Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 26 March 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (March 2025)** *Purpose: To **note** the Employee of the Month presentations for March 2025*	Film	Chair *(10 mins)*
10.10	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.25	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB25/017 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 26 February 2025*	Report	
	6.	**TB25/018 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
10.35	7.	**TB25/019 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*	Report	L Barnes G Lawrence obo L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Reports				
11.05	8.	**TB25/020 Committee Assurance Reports** 8.1. Executive Committee 8.2. Charitable Funds Committee 8.3. Quality Committee 8.4. Strategic People Committee 8.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper S Connor obo H Scott G Brown C Spencer obo L Knight C Spencer *(40 mins)*
Other Board Reports				
11.45	9.	**TB25/021 MWL Health Inequalities Strategy 2025-2028 and Delivery Plan 2025/26** *Purpose: To **approve** the MWL Health Inequalities Strategy 2025-2028 and Delivery Plan 2025/26*	Report	W Longshaw *(20 mins)*
12.05	10.	**TB25/022 Freedom to Speak Up Board Self-Assessment** ***Purpose:** To **approve** the Freedom to Speak Up Board Self-Assessment*	Report	AM Stretch *(10 mins)*
12.15	11.	**TB25/023 2025/26 Financial and Operational Plan** *Purpose: To **approve** the 2025/26 Financial and Operational Plan*	Report	G Lawrence / L Neary *(15 mins)*
12.30	12.	**TB25/024 CQC Compliance and Registration** *Purpose: To **approve** the CQC Registration Declaration*	Report	L Barnes *(10 mins)*
12.40	13.	**TB25/025 Elimination of Mixed Sex Accommodation Annual Declaration** *Purpose: To **approve** the Mixed Sex Annual Declaration*	Report	L Barnes *(10 mins)*
12.50	14.	**TB25/026 2024 Staff Survey Report and Action Plan** *Purpose: To note the 2024 Staff Survey Report and **approve** the action plan*	Report	M Szpakowska *(10 mins)*

13.00	15.	**TB25/027 Trust Objectives 2025/26** *Purpose: To **approve** the Trust objectives for 2025/26*	Report	R Cooper *(10 mins)*
Concluding Business				
13.10	16.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.15	17.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 30 April 2025 at 09:30		**13.20 close**
20 minutes lunch break				

Chair: Richard Fraser

The Board meeting is held in public and can be attended by members of the public to observe but is not a public meeting. Any questions for the Board may be submitted to Juanita.wallace@merseywestlancs.nhs.uk 48 hrs in advance of the meeting.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 March 2025
Agenda Item	**TB25/000**			
Report Title	Patient Story			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Yvonne Mahambrey; Quality Matron Lucy Talbot; Professional Lead SALT/ Therapy Operational Manager Naomi Parllaku; Physiotherapist Critical Care.			
Action Required		**To Approve**	X	**To Note**

Purpose

To present Neil's experience of stepping down from critical care and how the new rehabilitation passport aims to facilitate a seamless continuation of targeted therapy recommendations for patients to enable full rehabilitation potential.

Executive Summary

Critical care is specialised care and treatment for patients whose condition is life-threatening and who require constant monitoring. Critically ill patients frequently experience longer term physical and psychological complications. Prolonged stays in critical care are linked to impaired quality of life, functional decline, increased morbidity and mortality, cognitive impairments including delirium, low mood, higher costs of care and extended lengths of hospital stay.

Neil recently spent time in critical care after he was involved in a high-speed motor collision. He sustained extensive injuries which included fractures to his ribs and spine, damage to major vessels and traumatic brain injury. He received initial trauma specialised neurological care at other specialist hospitals. In August he was transferred to Critical Care at Whiston Hospital to continue his medical treatment and therapy input.

Neil is an avid runner, hill climber and heavy goods vehicle (HGV) driver. For him the impact of being immobilised in a HALO brace for months was huge on his emotional and psychological wellbeing. As such he was prevented from doing the things that mattered to him, running, climbing and driving his HGV. He only hoped of getting back to them one day.

Neil speaks candidly about his journey and describes a self-consciousness about the immobilisation of his neck and spine that was obvious to everyone. He lost some self-confidence and self-esteem and describes being very withdrawn at times. He built real trust in particular staff on the ward and found the photos of him doing the things he loved useful to enable staff to get to know the person behind the Halo. He talks about his rehabilitation targets being clear because of the passport and how this continued link with intensive care made him feel less nervous about leaving the security of that environment.

Therapists working in Critical care follow the guidance set out by National Institute for Health and Care Excellence (NICE) in Rehabilitation after critical illness in adults' Clinical guideline [CG83]. This guidance recommends that patients in Critical care should have agreed rehabilitation goals that are regularly reviewed and updated. It also advised that patients leaving Critical Care to step down to a ward should have a formal structured handover of recommendation and care to ensure that the transfer of patients is safe and effective and promotes continuity of care.

A review of current stepdown processes was carried out in 2024, this identified two main themes.

- Patient goals were not consistently documented
- Handover information to ward therapy staff was variable.

The impact of this was identified that due to a lack of handover a patient did not receive the appropriate amount of therapy input on the wards that was required. To improve compliance with NICE Guidance and promote an improved multidisciplinary team (MDT) approach to step down handovers, the rehabilitation passport was developed.

The passport is used for all patients who spend four days or more in Critical care and involves documenting daily updates of patients' progress, daily scores of the Chelsea Critical Care Physical Assessment tool (CPAx) outcome measure, and goal setting. Once the patients are discharged from Critical Care the handover is completed to include both physical and non-physical domains. The document is then provided to therapy staff on the stepdown ward.

Lessons Learned:

- The importance of a clear, thorough handover between Critical care and the ward Therapists to support with patients ongoing goals and rehabilitation.
- Limited feedback received from ward staff about how they use the passports.
- Audit completed against national guidelines on the use of Critical Care Rehabilitation passports at Whiston Hospital. Results showed that the rehab passports meet national guidelines and Therapy staff like them as a thorough handover of care (Audit results can be available on request)
- Occupational Therapists now follow up patients three months after leaving hospital via telephone.
- An audit on the usage/ completion of the rehabilitation passport has been completed

Next Steps:

- To explore the role of therapists in the Critical care follow up clinic (current running with Rehabilitation nurse and Consultant)
- Therapy involvement within the creation of a video tour of the critical unit for patients and families.
- More deliberate and focused sharing of the Rehabilitation passport with patients prior to discharge from Critical care and at specific touch points in their journey to discharge.
- Planned implementation of Quality-of-life assessment with patients (5EQ/5D/5L assessment).
- Work towards Standardisation of Rehabilitation passport Trust wide.

Financial Implications
None as a direct result of this paper.
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the Patient Story

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways

X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / or Microsoft Teams
Wednesday 26 February 2025
(Approved by the Trust Board on Wednesday 26 March 2025)

Name	Initials	Title
Richard Fraser	RF	Chair
Gill Brown	GB	Non-Executive Director & Deputy Chair
Rob Cooper	RC	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Lynne Barnes	LB	Acting Director of Nursing, Midwifery & Governance
Nicola Bunce	NB	Director of Corporate Services
Steve Connor	SC	Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	Non-Executive Director (via MS Teams)
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Acting Director of Human Resources
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Sarah Harwood	SH	ST7 Anaesthesia, MWL (Observer) (via MS Teams)
Katie Hurst	KH	Head of Strategic Relationships, HBSUK (Observer) (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Angela Ball	AB	Halton Council Representative (Stakeholder Representative)
Rani Thind	RT	Associate Non-Executive Director

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for February 2025 was Debbie Warburton, Ward Manager, Ward 1D, Whiston Hospital and the Board watched the film of LB reading the citation and presenting the award to Debbie. **RESOLVED:**

	The Board **noted** the Employee of the Month for February 2025 and congratulated the winner
2.	**Chair's Welcome and Note of Apologies**
	2.1. RF advised that he had recently visited Ian Clayton's (IC) widow who had passed on the family's thanks to everyone at MWL for their support through his illness. Mrs Clayton had felt that continuing as a NED had helped IC and distracted him from his illness. 2.2. RF welcomed all to the meeting including KH and SH who were attending as observers. 2.3. RF noted the apologies of RT and AB. 2.4. RF acknowledged the following awards and recognition for Trust staff and services: 2.4.1. Caitlin Riley from the Estates and Facilities team won the 2025 MWL Apprentice of the Year award. Stevie Murphy, from the Finance Team, and John Feather, of the Workforce Systems and Information Team were also congratulated as the other finalists. 2.4.2. Abbey Cookson-Cliffe, System Manager, Informatics, had won the Intec Business College Higher Apprentice of the Year Award for 2025 2.4.3. Ward 14A at Southport Hospital was the latest team to be awarded 5 Stars in the MWL Ward Accreditation programme. Apologies for absence were **noted** as detailed above
3.	**Declaration of Interests**
	3.1. There were no new declarations of interests in relation to the agenda items.
4.	**TB25/001 Minutes of the previous meeting**
	4.1. The Board reviewed the minutes of the meeting held on 29 January 2025 and approved them as a correct and accurate record of proceedings subject to the following amendments: 4.1.1. 8.2.1.7 to be amended to read *'The Committee received the first MWL annual report by the Controlled Drug Accountable Officer which had provided a high level of assurance in relation to practice at the Trust. Benchmarking information was requested for future reports, if available* 4.1.2. 13.3 to be amended to read *'PW noted that after a review cases were often downgraded as there was a greater understanding of the circumstances surrounding the deaths which were found to be unavoidable'* **RESOLVED:** The Board **approved** the minutes from the meeting held on 29 January 2025 subject to the amendments detailed above

