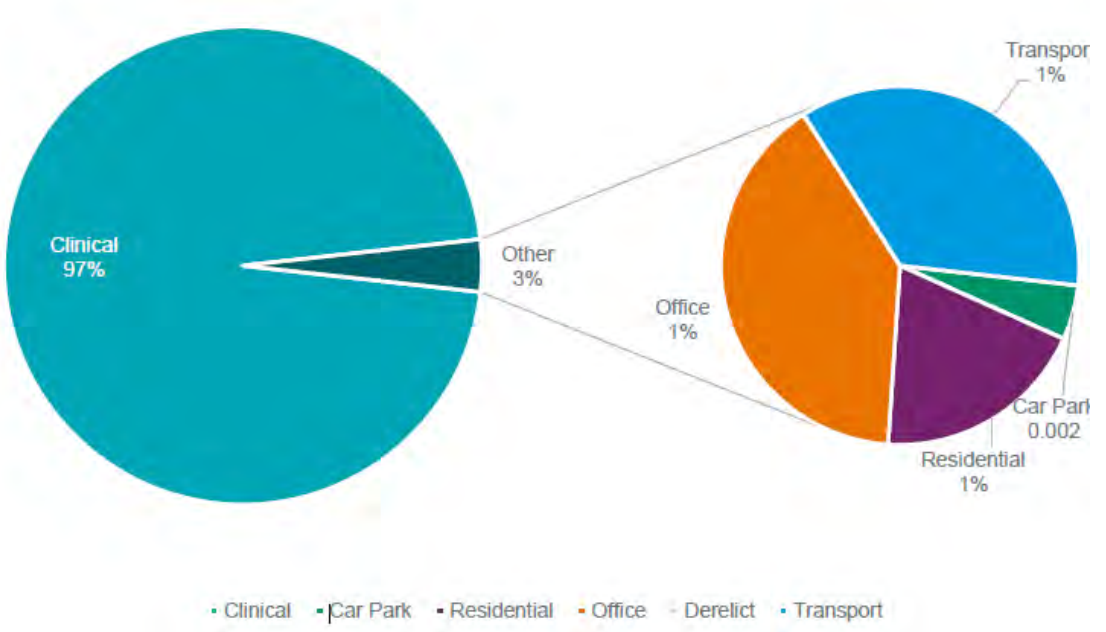


Figure 2 - 2023/24 Carbon Footprint Emissions by Site Type and Transport (tCO2e)

The NHS Carbon Footprint for key clinical sites is shown in Figure 3. Royal Albert Edward Infirmary has the greatest proportion of emissions associated with it, 6,409 tCO_2e. This is 98% greater than the second largest emitting site, Wrightington Hospital.

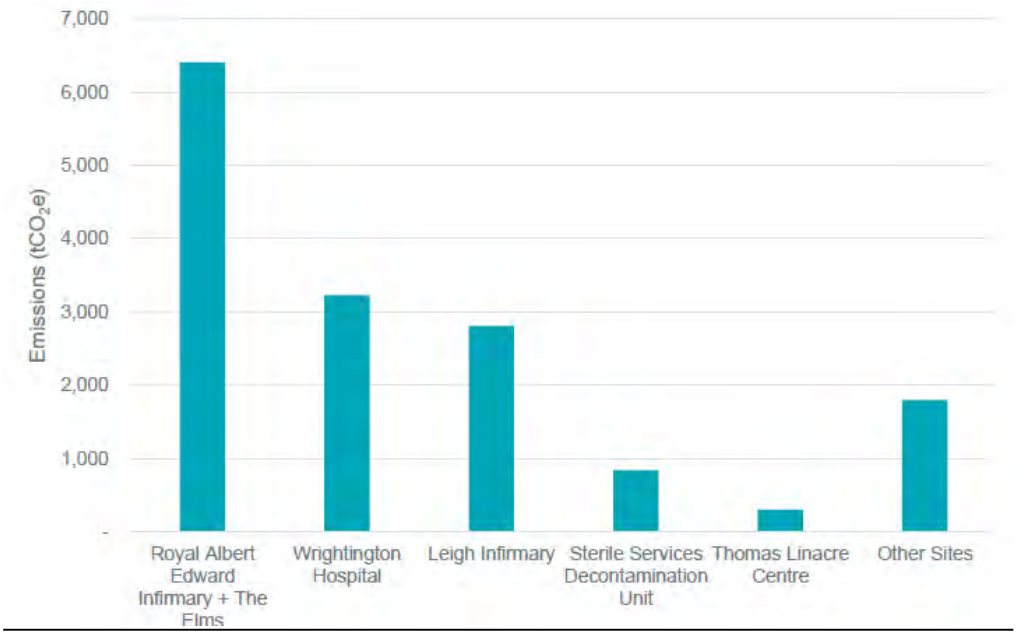


Figure 3 - 2023/24 Carbon Footprint Emissions by Key Clinical Site (tCO2e)

NHS Carbon Footprint Plus

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

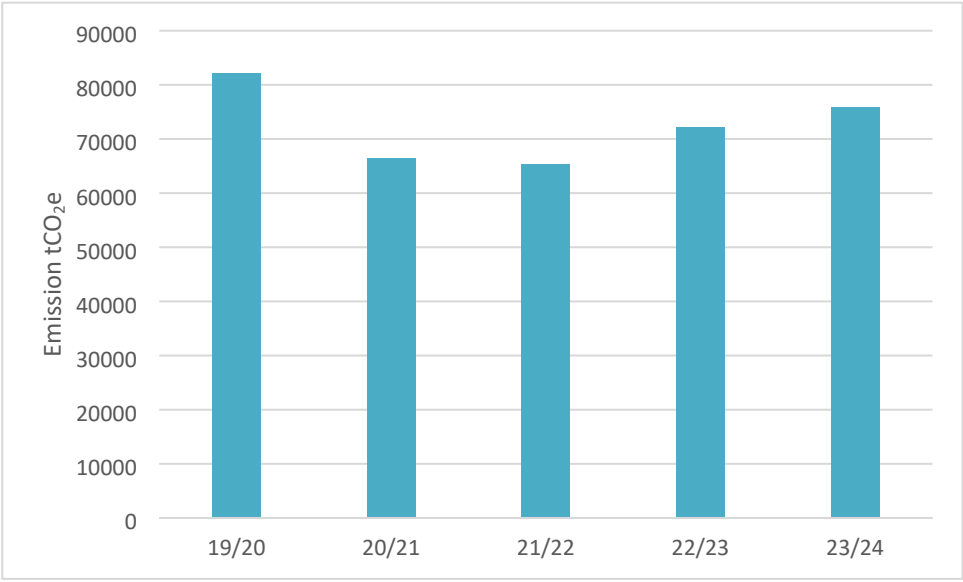


Figure 4 - NHS Carbon Footprint Plus

Progress in year

Medicines and Sustainable Models of Care:

WWL aims to reduce our carbon footprint associated with intravenous administration of paracetamol and promote oral preparations of paracetamol whenever intravenous therapy would be unlikely to be more beneficial. At present, WWL is prescribing less than any other acute provider in the ICS. On average the Trust is delivering 3000 fewer infusions of IV paracetamol per month.

The Trust is also looking to reduce its footprint associated with Metered Dose Inhalers. MDIs utilise gases with a high global warming potential as a propellant. Again, WWL has the lowest levels of prescribed MDIs in the ICS.

Dermogesic and Cryogesic cold sprays have a high global warming potential; there are other effective nerve block tests that do not use environmentally damaging chemicals. CoolStick devices were introduced to theatres to replace vapo-coolant sprays. CoolSticks are devices comprised of a stainless-steel body with a screw-on plastic handle that is kept in the refrigerator and can be decontaminated for reuse. WWL aim to implement a complete switch to Coolsticks where clinically appropriate.

Desflurane is routinely used as an anaesthetic gas in operating theatres; it is more than 2,500 times more potent a greenhouse gas than carbon dioxide (CO_2). WWL aimed for a complete phase out of Desflurane by 31st March 2024 switching to anaesthetic gases with a lower environmental impact such as isoflurane and sevoflurane. All remaining Desflurane within vaporisers has been safely disposed of in the most environmentally friendly option available at the time through a GM wide initiative.

Nitrous oxide (N_2O) is a medical gas that has been part of anaesthetic use since its discovery in 1772. Although its widespread use has mostly been superseded in modern practice with the availability of superior pharmacological agents, it is still used commonly in anaesthetic practice. The use of N_2O comes with a significant environmental cost. The global warming potential of N_2O is 310x that of CO_2 with a physical atmospheric presence of 150 years. As such, the use of N_2O represents a relatively large proportion of both anaesthetic and NHS CO_2 footprints. The Nitrous oxide mitigation project identified that trust wastage of N_2O via manifolds was more than 98%. The project found that leaks within the often very old, manifold systems contributed massively to trust N_2O usage and subsequent CO_2 footprints. The Trust decommissioned the manifolds and moved over to a bottled supply attached directly to anaesthetic machines. We estimate that this action has reduced our carbon footprint by approximately 800 tCO_2e per annum.

Digital Transformation

WWL aimed to achieve a 5% reduction in the total number of printed pages by implementing a digital tracking system to monitor monthly printing usage by department, aligning with the Trust's broader sustainability and environmental goals. Providing access to additional digital tools (e.g., PDF editors, digital signature software) reduces the need for printing, along with campaigns for staff on how to maximize the use of digital documents and minimize paper usage; involving staff at all levels to contribute ideas and participate in the initiative whilst emphasizing the environmental and cost-saving benefits. The rollout of new printers and tools has just been completed and benefits are being reviewed.

Supply Chain and Procurement

A contract was put in place for Wigan Council to provide inspection, replacement of worn parts, decontamination and delivery/collection of Walking Aids from key locations across WWL. Plans are to scale the service to include a wider range of walking aids to replace the demand for purchasing new. Case studies show an average 87% drop in carbon emissions vs use of a new walking aid; walking sticks are in the top 20 of medical device / equipment categories for carbon footprint. As a result of the scheme the Trust is procuring on average 8000 fewer mobility aids per annum with a saving of approximately £98,000.

Food and Nutrition

WWL aims to reduce the amount of food waste generated through services provided by the Catering Department and provide more sustainable menus to reduce the carbon footprint associated with ingredients. This will be achieved through menu planning, stock rotation, production, and portion control. Waste will be monitored in relation to overordering, spoilage, over production and plate waste. Success will be achieved by continuous monitoring and evaluation, identifying patterns in over-production and plate waste, and ongoing staff training. Zedible collaborated with Wrightington, Wigan, and Leigh Teaching Hospitals NHS Foundation Trust to assess the carbon emissions associated with our food and drink purchases from April 2023 to March 2024; the total carbon emissions from food and drink over the period of the report was 2229 tonnes – the equivalent of 71,000 ambulance responses. By implementing their suggested sustainable menu substitutions, there would be a reduction in carbon footprint of 545 tCO_2e and a reduction in cost of approximately £14,000 per annum.

Estates & Facilities

The Trust is gradually moving over to LED luminaires to reduce our carbon footprint and energy spend. Capital budgets are restrained, and this has meant in year investment in LEDs hasn't been possible, outside of refurbishment and new build capital schemes. However, existing installs have reduced our energy use by 675,000 kWh and our carbon footprint by 139 tCO_2e in 2023/24.

There is also acknowledgement that the Combined Heat and Power unit at RAEI is not efficiently utilizing the heat that it generates (it is still generating a significant reduction in energy spend). A bid has been submitted to the Heat Network Efficiency Scheme to fund much needed pipework upgrades which would allow us to better utilise the heat generated. If successful, this would reduce our carbon footprint by an additional 320 tCO_2e and reduce energy related spend by c.£96,000.

Climate Change Adaptation

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

Green Spaces and Biodiversity

Our charity partner Groundwork have completed assessments of green space on all our owned sites. The assessments will be used to develop a biodiversity plan which will be utilised within capital schemes to increase their biodiversity in line with Local Nature Recovery Schemes. They will also be used to influence the grounds maintenance programme with a view to better managing biodiversity.

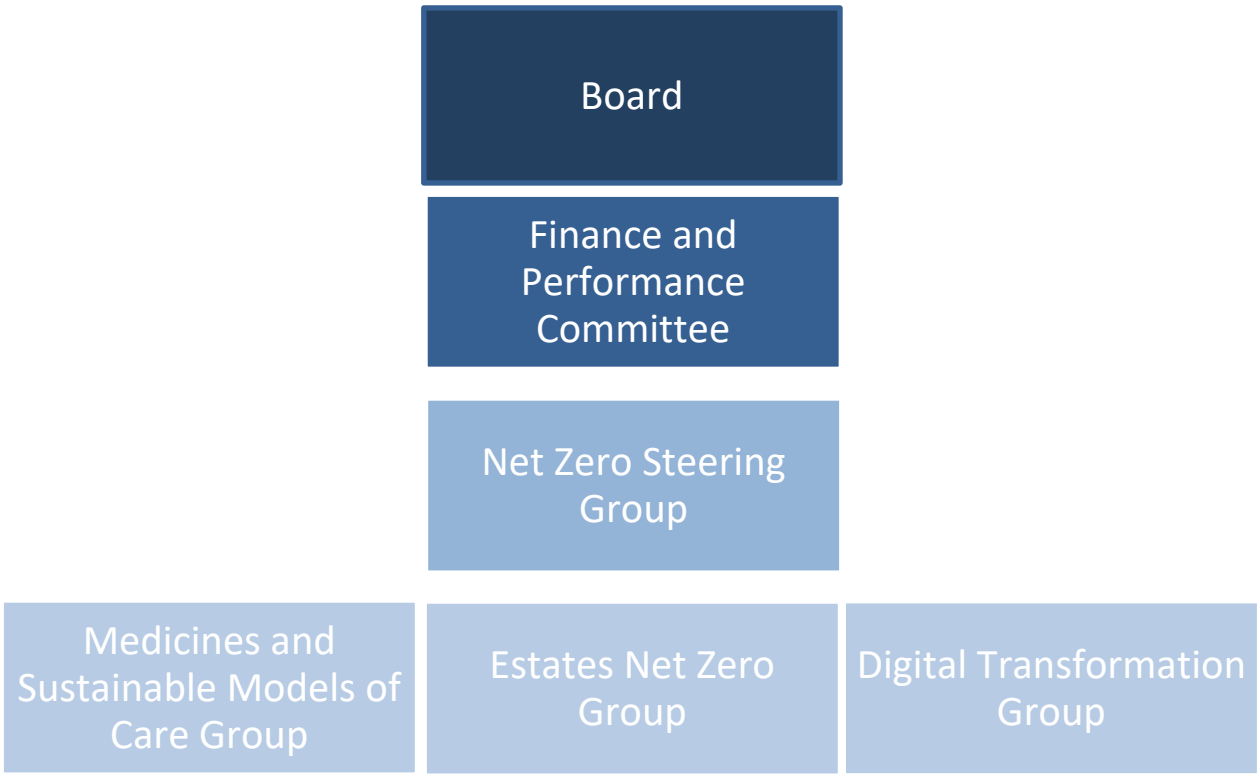
Workforce, Networks & System Leadership

The Sustainability team run a network of "Greener WWL Ambassadors" to provide a key role in the success of the Trust's Green Plan. Ambassadors can collaborate on projects, share experiences and best practice, and promote sustainability across the trust. Ambassadors, and all other staff, will have access to various training and development opportunities (generic and role-specific) to further support the Green Plan.

Climate Related Financial Disclosures

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

2023/24 have included endorsing the inclusion of sustainability considerations in local priorities and hospital-level strategies, and ensuring sustainability messaging is strengthened within leadership communications to support the agenda.



NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	EDI Annual Report 2023 - 2024
Presented to:	Board of Directors Meeting
On:	5th February 2025
Item purpose:	Approval
Presented by:	Juliette Tait, Chief People Officer
Prepared by:	Angelique Hartwig, Head of Staff Experience
Contact details:	Angelique.hartwig@wwl.nhs.uk

Executive summary

Wrightington Wigan and Leigh (WWL) Teaching Hospitals NHS Foundation Trust is committed to pursuing equality, diversity, and inclusion (EDI) for both patients and staff. This report aims to provide an overview of the Trust's EDI journey in the financial year 2023-24, highlighting the data collected between 1st April 2023 and 31st March 2024, and the actions taken to enhance EDI within this timeframe.

Alongside the annual Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and Equality Delivery System (EDS), this year the Trust has aligned EDI priorities to the NHS EDI Improvement Plan and continued to raise the profile of EDI across the Trust. A new EDI governance structure has been put in place to provide greater assurance that equality and inclusion becomes business critical at WWL and that we all support the implementation of the EDI Strategy. New this year, we have committed to becoming an anti-racist organisation by working towards accreditation of the North West BAME Assembly Anti-Racist Framework and have also signed up to implementing the 10 principles of the NHS Sexual Safety charter.

In 2023/24, we continued to raise awareness of equality, diversity and inclusion at WWL. Governors, Board and the Executive Team have had EDI training over the past year, and an EDI Communications Plan has meant that staff are regularly informed of awareness days and any cultural events. Staff have also been empowered to learn about and celebrate diversity with the launch of the new EDI Toolkit on our intranet.

WWL has continued to enhance patient experience, by engaging and involving patients, and their families. During 2023/24, WWL was awarded the 'PRIDE in Veterans' Standard demonstrating our commitment to delivering the highest standards in LGBT+ veteran inclusion. A review of the effectiveness of interpreter and translation services was untaken, along with the roll out of on-demand video remote interpreting for British Sign Language. WWL continues to work in partnership with AccessAble creating, developing and updating detailed access guides for patients to all the Trust's sites.

Over the past 12 months, the Trust has continued to work in partnership with patients and staff.

Engaging with patients enables us to understand and improve the experience of patients across all protected characteristics. From November 2023, equality monitoring across all 9 protected characteristics is now included in all WWL In-Patient surveys.

WWL has continued to make progress in relation to meeting the core requirements of the Accessible Information Standard. WWL will continue to review during 2024/25 and address current challenges in line with the implementation of the Reasonable Adjustments Digital Flag Information Standard.

Further Details of these key achievements are included within the annual report.

Link to strategy and corporate objectives

EDI Strategy
People Objective – We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish.

Risks associated with this report and proposed mitigations

There is a risk to the delivery of care to patients, the experience of our staff and a risk to meeting our legal obligations if we do not fully embed our EDI Strategy and meet our Corporate People Objectives.

Financial implications

N/A

Legal implications

There are legal implications in terms of the Equality Act if we fail to meet our obligations with regards to EDI.

People implications

Through advancing equality and inclusion we ensure that our people have an improved experience at work and throughout their careers, enabling them to provide excellent care to our patients.

Equality, diversity and inclusion implications

This report provides assurance that we have been progressing our EDI strategy to improve the staff and patient experience at WWL for those with and without protected characteristics.

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

The EDI annual report has been received by the Executive Team, People Committee and Quality and Safety Committee. The Committees have reviewed the report and discussed its content.

Recommendation(s)

The Board is asked to note the content of the report and approve the publication of the EDI annual report 2023-24 on our Trust website.

Equality, Diversity and Inclusion Annual Report 2023-24

Introduction

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Further Details of these key achievements are included within this report.

Key EDI Progress 2023-24

During the financial year 2023-2024, WWL has continued to lay the foundation to becoming a truly inclusive healthcare provider, including launching new organisational values for our Trust, setting up a new EDI governance structure and aligning our EDI programme to the NHS EDI Improvement Plan.

WWL is committed to creating an inclusive working environment where our people can thrive, feel they have a voice that counts, a true sense of belonging and will recommend WWL as a great place to work. We know from analysing the most recent staff survey that it is still the case that black and minority ethnic staff and staff living with a disability and long-term health conditions continue to report having worse experiences than other staff groups.

Many of the issues that our staff from protected groups face can be linked back to the standards of behaviours we would expect to see which are underpinned by our organisational values. At WWL, we want everyone to feel that they belong and is treated with kindness and respect. Having shared core values is integral to creating a foundation of our culture at WWL, and how together, we will achieve our vision.

In the year 2023/24, we aimed to reset our organisational values. To this end, we undertook a series of focus groups and engagement sessions at staff group forums to gain insight into staff stories and how and when they experienced high level of care. Using content analysis, we drew out common themes and used them to build a set of new shared values which will provide the foundation for an inclusive culture. Before final sign off, we engaged further with our colleagues to sense check how the values resonated with them and to encourage them to bring them to life within their teams and in their patient care. The values were approved by Board and launched in April 2024.

New EDI Governance Structure

In the financial year 2023/24, the Trust reviewed it's EDI governance structure to ensure that progress against our EDI Strategy is made by introducing an EDI strategy group chaired by the CEO and setting up People and Patient EDI workstreams chaired by members of the Executive Team and their deputies to address the evidenced disparities in staff and patient experience for those from black and minority ethnic groups and those with a disability or long-term health condition.