5.	**TB25/002 Matters Arising and Action Logs**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. LB provided an update on Action Log number 5 (TB25/008 Aggregated Incidents, Complaints and Claims Report (Q3)) and advised that a deep dive had been completed, and the report had been presented at Quality Committee. The information was included in agenda item TB25/015 Maternity and Neonatal Services Assurance Report Quarter 3. **Action closed.** **RESOLVED:** The Board **approved** the action log.
Performance Reports	
6.	**TB25/003 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for January 2025 was presented.
6.1.	**Quality Indicators**
	6.1.1. LB and PW presented the Quality Indicators. 6.1.2. LB highlighted the following: 6.1.2.1. The inpatient Family and Friends Test (FFT) recommendation rate in January 2025 had been 94% against the target of 90%. 6.1.2.2. The Nurse staffing fill rate was 96.4% against the target of 90%. 6.1.2.3. In quarter 3 the Clostridioides difficile (C.Diff) rate for MWL was 32.2 per 100,000 bed days which was below the Cheshire and Merseyside (C&M) rate of 38.6. The Trust was on track to achieve the NHSE threshold for 2024/25. 6.1.2.4. There had been 12 cases of Escherichia coli (E.coli) reported in January 2025 with 136 cases Year to Date (YTD) against a threshold of no more than 171 cases. 6.1.2.5. There had been a reduction in falls and falls resulting in harm across all Trust hospital sites. The decaffeinated drinks trial had been a success, and this would now be rolled out to additional wards. LB noted that a deep dive that had been undertaken by AMS had not highlighted any additional lessons to be learnt. LB advised that she had also commissioned an independent clinical peer review of falls and Trust falls policies to ensure MWL was following best practice. 6.1.2.6. One Never Event had been reported in January 2025 (local anaesthetic in wrong finger) and was undergoing a full investigation. LB assured that, whilst there had been no harm to the patient, safety checks for theatres across all hospital sites would be reviewed. LB also advised that as there had been more than one never event in theatres, incidents would be reviewed for trends and themes. PW noted the importance of having

	standardised best practice processes in place across all MWL theatres to embed learning and prevent similar incidents in the future. 6.1.2.7. PW advised that the reported Hospital Standardised Mortality Ratio (HSMR) data to June 2024 and the YTD HSMR remained below 100 at 94.7. However, the in-month figures for June were higher than expected at 110.5. PW reported that he had reviewed the data, and the increase was due to higher crude mortality rates for that month primarily at Whiston and St Helens Hospitals and was within the expected in-month variation. PW had asked for all the deaths in June 2024 at these sites to be reviewed to determine if there were any themes or any avoidable mortality, but to date the Mortality leads had not identified any issues of concern.
6.2.	**Operational Indicators**
	6.2.1. LN presented the operational indicators and highlighted the following: 6.2.1.1. The 4-hour mapped performance in January 2025 was 78.6% against the national target of 78%. This compared to 72.3% nationally and 72.93% for C&M. LN advised that, whilst the Trust remained a positive outlier, there had been challenges with ambulance handovers and long waits for admission in the Emergency Department (ED) during January. 6.2.1.2. A critical incident had been declared at Whiston Hospital on 02 January 2025 and had been stepped down on 13 January. LN noted that the system response and internal Trust recovery work that had continued since the critical incident had resulted in slightly better ED performance for January than originally expected. LN noted that all the escalation beds in use during this period had previously been risk assessed and there were standard operating procedures (SOP) in place to ensure that suitable patients were selected to be cared for in these areas and this included the ED corridors. 6.2.1.3. LN advised that the situation had improved in February and the EDs at Whiston and Southport Hospitals had been set ambitions for ambulance handover times by the Integrated Care Board (ICB) and these had been achieved to date. 6.2.1.4. A critical incident debrief had been undertaken to learn lessons from the Trust's and wider system response, as was good practice for any Emergency Preparedness, Resilience and Response (EPRR) incident. 6.2.1.5. Twice weekly meetings with system partners were continuing to facilitate patient discharges from the Trust. One of these meetings each week reviewed complex discharges and the longest length of stay patients in the Trust and there was sharing and learning between partners. The previous week 30 patients with the longest length of stay had been reviewed and seven discharges had been achieved. These meetings had led to a better understanding of the challenges for the different system partners but had not significantly reduced the number of non-criteria to reside (NCTR) patients. 6.2.2. LN advised that the Emergency Care Improvement Support Team (ECIST) were still supporting daily board rounds at Whiston Hospital to help improve

	the discharge processes and a consultant from North Tees and Hartlepool NHS Foundation Trust had met with clinicians and operational leads to discuss the Trust's model of care, in particular, medical input into the Whiston Hospital Accident and Emergency (A&E) department. LN noted that escalation processes and early warning metrics had now been introduced so that there could be earlier intervention and escalation to system partners. 6.2.3. GB asked why only seven of the 30 long stay patients had been discharged. LN responded that discharge capacity for elderly mentally infirm (EMI) patients was one of the biggest challenges for discharge from the acute hospital setting, there were also similar delays for patients needing specialist rehabilitation. Patients who were "out of area" or homeless were particularly challenging to arrange discharge for. To illustrate this LN informed the Board that three of the seven beds on the Critical Care Unit (CCU) at Southport Hospital were currently occupied by patients with complex needs who needed to be discharged to specialist units which had a waiting list, so remained in hospital until a place became available. C&M had recently instigated weekly reporting on patients with the longest length of stay in each Trust. GB agreed that having visibility of these patients would be a step forward but noted it did not create more capacity for super stranded patients in acute medical beds which was not something the Trust could control. 6.2.4. RF commented that this was one of the three shifts that the government wanted to see in the NHS and noted that super stranded patients and their impact on patient flow had been discussed at every forum that he had attended recently and it was good to see the system now working together to resolve the issue. 6.2.5. RC reflected that the ICB were planning on making funding available in 2025/26 to start to transform urgent and emergency care. It had been observed that there had been an increase in staff working in Urgent and Emergency Care but not an increase in attendances at ED. This was because of the big changes in the numbers of NCTR patients and the use of escalation beds in many hospitals. However, RC noted that corridor care was not currently included in bed numbers, because the care was being provided in the ED. This had been feedback to the ICB and hopefully would help counter the NHSE national team's belief that the patient flow issues were mainly due to reduced productivity and efficiency. 6.2.6. CS observed that some trusts had recruited Directors of Population Health to help better understand health equity issues, changing population demographics and the changing demand burden on social and health care. Additionally, CS observed that Directors of Adult Social Care were not yet involved in the strategic market management of the care home sector and this was something that was needed to ensure the necessary capacity was available to meet the local population needs. RC agreed that there was a fundamental issue with the care home sector and it appeared that Local Authority contracting arrangements were no longer fit for purpose to meet the

requirements of the system. RC advised that in his view there was not a lack of understanding of population characteristics or the changing demographics, but the main issue was that social care and healthcare systems were managed separately with different statutory responsibilities and imperatives and more coordination of these budgets would probably yield greater benefits.

6.2.7. RF commented that the pending increase in national insurance would likely mean that more care homes would close, putting even greater pressure on the NHS.

6.2.8. NB commented that the lack of active service commissioning since the Covid-19 pandemic meant that changes in activity and demand had not been funded.

6.2.9. LN advised that there had been a continued improvement in the referral to treatment (RTT) target with 60.7% of patients seen and treated within 18 weeks, in January (in C&M this was 56% and nationally 58.9%). LN commented that the opening of the two new theatres at Whiston Hospital had contributed to this improvement.

6.2.10. LN reported that the number of 65+week waiters had increased from 86 in December 2024 to 144 in January 2025 and noted that weekly updates were being received by Executive Committee. LN advised that the increases were due to patient choice (40%), complexity of cases (18%) and capacity issues (42%) mainly in plastic surgery. The Getting It Right First Time (GIRFT) team would be visiting all the Trust sites to provide support to optimise capacity to reduce waiting lists.