Also, a series of engagement sessions with the Board, senior leaders and staff groups were held to gain commitment to our EDI strategy and co-design our new consolidated EDI plan. Some of these activities included:

1. The Board Development Workshop, held in January 2024, facilitated by Ranjit Kirton from the Behaviour Garage in relation to Inclusion with Humanity.
2. The Listening Event held with Internationally Educated Nurses following the feedback received via the Professional Practice Team.
3. Listening events held by Chief People Officer with members of staff diversity networks to inform priorities for EDI plan
4. The broader Senior Leaders event held to discuss the results of the staff survey and reiterate the feedback received from staff with protected characteristics.
5. Cultural development plan presented at ETM on 22nd February 2024 in relation to the immediate actions that will be undertaken to support our internationally educated nursing workforce.
6. Away Day held for the staff diversity networks to commence support the reset and refresh of their visible presence across the Trust.

Delivering the EDI Plan

The EDI plan will be overseen and driven by an EDI Strategy Group chaired by our Chief Executive, Mary Fleming.

The actions will be implemented by the establishment of dedicated workstreams aligned to the NHS EDI Improvement Plan which are chaired by senior responsible officers who will report into the EDI Strategy Group. Work will continue to review the EDI action plan and align actions with the standards the Trust must meet. Delivery will be led by subject matter experts and delivered in partnership with staff side, staff networks and patient representatives as appropriate. It is anticipated that as the Trust EDI Programme develops and grows in strength and competency, the EDI plan will evolve and improve.

Workstream	Link to NHS England Plan	Chair
Disability Confident Scheme	NHS England High Impact Action 6	Associate Director of OD and Inclusion
Anti-Racist Framework, including civility & respect	NHS England High Impact Action 6	Chief People Officer
Inclusive Recruitment	NHS England High Impact Action 2	Deputy Chief People Officer
Supporting global majority colleagues	NHS England High Impact Action 5	Chief Nursing Officer
Pay Equality	NHS England High Impact Action 3	Medical Director
Health equality	NHS England High Impact Action 4	Health Inequality Lead
Patient access and experience	NHS England High Impact Action 4	Associate Chief Nurse
Working in partnership with people and communities	NHS England High Impact Action 4	Associate Chief Nurse

Key EDI frameworks and progress in 2023/24

The following table provides an update on the key EDI reporting frameworks and actions progressed during 2023/24:

People Services

NHS England equality, diversity and inclusion (EDI) improvement plan	
The NHS England equality, diversity and inclusion (EDI) improvement plan was published in June 2023. The aim of the EDI improvement plan is to improve equality, diversity and inclusion and to enhance the sense of belonging for NHS staff. The EDI improvement plan sets out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. Key actions to demonstrate progress against the NHS EDI improvement plan include:	
NHS high impact action 1: Measurable EDI objectives at Board level	• Establishing an EDI Strategy Group and associated workstreams • Launch of EDI related Corporate People Objective "We will have an inclusive and representative workforce that is free from discrimination and allows all staff to flourish" • Implementation of specific EDI section on all Board and Committee report templates along with ensuring that EDI is a standing item on sub committees of the Board.
NHS high impact action 2: Inclusive recruitment processes and talent management strategies	• New talent strategy launched and new talent tool being developed which will be available to all staff and support more inclusive recruitment practices • Band 5 – Band 6 Nursing development programme advertised to global majority staff with positive action to improve participation rate
NHS high impact action 3: Pay gap improvement plan	• Refreshed flexible working policy in place which has been advertised widely across the Trust Inclusive Recruitment workstream to be set up to increase diversity and reduce bias
NHS high impact action 4: Health inequalities	• Wellbeing conversations training roll out across the Trust • Self-assessment against NHS health and wellbeing framework • Partnership working with council and colleges/universities to support pathways into healthcare

NHS high impact action 5: Onboarding and development programme for internationally educated staff	• Dedicated pastoral support for our global majority staff • Support with induction and onboarding, new welcome day for all staff • Nursing development programme proactively advertised to global majority staff and application process simplified to make process more inclusive
NHS high impact action 6: Elimination of conditions for bullying, discrimination, harassment and violence	• New values launched to set out expected behaviour for all staff and foster civility culture • Regular review of ER cases to ensure consistency and fair treatment • New Freedom to Speak Up Guardian and policy to support speak up culture • Psychological support for staff affected by bullying, harassment, discrimination or violence • Introduction of Trauma Risk Management assessments for staff who may benefit from risk assessment following traumatic incidents at work

Workforce Race Equality Standard and Workforce Disability Equality Standards

WRES (Workforce Race Equality Standard) 2024

WWL's latest WRES report and associated action plan
is located at:
WWL Teaching Hospitals NHS Foundation Trust | Workforce Race Equality Standard.

This year's WRES metrics show some areas of improvement and some areas of continued concern, highlighting key priorities for us to improve the experience for our colleagues from Black, Asian and Minority Ethnic groups. Key findings include:

Areas of improvement

- Black and Minority Ethnic staff are more likely to access non mandatory and CPD training
- Black and Minority Ethnic staff are less likely to be the subject of a formal disciplinary process

Areas of focus

- Black and Minority Ethnic staff are over 3 times more likely to experience being subjected to discrimination by their manager or colleague

- Black and Minority Ethnic staff are more likely to experience bullying and harassment at work than from a colleague compared to white staff
- Black and Minority Ethnic staff are 2.4 times less likely to be appointed after shortlisting than white staff
- Within agenda for change clinical roles, there is a disparity between representations from band 5 – 6 roles, and a very low representation at more senior roles band 8a and above, indicating a barrier to career progression.
- Black and Minority Ethnic staff are less likely than white staff to say that the Trust provides equal opportunities for career progression and promotion

WDES (Workforce Disability Equality Standard) 2024

The latest WDES report and associated action plan can be found at:
WWL Teaching Hospitals NHS Foundation Trust | Workforce Disability Equality Standard.

This year's WDES metrics suggest that our position against some indicators has improved whilst others have deteriorated since 2023. People who are disabled or have long-term health conditions still have a less positive work experience across all People Promises compared to other staff and remain a key focus for our effort to eliminate inequalities and create an inclusive workplace culture. Key findings include:

Areas of improvement

- Slight decrease in likelihood of disabled staff entering formal capability process for performance management but still 2.9 time more likely

Areas of focus -WDES

- Disabled staff are more likely to experience bullying, harassment and abuse in the workplace from all sources
- Disabled staff more likely to experience bullying, harassment and abuse from their manager
- Third disabled staff have reported not receiving adequate adjustments to enable them to do their work
- Disabled staff feel less valued than non-disabled staff
- Disabled staff report greater pressure to come to work compared to their non-disabled colleagues
- Disabled staff are less likely than non-disabled staff to say that the Trust provides equal opportunity for career progression and promotion

Gender Pay Gap

The most recent Gender Pay Gap Report, available on publication of this EDI annual report, relates to data collected as of 31st March 2023 (see full report on our Trust website using this LINK

Key Points to note are:

- The Trust workforce is 80% female and 20% male.
- The Trust Medical & Dental workforce is 65% male and 35% female with 24% of the Trust`s overall male workforce being constituted within the Medical & Dental staff group.
- If we exclude Medical and Dental staff from the Trust wide gender pay gap figures, the Trust`s mean average gender pay gap is 3.07% which equates to females earning £0.52 less than male staff per hour.
- As at March 2023 the Trust has a 27.46% mean average gender pay gap with females earning £6.46 an hour less than males. The mean average gender pay gap in 2023 is comparable to 2022 data when, as at 31st March 2022, females earned £6.87 an hour less than males with a 30.11% mean average gender pay gap.
- As at March 2023 the Trust has a 12.69% median hourly rate gender pay gap with females earning £2.19 an hour less than males. The median hourly rate gender pay gap in 2023 has deteriorated in comparison with 2022 data when as at 31st March 2022 females earned £2.17 an hour less than males with a 13.27% median gender pay gap.

During this reporting period, there is acknowledgement that a key factor underpinning the Trust`s gender pay gap is due to a significant proportion of male staff being constituted within the Medical and Dental Staff Group which is within the higher earning quartiles. The Gender Pay Gap may decrease once there is a shift to higher recruiting rates of female consultants and senior managers at WWL. This will take time, but the Trust is committed to engaging with female staff to ensure that there is equitable career development opportunities and policies are family friendly.

National Staff Survey 2023

Data from the National Staff Survey 2023 was analysed for experiences of staff from minority groups. The results highlight continued disparity between the experiences of staff who are white compared to those from a black or minority ethnic background and staff who have a disability or long-term health conditions, compared to those who do not. You can find our organisation's results on the National Staff Survey website: Local results for every organisation | NHS Staff Survey

Key findings include:

- Disabled staff score lower on every People Promise and Theme compared to the Trust average. They also score lower than staff from ethnic minority groups.
- Staff from minority ethnic groups score the same as the Trust average on most People Promises and Themes. They score lower than Trust average for the People Promise 'We work flexibly' and higher for 'Staff Engagement' and 'We are Always Learning' where they score higher.
- Highlighting the disparity between white, non-disabled staff and disabled and ethnic minority groups (in particular black staff) regarding the organisation acting fairly with regard to career progression/promotion.
- We have a disproportionate amount of bullying occurring to those with protected characteristics.

Key actions we are taking to address these themes are below:

- Actively working towards becoming an anti-racist organisation
- Becoming a leader within the Disability Confident Scheme and being confident that we are an LGBTQIA+ friendly employer
- Building a core leadership development programme to equip our managers in promoting inclusion, role-modelling compassionate leadership and addressing incivility, bullying and abuse
- Developing new wellbeing policy and guidance for managers and staff, including refreshed health adjustments guidance and training
- Continuing the Culture and Engagement Programme for teams which fosters positive, inclusive team cultures
- Continue to develop career pathways, personal and professional development which are inclusive and ensure equality of opportunity for all staff; such as the Talent Management Strategy to be actively inclusive and to consider positive action programmes of work/opportunities for staff from protected groups.

Delivery of the in-year actions as defined by the following programmes:	**Northwest BAME Assembly Anti-Racist Framework** Over the past financial year, the Trust has committed to working towards Bronze accreditation of the NW BAME Assembly Anti-Racist Framework. Key actions taken in 2023/24 include:

• North West BAME Assembly Anti-Racist Framework • NHS Sexual Safety Charter	• Launching our commitment to becoming an Anti-Racist Organisation in line with the North West BAME Assembly Anti-Racist Framework • Anti-racism as mission critical: An anti-racism statement has been produced and published detailing organisational commitment to racial equity. See **Appendix 1** for the statement. • Anti-racism, civility and respect workstream has been set up by Chief People Officer to design and implement culture change initiatives to create an inclusive, anti-racist workplace for all staff • Listening events taking place between our CEO and our global majority colleagues who have been recruited overseas • Professional Education Team extending pastoral support for global majority nurses and exploring funding for dedicated global majority nursing fellows **NHS Sexual Safety Charter** In alignment with the statutory duty of care for its employees and patients and to prevent harassment and abuse at work, WWL aims to proactively foster a positive workplace culture where everyone feels safe and supported when experiencing unwanted sexual behaviour. To this end, WWL has signed up to the NHS England Sexual Safety Charter which was first launched in September 2023 in collaboration with key partners across the healthcare system. Organisations signing up the charter commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace to create a safe environment for staff working in the healthcare system. An action plan has been developed to address these gaps and to support our ambition to fully adhere to the ten principles of the Sexual Safety Charter. This includes actions to: 1. Develop an anti-sexism and civility campaign 2. Review policies/training and inclusion of specific reference to unwanted sexual behaviour 3. Promotion of resources and support networks 4. Enhance training offer on sexual harassment and abuse, disclosure, active bystander model, supporting colleagues who disclose having experienced sexual misconduct 5. Develop reporting SOPs for sexual misconduct which includes patient on staff and staff on staff incidents 6. Review intersectionality of staff groups which are more likely to be experiencing sexual harassment/abuse

	7. Improve data insights on sexual safety culture and experiences of sexual misconduct by reviewing incidents, ER cases, surveys and focus groups

Patient Services

Objective	Progress
Understand and improve the experience of patients across all protected characteristics. **Identify variations in patient access, safety and experience of our services and develop plans to address these.**	WWL has continued to enhance patient experience, by engaging and involving patients, and their families. During 2023/24: In May 2023, WWL was Awarded the 'PRIDE in Veterans Standard'. This programme was developed by Fighting with pride, a military charity that supports LGBT+ veterans, serving personnel and their families, particularly those who were affected by the 'gay ban', which was lifted in 2000. WWL is committed to delivering the highest standards in LGBT+ veteran inclusion. Continued to work in partnership with **AccessAble** creating, developing and updating detailed Access Guides for patients to all the Trust's sites. 55 Access Guides were reviewed during 2023. All venues om the Royal Albert Edward infirmary Site were visited and assessed by a trained AccessAble Surveyor. Engaging with patients enables us to understand and improve the experience of patients across all protected characteristics. From November 2023 equality monitoring across all 9 protected characteristics are now included in all WWL In-Patient surveys. WWL continues to undertake 3 yearly reviews of existing **Equality Impact Assessments** (EIAs) for all divisions. Equality Impact Assessments are now a pre-visit intelligence requirement within Ward Accreditation (ASPIRE) Programme. The Trust's EDI Service Lead now participates in the ASPIRE Ward Accreditation Assessment visits, working towards improving standards and the quality of care for all patients.
Meet the information and communication requirements of	WWL has continued to make progress in relation to meeting the core requirements of the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients with a disability, impairment or sensory loss.

patients, their families & carers with a disability impairment, or sensory loss.	Although a number of controls have now been implemented to demonstrate compliance with the AIS, currently there is no consistent approach Trust wide (across all standalone systems). Patients could have their information and communication needs met for some services, but not for others. WWL will continue to review during 2024/25 and address some of these challenges in line with the implementation of the Reasonable Adjustments Digital Flag Information Standard. A dedicated workstream has been established to progress the phased requirements of NHS England's Reasonable Adjustments Digital Flag Information standard incorporating outstanding actions of the Accessible Information Standard
To review the effectiveness of our interpreter and translation services.	From April 2023 an on-demand video remote interpreter service for patients requiring instant access to a British Sign Language Interpreter was implemented. Staff can access this service via an 'App' on a dedicated IPAD in A&E, Urgent Treatment Centre at Leigh and Maternity Services. This is an additional interpreter service which is not intended to replace face to face BSL Interpreters, but to provide instant access in an emergency environment, when a face to face cannot be accessed. This video remote BSL App has since been uploaded on to all compatible ward / department IPADs . Since Covid, there have been a lot of national challenges regarding the provision of face to face interpreters. Linguists preferring to use video remote, as opposed to meeting face to face; Wigan is located on the border of Greater Manchester, some linguists are now reluctant to travel to the borough. There is also a national shortage of certain languages, so recruitment campaigns are on-going. WWL has developed an improvement plan to increase face to Face interpreter fulfilment rates and is currently reviewing the implementation of additional interpreting methods, including other video remote services.
To improve the patient experience for **patient's changing gender identity,** who require their medical records updating.	Although the Trust acknowledges there are current gaps with the updating of patient records (both electronic and paper) and awaits the release of national guidance for Acute Trusts, WWL have continued to ensure patient requests for gender identity requests are managed. NHS England have advised that until guidance is implemented, Trusts are to continue with current in-house protocols (updating demographics of current record). The process of receiving and actioning patient requests is currently overseen by the EDI Service Lead within the Patient Experience Team. A process

	mapping exercise was undertaken to identify what actions were required to update a patient's records with their new gender identity (retaining previous medical history) and a draft operational procedure produced. Risks / implications and proposed mitigations have been formally recorded.

Equality Delivery System (EDS) 2023

The EDS is an accountable improvement tool for NHS organisations in England. The EDS 2023 is a third version of the EDS and comprises eleven outcomes spread across three domains, which are:

Domain 1	Commissioned or Provided Services
Domain 2	Workforce Health and Well-Being
Domain 3	Inclusive Leadership

The outcomes are evaluated, scored, and rated using available evidence and insight. It is the ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

Below is a summary of how WWL performed on EDS2022 in 2023-24. To read our full EDS2023 Report, please visit our WWL website at: https://www.wwl.nhs.uk/media/corporate/Our%20organisation/EDS2022%20report%202022-23%20FINAL.pdf

The Trust has scored as follows for EDS2023:

- **Overall rating:** Developing (18 – four points off 'Achieving')
- **Domain 1:** Commissioned or provided services: Score 12 out of 12 (excelling) – middle score of the three services reviewed.
- **Domain 2:** Workforce health and wellbeing: Score of 4 out of a possible 12 (Developing)
- **Domain 3:** Inclusive Leadership: Score of 2 out of a possible 9 (Undeveloped)

The 'Scores' Table below shows where WWL Scores sit within the national scoring criteria:

Score card	
Each Outcome	**Overall – adding all outcome scores in all domains**
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 30,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **31 or more,** adding all outcome scores in all domains, are rated **Excelling**

It is important to understand that the results WWL has achieved this year are a baseline and will give us greater understanding of where we need to focus our attention for 2024-25.

Action plans and next steps

Domain 1: Commissioned or Provided Services

From the assessment, it was clear that further engagement and higher quality data is needed. We are planning on engaging more closely with public / service users from all protected characteristics at future EDS Engagement Events to enrich our data insights. Also, any patient experience surveys will include data on 9 protected characteristics to enhance our data monitoring capabilities. Further, closer collaboration with divisional and service leads will be take place to educate about the requirements of EDS and importance of gathering diversity data for improvement of our services.

Domain 2: Workforce Health and Wellbeing

At WWL, there are established wellbeing and psychological support services available to all staff. WWL's EDS score was adversely affected by the Trust being unable to provide evidence of providing direct support for staff living with obesity, asthma, diabetes, and COPD. Relevant support information will be made available on the intranet and peer to peer support offered through the Disability and LHC staff network. There are a lot of services that provide support to staff experiencing bullying, harassment, and abuse, including a Freedom to Speak Up Guardian function. There is an opportunity for improved equality and diversity monitoring to better understand disparities for each of the nine protected characteristics under the Equality Act and to ensure that health and wellbeing services are accessed by those who may be affected by health inequalities.

Domain 3: Inclusive Leadership

The EDS process has highlighted that the Trust would benefit from a more robust EDI governance structure to implement the EDI strategy. Robust EDI and Health Inequalities governance will assist WWL meet its legal and contractual equality and health inequalities obligations. Equality and Health Inequalities is a Key Line of Enquiry for CQC – Well Led Domain. The new EDI Strategy Group chaired by the CEO and EDI workstreams will provide oversight and monitor implementation of key EDI actions.

The implementation of the above actions will be key to improving EDS in 2024/2025 and improving the experience of WWL's staff and patients.

Celebrating EDI across WWL

This year, we continued to celebrate **key annual EDI events,** such as LGBTQIA History Month, Black History Month, International Women's Day, Disability History Month etc.

Part of being actively inclusive and putting allyship into action is increasing your knowledge and understanding of others and the inequities they might face. We created an EDI Learning Toolkit for our staff to help give them a jumping off point in learning about a wide variety of EDI topics. The toolkit contains a variety of recommendations such as videos, tv shows, documentaries, tv shows, podcasts and books on various Equality, Diversity & Inclusion topics such as LGBTQIA+, Race Equality, Disability and Allyship.

WWL has been one of the early adopters of the new Oliver McGowan Mandatory Training on Learning Disability and Autism which is an important learning for our staff to contribute to our duty of care for all our patients. We are the leading Trust in GM to be successfully implementing this training and are working closely with NHS GM and the NHS England Regional Lead to effectively deliver the learning across our WWL workforce.

As in the previous year, we signed up to the Cultural Calendar Club and invited our colleagues to take part in the webinars educating on and celebrating diversity.

At our annual WWL's recognition STAR awards show, our EDI lead, Toria King, won the **Excellence in Equality, Diversity and Inclusion Award** for all the brilliant work she has done in her role to shape and implement the EDI strategy and promote inclusion across the organisation.

We launched our new WWL Welcome Day for all staff this year and have a dedicated section on EDI to explain why diversity and inclusion is important to us as an organisation and how staff can get involved in promoting this.

WWL is proud to have 3 diversity and inclusion staff networks who provide a supportive and welcoming space for colleagues to share their lived experience. Our Staff Networks offer their valuable expertise on matters relating to EDI, ensuring they have a voice in influencing strategies to improve staff experience.

The WWL **For All Minority Ethnicity (FAME) Network** has gone from strength to strength this year and increased its membership by over 100 members and allies during a road show in the spring. The network continues to celebrate cultural diversity and has been involved in international nurse welcome events, policy development group and advising WWL's Executive Team.

True Colours Network is WWL's LGBTQIA+ Network. The True Colours Network is WWL's LGBTQIA+ Network. Members and allies of the network last year successfully headlined Wigan Pride and will continue to have an important presence at this event to celebrate diversity but also to address health inequalities of the LGBTQIA+ community. The network have also helped to shape the trusts policies to support Transgender Staff and our Gender Identity policies.

WWL's Disability and Long-Term Conditions Network have been a major influence on programmes of work to raise awareness of hidden disabilities amongst staff and have held listening events for their members to inform the Trust's wellbeing strategy.

The Year Ahead – EDI Strategy

For our People

This year, our priority remains on creating conditions for inclusive, compassionate culture for all, by developing our leaders in becoming consciously inclusive, making our policies and processes more person-centred and creating more inclusive career development opportunities.

The focus will very much be on embedding EDI into everyday practice, getting governance structures right, and empowering divisional leads to lead on EDI improvement in their areas. The Trust is in a stronger place by having an EDI Strategy Group and workstreams to help deliver key actions that aim to improve staff experience and key EDI indicators associated with:

- Bullying and Harassment
- Inclusive Recruitment
- Health Inequalities
- Pay gap disparities
- Reasonable Adjustments
- Supporting global majority colleagues
- Working in partnership with our patients and communities

We continue to take actions to make EDI core business of the organisation in 2024/25, including:

1. Becoming intentionally anti-racist: Creating a Cultural Development Plan to support our multi-ethnic staff, ensuring their employment experience provides a sense of belonging and inclusion and eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur
2. Participation in the National NHSE Chief Nursing Officer 90 Global Challenge programme to provide focussed support for multi-ethnic colleagues
3. Refreshing our wellbeing policy and supporting our disabled colleagues to stay well at work through activities that improve the implementation of health adjustments
4. Roll-out of Active Bystander Training to empower our staff to challenge poor behaviours and role-modelling our values
5. Implementing the 10 Sexual Safety commitments by introducing new policy and processes for sexual misconduct
6. Self-assessment against the NHS England Civility and Respect Framework and development of culture change action plan, including developing a new core leadership development programme for all leaders to build capability around inclusive, compassionate leadership

This year's EDI action plans aim to improve our continued areas of focus, particularly around creating an inclusive culture free from bullying and harassment and working towards more inclusive policies and processes which allow for all staff to feel they belong and have equally positive experience at work and opportunities to develop or progress in our organisation. In line with what staff have told us would make the biggest difference to them, we plan on focusing on empowering staff to speak up and challenge unprofessional behavior in a respectful way and providing education and shared learning for our leaders to role model compassionate and inclusive leadership. We will also continue to prioritize improving inclusive recruitment processes and career development opportunities.

We will also continue to work with our staff inclusion networks to help them grow and thrive. We want our colleagues to feel valued and their voiced being heard through the networks. This will be achieved by creating engaging, inclusive network events throughout the year with growing

membership and wide attendance from staff across our organisation. We will also introduce new processes ensuring that any strategic initiative impacting our staff will include an engagement with the networks to understand any impact on protected groups.

To further develop our awareness on EDI and to advance the EDI agenda, we have signed up to the Diversity in Health and Care Partners Programme 2024, run by NHS Employers. Underpinned by the three principles of leadership, accountability and equity, the programme is designed as a year-long series of events to support the implementation of the People Plan to look after our people and creating a sense of belonging for all. It will support our ambition to deliver the NHS EDI Improvement plan and create sustainable inclusion practices across the organisation.

The EDI action plans will be implemented through the EDI people and patient workstreams overseen by the EDI Strategy Group.

For our Patients

In 2024/25 the Trust will continue to embed and integrate the EDS2022 in terms of both service provision for patients and employment practice for staff. In line with the requirements of EDS2022, the Trust will aim to continuously improve services for all service users and especially those that are categorised as having protected characteristics and underrepresented groups. This will be done in partnership with staff, service users and local interest groups.

We will continue to work in partnership with staff and patients. For staff, this means continuing to raise awareness of initiatives and engaging with protected groups to ensure that all staff feel valued, respected and able to progress through the organisation. It also means the opportunity to share and build on areas of good practice whilst addressing areas for development. For patients and carers, this means being able to access our services, receive care and support and be treated with respect and dignity. We will actively recruit Lived Experience Partners who are reflective of our local communities' needs, to work with our staff to drive forward service user quality improvements.

We recognise that people in our community have different needs and qualities. Understanding the diversity and needs of our local population can help us to plan and deliver services better. To achieve this we need to engage with our communities to better understand their needs based on their protected characteristics. We recognise the importance of equality monitoring. Data enables us to identify if any patients with a protected characteristic are facing any barriers to healthcare.

We will review the Trust's approach to providing reasonable adjustments for service users. We will develop and implement an action plan to ensure reasonable adjustments for service users are embedded within service delivery, as business as usual. We recognise the importance of making reasonable adjustments to ensure everyone, including those with disabilities or special needs can access and benefit from services. We will implement the requirements of NHS England's Reasonable Adjustments Digital Flag Information Standard incorporating any outstanding action requirements of the Accessible Information Standard (AIS). Although many controls have now been implemented to demonstrate compliance with the Accessible Information Standard (AIS), currently there is no consistent approach Trust wide (across all standalone systems). Patients could have their information and communication needs met for some services, but not for others. During 2024-2025, we will continue to integrate national standard requirements into the Trust's IT systems to support patients and service users in accessing care services appropriate to their needs.

We are committed to tackling health inequalities and understand that some groups of people, including protected characteristic groups, experience different access, experience, and outcomes when they use NHS services. We will continue to undertake Equality Impact Assessments (EIAs) to help us to understand how our policies and services may affect different groups of people. We will continue to pursue the culture of EIAs, educating staff and raising awareness.

We will review the effectiveness of our interpretation and translation services to ensure that service users can be communicated with appropriately and effectively as timely as possible. The fundamental and unprecedented combined effects of COVID 19 and the cost of living crisis has had an impact across the entire interpretation industry around the national availability of linguists, especially those who traditionally provided face to face services. We will implement an improvement plan to increase fulfilment rates and efficiencies. We will review the implementation of additional interpreting methods, including the pilot of video remote interpreting within targeted services.

Diversity Demographic Data

Having a clear profile of our staff and patients helps to advance equality of opportunity and meet the needs of our patients and staff in designing our services and employment practice.

Workforce:

Workforce data is collected routinely by the Trust:

- Age
- Disability
- Ethnicity
- Sex
- Marital Status
- Maternity
- Religion & Belief
- Sexual Orientation

In terms of workforce data, we have reviewed the data which is available to us with regards to age, disability, ethnicity, sex, marital status, maternity, religion & belief and sexual orientation. Other than in respect of Recruitment and Selection statistics, the Trust does not hold workforce data on gender reassignment

Summary of Headline Data:

- **83.6% of the workforce is of White Ethnicity**. This figure remains slightly lower than the Wigan borough figure of 95%. 14.7% of the workforce profile is from Black and Minority Ethnic Groups, with 6.3% of Trust Board being BAME, this is over representative of the Wigan population.
- **The split between staff aged under 50 and over 50 has remained static.**
- **4.2% of the workforce declared they are living with a disability**. This is under representative of the Wigan population (20%). Trust representation has increased slightly compared to the 2023 figure (3.7%). Undeclared rates are gradually decreasing from 19.1% to 17.4%.
- **The workforce profile remains predominantly female at 81%** whereas the local population is 51% female. However, this is in keeping with the gender profile of the healthcare profession in general and the NHS in particular.

- **Almost 59% of staff who have disclosed their religion and belief and describe themselves as Christian compared to 2021 Census Wigan borough figure of 63%.** 19% of Trust staff have not disclosed their religion and belief, a slight decrease compared to the previous year at 21%.

- **82% of staff describe themselves as heterosexual.** However, 15.7% of staff have not disclosed their sexual orientation, this is slightly less than last year's rate of 18%

See Appendix 2 for Full Details.

Service Users (Patients)

The Trust has historically only had very limited information on the protected characteristics of the people who use our services. As a consequence, it can be difficult for us to determine the extent to which we are providing services which are responsive to individual needs. The following patient demographics are collected routinely by the Trust:

- Age
- Sex
- Ethnicity
- Religion and Belief

For the purposes of this report, we have reviewed the data which is available to us in terms of age, sex, ethnicity and religion and belief, along with local data and reports. Where we do not have sufficient data in terms of disability, sexual orientation, marriage and civil partnership and transgender, we have used regional or national data as an estimate.

Summary of Headline Data:

- The population of England and Wales has increased by more than 3.5 million in the 10 years leading up to Census 2021. **In Wigan, the population size has increased by 3.6%, from around 317,800 in 2011 to 329,300 in 2021.** This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.
- **Overall picture of WWL patient service access continues to reflect broad similarity to local demographics** (Census 2021 Wigan Borough statistics).
- **Over last 12 months, 1% decrease in total in-patients/out-patients of British White ethnicity. 0.5% increase in patients of Black and Minority Ethnic (BAME) backgrounds. 88% British White / 6% BAME. No statistical significance reported.** 0.8% increase in those not stated (6.6%). Over last 13 years steady increase in BAME activity 2011/12: 2.9% / 2023/24: 5.7%.
- Ethnicity overall reflective of local population – Census 2021 Wigan Borough data reported that 95% of the local population were of British White ethnicity, 5% from other Black and Minority ethnic backgrounds. Asian people were the largest minority group in Wigan accounting for 1.8% of the population. 3,907 or 1% (3907) of the Wigan population are black. In England, in comparison the proportion of the population that is white is 81%, 10% Asian and 4% Black,
- **Over last 13 years, steady increase in % of patients of Black and Minority ethnicity attending A&E**. 2011/12: BAME 2.7%. 2023/24: BAME 10.1%.
- Higher % of Black and Minority Ethnic Groups using maternity services in comparison with overall out-patient / in-patient activity. Data historical – British White 80% / BAME 18% / 2% not stated. Data in line with growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.

- **In Wigan, the % of people who did not identify with at least one UK national identity increased from 2.2% in 2011 to 4.1% in 2021.** During the same period, the % increased from 5.4% to 9.5% in Bolton. Although figures are lower in Wigan, the borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years.

- **The top languages interpreted during 2022/23 were:** British Sign Language; Kurdish Sorani; Arabic, Romanian, Farsi, Polish, Urdu, Russian, Pashto, Portuguese, Cantonese

- **As with most healthcare services in the UK, women are more likely to use hospital services than men** – 58% of out-patients during the last 12 months were female.

- **The population has continued to age.** Census 2021 results reported 19.3% of residents were aged 65 years and over (16.3% a decade earlier). The proportion of Wigan residents aged 65+ was higher than the national average (18.6%) with Wigan also experiencing a higher rate of growth over the last decade (23%) compared to the national average (20%) Maintaining the health and resilience of older people is important both for the individuals themselves and in ensuring the sustainability of local health and adult social care services. The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs. During 2023/24 38% of patients accessing WWL services were aged 65 years and over. 42% aged 31-64 years.

- **Wigan Census 2021 showed that 20.2% of Wigan residents are living with a limiting long-term illness, health problems or disability** – higher than the national average 18%. 1 in 6 (16%) of the local population are living with hearing loss (60,500 residents). 10,500 Wigan Residents are estimated to be living with sight loss. Figures are expected to rise over the next 10 years.

- **Census 2021 data reported over 74,000 people in Wigan who have been diagnosed with a long-term condition. Long-term conditions or chronic diseases are conditions that currently have no cure, and are managed with drugs and other treatment**, for example diabetes, COPD, asthma, pulmonary disease, arthritis, and hypertension.

- **ONS data shows 6,773 people in Wigan identified as a sexual orientation other than heterosexual when the Census was undertaken in March 2021 (2.5% of respondents).** The most common LGB+ sexualities were gay or lesbian (57%) and bi sexual (35%). Data on sexual orientation is limited to those who responded, so data is expected to be higher. 84,983 people living in Greater Manchester do not identify as heterosexual (3.8% of the population aged 16 and over).

- **Census 2021 reported that 95% of resident's gender identity was the same as registered at birth.** 11,946 residents did not respond; 470 resident's gender identity was different from sex registered at birth; 372 residents identified as trans man/trans woman; 66 residents identified as non binary; and 57 residents identified as other gender identities. Data on gender identity is still currently limited, although data collection methodology and question design are developing. **Despite laws and attitudes towards people who identify as LGBTQI+ changing significantly in even just the last decade, discrimination remains. Research evidence demonstrates that LGBTQI+ people experience significant health inequalities in terms of health outcomes, health care service provision and health risk factors in comparison to cis-heterosexual populations.**

- **Levels of deprivation in Wigan are significantly worse than the England average.**

Within most deprived 20% in UK. People living in the most-deprived areas of Wigan have a life expectancy nearly a decade shorter than the least-deprived areas.

See Appendix 3 for Full Details.

Appendix 1 – Organisational Anti-Racist Statement

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) has recently published its Anti-Racist Organisation Statement, which you can find below, as part of its commitment to anti-racism and opposing all forms of discrimination.

WWL opposes all forms of racism and is committed to becoming an anti-racist organisation. We acknowledge that institutional racism exists in the NHS, our Trust and society at large. We are committed to providing a workplace where everyone is safe and protected from the harm caused by racism and feel a real sense of belonging. We will do this by adopting an explicitly anti-racist approach. Our work tackling racial inequalities is intertwined with tackling health inequalities and associated issues which disproportionately impact on people from black and minority ethnic communities.

In becoming an anti-racist organisation, we will take a number of steps, including, but not limited to:

Following engagement, launching our shared WWL values which will become the foundation of our culture and enable us to create a place to work and receive care that is diverse and inclusive, where everyone feels valued and supported, and a sense of belonging regardless of their race, ethnicity, or background
Strengthening the voice of our Staff Networks (FAME, True Colours and Disability and Long-Term Health Conditions) who work tirelessly to support our colleagues with protected characteristics
Providing specific and targeted support to our Internationally Educated Staff
Establishing an Equality, Diversity and Inclusion (EDI) Steering Group chaired by our Chief Executive, ensuring that senior leaders in our organisation have direct feedback in relation to our progress, providing strong and visible leadership to move forward with the improvements required
As we embark on this journey we will use the North West BAME Assembly Anti-Racist Framework to guide us and adopt strong partnerships with our FAME Staff Network, specifically to provide feedback on our progress. We will continue to monitor progress via the outcomes of our Workforce Race Equality Standard and other national tools which support us to help us in tackling race inequalities.

This pledge is a call to action for all of our WWL colleagues to join us and consider how you can become anti-racist and what actions you will take today to ensure everyone in our workforce feels valued, respected and welcome.

Speaking on WWL's Anti-Racist Organisation Statement, Jules Tait, WWL's Chief People Officer said: "The NHS is built on a founding principle of equality and social justice. It is clear from the evidence we have that our black and minority ethnic colleagues have experienced inequalities in the form of discrimination. We also know that people from black and minority ethnic communities have had negative experiences in terms of access and outcomes. It is essential that as an organisation we show our commitment to opposing all forms of racism and discrimination. "

“Through publishing our Anti-Racist Organisation Statement we are demonstrating this commitment and also showing how we will continue to tackle racism moving forward. We can no longer simply be not racist; we will be actively and visibly anti-racist.

“I would like to thank all my colleagues across the Trust who have contributed to putting together our Anti-Racist Organisation Statement and I’m really excited to see how this will be implemented across the Trust.”

WWL’s Workforce EDI Lead, Tim Brown added his thoughts on the importance of publishing this statement commenting: “At WWL we recognise that institutional racism exists in our Trust and the wider NHS. The latest NHS Staff Survey results show that there has been an improvement in the percentage of staff from Black and Minority Ethnic backgrounds reporting experiences of discrimination, however the percentage of staff from Black and Minority Ethnic backgrounds experiencing discrimination is still higher compared to white staff and compared to similar NHS Trusts.

“The statement can be a catalyst for creating safe spaces at WWL where racism is spoken about routinely with the aim to improve understanding of its impact on individuals, teams, and the Trust. The insights from engaging with staff with lived experience of discrimination can help co-produce a behavioural framework, which will introduce expectations of behaviour regarding race and the consequences of breaching them.

“WWL will explore opportunities to create an early reporting system that flags up issues of discrimination and provides opportunities for intervention. This will improve staff and patient experience at WWL.”

Tulika Sugandha, Chair of WWL’s For All Minority Ethnic (FAME) Network also added: “As the Chair of WWL’s FAME Network I am delighted to see the publication of the Trust’s Anti-Racist Organisation Statement.

“Through publishing this statement, we are able to show, in tangible ways, how we will continue to fight racism throughout the organisation.

“The statement also helps us to show all patients and all staff, both future and present, that we welcome everyone and are committed to making WWL a place where everyone is welcome.”

If you would like to learn more on what it means to be anti-racist there is a very useful video which explains this on the BBC Bitesize website. You can find the video here.

Appendix 2 – Headline Data

Our People (Workforce)

Age

As at 31 March 2024 WWL Trust staff breakdown was:

62% Age 50 or under **38%** Age 51 +

The proportion of staff in each age bracket has remained the same compared to last year.

Performance management and Disciplinary cases were representative of the Trust's age breakdown

Marriage and Civil Partnership

As at 31 March 2024

53% of staff were **Married**

2% were in a **Civil Partnership**

34% single, 7% divorced / legally separated, 1% widowed, 3% unknown.

Figures have remained relatively static over a period of several years.

Disability

As at 31 March 2024

4.2% of the Workforce have declared that they are living with a disability.

This has increased slightly compared to the 2023 figure (3.7%) although there is still a large amount of undeclared data 17.4% this has decreased over the previous years: 2023: 19.1%, 2022: 21.7%, 2021: 26.6%.

For Non-Clinical Staff there is an under representation of disabled staff in bands 8d and above. There is over representation of disabled staff in band 1.

For Clinical Staff there is an under representation of disabled staff particularly in Band 8c and in Medical & Dental.

Pregnancy and Maternity

As at 31 March 2024, a snap shot from the Electronic Staff Record indicated that:

2.71% of female staff were on **Maternity Leave**

This is comparable to the previous two years.

Religion and Belief

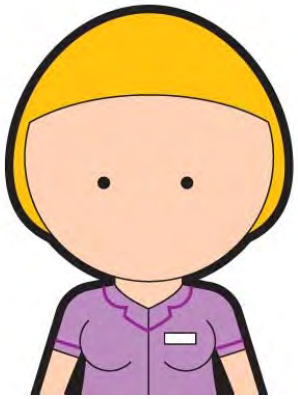
As at 31 March 2024

59% Christian **8%** Other **19%** Unknown

Remaining staff split across a range of religions and beliefs with the highest number being in Atheism category (8%).

A significant proportion of staff have not declared their religion and belief although this is down slightly from last year.
(2021 Census, The Wigan borough figure for Christianity is 63%)

Sexual Orientation



Workforce as at 31 March 2024:

82% Heterosexual
1.4% Gay or Lesbian
0.8% Bisexual
0.1% Other

15.7% did not wish to disclose
(a slight decrease from last year's 18%)

There is comparable representation of gay, lesbian or bisexual staff across AFC bands except from 8c and above.

Ethnicity

As at 31 March 2024:

83.6% of Staff of White Ethnicity
(2021 Census, Wigan Borough White representation is 95%)

14.7% of Staff from Black & Minority Ethnic Groups
1.8% Not Stated

6.3% of the Trust Board membership is BME.

28.6% of **Performance** cases were in respect of BAME staff members which is over representative of the workforce profile.

10.3% of **Disciplinary** cases were in respect of BAME staff members which is slightly below the workforce

Sex

Workforce as at 31 March 2024:
81% Female
19% Male
(2021 Census, 51% female / 49% male within Wigan population)

Gender Reassignment

Transgender information for current staff is not recorded on ESR so we cannot therefore undertake workforce profile monitoring at present.

28% of disciplinary cases were against male staff. Historically disciplinary cases have been over representative of male staff members, however this has decreased significantly over the last few years.

Appendix 3 – Headline Data on Service Users/Patients

Our Service Users (Patients)

Ethnicity (Out-Patients & In-Patients)

During 2023/24

87.7% of Patients of British White Ethnicity

5.7% of Patients from Black & Minority Ethnic Groups (BAME)

6.6% Not Stated

During last 12 months, 1% decrease in patients of British White Ethnicity. 0.5% increase in patients of Black & Minority Ethnic Origin. 0.8% increase in those not stated.