6.2.11. Diagnostic waiting time performance in January was 93.6% against the target of 95% to be seen within six weeks, with a focus on reducing long waiters.

6.2.12. LN highlighted the following in respect of Cancer performance:

6.2.12.1. Performance against the 62-day cancer standard was 75.7% (with the C&M performance at 74.9% and national performance at 71.3%).

6.2.12.2. Performance against the 28-day cancer standard had increased to 78.2% in December 2024 from 75% in November.

6.2.12.3. LN advised that Cancer Improvement Plans had been presented at the Finance and Performance (F&P) Committee. A Cancer Strategy Workshop was held recently. LN advised that a single cancer management team was now in place for MWL and were standardising processes. LN noted that one of the questions raised at the F&P Committee had been why there was a disparity between the cancer performance on the Southport and Ormskirk Hospitals sites compared to the Whiston and St Helens Hospitals sites. LN had noted that this was a historical issue linked to some of the fragile services at legacy S&O, but the improvement plans were tumour specific plans, with specific actions to reduce waiting times across the whole Trust, and assurance of their impact would continue to be

	reported to the F&P Committee. LN reported that there were several tumour site pathways, for example, head and neck that had one or two patients on the pathway each month and one breach would have a significant impact on the percentage performance.
6.3.	**Workforce Indicators**
	6.3.1. MS presented the Workforce Indicators for January and highlighted the following: 6.3.1.1. The compliance rate for appraisals was 86.9% against the target of 85%. 6.3.1.2. The compliance rate for mandatory training was 87.7% against the target of 85%. 6.3.1.3. Sickness absence had increased to 7.1% in January against the 5% target, and this was 0.7% higher than the same period in 2023/24. MS commented on the difficulty obtaining benchmarking data from other NHS Trusts to compare performance and noted that NHS Digital had not been updated since September 2024. However some data was available from NHS Workforce Intelligence which indicated that the Trust was comparable to other organisations in the North West region. MS assured the Board that reducing absence levels remained an area of focus and noted that stress, anxiety, and depression continued to be reported as the top three reasons for sickness. 6.3.1.4. Staff turnover had been 0.6% in month against the target of 1.1%. 6.3.2. LN asked if there was a correlation between the level of sickness absence and increased urgent care activity and operational pressures on the wards. MS responded that this did not seem to be the case as the biggest increases in sickness absence in January had not been amongst ward or ED staff. MS noted that focus remained on supporting staff to return to and remain in work.
6.4.	**Financial Indicators**
	6.4.1. GL presented the financial indicators and highlighted the following: 6.4.1.1. The final approved MWL financial plan for 2024/25 was a deficit of £10.9m which assumed: • Payment of £12m funds in line with the transaction business case • A Cost Improvement Programme (CIP) target of £48m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 elective activity plan • Non-recurrent deficit funding of £15.8m 6.4.1.2. At month 10 the Trust had reported a deficit of £13.1m and whilst this was £5.3m better than plan, GL noted that the Trust had received £8m of transaction support earlier than anticipated and this meant that the Trust should have been £8m better than plan. The main reasons for not meeting the plan were the unmitigated industrial action pressure of £1.1m and non-delivery of the activity plan. The Trust was £1.6m behind the recovery trajectory.

	6.4.1.3. The Trust remained on track to deliver CIP of £48m. At month 10, the Trust had successfully delivered £41.6m of CIP, of which £33.7m was recurrent with a further £1.0m of recurrent CIP at the finalisation stage. 6.4.1.4. The cash balance at month 10 was £3.4m, and the Trust anticipated a closing cash balance of circa £2.7m as per plan at the end of the financial year. 6.4.1.5. Agency spend was 3.6% of the pay bill and GL noted that this was an improvement from 4% at the start of the financial year. 6.4.1.6. The Trust continued to forecast full delivery of the Capital Programme. 6.4.2. GL reported that he was discussing the finalisation of the year end outturn with the ICB. 6.4.3. LN reported that the Medicine and Urgent Care Division CIP update had been presented at the F&P Committee and advised that the staff had been commended for the delivery of CIP despite the challenges faced by the Division. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB25/004 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. RC presented the Executive Committee Assurance report from the meetings held in January 2025 and noted that any bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. Additionally, the meeting received Assurance Reports from the Premium Payments Scrutiny Council and the weekly vacancy control panel. 7.1.2. RC highlighted the following: 7.1.2.1. The Committee had discussed the Performance Management Framework needed for MWL and RC noted that monthly Performance Management meetings would take place with each division. 7.1.2.2. The Committee had received the Urgent and Emergency Care (UEC) National Patient Survey results and the number of UEC action plans and cross over of these had been discussed with a view to centralise these into a single UEC action plan. 7.1.2.3. The Committee had discussed the financial position for the remainder of 2024/25 and had noted that the 2025/26 planning assumptions would change once the national planning guidance was published. 7.1.2.4. The Committee had received an update on the 2024/25 Staff Vaccination Programme, and it was noted that the uptake of the Covid-19 and Flu vaccine offers had remained low at the Trust and this reflected the position nationally.

	7.1.2.5. The Committee had received the Theatre Improvement Plan update and RC stressed the importance of achieving the elective activity targets in 2025/26. 7.1.2.6. The Committee had reviewed the Carbapenamase Producing Enterobactererales (CPE) Business Case which presented options for increasing the screening capacity to meet new national guidance. RC noted that, whilst the Committee had supported the business case in principle, additional work was required to understand the operational implications, and the team would re-present the case with this additional information. 7.1.2.7. The Committee had received an update on the UEC Improvement Programme and RC referred to the discussions of earlier reports on the Board agenda and the importance of discussing what could be done by both the Trust and wider system to improve UEC performance and the experience for patients. 7.1.3. RC advised that the following investments had been approved in January 2025: 7.1.3.1. Histopathology Consultant Business Case to recruit substantive consultants into roles that were currently being filled by agency locums and RC noted that this would offset the agency spend. 7.1.3.2. The capital purchase of the former Rainhill Library building The remainder of the report was **noted.**
7.2.	**Audit Committee**
	7.2.1. SC presented the Audit Committee Assurance Report for the meeting held on 19 February 2025 and highlighted the following: 7.2.1.1. The Audit Committee had received the External Audit Update, and it was noted that planning for the 2024/25 external audit had started. Grant Thornton (GT) had advised that work would be completed in line with the national timetable and the External Audit Opinion as well as the Value for Money (VFM) report would be completed in June 2025. 7.2.1.2. The Committee had received a report which detailed the Trust audit risk assessment and management responses, and no new significant risks had emerged since 2023/24. 7.2.1.3. MIAA had issued four internal audit review reports since October 2024. Three reports (Complaints Management, Council Effectiveness and Patient Activity Data Capture) had received substantial assurance and the 5 Star Ward Accreditation report had received high assurance. 7.2.1.4. The Committee had received the MWL Audit Log, which listed all the recommendations from previous internal audit reports and provided assurance that the agreed management actions had been implemented in the planned timescales. 7.2.1.5. The Committee had received the anti-fraud progress report and it was noted that 11 elements were rated as green and one was rated amber (the Conflict of Interest (COI) return percentage completion rate) and work was ongoing to achieve the 80% target.

	7.2.1.6. The Committee had received the proposed workplan for 2025/26 and this had been approved with one minor amendment that the Auditors Annual Report and Audit Findings Report and Opinion was moved to June 2025. 7.2.1.7. The Committee had received the Losses and Special Payments report and had requested that a report on pharmacy write-offs be presented to a future meeting. 7.2.1.8. The Committee had noted the Aged Debt report. 7.2.2. SC reported that following the closure of the main meeting, the Committee had approved the process for the procurement of an external auditor contract for 2025/26 onwards. 7.2.3. RF asked for more information about the reported losses of £334k. SC explained that this predominately related to a write-off of pharmacy stock, but lesser amounts were due to the loss or damage of patient property. SC commented that there had been a decrease in pharmacy write-offs compared to 2023/24. The remainder of the report was **noted**.
7.3.	**Quality Committee**
	7.3.1. GB presented the Quality Committee Assurance Report for the meeting held on 18 February 2025 and highlighted the following: <u>Quality Committee Corporate Performance Review (CPR)</u> 7.3.1.1. The Committee had discussed the Never Event that had been reported in January 2025 (wrong site anaesthetic block) as well as the ongoing clinical review in theatres which focused on the three Never Events YTD. 7.3.1.2. There had been a reduction in falls resulting in moderate or severe harm in month and there were focused actions which included medication reviews and the decaffeinated drinks project to sustain this improvement. GB advised that the business case for supplementary care for substantive staff for five ward areas had been approved by the Executive Committee. The Committee had been informed that an external falls review had also been commissioned. 7.3.1.3. There remained a focus on the improvement actions for Whiston Hospital for Venous Thromboembolism (VTE) and the Committee were assured that the VTE risk assessment was available on the Electronic Prescribing and Medicines Administration (EPMA) system and that there had been an improvement in compliance. It was noted that a single EPMA was not yet available across all MWL sites. 7.3.1.4. There had been an improvement against the nutrition metrics, however dietetic referrals remained an area of focus, and the Dietetic IT referral process was under review. 7.3.1.5. A deep dive into the Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) cases was ongoing, with the aim of identifying where clinical practice needed to be improved.

7.3.1.6. Level 2 Aseptic Non Touch Technique (ANTT) training compliance remained challenged and the divisional areas that required increased focus had been identified.

7.3.1.7. The Committee noted a deterioration in performance of issuing outpatient discharge letters process. The Committee had been assured that the urgent letters were issued within 48 hours and actions to improve the performance for routine letters were underway.

7.3.1.8. The Committee had noted the Executive Committee was reviewing the reporting of sepsis metrics.

Mandatory Training Compliance Report Q3

7.3.1.9. The Committee had noted the ongoing work to align mandatory training across MWL, and that the training needs analysis (TNA) had now been completed.

7.3.1.10. The implementation would commence from the start of 2025/26.

7.3.1.11. The Committee had noted that while both mandatory and compulsory skills training compliance was above the 85% target overall; there were still subjects and services/departments that were not yet achieving 85% compliance and these were being reviewed to identify the reasons.

Patient Experience Report

7.3.1.12. The Committee had received a comprehensive report which included an update on various patient surveys and noted the importance of aligning the various action plans where there were common themes.

7.3.1.13. The draft Patient Experience and Inclusion Strategy had been received for comment and would be presented to the Board for approval.

Patient Safety Report

7.3.1.14. The MWL InPhase system was due to be launched in March 2025.

Monitoring of the Annual Trust's Objectives aligned to Quality Committee Q3 Update

7.3.1.15. The Committee had noted that good progress had been made against some objectives but for others the improvement would take longer and the objectives would need to be carried into 2025/26.

7.3.2. RC reflected on the maternity patient survey and commented that by the time the results were published the next survey cycle was due to start, so the impact of the actions agreed following the 2024 survey results were unlikely to be reflected in the 2025 results. For this reason, the Trust was also undertaking local surveys to understand patient feedback in real time. RF reflected on the importance of triangulating all sources of patient feedback.

7.3.3. RF asked for additional information about the reported consultation on Trust visiting hours. LB responded that extending visiting hours was an important part of the plans to address supplementary care needs, reduce falls and ensure families were involved in the patients care. LB noted that one of the main themes from complaints was communication with patients and families and consultations were taking place to introduce more flexible visiting times

	with a view to make these more family than patient centred. There would be challenges for Infection Prevention and Control (IPC) as well as ward rounds and these needed to be taken into account. The objective was to extend visiting hours initially. LB assured the Board, that if a patient had dementia and delirium or any kind of extensive need, family members were currently accommodated, and John's Campaign was implemented. RF commented that this was a complex area but would be one of the main areas that patients would judge the Trust as being compassionate and caring. The remainder of the report was **noted**.
7.4.	**Strategic People Committee**
	7.4.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 19 February 2025 and highlighted the following: 7.4.1.1. The Committee received the first Employee Relations (ER) Annual Update for the Trust and Lead Employer (LE) which also provided an overview of the national landscape around policy and guidance. 7.4.1.1.1. The report detailed the steps that had been taken to reduce the time taken to complete ER cases and ensure consistency in the process across MWL. There was assurance that there had been improvements but further work was required. 7.4.1.1.2. The complexity of the ER cases was discussed and it was noted that one of the issues was the capacity of managers and their expertise and confidence to conduct investigations such as the initial 72 hour reviews. The workforce team were developing additional support and training materials for managers. 7.4.1.2. The reasons for the delay in finalising cases included the limited supply of trained mediators as well as the challenge of taking these people away from their clinical and operational roles to undertake mediation. 7.4.1.3. The Committee had discussed the number of ER cases arising from the breakdown of relationships within teams. There had also been an increase in the number of complex cases, for example involving allegations of domestic or child abuse, that needed to involve safeguarding and other external agencies. Some of these cases could be traumatic and the staff involved needed specialist support. An increasing trend of cases arising from the use of recreational drugs by staff had also been noted. 7.4.1.4. The report had included an action plan that the Employer Relations Team was implementing and progress and the impact would be monitored via the Strategic People Council (SPC) and the Employee Relations Oversight Group (EROG). The remainder of the report was **noted**.
7.5.	**Finance and Performance Committee**
	7.5.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 20 February 2025. It was noted that the Committee had reviewed the F&P CPR and monthly finance report, but the

	key points had already been discussed in earlier reports at the meeting so would not be repeated. Other points to highlight from the report were: 7.5.1.1. The Committee received an update on the national planning guidance for 2025/26 and what this meant for the Trust's planning. The significant financial challenges across the NHS, C&M and for the Trust had been discussed and the Committee had noted that work was ongoing to identify opportunities for improvement. It was noted that recent changes in the NHSE leadership had created some uncertainty, and the difficulty of planning in this environment had been acknowledged. 7.5.1.2. The Committee had highlighted that the NCTR numbers, despite an improvement from December 2024, remained significantly high. The Committee had discussed the impact of the NCTR on overall operational performance and the Executive Committee had been asked to review the reported metrics in this area to assist the Trust in making the wider system aware of the challenges being faced. 7.5.1.3. The Committee had received the Month 10 CIP report and recognised the hard work required to deliver a strong CIP programme, which already included a pipeline of schemes for 2025/26. The Committee had received a CIP presentation from the UEC Division which provided assurance that the Division was on track to deliver their CIP target of £9.7m. Additionally, the Division had already identified £5.2m of CIP ideas for 2025/26. 7.5.1.4. The Committee had received the Cancer Performance report which detailed the waiting time performance for each tumour pathway and the faster diagnostic standard, with the planned improvement actions. A deep dive into each tumour site pathways was planned during March and April to test the improvement actions. 7.5.2. The Committee received the council assurance reports from the CIP Council, Capital Planning Council, Estates & Facilities Management Council, and IM&T Council. There had been no issues escalated to the Committee from the reporting councils. 7.5.3. RF reflected on the importance of being able to demonstrate the impact of the % of beds occupied by NCTR patients to system partners. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
8.	**TB25/015 Maternity and Neonatal Services Assurance Report Quarter 3**
	8.1. LB presented the Maternity and Neonatal Services Assurance Report Quarter 3 which provided information about the quality and performance of the maternity and neonatal services across the Trust. It was noted that a more in-depth report had been presented at the Quality Committee. LB extended her thanks to the Divisional Director of Midwifery for compiling the report.

8.2. The detailed Maternity Incentive Scheme (MIS) Year 6 report had been presented to the Quality Committee and Board in January 2025 with representatives from the Local Maternity and Neonatal System (LMNS) in attendance. The Trust had self-declared full compliance, and this had been signed by RC as well as the CEO of the C&M ICB.

8.3. LB highlighted the following:

Maternity and Neonatal Dashboards

8.3.1. There was a continued focus on the referral of pregnant women who smoked to the stop smoking services with an aim to support a smoke-free pregnancy. 100% compliance for referrals had been achieved in December 2024.

8.3.2. The percentage of women who had initiated breast feeding in December 2024 had improved to 67.8% (YTD 61.8%) and work was ongoing to further increase this, including additional staff training.

Perinatal Mortality (Safety Action 1)

8.3.3. Cases were presented to the Maternity Safety Champions meetings, Quality Committee and to the Board via the Patient Safety report. LB reported that ten cases had been reported in Q3 and all the cases were undergoing a multidisciplinary review using the Perinatal Mortality Review Tool (PMRT) and the Mothers and Babies: Reducing Risk through Audits (MBRACE) categorisation.

Serious Incidents

8.3.4. Two incidents had been reported in Q3 and were subject to internal review and the Maternity and Newborn Safety Investigation (MNSI) process.

8.3.5. The Board had received an aggregated incident, complaints and claims report for Q3 in January 2025 that had identified labour and delivery as the fifth most common category of incident reported on the Ormskirk site. Following a deep dive, it had been established that the category had been changed to include blood loss of 500-999mls on the Ormskirk reporting system in August 2024 and this had accounted for the increase in reported incidents. 194 incidents had been reported for the Ormskirk site, and if the same category definitions were applied to the Whiston, 305 incidents would have been reported. LB commented that this was a proactive thing to do and assured that every incident had been reviewed and there were no lessons to be learned. The categorisation of maternity incidents was being standardised across MWL.

Saving Babies Lives (SBL) (Safety Action 6)

8.3.6. LB reflected on the improvement in outcomes for babies and mothers since the introduction of Clinical Negligence Scheme for Trusts (CNST) and SBL.