Over last 13 years steady increase in BAME activity 2011/12: 2.9% / 2023/24: 5.7%.

Ethnicity (Accident & Emergency)

During 2023/24

88.3% of Patients of British White Ethnicity

10.1% of Patients from Black & Minority Ethnic Groups (BAME)

1.6% Not Known

During last 12 months, 0.9 decrease in patients of British White Ethnicity. 1.2% increase in patients of BAME Origin.

Over last 13 years steady increase in BAME activity in A&E. 2011/12: 2.7% / 2023/24: 10.1%

Ethnicity overall reflective of local population – Census 2021 Wigan Borough data reported that 95% of the local population were of British White Ethnicity, followed by the Asian ethnic group 2%, mixed multiple ethnic groups 1%, Black 1% and Other 1%.

In England more broadly the portion of the population that is white is 81%. 10% are Asian and 4% are Black.

Ethnicity (Maternity Admissions)

During 2023/24

80% of Patients of British White Ethnicity

18% of Patients from Black & Minority Ethnic Groups

2% Not Known

Higher % of Black and Minority Ethnic Groups using maternity services than overall out-patient / in-patient activity. Data in line with significant growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.

Interpreter & Translation Services

During last 12 months: 3% decrease in patients of British White Ethnicity. 2.5% increase in patients of Black and Minority Ethnic Backgrounds. During last 13 years: 13% decrease in patients of British White Ethnicity. 12% increase in patients of Black and Minority Ethnic Backgrounds. **2011/12: 6.3% BAME/ 2023/24: 18% BAME**

During 2023/24
Top Languages Requested

British Sign Language; Kurdish Sorani; Arabic, Romanian, Farsi, Polish, Urdu, Russian, Pashto, Portuguese, Cantonese

During 2023/24:

36 Translations into other languages
3 Other formats - Braille Translations requested
This will continue to increase with the implementation of the Accessible Information Standard

Ethnic Population in Greater Manchester

In Wigan, the percentage of people who did not identify with at least one UK national identity increased from 2.2% in 2011 to 4.1% in 2021. During the same period, the % increased from 5.4% to 9.5% in Bolton. In 2021, over 95% of the population was White British. This compares to just under 80% in England as a whole. Although figures are lower in Wigan, the borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years.

Ethnic minority populations living in Wigan include Long-term resident ethnic minority population and asylum seekers and refugees, migrants, Gypsies and Travellers, European Roma and Overseas students. Although the numbers are small compared to the size of the total population and some only stay for a short period of time, some will have specific health needs that need to be addressed.

Local Authority (Census 2021)	White British	Mixed	Asian or Asian British	Black or Black British	Other
Wigan	95%	1%	2%	1%	1%
Bolton	71.9%	2.2%	20.1%	3.8%	1.9%
Salford	82.3%	3.1%	5.5%	6.1%	2.9%
Manchester	56.8%	5.3%	20.9%	11.9%	5.1%
Oldham	68.1%	2.5%	24.6%	3.4%	1.4%

2021Census Wigan Borough figures: 51% of the local population female

Sex (Out-Patients)

During 2023/24
58% Female
42% Male

As with most healthcare services in the UK, women are more likely to use hospital services than men.

Age

During 2023/24
% of patients accessing hospitals services

9% Under 18 **11%** 18-30 Years
42% 31-64 Years **38%** 65+ Years

1 in 6 residents in Wigan are now aged over 65 years.

Set to increase over the next 20 years

Age overall reflective of local population – Wigan Census 2021 reported 19.3% of residents were aged 65 years and over (16.3% a decade earlier). **The proportion of Wigan residents aged 65+ was higher than the national average (20%)**

Religion and Belief

Maintaining the health and resilience of older people is important both for the individuals themselves and in ensuring the sustainability of local health and adult social care services.

The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs.

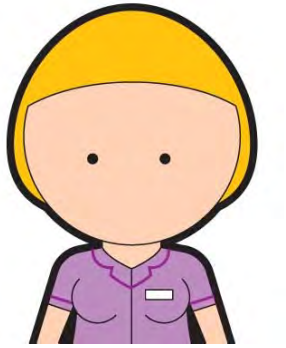
During 2023/24
% of patients accessing out-patient services

64% Christian **21%** Unknown
14% None **0.2%** Hindu
0.6% Muslim **0.2%** Atheist
0.1% Buddhist **0.2%** Islam
0.1% Jewish **0.0%** Unitarian
0.1% Spiritualist

Religion overall reflective of local population – 2021 Census Wigan Borough figure reported that 63% of the population were of Christian Belief

Trust Data affected by the high proportion of religion not known (140,258 patients).

Sexual Orientation and Gender Identity



Census 2021 Data

6,773 Wigan Residents (2.5%) identified as a sexual orientation other than heterosexual.

Most common LGB+ sexualities were gay or lesbian (57.4%) and bisexual (35.2%)

Data on sexual orientation is limited to those who responded, so data is expected to be higher.

Census 2021 Data

255,782 Residents (95%) Gender identity is the same sex as registered at birth

11,946 Residents (4.5%) Chose not to answer

470 Residents Gender identity different from sex registered at birth (no specific identity given)

216 Residents Trans man

156 Residents Trans woman

66 Residents Non-binary

57 Residents All other gender identities

Data on gender identity is still currently limited, although data collection methodology and question design are developing. Despite laws and attitudes towards people who identify as LGBTQI+ changing significantly in even just the last decade, discrimination remains. Research evidence demonstrates that lesbian, gay, bisexual, and trans (LGBTQI+) people experience significant health inequalities in terms of health outcomes, health care service provision and health risk factors in comparison to cis-heterosexual populations.

84,983 people living in Greater Manchester do not identify as heterosexual (3.8% of the population aged 16 and over)

In response to national research, NHS England is spearheading a collective drive to improve the experience of trans and non-binary people when accessing health and care services.

Disability

Wigan Census 2021 showed that 20.2% of Wigan residents are living with a limiting long-term illness, health problems or disability – higher than the national average 18%.

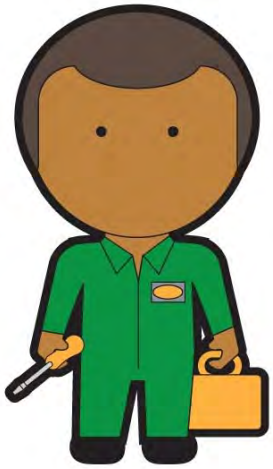
The Royal National Institute for Deaf People (RNID) estimates that

1 in 6 (16%) of the population are living with hearing loss.

60,500 Wigan Residents (RNID, 2020a).

Improving Health & Lives (IHAL) estimate that

1.9% (6,170 residents) have learning disabilities.



Royal National Institute for Blind People estimates that

10,500 of Wigan Residents are living with sight loss (**1,730** registered blind or partially sighted)

By 2032, figures are expected to rise to

12,600 of Wigan Residents living with sight loss

1 in 5 people will start to live with sight loss in their life time / Every day **250 people** start to lose their sight (UK Stats)

The Accessible Information Standard

A law to ensure that people who have a disability, impairment or sensory loss are given information they can easily read or understand. Making information easier to understand for people living with communication and information needs.

WWL is committed to working towards meeting the core requirements of the Standard for everyone we serve.

Patients with disabilities often report barriers to using health services, in terms of transport difficulties, distance and needing someone to accompany them. Poor communication leads to non-attendance for appointments. These are issues currently being reviewed within Wigan Borough Locality Plan.

Census 2021 Wigan Borough reported

20% of Wigan Residents living with a limiting long-term illness, health problems or disability which limits daily activities at work.

Higher than national average 18%

The 5 most common conditions which account for 54% of DLA Claims

Arthritis; Learning Disabilities; Heart Disease; Disease of muscles, bones & joints; Hyperkinetic syndromes

1 in 4 people experience a mental health problem during their life. Having a long-term condition increases the risk that an individual will have a mental health.

The number of people who are at risk of having poor mental wellbeing in Wigan is high because of the high levels of deprivation.

Marriage and Civil Partnership (aged 16 and over)

Census 2021 Wigan Borough reported

43.8% Wigan Residents are **Married or in a registered Civil Partnership**

37.2% Wigan Residents have **never been Married or in a registered Civil Partnership**

386 Wigan Residents are or have been in a **Registered Civil Partnership (opposite sex and same sex), this includes 219 people currently in a same sex civil partnership. 625 were in a same sex marriage.**

Complaints

501 Complaints Received during 2023/24

278 Female **223** Male **0** Unknown

473 British White Ethnicity

12 Black & Minority Ethnic Background

16 Not Stated

61% Aged 50 years or above

5 Main Subject Complaints

- Clinical treatment
- Communications
- Patient Care
- Admissions and Discharges
- Value and Behaviour

No trends in relation to protected characteristics noted

Wigan Borough Population

The population of England and Wales has increased by more than 3.5 million in the 10 years leading up to Census 2021.

In Wigan, the population size has increased by 3.6%, from around 317,800 in 2011 to 329,300 in 2021. This is lower than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.

In 2021, Wigan ranked 31st for total population out of 309 local authority areas in England, which is a fall of six places in a decade.

As part of the 2021 census, households in England and Wales were classified in terms of four different "dimensions of deprivation"; based on unemployment, health, education, and type of dwelling. Analysis from the Office for National Statistics recorded that 53.4% of households in Wigan and Leigh were classed as being deprived.

At 3.6% increase, Wigan's population is lower than the increase for the North West (5.2%)

Levels of deprivation in Wigan significantly worse than England average.

Within most deprived 20% in UK.

People living in the most-deprived areas have a life expectancy nearly a decade shorter than the least-deprived areas.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	GOSWH Quarterly Report (Oct- Dec 2024) Quarter 3
Presented to:	Board of Directors
Date of paper:	05 February 2025
Item purpose:	Information
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Executive summary

For the period Oct-Dec 2024 (Quarter 3), there have been:

- 84 exception reports submitted by 30 doctors (103 ERs & 38 doctors respectively for Q2).
- 55 hours and 26 minutes of overtime claimed (63h 5min for Q2).
- 66% submitted by FY1 doctors and 24% submitted by FY2 doctors (63% FY1; 28% FY2 for Q2).
- General Surgery (38%) had the most exception reports followed by General Medicine (27%); (40% for Q2).
- The main reasons for exception reported for overtime included: completing jobs, ward workload, unwell patient, missed breaks and staffing shortages.
- 4 Immediate Safety Concerns (ISCs): (5 ISCs in Q2).
- 14 Breaches: 14 fines to be levied (14 breaches in Q2).
- £437.88 to be added to the Guardian Pot for this period.

There has been a slight decrease in the number of exception reports for this period (84) as opposed to 103 ERs for Q2. The top 3 specialities for the highest number of Exception reports included General Surgery (38% Q3 vs 28% Q2), General Medicine (32% Q3 vs 40% Q2) and Trauma and Orthopaedics (19% Q3 vs 21% Q2).
There is the continued trend of FY1s submitting the most exception reports. There has also been an improvement in the number of exception reports submitted in General medicine.
There has been a similar number of Immediate Safety Concerns (4 Q3 vs 5 Q2) and breaches (14 for both Q3 and Q2).

Link to strategy and corporate objectives

The safety of patients is a paramount concern for the Trust. The well-being of staff is also important to the trust with 'People at the Heart' being one of the Trust's values. Significant staff fatigue is a

hazard both to patients and to the staff themselves. The safeguards around working hours of resident doctors are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured.

Financial implications
Fines are levied against the Trust when working hours breach specific conditions outlined in the 2016 Terms and Conditions of Service.

Legal implications
Exception Reports were introduced in the 2016 Resident Doctors' contract. The GOSWH monitors the working hours of resident doctors through exception reports. Exception reports could be submitted by residents whose working hours or patterns deviate from their work schedules. Where exceptions form a pattern, steps should be taken to prevent recurrences. The GOSWH oversees the safety of resident doctors working and provides assurance in the system of exception reporting and rest monitoring.

People implications
Resident doctors are a vital part of the Trust's workforce. It is important that they are sufficiently rested as it impacts safe and quality patient care and resident doctor well-being. Resident doctors require educational opportunities that enable them to learn and progress.
There was an end to the resident doctor strikes in September 2024 with the acceptance of the new pay deal. There was also a change in the BMA communications introducing the term 'resident doctors' in their references to junior doctors. There is also a wider focus on the well-being of the resident doctors.

Wider implications
Resident doctor burnout is associated with increased levels of staff sickness, staff attrition and dissatisfaction with the working environment.

Recommendation(s)
1. The GOSWH Quarterly and Annual Reports will be presented to LNC, JDF, TMEC and People's Committee. It will also be shared with the departmental leads who will consider the implications for their department and staff.
2. Each speciality/area to be represented at the JDF by at least 1 resident doctor. The GOSWH will liaise with the medical education department and rota coordinators for each area.
3. Trauma and Orthopaedics, Medicine and Surgery- to be cognisant of reports of missed breaks and to encourage the residents in these areas to take their breaks.
4. Teams to investigate any exception reports highlighting lack of senior support when contacted by the GOSWH.

5. Introduction

This is the third Quarterly report for the financial year 2024/2025, based on a national template, by the Guardian of Safe Working. THE GOSW's primary responsibility is to act as the champion of safe working hours for resident doctors and to provide assurance to the Trust that they are safely rostered and that their working hours are compliant with the 2016 Terms and Conditions of Service. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. It also highlights missed training opportunities.

6. High Level Data for the Period Oct-Dec 2024

Total number of doctors/dentists in training on 2016 TCS: 199
Total number of Full-time doctors/dentists in training: 152
Total number of Less than Full-Time doctors/dentists in training: 48
Total number of locally employed junior doctors: 110
International Training Fellows: 31.
Amount of time available for the Guardian to do the role per week: 4 hours.
Administrative support provided to the Guardian per week: 3 hours.
Amount of job planned time for Educational Supervisors: 0.25 PA.

7. Exception Reports- Quarter 3 (Oct-Dec 2024)

Quarter 3 (Oct-Dec 2024)	**Quarter 2 (Jul-Sept 2024)**
Total number of ERs: 84	**103**
Breach Type	
Hours/Overtime: 69	**86**
Educational: 6	**6**
Service support: 2	**5**
Pattern: 7	**6**

The number of doctors who engaged with Exception Reporting for Q3: 30 doctors (15% of resident doctors in the Trust) generated 84 exception reports (Q2: 38 doctors, 23%, generated 103 exception reports in Q2)
Number reported as an Immediate Safety Concern: 4 (5 in Q2)
Total number of work schedule reviews: 0
14 Breaches this quarter (14 in Q2): 3 General Medicine, 5 General Surgery, 5 Trauma & Orthopaedics and 1 Paediatrics.

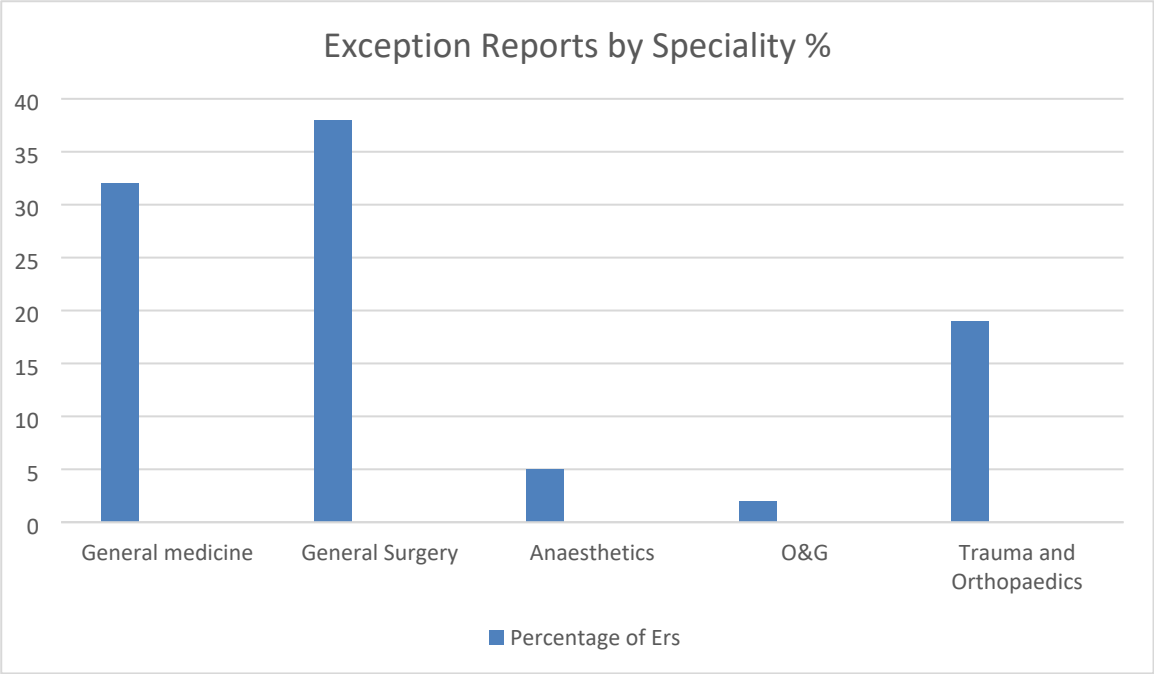
7.1 Exception Reporting by Speciality:

Quarter 3 (Oct-Dec 2024)

General Medicine- 32% (27)
General Surgery- 38% (32)
Paediatrics- 1% (1)
Obs & Gynae- 2% (2)
A&E- 1% (1)
General Practice- 0
Trauma and Orthopaedics- 19% (16)
Geriatric Medicine- 0
Cardiology- 0
Urology- 1% (1)
Anaesthetics- 5% (4)

Quarter 2 (Jul- Sept 2024)

General Medicine- 40% (41)
General Surgery- 28% (29)
Paediatrics- 2% (2)
Obs & Gynae - 0
A&E- 2% (2)
General Practice 1% (1)
Trauma and Orthopaedics 21% (22)
Geriatric Medicine- 1% (1)
Cardiology- 1% (1)
Urology- 4% (4)



The top 3 specialities generating the highest number of exception reports included: General Surgery (38%), General Medicine (32%) and Trauma and Orthopaedics (19%). There has been a significant decrease in the number of General Medicine ERs and a rise in the number of General Surgery ERs.

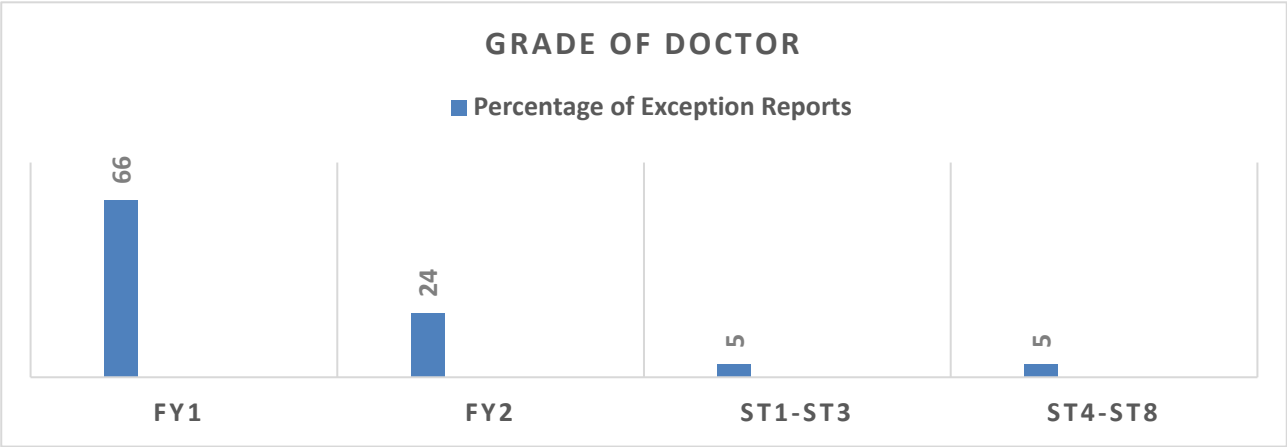
7.2 Exception Reports by Doctor's Grade

Quarter 3 (Oct-Dec 2024)

Foundation Year 1- 66% (56)
Foundation Year 2- 24% (20)
Specialist Trainee 1- ST3- 5% (4)
ST4-ST8- 5% (4)

Quarter 2 (Jul-Sept 2024) (103 ERs)

Foundation Year 1- 63% (65)
Foundation Year 2- 28% (29)
Specialist Trainee 1- ST3- 7% (7)
ST 4-ST8- 2% (2)

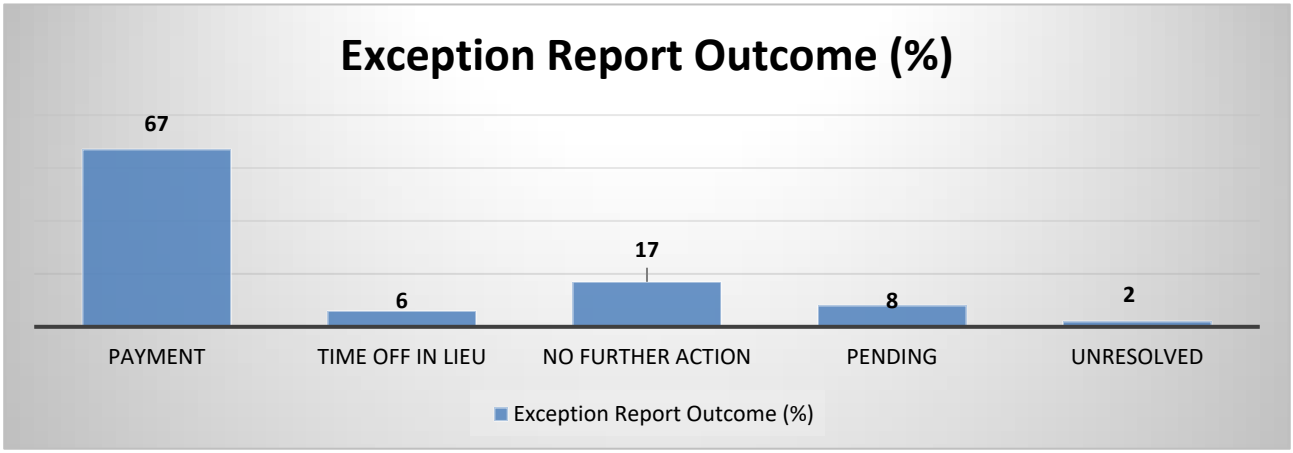


FY1 doctors continue to submit the most ERs.

7.3 Exception Report Outcomes

Payment- 67% (56)
Time off in Lieu- 6% (5)
No further Action- 17% (14)- mostly ERs highlighting missed breaks

Unresolved/ Submitted in error- 2% (2)
Pending- 8% (7)



Total number of overtime hours claimed:

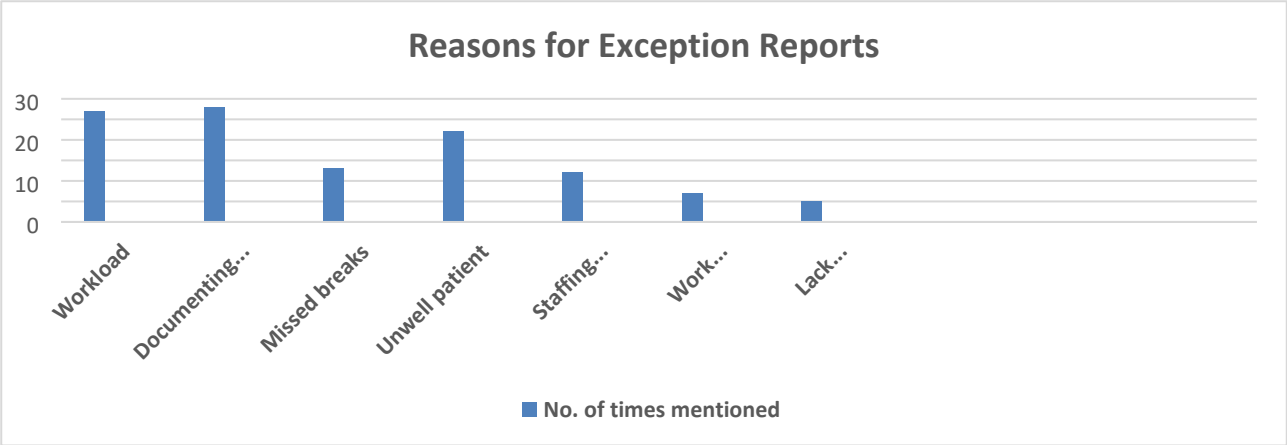
- Extra normal hours: 42 hours 5 minutes (55 h in Q2)
- Extra premium hours: 13 hours 16 minutes (8 h 5 min in Q2)
- Total 55 hours 26 minutes (63 h 5 min in Q2)

On average doctors were working an extra 8.5 minutes per week per doctor (7.7 min in Q2).

7.4 Reasons for Exception Reports in this period (very similar to Q2)

Please note that one exception report might have highlighted more than one reason. There is an ongoing concern about missed breaks. The number in brackets refers to the number of exception reports in which the reason was mentioned.

- Documenting/Completing jobs- (28)
- Workload- (27)
- Unwell patient/Emergency- (22)
- Missed breaks- (13)
- Staffing shortages- (12)
- Issue with work schedule. It says 8-4 PM when shift is 8-5 PM- (7)
- Lack of senior support; ward round finished late-(5)
- 13-hour Anaesthetic shifts; theatre emergencies- (4)
- Late for Grand round; Waiting for registrar reviews; Late handover; Clocks roll back- (3)
- Missed teaching; Unable to take SDT; Patient safety; missed grand round- (2)
- Late consultant; administering infusion; holding 2 bleeps, nurse staffing issue; Induction- (1)



Missed breaks continues to be a concern. Lack of senior support is an emerging theme.

7.5 Immediate Safety Concern

There were 4 ISCs in this quarter: 3 General Medicine and 1 General Surgery. There were 5 ISCs in quarter 2.

1. General medicine FY2- Staffing levels because of annual leave and Induction
2. General medicine FY2- Down a registrar for the night shift
3. General medicine- FY1- No night SHO who FY1 carried both bleeps.
4. General surgery- FY1- Extra 1 hour worked because the clocks rolled back. The doctor reported tiredness during the shift.

"No #5785 on night shift, registrar down meaning member down on crash team overnight and only 1 person clerking, putting patient safety into concern."

"No SHO support on shift"

"working on langtree with Dr. R, below minimum staff when ward staff on AL or induction"

"pushed shift over 13hr limit in context of 64hr + worked within 7 days."

7.6 Breaches that attract Financial Penalty

Fines are levied when working hours breach one or more of the following situations:

i. The 48 hours average working week.
ii. Maximum 72 hours worked within any consecutive period of 168 hours.
iii. Minimum of 11 hours continuous rest between rostered shifts.
iv. Where meal breaks are missed on more than 25% of occasions.
v. The minimum non-residential on call overnight continuous rest of 5 hours between 22.00 – 07.00 hours.
vi. The minimum 8 hours total rest per 24 hours non-resident on call shift
vii. The maximum 13 hours shift length
viii. The minimum 11 hours rest between resident shifts

Breaches for the Period Oct-Dec 2024: Breaches of the Maximum 13-hour shift

- 14 for this quarter 3 (Oct-Dec); 14 for Quarter 2 (Jul-Sept).
- General Medicine- 3
- Trauma and Orthopaedics- 5
- General Surgery-5
- Paediatrics- 1

3.6.1

A proportion of the fine, apart from fines for breaks where payment is 100%, is paid to the Guardian of Safe Working, as specified in the 2016 Terms & Conditions of Service (TCS) (see penalty rates and fines below). The TCS also specifies that the JDF is the body that decides how accrued monies are spent within the framework identified within the TCS.

	Total Value of Penalty	**Hourly Penalty Rate Paid to the Doctor**
Additional hours worked attract a basic rate	X 4 the basic hourly rates	X 1.5 of the basic hourly locum rate
Additional hours worked attract an enhanced (night) rate	X 4 the enhanced hourly rate	X 1.5 of the enhanced hourly locum rate

Breaches and Fines to be Levied for Quarter 3 (Oct-Dec 2024)

Date	Department	Time/min	Doctor £)	Guardian Fund (£)	Total Fine (£)
07/10/2024	Surgery	15	8.16	13.61	21.77
08/10/2024	Surgery	15	8.16	13.61	21.77
10/10/2024	Surgery	30	16.32	27.22	43.54
18/10/2024	Orthopaedics	5	3.15	5.25	8.40
20/10/2024	Orthopaedics	40	25.19	42.00	67.19
24/10/2024	Orthopaedics	10	4.60	7.66	12.26
28/10/2024	Orthopaedics	45	28.34	47.24	75.58
24/10/2024	Medicine	90	67.08	111.80	178.88
26/10/2024	Surgery	30	16.32	27.22	43.54
29/09/2024	Surgery	5	2.72	4.54	7.26
26/10/2024	Medicine	45	20.69	34.48	55.17
10/11/2024	Paediatrics	30	19.00	31.50	50.50
26/10/2024	Medicine	45	20.69	34.48	55.17
24/12/2024	Orthopaedics	30	22.36	37.27	59.63

Total addition to Guardian Fund- £437.88
Total fine to trust- £700.66

7.7 Speciality Specific Trends: Comparison Jul-Sept 2024 (Q2) with Oct-Dec (Q3)

General Medicine- 32% (27 exception reports) 40% in Q2
Workload/ Ward pressures(13); Completing jobs (8); Missed breaks (6); Staffing shortages (5); Unwell patient (4); Late ward round (3); late for Grand Round (2); Clocks roll back (2); Nurse staffing issue (1), Unable to attend grand Round (1); Missed teaching (1); Staff sickness (1); Administering infusion (1); Lack of senior support (1); Holding 2 bleeps (1); Patient safety (1); Induction (1); Emergency 91)
Workload was mentioned in the most ERs, followed by staying late to complete jobs/documentation and missed breaks.
General Surgery- 38% (32 exception reports) 28% in Q2
Unwell patients (12); Completing jobs (10); Ward workload/Ward pressures (10); Issue with work schedule (7); Missed break (4); Emergency (2); Clocks rolled back (1); Late for grand Round (1); Missed SDT (1); Waiting for registrar (1); Missed Grand Round (1); Longer ward round (1); Scrubbed in theatre (1); Late Ward round (1)
Top 3 reasons for ERs were Unwell patients, completing jobs and ward workload.
A&E- 1% (1 exception report)
Unwell patient- emergency trauma call (1)
Anaesthetics-5% (4 exception reports)
13- hour shifts (4)
Trauma and Orthopaedics-19% (16 exception reports) 21% in Q2
Completing jobs (9); Ward workload/pressures (9); Lack of senior support (4); Emergency (4); Missed breaks (3); Unwell patients (2), Registrar late from Wrightington (2); Missed 12 out of 16 teaching sessions (1), On-call pattern affecting ability to take annual leave (1); Ward round finished late; Consultant late.
Top 3 reasons for ERs included: completing jobs, Ward workload, lack of senior support and emergencies.
Ongoing reports of lack of senior support.
Obstetrics and Gynaecology- 2% (2 exception reports)
Assisting with Emergency LSCS (2)
Paediatrics- 1% (1 exception report)
Emergency (1); Documenting (1)
Urology- 1% (1 exception report)
Missed breaks (1)

7.8 Recommendations

1. **GOSWH**
   GOSWH will liaise with the medical education department to get the names of the resident doctor representatives for each area. These representatives will then bring the issues in each area to the JDF.
2. **Trauma and Orthopaedics, General Medicine and General Surgery:**
   Ongoing reports of missed breaks. I would recommend that the resident doctors in these areas are encouraged to take their breaks.
3. **Trauma and Orthopaedics and General Medicine**
   There have been reports of lack of senior support. I will continue to monitor the ERs highlighting this issue. I will continue to contact the teams to highlight and investigate any exception reports that highlight a lack of senior support.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Safeguarding Annual Report 2023-2024

(Forward Plan 2024-2025)

Think Family Safeguarding Service

Contents

Foreword

Welcome to this, the third Wrightington, Wigan and Leigh Teaching Hospital NHS Foundation Trust (WWLTH) Safeguarding Annual Report. For the first time, following the integration of the commissioned Children in Care Health Team into the Think family Safeguarding Service, it incorporates an overview of the activity and performance in relation to Children in Care. This report provides insights into the breadth and quality of safeguarding activity across the Organisation during the period April 2023 to March 2024 whilst demonstrating delivery of statutory, regulatory and commissioning requirements as a measure of overall assurance.

The Think Family Safeguarding Service continues to mature and develop with improvements driven by the WWLTH Safeguarding Strategy 2023-2025 to deliver clear aims aligned to the Trust's Corporate Objectives. This approach ensures that the **4Ps** of **Patients**, **People**, **Performance** and **Partnerships** remain the focus of workstreams where measurable goals can be achieved by utilising the ***Improve***, ***Integrate*** and ***Innovate*** delivery framework in collaboration with our key stakeholders. The opportunity to review and reflect on the previous year promotes a sense of shared responsibility and accountability and this stocktake supports refocus on our safeguarding mission and vision whilst allowing for a refresh and reset of priorities.

Themes and trends in safeguarding remain very similar to those observed in previous reports, particularly in relation to the demands placed on WWLTH practitioners, services, divisions and corporately up to Trust Board level. The commitment however to progress, grow and advance the safeguarding ambition for our patients, staff and community as a whole continues to be strong. Complexity across the safeguarding agenda remains a significant factor in terms of resource and capacity considerations across the Organisation which are similarly experienced by our multi-agency partners. The pressures resulting can often be a barrier to progress however the Trust continues to build on a now solid foundation, shaped by the Think Family Service, to create a culture of continuous improvement integral to ensuring effective arrangements are in place in every service we deliver to safeguard and promote the welfare of children and adults at risk of harm and abuse.

At WWLTH our behaviours and values are important to us and help to underpin the delivery of our strategic ambitions. This approach is very much mirrored when it comes to safeguarding our patients, people and partnerships and promotes consistency, efficiency and equity. Our new Trust Values represent our motivation around safeguarding perfectly and will form the basis for our future priorities as we move forward into 2024 and beyond. Safeguarding is very much centred on the individual therefore our Trust Values of People at Heart, Listen and Involve, and being Kind and respectful encapsulate the essence of *'Making Safeguarding Personal', 'Understanding Lived Experience'* and truly hearing the *'Voice of the individual'*. Our final Trust Value of One team reinforces the importance of '*Safeguarding is everyone's business'* and helps to empower staff, encourage resilience and build the confidence and competence required across the entire Organisation to make a positive difference to the lives of those we seek to advocate for, support and protect. WWLTH are important within the Wigan Borough Partnership, often leading on development and improvement work that can be adapted and embedded by others. It is acknowledged that achievements in safeguarding are only possible with the commitment and drive of all our staff and it is in them the significant improvements in safeguarding compliance and assurance can be seen.

Reflecting Back

The Safeguarding Annual Report of 2022-2023 outlined one key priority for the service which may have been perceived as a very moderated approach to improvement. However, the activity surrounding this one key area has been rich and intensive and whilst the journey to achieving this goal is not yet complete there have been extensive enhancements in this area.

Key Priority for 2023/24
Develop a data system and dashboard that is able to articulate the breadth of safeguarding activity and intervention by all Divisions and Services across the Trust
Progress against Priority
✓ Throughout 2023/24 a review of data collection and safeguarding notification processes was undertaken utilising Business Intelligence support to identify improvements in data integrity and influence future service development ✓ Whilst service level review has been completed there has not been the necessary resource or infrastructure across the Trust to make the required changes within the timeframe anticipated. Some transformation work has been commenced but additional support from Data Analytics and Clinical Informatics colleagues was required and very recently acquired ✓ Review of internal data has created the opportunity to focus on supporting links at Divisional level to develop safeguarding pathways and improve patient level practice ✓ The introduction of monthly Safeguarding Operational Group will enable divisional level analysis and subsequent presentation of safeguarding activity to create greater depth of insight into emerging trends in safeguarding assisting in roll out of targeted responses to protect patients, services users and staff within WWLTH

The Think Family Safeguarding Strategy is underpinned by a comprehensive operational workplan which outlines in more detail the approach to meeting our agreed Safeguarding Objectives which are aligned to those of the Trust. Each of the objectives is represented by one of the '4Ps' and convey the specific goals of the Think Family Safeguarding Service with underlying aims that set out the intention of these to help achieve the desired outcomes.

Patients	**People**
To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience	**To create an inclusive and people centred experience at work that enables our WWL family to flourish**
Performance	**Partnerships**
To consistently deliver efficient, effective and equitable patient care	**To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester**

Key Objectives	Achievements in 2023/24
 Patients	❖ Throughout 2023/24 the Think Family Safeguarding Service has developed and delivered a rolling and continued programme of bitesize and full training packages committed to the establishment of a trauma informed workforce embedding 'lived experience' as central to safeguarding practice ❖ The Think Family Safeguarding Service have been key members of Divisional Patient Safety Groups to ensure cross-population of learning from reviews to support richer action plans to be shared and implemented on a wider footprint ❖ A cohesive 'Think Family' approach internally within the service allows for improved data collection and analysis to build preventive responses to emerging safeguarding concerns for patients and service users – this includes merger of adult, children and children in care pathways/processes/workstreams that were traditionally managed in isolation ❖ Co-design and launch of new Care Leaver Health Passport
 People	❖ Think Family Safeguarding Training Strategy and associated Training Needs Analysis progressing to support ongoing developments ensuring WWLTH effectively maintains compliance against mandated Safeguarding Training targets whilst establishing a confident and competent workforce able to safeguard children and adults at risk ❖ All Think Family Service practitioners now trained in restorative supervision - Revised Safeguarding Supervision Offer underpinned by new policy launched with extended opportunities for access across the Trust ❖ The introduction of tripartite and multiagency supervision with Local Authority partners has increased the successful management of safeguarding cases with increased complexity ❖ Safeguarding Champions programme to share expertise and knowledge providing support and guidance to peers within services is now embedded
 Performance	❖ External MIAA Safeguarding Audit completed August 2023 with an outcome of High Assurance ❖ Highest compliance across Greater Manchester achieved against ICB Safeguarding Contractual Standards ❖ Commencement of SystmOne Optimisation to support data quality around Children in Care Team activity
 Partnerships	❖ The Think Family Safeguarding Service throughout 2023/24 have been an active participant in Partnership multi agency audits with findings embedded into service delivery to ensure improvements at Trust level ❖ Active members of both Wigan Safeguarding Children Partnership and Wigan Safeguarding Adult Board advocating for patient safety via participation in Child safeguarding Practice Reviews and Safeguarding Adult Reviews to influence wider service improvements to health and wellbeing ❖ The introduction of Key Worker role to provide sustained support for families during times of child bereavement and ensure family voice into partnership meetings

Introduction

This is the third annual report since the founding of the Think Family Safeguarding Service and showcases the continued improvement journey of safeguarding across the Trust with clear leadership and vision that is shared and embraced. The profile of safeguarding and the accepting of a 'Think Family' approach has increased exponentially and has seen advances in practice and process that continue to ensure those at risk are protected.

This report will provide assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with WWLTH services. A summary of safeguarding activity during 2023/24 (April 2023 to March 2024) in relation to Safeguarding Adults, Children and Children in Care[1] is provided with an overview of data and performance relating to acute and community services inclusive of maternity provision.

WWLTH has a diverse and experienced Safeguarding Service with specialisms that provide additional support to patients and staff affected by Domestic Abuse; the activity of the WWLTH HIDSVAs (Health Independent Domestic and Sexual Violence Advocates) alongside WWLTH input into Wigan Safeguarding Children multi-agency 'Front Door', Children First Partnership Hub (CFPH), and Wigan Complex Safeguarding Team who support those at risk of exploitation or experience contextual safeguarding, is included.

The 2023/24 Safeguarding Annual Report will provide the Trust Board with the local, regional, and national context of safeguarding. Safeguarding practice within the Trust including progress and developments will be outlined to give assurance that we are meeting our statutory obligations. Key priorities for the year ahead will be determined to give a level of confidence around the commitment of the Organisation and the Think Family Safeguarding Service moving into 2025.

Wrightington, Wigan and Leigh NHS Foundation Trust is a teaching hospital where learning, improvement and innovation is central. A summary of mandatory Safeguarding Training compliance as reported at year end is provided whilst key themes and trends arising from statutory safeguarding reviews and internal patient experience events demonstrate how embedding lessons learnt is vital in ensuring enhancements in care arise from understanding when things have gone wrong. Throughout the year internal governance and reporting arrangements ensure that operational detail in regard to safeguarding is scrutinised with analysis of risk alongside monitoring and oversight of improvement workstreams whilst ensuring executive support to advancements and changes to practice.