8.3.7. SBL focused on reducing smoking in pregnancy, risk assessment and surveillance of fetal growth restriction and reducing preterm birth.

8.3.8. As reported at the January Board the Trust was compliant with safety action 6.

Safety Champions (Safety Action 7)

8.3.9. LB reported that Safety Champion meetings were held monthly. LB and RT also took part in the Safety Champion Walkabouts attended by the Maternity and Neonatal Voices Partnership (MNVP) leads.

8.3.10. The Perinatal Quality Surveillance Model (PQSM) had been reviewed at the Safety Champion meeting and the Quality Committee. LB advised that the role and focus of the Safety Champions would be reviewed and refreshed to reflect the key issues for improvement in the next 12 months.

Complaints and Claims

8.3.11. Ten maternity/neonatal complaints had been received YTD, and one complaint remained open, and the complainant had been kept informed.

8.3.12. One new maternity claim had been received in Q3 and LB advised that the NHS Resolution claims scorecard was produced annually in September each year.

Maternity Red Flags

8.3.13. LB reported that the delay of 15 minutes or more between presentation and triage was a red flag incident and these had been discussed at Quality Committee. Most incidents occurred at the Whiston site.

8.3.14. LB reported on the actions to reduce the time to triage which included the installation of a new telephone system and training for staff. Every red flag incident was reviewed and none had resulted in any harm.

8.3.15. LB noted that as a result of the actions the Triage team was now consistently achieving over 98% of patients triaged within 15 minutes from arrival.

Workforce (Safety Action 4)

8.3.16. It was a requirement of MIS that maternity staffing reports were presented at Board twice a year and LB noted that the detailed staffing reports were included as Appendix 2 and 3.

8.3.17. LB noted there had been an increase in the number of births and bookings at the Ormskirk site since the last birthrate+ assessment in January 2022 and advised that, if this still formed part of the 2025 CNST requirements , a review would need to be commissioned.

8.3.18. LB advised that the birthrate+ staffing calculations were complex and included elements of direct clinical care and non-direct clinical care.

8.3.19. There was a historical difference in budget headroom between the Whiston and Ormskirk units but with an agreement in place to over recruit for the Whiston site from each new cohort of qualified midwives, whereas the establishment was higher at Ormskirk Unit. LB advised that a standardised approach would be adopted for MWL going forward.

8.3.20. Both sites had achieved 100% compliance for one to one care and midwife to birth ratio was static at 1 to 24 at Ormskirk site and 1 to 27 at Whiston site.

8.3.21. There had been numerous discussions around Neonatal staffing at the Executive Committee and Quality Committee due to the differences in acuity and activity levels. It was noted that issues with neonatal cot capacity were more frequent at Whiston site and options were being considered by the Executive Committee. LB also reported that discussions about neonatal cot capacity were taking place with the Specialist Commissioners.

	8.3.22. Both Neonatal units currently met the British Association of Perinatal Medicine (BAPM) Neonatal Nursing Standards outlined in MIS Year 6 utilising the Neonatal workforce calculators for each site which was undertaken in 2024 and shared with the Operational Delivery Network (ODN) which had been based on the current cot configuration. 8.3.23. Transitional care was in place at Ormskirk site and plans were in place for this to be rolled out to Whiston site by the end of Q4. Staff had been recruited and trained and were currently supporting the Neonatal unit at Whiston site where there were some staffing challenges. <u>Qualified in Speciality (QIS) Training Staff across MWL</u> 8.3.24. This was a mandatory requirement to ensure that 70% of the neonatal workforce were QIS trained and the Trust was working towards compliance. 8.3.25. LB highlighted the challenges around releasing staff to attend the training. <u>Maternity Suspensions of Services</u> 8.3.26. LB reported there had been no suspensions of maternity services at the Whiston or Ormskirk sites during Q3 and highlighted that Neonatal services had remained open to emergency admissions at all times. 8.4. LB advised that there remained an improvement focus on antenatal care to ensure the service met patient expectations. LB proposed that antenatal care be carried forward to the Trust objectives for 2025/26 to ensure this focus was maintained as a Trust priority. 8.5. LB reported that the Trust was currently in the second year of the NHSE 3-Year Plan for Maternity and Neonatal services and there were no areas of concern. The NHS England Regional Maternity Team had developed a process via a Maternity Provider Oversight Panel (MPOP) to review ongoing actions and progress around enhancing the continuity of care, to ensure that vulnerable women received targeted care and work continued to implement the recommendations. 8.6. RF reflected on the impact of SBL and asked if mothers to be were offered nicotine replacement patches. LB responded that she would need to investigate whether this was an option offered, but emphasised that the aim of the programme was to encourage mothers to stop smoking completely. PW advised that whilst nicotine replacement therapy was less harmful than smoking it was not risk free. **RESOLVED:** The Board **noted** the Maternity and Neonatal Services Annual Report Quarter 3
9.	**TB25/016 2023/24 Safeguarding Annual Report (Adults and Children)**
	9.1. LB presented the 2023/24 Safeguarding Annual Report (Adults and Children) which provided an overview of safeguarding activity across the Trust, and assurance that the Trust fulfilled all statutory requirements. LB advised that

	the 2024/25 Safeguarding Annual Report would be presented to the Board in June 2025 and annually thereafter. 9.2. LB highlighted the good work undertaken by the Safeguarding team and provided an overview of the various meetings attended by the team both internally and externally and noted that the team interacted with six PLACEs, two local authorities, two fire services and two police departments. Additionally in 2023/24 the team had attended Strategy meetings and professional case conferences and had been involved in safeguarding adult reviews with colleagues across the system. 9.3. LB highlighted the following key achievements: 9.3.1. The team had worked collaboratively to review and harmonise policies, processes and procedures for MWL. 9.3.2. The Safeguarding team had worked with the Digital Nursing Team to introduce electronic referrals via Care Flow Connect. 9.3.3. LB commended the team for the work that had been carried out from a learning disabilities perspective and noted the importance of having the right processes in place for patients with learning disabilities or autism and this included learning from Section 42 information requests made by Local Authorities to investigate any safeguarding concerns raised. 9.4. LB advised that there was an emerging pressure around the special educational needs and disability (SEND) agenda as there was increased demand following national inspections of local authority children's services. Another pressure was the increase in complex mental health cases. The Trust had been required to navigate some unique cases where no guidance was available. 9.5. LB highlighted the following: 9.5.1. 3,836 deprivation of liberty safeguards (DOLS) applications had been received in 2023/24 compared to 3,146 applications in 2022/23. 9.5.2. There had been an increase in the number of referrals to social care, mainly adults, and the number of referrals for children remained static. 9.5.3. There had been a big increase in multi-agency risk assessment conferences (MARAC) procedure referrals from 458 referrals in 2021/22 to 674 in 2023/24. 9.5.4. The Trust had received external funding for two Health Independent Domestic Abuse advisors based at Southport Hospital to manage cases of domestic and sexual abuse and to provide support to the victims throughout the process. However, this funding had now ended. 9.6. LB reported that under the PREVENT agenda there had been one referral made in 2023/24 from Whiston Hospital, however, this had resulted in no further action by the Police although the case had been managed via the allegations process. The Trust was compliant with PREVENT training.

	9.7. There had been an increase in the number of patients detained to the Trust under the Mental Health Act in 2023/24. LB noted that these cases were becoming more complex and included eating disorders. It was noted that a number of patients that had been overseen for safeguarding by the Children and Adolescent Mental Health Services (CAMHS) were now transitioning over to the Adult Safeguarding service. 9.8. An audit undertaken by MIAA in December 2023 of the safeguarding process had received a substantial assurance rating. 9.9. LB thanked the Safeguarding team for their continued hard work. 9.10. RC reflected on the audit activity reported and asked whether these audits were undertaken internally by the team. LB responded that the safeguarding audit process had now been harmonised across MWL and undertook to provide further detail on how the audits would be conducted. **Action** LB to provide further information on how the safeguarding audits were being undertaken in 2024/25. 9.11. RC reflected on the three safeguarding risks in the report which related to systems or processes outside of the organisation and asked if these needed to be escalated to partners. LB responded that a Service Level Agreement (SLA) with another organisation had been escalated to her and there had been a discussion about bringing the Mental Health Act Administration service in-house, however, the SLA system currently worked well for Sefton and West Lancashire patients and the Trust did not have the same levels of mental health expertise internally, however, there were capacity issues with the current provider that needed to be resolved. 9.12. RC reflected on the workplan for 2024/25 and asked how success would be measured. LB responded that all the actions were being tracked and a review of the 2024/25 action plan would be included in the 2024/25 Safeguarding Annual Report. 9.13. AMS reflected on the CAMHS challenges in ED and asked about the discussions with Merseycare to increase their service provision to support young people at home. LB responded that the low level CAMHS services were having an impact but the complex cases remained very time consuming and resource intensive. A system escalation process was in place that included the Director of Nursing and then the CEO to ensure the correct interventions and support were provided for children with Mental Health issues who ended up in an acute hospital setting. 9.14. GB commented that the report that was presented at Quality Committee had included case studies which illustrated the extraordinary lengths that staff went to keep patients safe and thanked all the staff involved in safeguarding patients for their hard work and dedication. GB acknowledged that these

	included patient identifiable details and were not appropriate for the public report but had vividly brought the issues to life. 9.15. RF asked that the Board's appreciation and thanks were passed onto the Safeguarding team. **RESOLVED:** The Board **noted** the 2023/24 Safeguarding Annual Report (Adults and Children)
Concluding Business	
10.	**Effectiveness of Meeting**
	10.1. RF invited SH and KH to reflect on the effectiveness of the meeting. SH commented that she had found the meeting interesting and gained a better perspective of what the Board did. SH commented that the Maternity and Neonatal Services Assurance report had been of particular interest to her as she had a special interest in maternity and obstetrics anaesthesia. 10.2. KH commented that she was currently undertaking research around how trusts were approaching elective recovery, and whilst this had not been discussed in detail at the meeting, she had reviewed previous Board papers. KH advised that she was involved in various initiatives with NHSE to bring a digital element to the faster diagnosis of cancer.
11.	**Any Other Business**
	11.1. RF advised that Graham Urwin (GU) had announced his retirement, and following the interview process that both RC and RF had been involved in, Cathy Elliott, who was currently the Chair of the West Yorkshire ICB, had been appointed as the new ICS Chief Executive. RF whished GU all the best for his retirement. 11.2. RF reported that Amanda Pritchard (AP) had also announced that she was stepping down from leading NHS England and Sir James Mackey would be taking over as the Transitional CEO of NHSE from 01 April 2025. 11.3. RF commented that the interview process for two new NEDs had been completed and commented that the Trust had received many high calibre applications. The appointments would be announced once the NHS England approval process had been completed. 11.4. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.32. The next Board meeting would be held on **Wednesday 26 March 2025 at 10.00**

Meeting Attendance 2024/25												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)	✓	✓	✓	A		✓	✓	✓		A	✓	
Ann Marr	✓	✓	✓	✓		✓	✓	✓				
Anne-Marie Stretch	A	✓	✓	✓		✓	✓	✓		✓	✓	
Geoffrey Appleton	✓	✓	✓									
Lynne Barnes	✓	✓	✓	✓		A	✓	✓		✓	✓	
Gill Brown	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Nicola Bunce	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Ian Clayton	✓	✓	A	✓		✓	✓					
Steve Connor	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Rob Cooper	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Malcolm Gandy	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Paul Growney	✓	✓	✓	✓								
Lisa Knight	✓	✓	✓	✓		✓	✓	✓		A	✓	
Gareth Lawrence	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Lesley Neary	✓	A	A	✓		✓	✓	✓		A	✓	
Sue Redfern	A	A	A	A		A	A	A				
Hazel Scott	✓	✓	✓	A		✓	✓	✓		✓	✓	
Carole Spencer		✓	✓	✓		✓	✓	✓		✓	✓	
Malise Szpakowska			✓	✓		✓	A	✓		✓	✓	
Rani Thind	✓	✓	✓	✓		✓	✓	✓		✓	A	
Peter Williams	✓	✓	✓	✓		✓	✓	✓		✓	✓	
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball	A	A	✓	✓		A	✓	✓		✓	A	
Richard Weeks	✓	✓	✓	✓		✓	✓	✓		✓	✓	
✓ = In attendance A = Apologies												

Trust Board (Public)
Matters Arising Action Log
Action Log updated 21 March 2025

Mersey and West Lancashire Teaching Hospitals NHS Trust

Status	
Yellow	On Agenda for this Meeting
Red	Overdue
Green	Not yet due
Blue	Completed

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
2	25/09/2024	**TB24/067 Statutory Pay Gap Report 2023/24**	Strategic People Committee asked to consider what the Trust value 'we are inclusive' means for staff	MS	~~01/01/2025~~ Apr-25		Report to be presented at Strategic People Committee
3	27/11/2024	**TB24/084 2024/25 Trust Objectives Mid-Year Review**	A report on actions being taken to improve discharges and reduce TTO delays to be presented at a future Quality Committee Update (March 2025) Report presented at the Quality Committee held on 18 March 2025. Action completed	LN & MG	Mar-25		**Completed**
4	29/01/2025	**TB25/006 Board Assurance Framework**	MG to review BAF 8 to include the implementation of the maternity information system for Whiston or the expansion of the Electronic Prescribing and Medicines Administration (EPMA) system at Southport as actions	MG	Apr-25		
6	26/02/2025	**TB25/016 2023/24 Safeguarding Annual Report (Adults and Children)**	LB to provide further information on how the safeguarding audits were being undertaken in 2024/25	LB	Apr-25		

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
5	29/01/2025	**TB25/008 Aggregated Incidents, Complaints and Claims Report (Q3)**	LB to review maternity incidents for Q3.	LB	May-25	**21/02/2025** - LB advised that a deep dive had been completed, and the report had been presented at Quality Committee. The information was included in TB25/015 Maternity and Neonatal Services Assurance Report Quarter 3. **Action closed**	**Closed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 March 2025
Agenda Item	**TB25/019**			
Report Title	**Integrated Performance Report**			
Executive Lead	Gareth Lawrence, Director of Finance, and Information			
Presenting Officer	Gareth Lawrence, Director of Finance, and Information			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) across four key areas:

1. Quality
2. Operations
3. Workforce
4. Finance

Executive Summary

Performance for MWL is summarised across 30 key metrics. Quality has 10 metrics, Operations 13 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

The forecast for 2024/25 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

The 10 metrics for Quality provide an overview for summary across MWL

Recommendations

The Trust Board is asked to note performance for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary

Overview

Mersey and West Lancashire Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.
The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.
The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Jul-24	103.3	100	96.7	Best 50%
FFT - Inpatients % Recommended	Feb-25	94.8%	90.0%	94.6%	Best 50%
Nurse Fill Rates	Jan-25	97.3%	90.0%	96.8%	
C.difficile	Jan-25	12	113	94	Best 50%
E.coli	Jan-25	12	171	136	Best 40%
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.13	0.00	0.14	
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.11	0.00	0.19	
Stillbirths (intrapartum)	Feb-25	0	0	0	
Neonatal Deaths	Feb-25	0	0	9	
Never Events	Feb-25	1	0	4	
Complaints Responded In 60 Days	Feb-25	65.2%	80.0%	64.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jan-25	73.6%	77.0%	73.6%	Worst 30%
Cancer 62 Days	Jan-25	82.0%	85.0%	78.9%	Best 20%
% Ambulance Handovers within 30 minutes	Feb-25	46.1%	95.0%	47.4%	
A&E Standard (Mapped)	Feb-25	79.4%	78.0%	78.0%	Best 20%
Average NEL LoS (excl Well Babies)	Feb-25	3.9	4.0	4.2	Best 30%
% of Patients With No Criteria to Reside	Feb-25	22.0%	10.0%	20.7%	
Discharges Before Noon	Feb-25	19.0%	20.0%	18.6%	
G&A Bed Occupancy	Feb-25	97.9%	92.0%	97.7%	Worst 30%
Patients Whose Operation Was Cancelled	Feb-25	1.2%	0.8%	1.0%	
RTT % less than 18 weeks	Feb-25	63.1%	92.0%	63.1%	Best 40%
RTT 65+	Feb-25	133	0	133	Worst 30%
% of E-discharge Summaries Sent Within 24 Hours	Feb-25	83.0%	90.0%	82.7%	
OP Letters to GP Within 7 Days	Jan-25	53.0%	90.0%	62.9%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Feb-25	85.1%	85.0%	85.1%	
Mandatory Training	Feb-25	88.0%	85.0%	88.0%	
Sickness: All Staff Sickness Rate	Feb-25	6.9%	5.0%	6.1%	
Staffing: Turnover rate	Feb-25	0.5%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Feb-25		36,200	26,994	
Cash Balances - Days to Cover Operating Expenses	Feb-25	2.7	10		
Reported Surplus/Deficit (000's)	Feb-25		-21,136	-14,114	

Board Summary - Quality

Quality

Clostridium difficile infection – The Trust is on the NHSE threshold for 2024/25. In Q3 the MWL rate of 32.2 per 100,000 bed days is below the C&M rate of 38.6. MWL and the legacy Trusts have been below the C&M rate for the last four quarters. The CDI Improvement Plan remains on track.

E coli -The E coli Improvement Plan continues, and the Trust remains below the NHSE threshold.