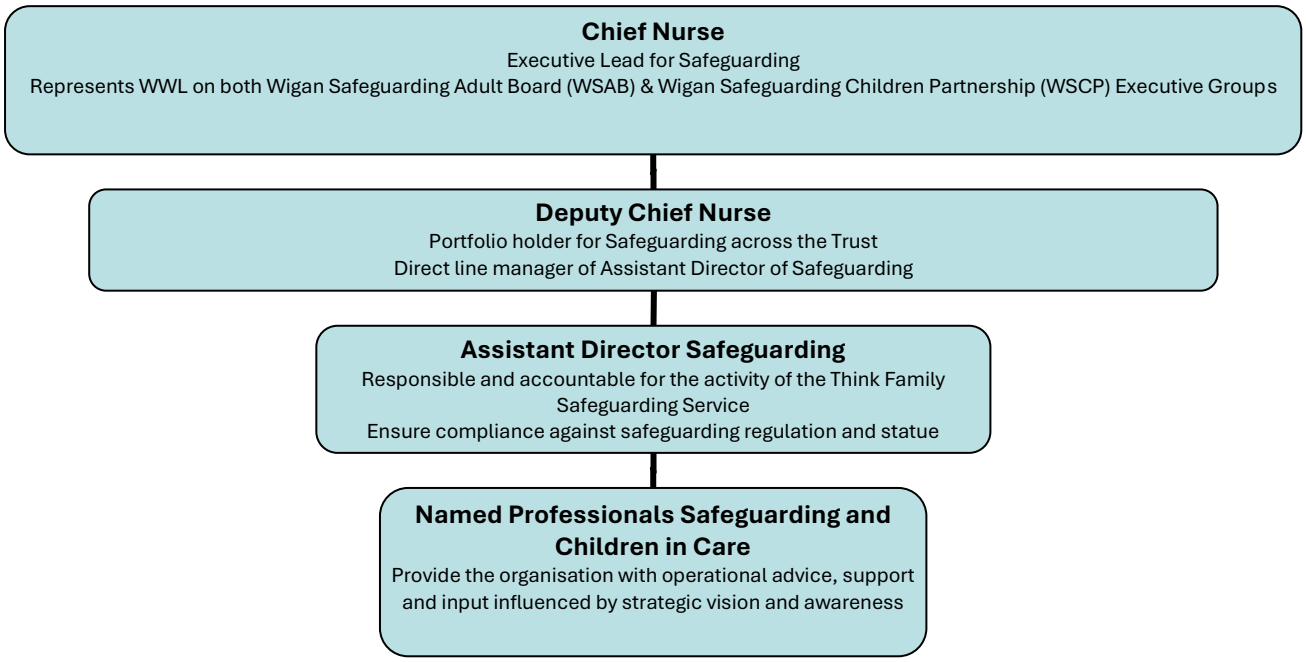
Safeguarding includes the early identification and/or prevention of harm, all forms of exploitation, and abuse by adherence to national guidelines and legislative frameworks. The promotion of independence and wellbeing whilst maintaining dignity and advocating choice is paramount therefore the communication of a clear safeguarding vision and mission is necessary to promote the importance of safeguarding to all. This Safeguarding Annual Report seeks to convey our safeguarding journey, both internally and to our key partners, over the last year but it will ultimately be the people of Wigan, by the evidencing of positive patient experience and improved health outcomes, who will showcase our accomplishments. Safeguarding must be at the core of every contact, intervention and communication as a golden thread that helps to weave a supportive web to hold safe and secure those in need of protection.

[1] Children in Care (CiC) are referred to in legal terms as 'Looked After Children'. In England and Wales, the term 'Looked After Children' is defined in law under the Children Act 1989

Governance Arrangements for Safeguarding

The Trust discharges its responsibility for Board-level assurance, scrutiny, and challenge of safeguarding practice within the Trust, in line with the statutory requirements of *Section 11 Children Act (2004), Working Together to Safeguard Children (2023), the Mental Capacity Act (2005)* and the *Care Act (2014)*. In addition to the requirements of these legal acts, WWLTH as a registered provider with the Care Quality Commission (CQC), must have regard for the regulations as established under the *Health and Social Care Act (2008)*.

WWLTH is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements. Significant changes across the national healthcare system took place in 2023 and impact how we all safeguard our people and populations. The fourth edition of *NHS England 'Accountability and Assurance Framework'* [2] was circulated in July 2024 however the requirements under statute and regulation for WWLTH as a health provider to have effective arrangements in place to safeguard adults and children at risk remain unchanged. The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding; these have been fulfilled throughout 2023/24. Governance aligned to specific roles and responsibilities is summarised below with further detail of the Think Family Safeguarding Service structure, inclusive of Safeguarding Named Doctor provision is found in *Appendix 1*.



The Think Family Safeguarding Service has undergone significant developments with an internal restructure including review of job roles, work plans and objectives resulting in wider exposure of the service and adding to an improving culture around safeguarding. The visibility and reputation of the service has continued to grow both internally and externally throughout this reporting period. This has generated a sense of shared responsibility to protect patients, service users and staff from abuse or harm which needs to be further built upon to maintain traction in relation to continual improvements. Safeguarding governance arrangements include the WWLTH Safeguarding Effectiveness Group (SEG) held monthly until April 2024 and chaired by the Chief Nurse. SEG has membership comprising, but not

[2] NHS England » Safeguarding children, young people and adults at risk in the NHS

limited to, Non-Executive Director with lead for Safeguarding, Divisional Directors of Nursing and Designated Professionals representing NHS Greater Manchester Integrated Care Board Wigan (NHS GM Wigan).

SEG's purpose is to provide assurance in regard to safeguarding arrangements, compliance and activity; to approve reports for internal and external dissemination whilst assessing and monitoring risk in relation to organisational safeguarding duties. SEG feeds directly upwards to Trust Board via the Executive Quality and Safety Committee with lateral input into internal Divisional Quality and Effectiveness Groups. Assurance is provided to NHS GM Wigan via the Quality and Safeguarding Relationships Group which further reports at both a Wigan Borough Partnership and NHS Greater Manchester ICB level.

The culture and leadership in relation to safeguarding has significantly changed in the last three years; there has been improved compliance with safeguarding standards that have been evidenced robustly at SEG up to Quality and Safety Committee and Trust Board. As a result of this increased and continued assurance a consideration was posed to SEG members in regard to reduced frequency of meetings. This consideration elicited wider debate regarding the current format and structure of SEG with views considered regarding a sub-group structure, report presentation and frequency/format of meetings. Agreement was reached that from April 2024 SEG would operate on a quarterly basis with increased time allocation, stronger divisional reporting into the agenda and a return to face-to-face meetings.

Safeguarding Effectiveness Group is an established, successful model within WWLTH to facilitate robust oversight of safeguarding activity within the Trust with additional remit to consider information, data and reports to gain assurance and evidence positive outcomes whilst recognising areas for improvement and identifying risk in order to implement necessary mitigation. Throughout 2023/24 SEG has overseen WWLTH input into local safeguarding reviews to gain assurance that any systemic changes to improve the safeguarding of our population have been actioned and evaluated. There has been rich and plentiful data provision up to executive board level to ensure a clear picture of the improvements and challenges in relation to the protection of children and adults at risk is considered alongside all corporate objectives. WWLTH places a strong onus on the provision of safe, compassionate and individualised care particularly for those who require additional protection and who often access a number of our services throughout their life course. It is therefore imperative that the breadth and complexity of safeguarding is understood not just strategically and through a regional and national lens but at a frontline level hence the investment in strengthening safeguarding governance arrangements from ward to board *(see Appendix 2*).

The Safeguarding Operational Group (SOG) as a sub-group of SEG has been established monthly from April 2024 and will provide an additional layer of governance. SOG is chaired by the Named Nurses/Midwife and receives divisional and service level data and activity reports to gain further understanding of themes and trends in regard to safeguarding issues affecting patients, services users and staff within WWLTH. SOG is responsible for continued review of actions arising from internal investigations, incidents and audits with a safeguarding element, and local partnership safeguarding reviews to ensure the embedding of practice change at the frontline to prevent repeated or increased episodes of harm.

It is clear the value of effective governance in regard to safeguarding however there is an opportunity to further strengthen this whilst enabling the inclusion and channelling of staff expertise and insight from across the organisation. The implementation of SOG has widened the exposure of safeguarding governance to more varied staff groups across the Trust.

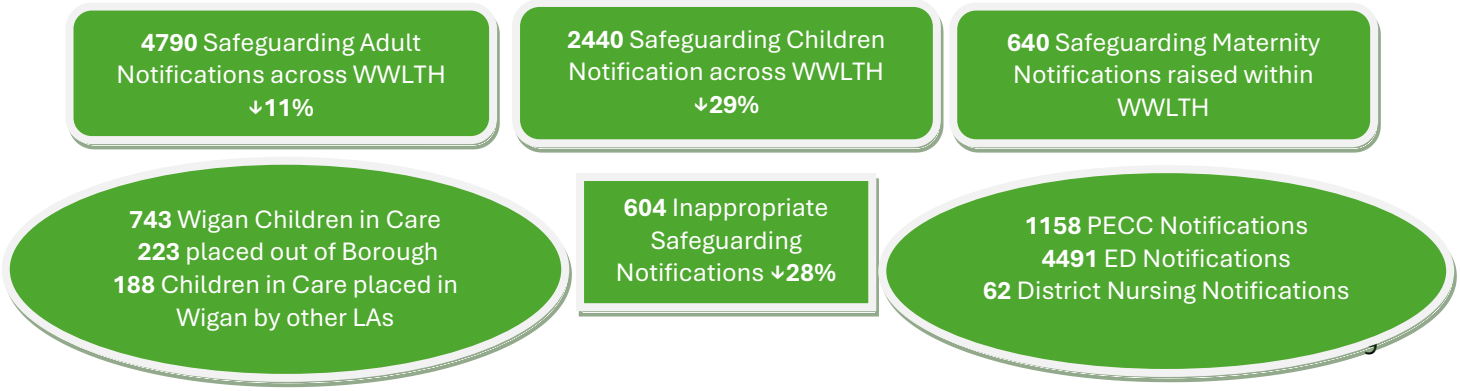
Our Patients - Safeguarding Activity

The Think Family Safeguarding Service has continued to capture Safeguarding Notifications to the Safeguarding Adult and Children Teams to identify and quantify activity via the mandatory prompt for safeguarding concerns within the HIS system used by acute services. Whilst this provides an overview of safeguarding activity within the Acute areas of the Trust this data does not detail outcomes, learning identified or positive case studies that can evidence these aspects and therefore provide higher level assurance.

HIS notifications to the Think Family Safeguarding Service in 2023/24 regarding both adults and children have decreased for the second year running however this is not demonstrative of reduced safeguarding incidence in the borough nor should this invoke a level of concern suggestive of 'missed safeguarding' by WWLTH staff. Primarily the increased visibility and support across divisions by the Safeguarding Service has driven this reduction and positive outcomes captured via case review, supervision and debrief opportunities have highlighted an encouraging level of confidence amongst practitioners in not only identifying safeguarding issues but responding to such to ensure immediate action is taken to protect the individual. Additionally a continued reduction in inappropriate safeguarding notifications to the service has been seen.

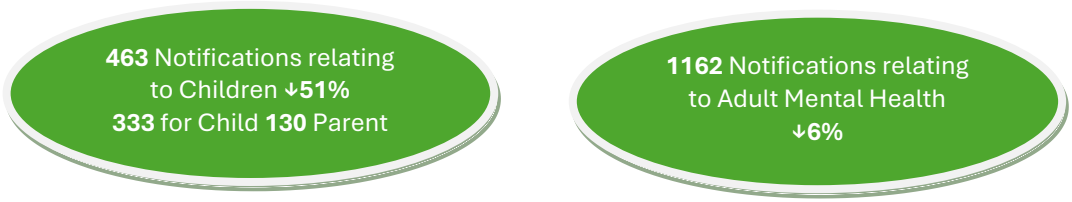
The capture of safeguarding events occurring within community services remains a challenge and at the moment the service is unable to retrieve data from the electronic health record system used across the Community Division, SystmOne. The Think Family Safeguarding Service has however developed data capture via case supervision for adult community service practitioners as a means of understanding some level of activity across community caseloads. Whilst this method of data collection and analysis is somewhat crude it has provided a basis for understanding community safeguarding activity and has therefore been helpful in terms of targeted staff training and support alongside providing an ability to ensure effective escalation and risk management of invariably complex safeguarding issues is considered by multiagency partners. There are additional data capture methods for Maternity Services which have much improved over the last year with an increased confidence in terms of accuracy and validity. The level and complexity of community safeguarding activity for children is readily evidenced via multiagency forums.

In keeping with previous years, both Paediatric Emergency Care Centre (PECC) and the Emergency Department (ED) as the main entry points for WWLTH remain the highest notifier of safeguarding concerns to the Think Family Safeguarding Service. This provides assurance of early recognition and response to concerns of abuse and neglect on presentation to the Trust. In the community over half the proportion of adult safeguarding cases identified are done so following liaison with the District Nursing Service. In terms of community Safeguarding Children data there is no way to consistently and accurately capture this however assurance is obtained via mandatory supervision for 0-19s practitioners around the effectiveness and quality of interventions. Throughout 2023/24 there have been periods of significant pressure across the Trust in terms of presentation and capacity within ED, acute bed capacity, staff resource across services and divisions with periods of Critical Incident but despite this recognition and response to safeguarding concerns has consistently remained high.



Our Patients- Safeguarding Presentations

In terms of safeguarding presentations data highlights a similar pattern to previous years with the main concerns for children and adults relating to Mental Health issues; for children there is an added complexity in that concerns often relate to not just their own mental health but that of their parents/carers. Whilst there is a decreasing trend overall in terms of quantity at the 'front door' this conveys only where staff have required additional safeguarding service support. The patients who require admission in regard to their mental heath are increasingly complex and require secondary support that is often difficult to access, implement or transition to. The *Mental Health of Children and Young People in England (2022) report*[3], published by NHS Digital, identifies rates of probable mental disorder have increased overall for children and young people; the latest evidence suggests that rates of mental illness in children may be growing at a faster rate than those amongst adults.



The 'Think Family' approach across the Organisation has progressed with recognition of the impact of parental/carer mental health issues, which often translate to physical health concerns, on children and the wider family readily being identified by WWLTH practitioners. In addition, collaborative work with Greater Manchester Mental Health Foundation Trust (GMMH) as the main provider of mental health services in the borough has helped to improve the response to these presentations. Facilitation of joint meetings between safeguarding and mental health practitioners at all levels throughout the year has supported in the development of joint policy and process creating a shared understanding to effectively manage incidents of a safeguarding nature whereby both physical and mental health are a presenting concern. Regular meetings to discuss complex cases are set as rolling invites to enable a quick and responsive collaborative approach.

There has been continued high levels of community and inpatient activity on Rainbow Ward for children with eating disorders; reflecting the previous year, these are invariably long stay admissions requiring *Section 85 (Children Act 1989)*[4] notifications to the Local Authority. The medical, clinical, social and emotional complexity of these children mean that a robust package of care with clear multi-agency support plan is required. Often there is a requirement to detain children with eating disorders under the Mental Health Act; this presents further challenge for Paediatric staff however support and intervention by the Think Family Safeguarding Service and WWLTH Head of Legal Services is readily available and initiated. Likewise within adults there has been increased number of Avoidant/Restrictive Food Intake Disorder (ARFID)[5] cases and under the mental health umbrella result in long admissions often linked to limited community services and have required a multi-agency approach, especially when admission to an acute hospital bed has been the only provision available.

WWLTH Children in Care (CiC) Team, now part of the Think Family Safeguarding Service, are responsible for delivery of health activity for this cohort of children as outlined in statutory guidance[6] and commissioned service specification. The team are responsible delivery of Key Performance Indicators (KPIs) related to Wigan CiC, regardless of placement in or out of borough, together with any

[3] Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey - NHS England Digital
[4] Children Act 1989 (legislation.gov.uk)
[5] WHAT IS ARFID? | ARFID Awareness UK
[6] Promoting the health and wellbeing of looked-after children - GOV.UK (www.gov.uk)

CiC placed into Wigan from other Local Authorities (CiCOLAs). Alongside these interventions is a requirement to recognise and respond to incidents of increased safeguarding concern requiring additional support. Research outlines the increased likelihood of poor social and mental health outcomes for children in care and care experienced adults therefore early activity to help to address emerging or longstanding, but previously unmet need is crucial. The CiC Team utilise a RAG rating system to rate the complexity of need for health interventions, associated risk, and safeguarding. The current number of Children in Care who require additional support and intervention (those rated as red or amber) in addition to statutory health assessments, account for **66%** of the CiC Team caseload. A Case Study by the CiC Team can be found in *Appendix 3* to provide greater insight into their offer.

48 children rated RED	**327** children rated AMBER	**196** children rated GREEN

Common areas of additional need for CiC often relate to mental health concerns which are extremely complex and can result in multiple placement changes and requirement of Court directed Deprivation of Liberty Safeguards (DoLS) via Inherent Jurisdiction. There is a noted high proportion of CiC with neurodiversity, often part of the SEND (Special Educational Needs and Disability) cohort, with several CiC also open to the Complex Safeguarding Team due to concerns around risk of or actual criminal and/or sexual exploitation. Pregnancy information is now shared with the WWLTH Children in Care Team by our maternity services to support with care planning and preventative interventions for any woman or father of the unborn who is recognised as a child in care or care experienced adult under twenty-five years of age. This activity is as a direct result of recognition of increased support, care and intervention required to ensure preventative approaches to safeguarding both the parents and the child and which has been evident within recent local reviews.

Response to identification of safeguarding concerns is crucial in protecting individuals from further harm and in ensuring improved outcomes. There has been continued extensive input throughout 2023/24, led and supported by WWLTH Safeguarding Service, in relation to the Harm Free Care agenda with activity relating to Pressure Ulcers, Unsafe Discharge and Falls being a focus of improved data collection and analysis. Similarly from a children, children in care and maternity safeguarding perspective there has been initiation and involvement in a number of internal rapid reviews, After Action Reviews (AAR)[7] which often pre-empt the statutory safeguarding review processes to ensure swift learning and implementation of changes to practice improving care delivery and assuring against repeated incidents of harm.

All patient safety meetings throughout WWLTH divisions have a safeguarding representative in attendance which has enabled more focused reviews with themes and trends being viewed through a safeguarding and trauma informed lens. Positive case examples throughout the year provide assurance around a strong focus on individuals and their lived experience and highlight significant practitioner input and impact in response to identified need.

The introduction of a collaborative duty system within the Think Family Safeguarding Service has ensured that a 'Think Family' approach is utilised with a move away from the historic transfer of adults/children/CiC between specialist teams. The Think Family Safeguarding Service continue to review current safeguarding data collection and processes with the aim of providing greater assurance around outcomes and lived experience for children and adults. Transformation work with both SystmOne Team and the Innovation Team had commenced internally in 2022/23 to develop a system and dashboard that is able to articulate the breadth safeguarding activity by all divisions and services plus the interventions completed to safeguard individuals. This work continued during 2023/24 and remains an ongoing piece of work and key priority for 2024/25.

[7] learning-handbook-after-action-review.pdf (england.nhs.uk)

Domestic Abuse

Domestic Abuse is one of the ten categories of abuse as legislated by the *Care Act 2014*. Improvements were made in November 2022 to the referral process where additional specialist support is required in relation to domestic abuse concerns via the introduction of a new internal online referral system to the WWLTH HIDSVAs. This system ensures a standard process across the Trust accounting for staff and services that do not utilise the HIS system (as per previous process) and allows for more accurate data collection to evidence recognition, response, interventions and outcomes following receipt of referral. Whilst the data shows a decrease in activity around Domestic Abuse from a WWLTH perspective this is a result of improved processes leading to more accurate analysis of the wider context of domestic abuse across the borough. WWLTH staff are also able to access HIDSVA assistance themselves via self-referral or as part of a management support plan and whilst this number has also reduced it again is considered to be more reflective of actual level of need for input as opposed to previous data collection which included 'alerts' of domestic abuse rather than those individuals requiring specialised HIDSVA support. Audits provide further assurance around this narrative with evidence now readily available to review input and outcomes of HIDSVA intervention. Additional guidance for NHS staff who experience sexual harassment within the workplace was released in September 2023 with a requirement to reflect the responsibility of the Trust in responding to such as part of the Domestic Abuse policy. There remains close and positive working relationships between safeguarding, HIDSVA and Human Resources colleagues in ensuring effective support is available to any member of WWLTH staff who experiences domestic abuse.

832 victims/survivors of Domestic Abuse identified by WWLTH practitioners **↓28%**

757 referrals identified females **↓23%**
75 referrals identified as male **↓54%**
Most prevalent age group was **20 39 years of age**

46 WWLTH Staff referred to HIDSVA service **↓43%**

Building from the previous year regarding safety planning being a top intervention/outcome for the HIDSVA service training in relation to recognition and response and safety planning framed around the SAVED model has been rolled out to all WWLTH staff, along with additional bitesize training on completing a DASH[8] form and MARAC[9] (Multi Agency Risk Assessment Conference) referral. This provision extends support to patients out of hours when the HIDSVA service is unavailable.