Pressure Ulcers - The main themes for pressure ulcers are attributed to Emergency care particulalry with issues with relating to agency staff not having access to or unfamiliar with electronic systems. This is now resolved with access for IT systems for temporary workers and local induction procedures. TVN training for new starters rolled out in Emergency care in 2025, link nurse band 7 identified to embed quality improvement projects for pressure ulcer prevention in ED, this will focus on nursing documentation and risk assessment.

Patient Falls – Patient falls resulting in moderate or worse harm have reduced at both sites in December. Falls Learning Reviews (FLR) have been completed and an associated action plan has been developed. Audits of falls compliance have been performed and findings fed back to ward managers by the Falls team. Expanding the decaffeinated drinks trial to a further 6 acute wards across the trust. Collaboration with pharmacy and frailty specialist colleagues continues with plans to increase medication reviews for patients at high risk of falling in hospital on the Southport site. Meetings to discuss how EPMA system can be used to make similar improvements across Whiston, St Helens and Newton sites ongoing.

Never event - An Never Event was reported in Feb (YTD 4). An initial Patient Safety Incident Review has been undertaken and presented at Patient Safety Panel in March, with an initial action plan. As per Trust PSIRP this incident will undergo Patient Safety Incident Investigation (PSII) to be aggregated with other incidents for joint learning.

Complaints – there has been a 33% reduction in MWL formal stage 1 complaints received in the month of Feb 25 in comparison to Jan 25. There is a marked improvement in complaints responded to against the Trust policy of 60 working days. With the reduction of complaints received in February it is anticipated that complaint performance overall will continue to improve into Q1 of the new financial year.

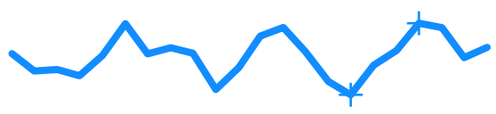
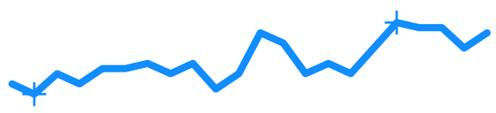
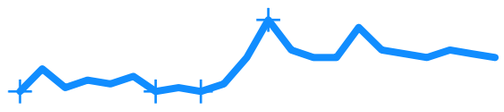
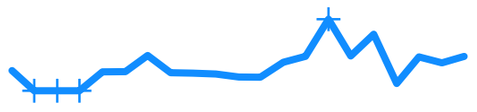
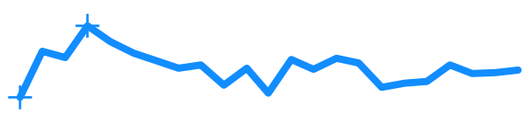
Mortality - Data covers deaths in the Trust until July 2024. The latest month (Jul-24) HSMR for MWL was 103.3, primarily driven by a decrease in monthly HSMR at legacy STHK to 101.4, which although higher than expected is within tolerances for monthly variation. All individual diagnoses groups with HSMR alert at STHK for this period have had deaths reviewed with none highlighting any areas of concern. The latest 12 months (ending Jul-24) had an overall low HSMR (93.2 for MWL, 96.1 for S&O and 92.1 for STHK). The YTD HSMR remains below 100 (96.7 for MWL, 95.2 S&O and 97.2 for STHK). The latest SHMI data for September has reduced to 1.03, which is statistically lower than expected.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Jul-24	103.3	100	96.7	Best 50%	
FFT - Inpatients % Recommended	Feb-25	94.8%	90.0%	94.6%	Best 50%	
Nurse Fill Rates	Jan-25	97.3%	90.0%	96.8%		
C.difficile	Jan-25	12	113	94	Best 50%	
E.coli	Jan-25	12	171	136	Best 40%	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.13	0.00	0.14		
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.11	0.00	0.19		
Stillbirths (intrapartum)	Feb-25	0	0	0		
Neonatal Deaths	Feb-25	0	0	8		
Never Events	Feb-25	1	0	4		
Complaints Responded In 60 Days	Feb-25	65.2%	80.0%	64.4%		

Board Summary - Operations

Operations

A&E: 4-Hour performance increased in February, achieving 74.3% (all types). Trust performance remained ahead of National (73.4%), and ahead of C&M (73.1%). The Trusts mapped 4-Hour performance achieved 79.4%.

18 Weeks: The Trust had 2,021 52-week waiters at the end of February, (391 S&O and 2,021 StHK), 133 65-week waiters and 2 78-week waiters.
The 52-week position is a decrease of 202 from January and the 65-week waiters have reduced by 8% from January to February. 18-Week performance in
February for MWL was 63.1%, S&O 65.0% and StHK 62.3%. This was ahead of national performance (latest month January) of 58.9% and C&M regional performance of 56.5%.

Diagnostics: Diagnostic performance in February achieved 97.5% for MWL, more than achieving the 95% target, with S&O achieving 97.1% and StHK 97.7%. MWL performance is ahead of national performance (latest month January) of 77.6% and C&M regional performance of 88.8%.

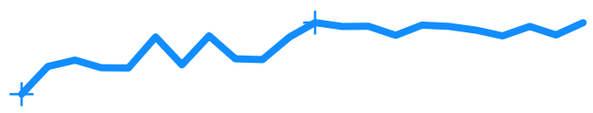
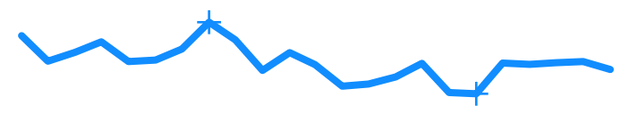
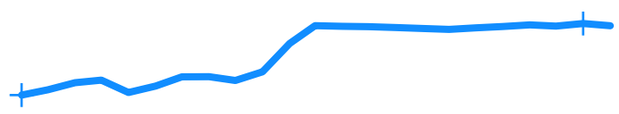
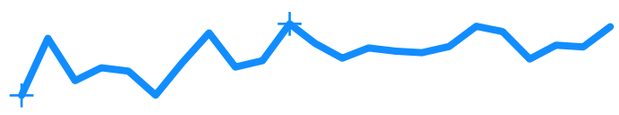
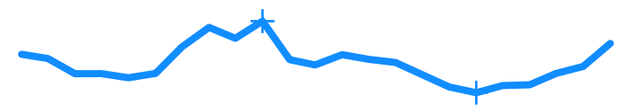
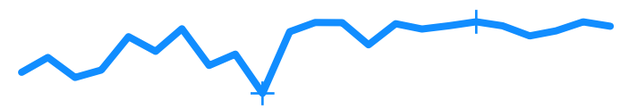
Patient Flow: Bed occupancy across MWL averaged 106.4% in February equating to 101.7 patients - a slight reduction on the 107.3% reported in January. There was a peak of 134 patients (69 at S&O, 80 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED.
Admissions were 4% higher than last February, driven by a 9% increase in 0 LOS activity, and an 0% increase in 1+ day LOS activity. Southport had a 146% increase in 0 LOS from February 24 to February 25, driven by the use of the new ED SDEC.
Average length of stay for emergency admissions remains high, at 10.5 at S&O and 7.1 at StHK, with an overall average of 8.0 days, the impact of non CTR patients being 22.0% at Organisation level, 3.1% higher than January but 0.1% higher than February 2024 (21.5% StHK and 23.0% S&O).

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Jan-25	73.6%	77.0%	73.6%	Worst 30%	
Cancer 62 Days	Jan-25	82.0%	85.0%	78.9%	Best 20%	
% Ambulance Handovers within 30 minutes	Feb-25	46.1%	95.0%	47.4%		
A&E Standard (Mapped)	Feb-25	79.4%	78.0%	78.0%	Best 20%	
Average NEL LoS (excl Well Babies)	Feb-25	3.9	4.0	4.2	Best 30%	
% of Patients With No Criteria to Reside	Feb-25	22.0%	10.0%	20.7%		
Discharges Before Noon	Feb-25	19.0%	20.0%	18.6%		
G&A Bed Occupancy	Feb-25	97.9%	92.0%	97.7%	Worst 30%	
Patients Whose Operation Was Cancelled	Feb-25	1.2%	0.8%	1.0%		
RTT % less than 18 weeks	Feb-25	63.1%	92.0%	63.1%	Best 40%	
RTT 65+	Feb-25	133	0	133	Worst 30%	
% of E-discharge Summaries Sent Within 24 Hours	Feb-25	83.0%	90.0%	82.7%		
OP Letters to GP Within 7 Days	Jan-25	53.0%	90.0%	62.9%		

Board Summary - Workforce

Workforce

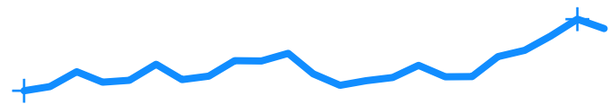
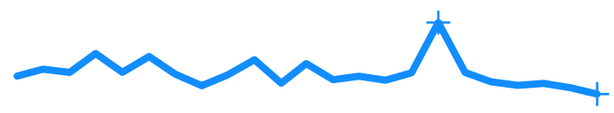
Mandatory Training - The Trust continues to exceed its mandatory target at 88% against a target of 85%.
Work continues to standardise our approach to the management and monitoring of core statutory and mandatory and compulsory skills training in line with the national framework.
Appraisals - The Trust is currently exceeding its appraisal target (85%) achieving 85.1%. The Learning and Development Team are preparing for the launch of the next appraisal window from 1st April 2025 and are supporting with appraisal and wellbeing conversation training.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Feb-25	85.1%	85.0%	85.1%		
Mandatory Training	Feb-25	88.0%	85.0%	88.0%		
Sickness: All Staff Sickness Rate	Feb-25	6.9%	5.0%	6.1%		
Staffing: Turnover rate	Feb-25	0.5%	1.1%	0.8%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 24/25 gave a deficit of £26.7m, which assumed:

- Payment of £12m funds in line with transaction business case
- Delivery of £36.2m recurrent CIP
- Delivery of £11.8m non-recurrent CIP
- Delivery of the 24/25 activity plan, in order to achieve planned levels of income including ERF/API variable funding
- Contract agreements in line with planned values

Additional non-recurrent deficit support was agreed with commissioners during September. This has reduced the planned deficit by £15.8m, to a £10.9m deficit for 24/25.