Child Death

Significant progress has been made during the year across the Organisation and in conjunction with the relevant Divisions in understanding Child Death processes and how this aligns to the *Child Death Statutory Guidance (2018)*[10] in line with the *Children and Social Work Act 2017*. Process around Child Deaths is overseen by the Named Nurse Safeguarding Children supported by the Safeguarding Children Team working closely with the Designated Doctor for Child Death hosted by WWLTH and who is jointly responsible for contributing to the *Child Death Overview Panel (CDOP)* processes which for Wigan is convened in partnership with Bolton and Salford. Sadly there were eighteen Child Deaths during the reporting period; this number has decreased slightly from the previous year. Whilst the death of any child is tragic, in terms of safeguarding around a quarter of all these were expected due to the presence of life-limiting conditions or complex heath needs. The introduction of the Key worker role working in conjunction with the Bereavement Team and Chaplaincy now provides increased support to parents.

[8] Dash risk checklist - SafeLives
[9] Learn more about Marac - SafeLives
[10] Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk)

Our People – Support, Supervision, Training

Support

The Think Family Safeguarding Service has focussed on training, advice, and supervision afforded to all WWLTH staff to support development and ensure early identification of safeguarding initiating timely responses to concerns of abuse and neglect. The increased presence of the Safeguarding Service across all areas of the Organisation to support collaborative work across Divisions and with frontline practitioners has been significantly beneficial and there continues to be a strong focus on visibility and training across PECC, Rainbow, Neonates and Midwifery, alongside adult practitioners in community services, ED and all acute adult wards who have a linked Safeguarding Adult Nurse. This model of visibility has raised the profile of the service, upskilling staff via supervision and bitesize training resulting in frontline practitioners responding in a timely and appropriate manner to safeguarding concerns. In an example of co-production a task and finish group undertook a piece of work to review the information sharing process to other services when a child attends the Accident and Emergency Department (A&E) resulting in the development of a new information sharing Standard Operating Procedure.

The Safeguarding Children Team have traditionally been very visible within community services however there has been a switch of focus around key workstreams to further support our Acute, Outpatient and Allied Health Professional colleagues in a similar way; this additional investment has been well received and has yielded positive outcomes in terms of relationship building but more importantly staff confidence around safeguarding leading to improved outcomes for children. Similarly the Safeguarding Adult Team have increased visibility into acute areas across all three of our hospital sites but have outlaid more resource and contact with our adult community services to mirror the support offered to children's practitioners. This again has had a huge impact in managing complex cases, supporting staff and coordinating effective approaches to facilitate better outcomes for adults at risk. The incorporation of the CiC Team has meant there is a greater awareness of the needs of children in care and care experienced adults which further builds on practitioner's ability to be trauma aware, alert and responsive. A focus for maternity safeguarding has been increased contact, education, training and support. Upskilling practitioners to recognise and respond to abuse and neglect concerns by raising awareness of the legal framework of significant harm, what makes and good referral and importance of impact and analysis. 2023/24 has seen is an increased recognition and response to safeguarding concerns by midwives and understanding of the Threshold of Need resulting in significant reduction in the number of inappropriate referrals to the Local Authority being closed with no further action.

At times, this very proactive, hands-on approach by safeguarding/CIC practitioners has posed significant challenge due to reduced staffing numbers across all teams within the Safeguarding Service and staffing demands within the Divisions. It has been well evidenced that access and availability of safeguarding support improves response and confidence in managing safeguarding concerns which importantly results in improved patient experience. Whilst the 'formal' programme of contact and visibility has been hindered at times, the Safeguarding Service has responded to urgent and emerging incidents readily and as required.

Supervision

Safeguarding Supervision is key for all community and acute services staff during very challenging, demanding times and to support practitioners with the increasing number of difficult cases. The Think Family Safeguarding Supervision policy has been reviewed and offer re-launched with extended opportunities for practitioners to access supervision across the Trust with a **100%** increase in staff

accessing supervision staff being seen. The Safeguarding Adult Team have developed links with the Community Division supporting with complex cases by providing oversight and support via reflective practice. A review of the supervision offer to Midwives with mapping of requirements across the workforce in line with the new policy has also been undertaken.

Think Family Safeguarding Practitioners are trained in restorative supervision which supports the emotional challenge of addressing safeguarding needs whilst retaining a focus on the lived experience and needs of the child/adult. Safeguarding Supervision is delivered in a mandated but also flexible format. This year has seen The Think family Safeguarding Service creating new ways of enhancing supervision and promoting partnership working for WWLTH practitioners across children, community and midwifery services. Two methods of joint tripartite supervision are now routinely offered for high-risk complex cases where either escalation or action planning is required. Joint supervision is offered as multi-agency partnership working between caseload holder and Children Social Care (CSC) social worker, with tripartite supervision of high-risk complex cases at Public law Outline level being held between midwifery, neonatal, and 0-19 practitioners to promote joint working and communication between services. Additionally, the WWLTH Think Family Safeguarding Service have been increasing visibility and presence across acute Maternity Wards and Community Midwifery Clinics to promote reactive supervision and advice regarding safeguarding concerns ensuring practitioners are supported in their safeguarding duties.

Training

Think Family Safeguarding Training Strategy and associated Training Needs Analysis has been reviewed to support ongoing developments ensuring WWLTH effectively maintains compliance against mandated Safeguarding Training targets whilst establishing a confident and competent workforce able to safeguard children and adults at risk. The current mandated programme remains the same but has been enhanced by the introduction of bitesize training sessions to support development of practitioner knowledge in line with the emerging themes of Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adult Reviews (SARs), Brief Learning Reviews (BLRs), and internal learning from IPIRs (Immediate Post Incident Review). Identified subject areas this year have been *Professional Curiosity, Trauma Informed Care, Strategy Meetings, Professional Curiosity, Lived Experience/Voice of the Child* and *use of evidence-based tools*. Current workstreams are focussed on tailoring existing training sessions into a 'Think Family' context in order to support increased skills, knowledge and competence of all staff regardless of adult, maternity or paediatric specialism. The Think Family Safeguarding Service have embedded the Wigan Safeguarding Partnership priorities within all safeguarding activity with the child's Lived Experience being a focus throughout maternity safeguarding training stressing the importance of considering individuals in the context of family and the cumulative effect of harm.

A positive pattern of compliance throughout the year has resulted in all but one level of Safeguarding Adults and Children Training now meeting expected threshold as per NHS GM Contractual Standards. A slight dip against required threshold of 85% down to **83%** was seen against the Safeguarding Children Level 3 Standard, having been above this for most of the year. Whilst on face value this is disappointing it is important to note the increased cohort identified who require this training; the Safeguarding Service, in conjunction with the Learning and Development Team have reviewed requirements per staff role in recognition of increasing numbers of children being cared for in adult areas. Additional face to face Level 3 Safeguarding Children sessions were facilitated throughout the year to support staff in accessing and achieving compliance with a new cohort of professionals within Specialist Services Division being trained to ensure safety and competence following the introduction of extended surgery option on the Wrightington Hospital site for sixteen- to seventeen-year-olds. A review of all safeguarding training has occurred to ensure that the health needs of Children in Care and Care Experienced Adults in integrated; this has been an area of limited training focus for the Safeguarding Service and the Trust previously. Additional bespoke sessions for a wide range of practitioners specifically around the CiC and care experienced cohort have been developed further building upon the ambition to be a truly trauma responsive organisation; these have included specific focus on safe discharge planning, consent, effective information sharing and Corporate Parenting[11] responsibilities.

Mandatory Safeguarding Training	Compliant	Non-Compliant	Total Cohort	% Compliance
WWLTH Safeguarding Vulnerable Adults Level 1	2126	5	2184	97%
WWLTH Safeguarding Vulnerable Adults Level 2	1455	53	1508	97%
WWLTH Safeguarding Vulnerable Adults Level 3	2759	325	3084	90%
WWLTH Safeguarding Vulnerable Adults Level 4	7	0	7	100%
WWLTH Safeguarding Children Level 1	2397	75	2472	97%
WWLTH Safeguarding Children Level 2	3394	187	3581	95%
WWLTH Safeguarding Children Level 3	603	120	723	83%
WWLTH Safeguarding Children Level 4	7	0	7	100%
WWLTH Mental Capacity Act Level 1 (for HCAs)	982	33	1015	97%
WWLTH Mental Capacity Act Level 2 (for Registered)	2901	175	3076	94%
PREVENT Basic	6633	260	6893	96%
PREVENT Clinical	2924	181	3105	64%

Least Restrictive Practice

A significant piece of collaborative work continues to be undertaken between the Think Family Safeguarding Service and Professional Practice Development in relation to the development and implementation of Least Restrictive Practice proposals across WWLTH. The Trust has committed to implementing Least Restrictive Practice with the ratification of WWLTH Least Restrictive Policy and associated adult and children Standard Operating Procedures. Training front-line practitioners, including those in Acute and Community settings, in Crisis Prevention Intervention (CPI)[12] Safety Intervention Foundation and Clinical Holding Training has been a key priority. Further review and escalation of Least Restrictive cases are supported via divisional and corporate patient safety groups with input from the Safeguarding Service to ensure consistency of learning and linking theory to practice.

400 WWLTH Staff to date now trained in Least Restrictive Practice via CPI Safety Interventions Course

[11] Applying corporate parenting principles to looked-after children and care leavers.pdf (publishing.service.gov.uk)
[12] Crisis Prevention Institute (CPI) | CPI Training | United Kingdom

Our Partnerships – Contribution to Multiagency Safeguarding

The Think Family Safeguarding Service contributes widely to the partnership via Wigan Safeguarding Adult Board (WSAB) and Wigan Safeguarding Children Partnership (WSCP) subgroups and workstreams; at board level there is strong Chief and Deputy Chief Nurse presence to ensure WWLTH executive commitment to the borough's safeguarding agenda. Additionally full participation by WWLTH Safeguarding representatives occurs via the Domestic Abuse Strategic Oversight Board and Community Safety Partnership. This interface is further strengthened by the attendance and commitment of executive and divisional senior leads in a variety of explicit or associated safeguarding forums such as the Care Consortia. WSCP revised their governance structure during the year resulting in a change to the subgroups. There are now three main overarching subgroups: the *Safeguarding Performance subgroup* and *Learning and Improvement subgroup*, alongside the *Wider Safeguarding Forum*. WSAB subgroup structure continues to reflect *Organisational Safeguarding* which the Named Nurse Safeguarding Adult has continued to co-chair, *Learning and Quality* and the introduction of *Risk and Complexity* to encapsulate self-neglect and Mental Capacity Act (MCA).

Work alongside the WSAB has provided access to MOSAIC (Local Authority Safeguarding Case Recording System) for the WWLTH Safeguarding Adult Team, and has been key in ensuring safeguarding oversight, quicker feedback to WWLTH staff to enable safe discharge, additional support for community health services to improve and inform care planning whilst reducing inappropriate/ duplicate referrals to the Local Authority. It has enabled the professional challenge of closed referrals which has aided the Named Nurse Safeguarding Adults to address within the Risk and Complexity subgroup.

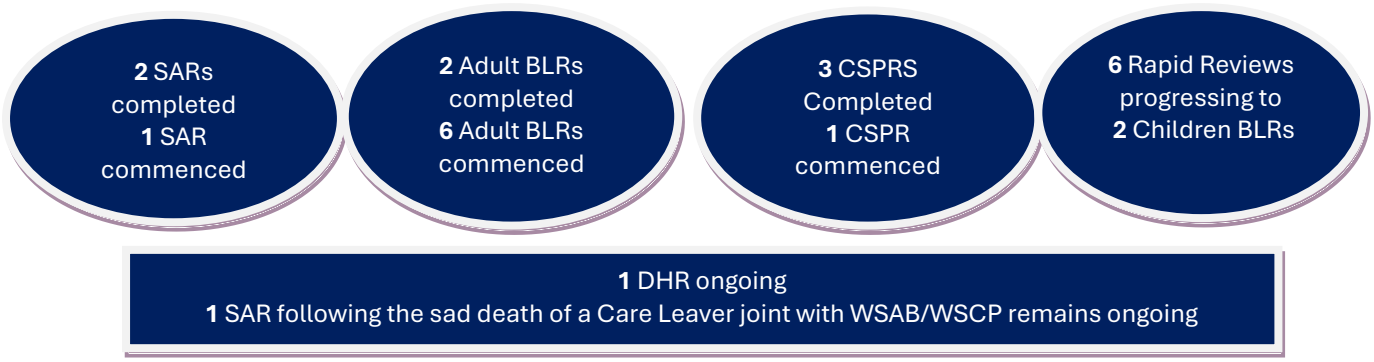
The WSCP adopted practice priorities were *Voice of the Child, Professional Curiosity, Critical Thinking and Challenge, Impact and Analysis* and *SMART Action Planning*. These priorities have been embedded within WWLTH Safeguarding Children Team training plan and reflect the learning identified within IPIRs. The Safeguarding Children Team play a key role in the development and delivery of WSCP multi-agency training, delivering sessions on *Graded Care Profile 2, Level 3 Safeguarding Children training, Safe Sleep 'out of routine' training, Professional Curiosity* and *SMART Action Planning* which is accessible by all multi-agency partners with professionals from a variety of disciplines in attendance.

The WSAB/WSCP Resolution and Escalation Policy is consistently utilised effectively by WWLTH at all levels including involvement from the Named Nurses where escalation cannot be resolved at practitioner and first line manager level. Training has been provided around "Escalation" for a wide range of WWLTH staff and the increase in escalations provides some assurance around the effectiveness of this training delivered throughout the year. There were escalations of cases across both acute and community services throughout 2023/24, with community cases predominantly around neglect with drift and delay resulting in little change in circumstances for the child/ren with similar themes linked to adults who self-neglect. The themes around acute escalations are mainly linked to discharge and placement suitability, drift and delay resulting in inappropriate length of stay due to safeguarding concerns alongside underlying mental health issues; these escalations are similar for adults, children and indeed children in care.

Partnership workstreams associated with the Safeguarding Adult agenda via Brief Learning Reviews (BLR) and Serious Adult Review (SAR) have continued to increase over 2023/24; 7-minute Briefings[13] are readily shared across WWLTH and within the quarterly Think Family Safeguarding Service Newsletter. There are similar levels of activity regarding BLRs and Child Safeguarding Practice Reviews (CSPRs)

[13] Learning and improvement (wigansafeguardingadults.org)

however the number of ongoing CSPRs has reduced throughout the year due to completion of legacy reviews with positive NHS GM Wigan ICB validation visits to acknowledge that learning from such has been embedded across the Trust. Validation visits for the CSPRs are undertaken by the NHS GM Wigan Designated Nurse Safeguarding Children and review the Trust's evidence for the legacy Serious Case Reviews and recently published Child Safeguarding Practice Review. Positive feedback was received against progress and onward innovation to embed lessons learned. The Named Nurse Safeguarding Children attends WSCP Case Review subgroup and meets with the Partnership monthly to update ongoing actions. In addition to BLRs/SARs and CSPRs the Named Nurses commenced in supporting a Domestic Homicide Review (DHR) from a Think Family Safeguarding Service perspective. All reviews, both adults and children, generate Action Plans which are key to supporting single and multiagency learning with WWLTH Think Family Safeguarding Service, via the leadership of the Named Professionals, vital in driving this agenda.



Community Safety Partnership Domestic Abuse Strategy 2021 – 2024 aims at being *'aspirational and that Wigan as a Borough deem domestic abuse as being unacceptable in all its forms, and where we want people in our community to be able to live safely and have happy lives free from abuse'*. WWLTH as a major health provider within the Borough advocates and works as a key partner agency in fulfilling this strategy. The Assistant Director for Safeguarding is a member of the Domestic Abuse Strategic Oversight Board with the Named Professionals supporting subgroup activity whilst the HIDSVA and Safeguarding Practitioners are operationally involved in MARAC meetings. The Multi Agency Tasking and Coordination (MATAC)[14] programme commenced in Wigan in 2022 with meetings every 10 weeks through 2023/24 identifying perpetrators and their impact on victims. The programme has seen positive success in reducing repeat offending behaviours and has enabled WWLTH to ensure records are updated relating to MATAC to ensure professionals are also aware of risks.

The Think Family Safeguarding Service consistently contribute to the PREVENT agenda with the Assistant Director of Safeguarding being the PREVENT Lead for the organisation and a core member of Monthly Channel Panel. WWLTH has a statutory responsibility to comply with requirements outlined within the PREVENT duty guidance[15] and has effectively maintained this throughout 2023/24. Sharing of health information and dissemination of risk management and support plans for those adults and children discussed within Channel panel is vital in ensuring successful outcomes. It has been noted throughout the year that the highest proportion of those referred to Channel Panel are children; all referrals related to males regardless of age.

[14] Multi-agency tasking and coordination (MATAC) to reduce domestic abuse offending | College of Policing
[15] Prevent - NHS England Digital

WWLTH as a Corporate Parent

When a child comes into care, the Local Authority becomes the 'Lead Corporate Parent'. The term 'corporate parent' means the collective responsibility of the council, elected members, employees, and partner agencies, for providing the best possible care and safeguarding for the children who are in the care of the Local Authority; WWLTH therefore too has this duty. As Corporate Parent we want to see children in care flourish with good health and to be safe and happy, to do well at school and enjoy good relationships with their peers, to make the most of leisure opportunities, hobbies, and interests, and to grow towards adulthood equipped to lead independent lives and make their way in life via higher education, good careers and jobs, and to be financially secure. Our ambition for children in care should be that what we hold for our own children, and this is the fundamental principle held by the CiC Team and wider Safeguarding Service.

The Named Nurse Children in Care sits on Operational Corporate Parenting Group, and other forums such as Placement Stability Panel, Vulnerable Care Leavers Panel, Separated Children Panel (which is focused exclusively on ensuring a coordinated approach to supporting Unaccompanied Asylum-Seeking Children), and Residential Managers Care Provider Forum. The Assistant Director, as Corporate Parenting Lead for WWLTH, sits on Corporate Parenting Board. There is a senior and strategic level of commitment from WWLTH to ensure the holistic needs of our CiC and Care Leaver cohort are recognised, acknowledged and responded to in order that our high ambitions for them can be realised.

The Named Doctor Children in Care also acts as Medical Advisor for Adoption and Fostering and is a crucial colleague in ensuring positive outcomes for CiC. There is a significant level of activity, both operational and strategic, associated with these roles, which at times throughout 2023/24 has been a challenge. Work was commenced between WWLTH, GM ICB Wigan and Wigan Children Social Care to review and revise the Fostering Medical Pathway due to increasing demands and limited understanding by some partners of commissioning and statutory responsibilities. Whilst this newly implemented pathway has not fully resolved issues there is an ability for WWLTH to manage and report on demand more effectively which ultimately improves processes for children and carers. A similar piece of work is planned for 2024/25 around the Adoption Medical Pathway and subsequent reporting to WWLTH Trust Board and externally to partners will be able to include a rich and accurate picture of the impact and improvements against WWLTH input into Adoption and Fostering processes.

Transition is a key area of focus for our children in care and has featured within a number of internal and partnership reviews, audit and inspections as being an area for improvement. Whilst the borough is collectively working hard to support our care leaver cohort there is a preventative approach to transition embedded within WWLTH CiC Team workstreams. The CiC Specialist Nurses utilise *Every Contact Counts* approach understanding that preparing to leave care is a significant time in a child's life. It is important CiC know where to access health information and use this when making decisions about their health therefore every young person receives a copy of a Health Passport (codesigned with the Children in Care Council) before their eighteenth birthday along with a copy of their final health plan. Further work is planned to consider implementing a 'Care Leaver' flag within health records.

743 Wigan Children in Care
223 Wigan CiC placed out of area
188 CiCOLAs placed in Wigan, under care of CiC Team
137 total CiC on Health Visitor caseloads
571 total CiC on CiC Team caseload

549 CiC placed in Foster Care Placements (including Friends & Family)
49 CiC remaining on Care Orders at home with Parents
100 CiC placed in Residential Care Settings

Partnership in Action

WWLTH contribution to partnership working extends much further than attendance at formal boards and subgroups, with the greatest impact on our patients arising from our operational and person-centred approach to collaboration and working together with multi-agency professionals. The Think Family Safeguarding Service continues to host co-located 'Health' roles via the employment of a Complex Safeguarding Nurse within the Complex Safeguarding Team based at Wigan Police Station, and Specialist Nurses Safeguarding Children based within the Children First Partnership Hub. Whilst these post holders have a specific remit in terms of the multi-agency approach to exploitation of children and the 'Front Door' to Safeguarding, practice is embedded widely in terms of the 'Think Family' method embraced by the whole safeguarding service.

The Complex Safeguarding Nurse Post sits within the CiC Team, a deliberate move to ensure cross-cover and robust care planning for children who are invariably 'known' to many services and professionals as the risk and complexities they are exposed to increase. The CiC Team successfully utilise an assertive outreach model of health intervention which has been implemented by the new Complex Safeguarding Nurse. The Complex Safeguarding Nurse post had been vacant for significant periods due to recruitment challenges and sickness however moving into 2024/25 we have a committed, passionate and experienced practitioner in place who has begun to reestablish the role within multi-agency forums. As the Local Authority implement the new REACH Model for working with adolescents open to Complex Safeguarding, Youth Justice and Targeted Youth Support Teams to combine expertise and resource WWLTH are in a comfortable position to adopt this having been working towards a similar model internally for some time via CiC and 0-19s Team pathways and processes. The role of the WWLTH Health Practitioners within the Children First Partnership Hub is to undertake immediate health information sharing and attend Initial Strategy Meetings. Activity in relation to attendance at Strategy Meetings, sharing of Health Information and Health screenings sheds light on the volume of activity related to the partnership and the vital role of Health Practitioners in supporting multi-agency assessments and interventions to safeguard children and families. In 2024/25 the Local Authority will begin to launch 'Family Safeguarding' – this model has been successful across the country and WWLTH, having embraced a 'Think Family' approach to safeguarding and provided significant input into all strands of partnership working, feel confident and committed to building on this concept.

Much like the Children First Partnership Hub 'one front door', the Risk and Complexity sub group within WSAB began to pilot the same principles at the end of 2023, with a view to health partners joining the panel to oversee cases of 'no further action'. This is seen as a positive step, particularly where 'health' have escalated previously under VARM/self-neglect panels concerns for individuals when there appears to be a limited or lacking multi-agency approach to managing risk. Shared understanding of risk and/or harm and abuse is vital to implementing appropriate responses under statutory frameworks but more practically in terms of care planning and risk management. This is a consistent approach for both adults and children at risk with 'Strategy Meeting' contribution being a significant workstream for practitioners in the Think Family Safeguarding Service and wider across the Trust. The Named Nurse Safeguarding Children has contributed to an ongoing workstream with social care and police partners, with improvements made and demonstrated by assurance activity highlighting timeliness of Strategy Meetings, thresholds being met and clear evidence of excellent multi-agency information sharing and decision making. Pre-birth Protocol Meetings, supported by the Named Midwife Safeguarding, provide a collaborative approach to pre-birth assessment plans for unborn babies in a timely and effective manner, with robust and proportionate arrangements agreed for the birth to avoid delays and/or unsafe discharge from the maternity unit. The Named Nurse Safeguarding Adult has been proactive in ensuring multi-agency approach and decision making to Pressure Ulcer harms via WWLTH Pressure Ulcer Panel a driver for the now joint Wigan Borough Pressure Ulcer Policy endorsed by WSAB.

Our Performance –Assurance

Key priorities set within the previous Annual Report (2022/23) outlined a number of objectives for the Think Family Safeguarding Service. Whilst focus on these has remained it is inevitable that additional or adapted workstreams have been developed as influenced by the political climate, social contexts, and local agendas. The service has ensured prioritisation of statutory obligations therefore maintaining a clear focus via SEG on the multi-faceted nature of safeguarding. Reporting to internal and external groups, committees and boards has much improved providing assurance and reassurance to executives, governors, and key stakeholders in regard to performance.

Learning themes have been addressed by workstreams, with continuing assurance activity planned to evidence the impact of work completed. Ongoing work around safeguarding governance processes has been facilitated throughout the last year to ensure the effective management and transfer to the new PSIRF[16] reporting system. Throughout 2023/24 the Think Family Safeguarding Service has had input and oversight into Datix and IPIRs where there are concerns around safeguarding; learning themes reflect those identified within safeguarding reviews locally and nationally in terms of *escalation, voice of the child/making safeguarding personal, critical thinking and challenge* and *trauma informed practice*. WWLTH Datix Incident Team and divisional governance teams have supported the process linked to the Local Authority submitting safeguarding enquires relating to potential harm caused by the Trust with the majority of alerts now responded to and closed within allotted timelines following coordinated review.

The *Child Protection - Information Sharing CP-IS Standard Operating Procedure* was reviewed and re-launched to ensure timely sharing of Child Protection information of children, 24 hours a day 365 days a year, who visit NHS unscheduled care settings within WWLTH, including children residing out of area and unborn babies. A collaborative re-written Standard Operating Procedure for Maternity Care of Women Affected by Female Genital Mutilation (FGM) between safeguarding, midwifery and obstetrics, provides a joint a holistic approach to caring for victims of FGM whilst following statutory safeguarding procedures. It ensures a standardised process to improve quality of evidenced based care whilst also providing a statutory safeguarding response to recognise and respond to risks associated with FGM. In addition, new innovative practice and documentation has allowed, for the first-time, full collection of the FGM national data set by WWLTH.

<u>Audit</u>

An audit was undertaken by MIAA and concluded in a final report issued in August 2023. The overall objective of the audit was to assess the systems and processes in place across the Trust with regard to safeguarding children and adults, reviewing compliance with national policy and guidance. The conclusion detailed below evidences the positive outcome of a significant development journey for not only the Think Family Safeguarding Service but the Organisation as a whole demonstrating significant improvements.

High Assurance	There was a strong system of internal control which was effectively designed to meet the system objectives, and controls were consistently applied in all areas reviewed.

[16] NHS England » Patient Safety Incident Response Framework

Participation in a range of internal audits and reviews, shared and ratified via SEG, results in the implementation of policy and procedure whereby impact to improve outcomes alongside a willingness to share good practice and data to further support WWLTH and partnership developments can be seen. Collaboration with all has been embraced and a confident safeguarding workforce is being established. The Think Family Safeguarding Service have participated in WSCP and WSAB multi-agency audits throughout the year with action plans developed from learning points identified which are then embedded internally across WWLTH via forums and focused workstreams.

Our Performance – Contractual and Regulatory Obligations

The Safeguarding and Relationships Group is a subgroup of the NHS GM Wigan Clinical Governance Committee. The Group reviews and monitors compliance against statutory safeguarding responsibilities using the 'NHS Provider Safeguarding Audit Tool' included in the contract. Sixty-three Key lines of Enquiry (Standards) are reviewed by the Designated Nurses alongside the WWLTH Think Family Safeguarding Service with submission of evidence and regular validation visits to ensure delivery against any agreed action plan resulting from this submission. There were fifty-three standards assessed as GREEN and fully compliant at the end of 2023, including all nine standards associated with children in care and care leavers. Of the ten standards rated AMBER only three of these remain at this status at the end of March 2024 with seven additional standards now achieving full compliance and considered GREEN following completion of necessary actions. The Trust has remained consistent in terms of compliance against GM Safeguarding Standards and in terms of performance utilising this framework as a measure WWLTH have the highest rating across the Greater Manchester footprint.

Children in Care – Key Performance Indicators overview

The CiC Team is commissioned by NHS GM Wigan under an agreed service specification with performance measured against a number of locally defined outcomes, which in the main are reflective of national performance indicators reportable by the Local Authority. These indicators (SSDA903)[17] provide performance data that is required by central government from Childrens Social Care departments. Performance of the service is determined via agreed Key Performance Indicators (KPIs) and scrutiny of the adherence to the agreed standards for Children in Care. The current KPI schedule is collated quarterly and presented to the Safeguarding and Relationships Group (formally IQSG) following approval at SEG. Delivery against KPIs is codependent on the performance of external services and partner agencies however WWLTH recognises explicitly the responsibilities of the organisation ensuring compliance with statutory frameworks and legislative requirements therefore the workstreams of the CiC Team focus heavily on internal improvements whilst facilitating external discussions to overcome system challenges.

Initial Health Assessments (IHA) are required to be completed within twenty working days of a child entering care. All Initial Health Assessments are completed by a qualified doctor which is a requirement set out in Statutory Guidance and there is a reliance on the establishment of effective partnership working and excellent communication pathways which have in recent times required strengthening. The WWLTH CiC Team and Named Doctor CiC along with Local Authority colleagues and supported by GM ICB Wigan have prioritised performance against this metric in acknowledgement of its importance in ensuring children new into care have the best opportunity to overcome any health adversity. Robust discussions have ensured understanding by divisional, medical and finance staff of our obligations in this process. Whilst performance against the set KPI of 100% compliance with IHA timescales has been a challenge the year ended positively with all children, regardless of placement

[17] Children looked after return 2023 to 2024: technical specifications - GOV.UK (www.gov.uk)

and local authority origin, requiring IHA in March 2024 receiving one within the statutory timescale expected.

The number of children who have been in care for a period of twelve months or more, is identified as the qualifying cohort for the SSDA903 return to Central Government. SSDA903 data tables are published yearly and provide an overview of national, regional, and local performance against a wide range of indicators inclusive of those specially designed to demonstrate health outcomes. A national overview for comparative considerations will not be published until late 2024 therefore provision of Wigan CiC Team contribution to this dataset is provided as a measure of assurance and performance. Data in relation to completion of Review Health Assessments, Development Checks, Immunisation status, Dental Checks, Substance Misuse concerns and Strengths and Difficulties Questionnaires (SDQs) are all captured. A cohort of **507** Wigan children were identified as being 'Looked After' for a period of more than one year and therefore eligible for reporting within the SSDA903 return; all metrics have improved.

National Performance Indictor	Wigan 2023/24	Wigan 2022/23	National Average
% of Children in Care who have had a health assessment in the last 12 months	**100%↑**	**96%↓**	**89%↔**
% of Children in Care who are up to date with immunisations	**90%↑**	**87%**	**82%↓**
% of Children in Care who have had an annual dental check in the last 12 months	**91%↑**	**84%↑**	**76%↑**
% of Children in Care with an up-to-date developmental assessment (under 5's)	**100%↔**	**100%↔**	**88%↓**
% of Children in Care aged 5-16 years with SDQ score reported (completed by CIC nurse)	**95%↑**	**75%↓**	**75% ↓**
% of Children in Care identified as having substance misuse concerns	**3%↑**	**2%↓**	**3%↔**

Deprivation of Liberty Safeguards

WWLTH fully complies with the *Mental Capacity Act 2005* and *Deprivation of Liberty (DoLS)* legislation. Patients subject to DoLS are discussed in partnership with Local Authority colleagues and key areas for consideration include the level of enhanced nursing care applied, use of covert medications and use of sedations. Patients requiring Level 4 enhanced care (1:1) call for additional consideration and oversight by the MCA/DoLS Lead and Safeguarding Adult Practitioner in conjunction with ward staff regarding this level of restriction. Clear explanations are given as to what this means under the MCA (2005) which compliance against is audited regularly to ensure reduction in restrictions are applied at the earliest opportunity. The MCA/DoLS Lead for WWLTH, an integral team member within the Think Family Safeguarding Service, provides oversight on all DoLS supporting staff to rescind the application when it is no longer applicable. Robust processes are in place to ensure timely notification to the Care Quality Commission (CQC) regarding DoLS applications and outcomes[18]. In tandem with the Trust's approach to Least Restrictive Practice a number of audits against MCA and DoLS standards are to be conducted in 2024/25.

1901 DoLS applications submitted to the Local Authority in 2023/24
96% evidenced recorded MCA ↑**7%**

[18] Outcome of an application to deprive a person of their liberty (DoLS) – notification form - Care Quality Commission (cqc.org.uk)

Next Steps – Looking Forward to 2024/25

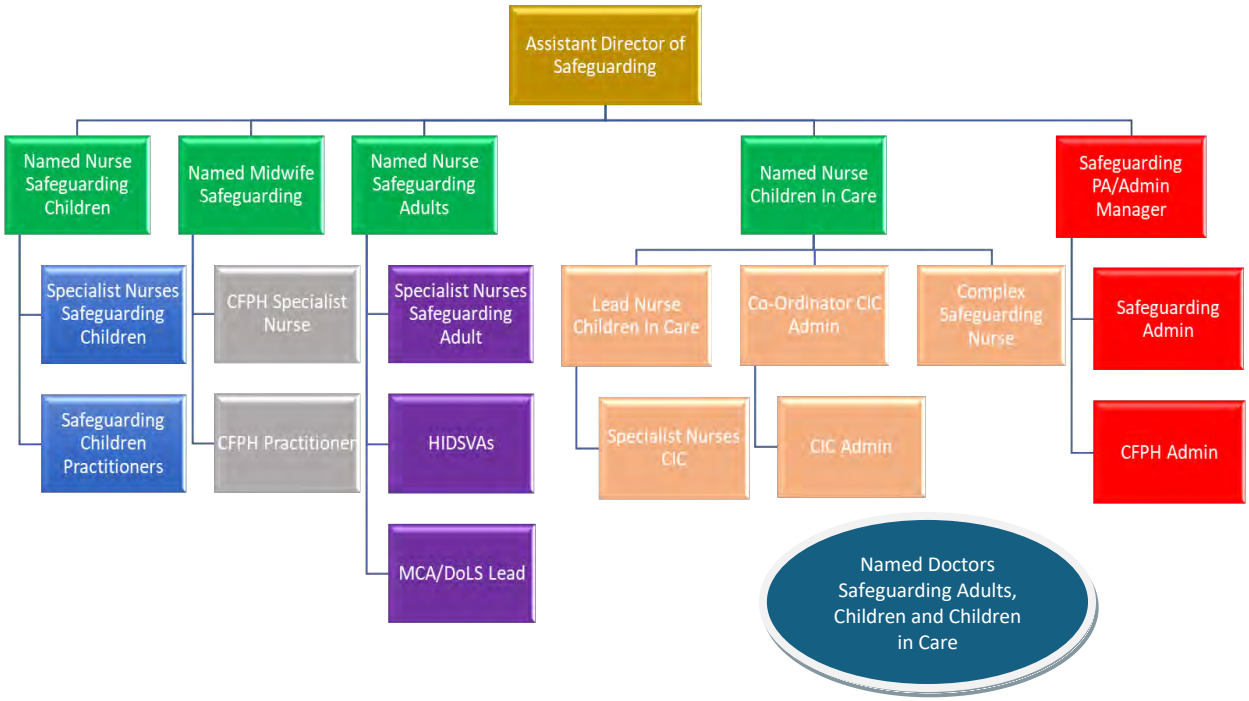
As outlined within the Safeguarding Strategy 2023-2025 and underpinned by a comprehensive operational workplan there is a clear direction set in terms of what the Trust wants to achieve in the coming year. The **four Ps** encapsulate the areas on which we want to focus our development and improvement and define annual objectives which will be reviewed against measurable goals to keep us on track to deliver our ambitions. We will embed the WWLTH Trust Values to provide direction utilising the Improve, Integrate and Innovate framework to motivate.

Key Priorities for 2024/25	
Develop a data system and dashboard that is able to articulate the breadth of safeguarding activity and intervention by all Divisions and Services across the Trust 	*to clearly convey the levels of complexity and demand at an individual, service and divisional level but more importantly will start to evidence impact of the organisation in terms of improving health outcomes for those whom it seeks to safeguard based on the success of interventions resulting from increase knowledge, skill and competence of WWLH Staff*
To contribute to Least Restrictive Practice agenda promoting the principles of *Safe, Effective, & Acceptable via a Safeguarding Lens* 	*to ensure delivery of safe, personalised and compassionate care that reduces harm by minimising restrictive practices and preserves patient's inherent rights to make choices about their care*
To launch a 'Think Family' approach to Mandatory Safeguarding Training package inclusive of Intercollegiate standards for Adults, Children & Children in Care 	*to ensure WWLTH effectively maintains compliance against mandated Safeguarding Training targets whilst establishing a confident and competent workforce able to safeguard children and adults at risk with greater understanding of lived experience to promote individualised care*
To review and refresh the suite of Safeguarding Policies in line with Think Family Principles 	*to support all WWLTH practitioners in understanding their roles and responsibilities under safeguarding to promote effective, high-quality care in line with statutory and legislative frameworks, and in reference to*

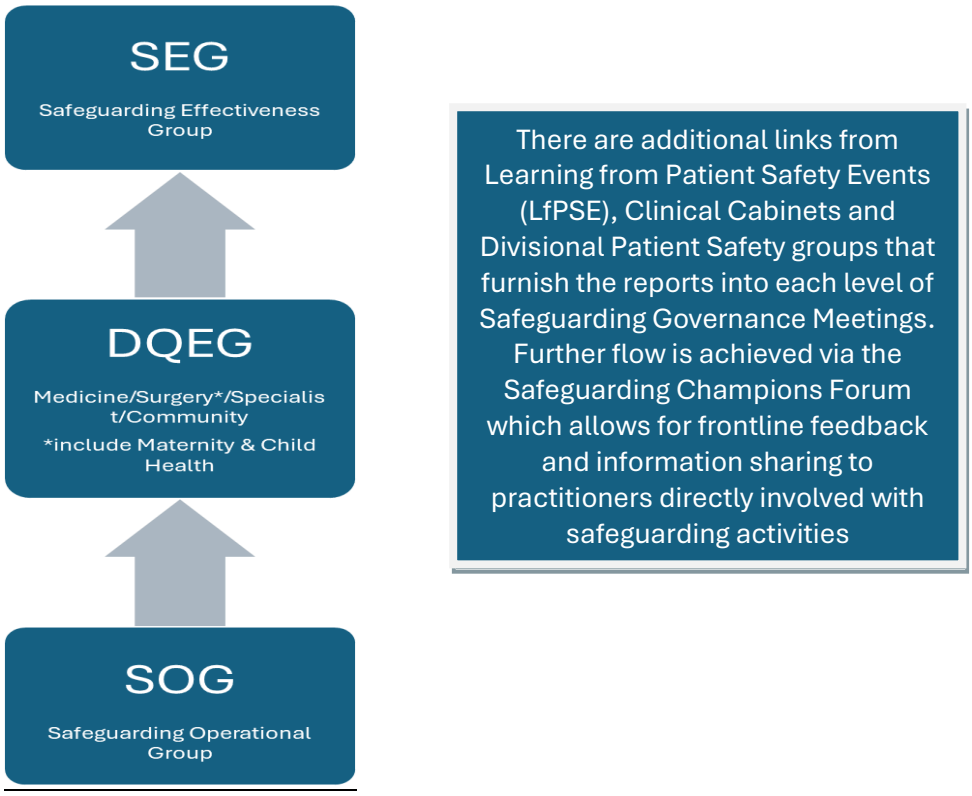
The 'Think Family' approach to safeguarding has become further mainstreamed across the Trust. Members of the Think Family Safeguarding Service have worked positively and enthusiastically to embed this ethos reviewing internal processes and acting on staff and service user feedback. Future development of the Think Family Safeguarding agenda remains a priority and supports new ways of working to ensure staff are supported and patients are protected. The commitment to improve safeguarding provision via effective care demonstrated within this report will continue to be built upon. From policies to process, supervision to training, education to advice and recognition to response, every single strand of safeguarding activity, provision and intervention will remain a focus for the Trust using the Think Family Safeguarding Service as a vehicle to deliver set objectives and priorities.

Appendices

Appendix 1 – Think Family Safeguarding Service Structure



Appendix 2 – New internal safeguarding governance framework 2024/25



Appendix 3 – Children in Care RAG Tool

Red = visit/contact 1 monthly dependent on need	Tick all that apply
1. Resident in children's home **WITH** safeguarding concern/ unmet health needs	
2. Poor attendance at school or NEET **WITH** safeguarding concerns/ criminality etc	
3. Unstable placement/ frequent moves	
4. Medical condition not managed or not under control	
5. Escalating emotional and behavioural issues e.g., anger, self-harm, anxiety, low mood	
6. CSE risk, Missing from home	
7. Criminality, missing from home	
8. Frequently missing from home	
9. Living at home with parents with safeguarding concern/ unmet health needs	
10. Concern re, safety and risk substance misuse, sexual health concerns	
11. Other- please state	
Amber = visit/contact 3 monthly dependent on need	
1. Average attendance at school	
2. Unsettled or change in placement	
3. Medical condition that is managed but needs oversight	
4. Low level emotional behavioural (accessing CAMHS/counselling)	
5. Missing from home episodes	
6. New move to pre adoptive placement	
7. Neurodevelopmental disorder / investigations	
8. Outstanding immunisations	
9. Resident in children's home but no safeguarding concerns	
10. Other – please state	
Green = visit/ contact 6 monthly dependent on need	
1. Settled in college/school	
2. Settled in placement for over 6 months	
3. No medical condition	
4. Minimal limited emotional behavioural difficulties	
5. Other - please state	