Surplus/Deficit – At Month 11, the Trust is reporting a year to date deficit of £14.1m which is £7m better than plan. The ICB agreed to fund the previous pressure with respect to industrial action, resulting in a £1.6m improvement to the position. The £7m favourable variance relates to £8m of transaction support received in September and December, £0.6m income for pay award, both partly offset by the £1.6m pressure following the critical incident. The plan assumed all transaction support funding would be received in March 2025.

CIP - The Trust's CIP target for financial year 2024/25 is £48.0m, of which £36.2m is to be delivered recurrently and £11.8m non-recurrently. As at Month 11, the Trust has successfully transacted CIP of £42.2m, of which £34m is recurrent, with a further £1.0m of recurrent CIP at finalisation stage.

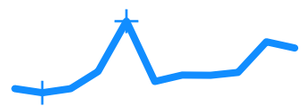
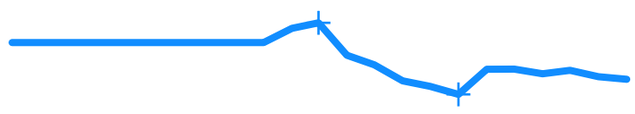
Cash - At the end of M11, the Trust's cash balance was £7.7m. The Trust anticipates a closing cash balance of c.£2.7m as per plan, at the end of the financial year.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Feb-25		36,200	26,994		
Cash Balances - Days to Cover Operating Expenses	Feb-25	2.7	10			
Reported Surplus/Deficit (000's)	Feb-25		-21,1...	-14,1...		

Board Summary

Legacy S&O

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Jul-24	109.1	100	95.2	
FFT - Inpatients % Recommended	Feb-25	96.0%	90.0%	94.3%	
Nurse Fill Rates	Jan-25	97.4%	90.0%	95.8%	
C.difficile	Jan-25	6		41	
E.coli	Jan-25	3		47	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.16	0.00	0.11	
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.16	0.00	0.22	
Stillbirths (intrapartum)	Feb-25	0	0	0	
Neonatal Deaths	Feb-25	0	0	3	
Never Events	Feb-25	0	0	0	
Complaints Responded In 60 Days	Feb-25	64.3%	80.0%	67.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jan-25	68.0%	77.0%	68.3%	
Cancer 62 Days	Jan-25	69.4%	85.0%	63.2%	
% Ambulance Handovers within 30 minutes	Feb-25	56.0%	95.0%	59.7%	
A&E Standard (Mapped)	Feb-25				
Average NEL LoS (excl Well Babies)	Feb-25	4.3	4.0	5.0	
% of Patients With No Criteria to Reside	Feb-25	23.0%	10.0%	17.2%	
Discharges Before Noon	Feb-25	22.0%	20.0%	20.1%	
G&A Bed Occupancy	Feb-25	97.9%	92.0%	97.0%	
Patients Whose Operation Was Cancelled	Feb-25	1.1%	0.8%	1.0%	
RTT % less than 18 weeks	Feb-25	65.0%	92.0%	65.0%	
RTT 65+	Feb-25	33	0	33	
% of E-discharge Summaries Sent Within 24 Hours	Feb-25	80.9%	90.0%	79.9%	
OP Letters to GP Within 7 Days	Jan-25	62.5%	90.0%	66.4%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Feb-25	79.5%	85.0%	79.5%	
Mandatory Training	Feb-25	89.4%	85.0%	89.4%	
Sickness: All Staff Sickness Rate	Feb-25	6.6%	5.0%	6.3%	
Staffing: Turnover rate	Feb-25	0.4%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Reported Surplus/Deficit (000's)	Feb-25				

Board Summary

Legacy STHK

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Jul-24	101.4	100	97.2	
FFT - Inpatients % Recommended	Feb-25	94.5%	94.0%	94.7%	
Nurse Fill Rates	Jan-25	97.1%	90.0%	97.8%	
C.difficile	Jan-25	6		53	
E.coli	Jan-25	9		89	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.12	0.00	0.15	
Falls ≥ moderate harm per 1000 bed days	Dec-24	0.08	0.00	0.17	
Stillbirths (intrapartum)	Feb-25	0	0	0	
Neonatal Deaths	Feb-25	0	0	6	
Never Events	Feb-25	1	0	4	
Complaints Responded In 60 Days	Feb-25	65.2%	80.0%	62.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jan-25	77.0%	77.0%	77.0%	
Cancer 62 Days	Jan-25	88.0%	85.0%	85.4%	
% Ambulance Handovers within 30 minutes	Feb-25	40.6%	95.0%	40.6%	
A&E Standard (Mapped)	Feb-25				
Average NEL LoS (excl Well Babies)	Feb-25	3.6	4.0	3.8	
% of Patients With No Criteria to Reside	Feb-25	21.5%	10.0%	22.7%	
Discharges Before Noon	Feb-25	17.5%	20.0%	17.8%	
G&A Bed Occupancy	Feb-25	97.9%	92.0%	98.0%	
Patients Whose Operation Was Cancelled	Feb-25	1.2%	0.8%	1.0%	
RTT % less than 18 weeks	Feb-25	62.3%	92.0%	62.3%	
RTT 65+	Feb-25	100	0	100	
% of E-discharge Summaries Sent Within 24 Hours	Feb-25	83.6%	90.0%	83.5%	
OP Letters to GP Within 7 Days	Jan-25	47.7%	90.0%	60.8%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Feb-25	87.7%	85.0%	87.7%	
Mandatory Training	Feb-25	87.4%	85.0%	87.4%	
Sickness: All Staff Sickness Rate	Feb-25	7.0%	5.0%	6.0%	
Staffing: Turnover rate	Feb-25	0.5%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Feb-25				
Cash Balances - Days to Cover Operating Expenses	Feb-25				
Reported Surplus/Deficit (000's)	Feb-25				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 March 2025
Agenda Item	**TB25/020 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in February 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held during February 2025. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The weekly vacancy control panel decisions were also reported, at each committee meeting. The Women and Children Division team to team meeting with the Executive took place on 27 February 2025.		
06 February 2025		
Supplementary Care Business Case	• The Acting Director of Nursing, Midwifery and Governance presented the business case to recruit additional Health Care Assistants (HCAs) to support the wards with the highest demand for supplementary care, for patients who required additional support to maintain their safety. • Increasing the ward establishment by one band 2 HCA on each shift for these high intensity wards would enable bay tagging and reduce the need for bank and agency HCA staff. • Committee supported the business case as a safer and more cost-effective way of supporting patients who required supplementary care but asked for a recruitment plan to provide assurance that with the HCA turnover rate, the establishment could be increased and sufficient staff recruited. • A benefits realisation report would be required six months post implementation. • The business case was approved.	Approval
Emergency Preparedness Response and	• The Chief Operating Officer briefed the Committee on planned EPRR exercises being coordinated by the Integrated Care Board (ICB) in February and March.	Assurance

Resilience (EPRR) Exercises	• These included both planned and no-notice exercises to allow the Trust to test its EPRR response.	
Mandatory Training and Appraisal Compliance	• The Acting Director of HR presented the performance for January. • Core mandatory training compliance was 88% and compulsory training compliance was 87.8% against the target of 85%. • Appraisal compliance was 87.5% against the Trust target of 85% • Committee reviewed the detail of teams and subjects which were reported as being below the 85% target and discussed how these were being managed.	Assurance
Nursing Safer Staffing Report – December 2024	• The Acting Director of Nursing, Midwifery and Governance presented the report. Overall fill rates in December were 96.32% for Registered Nurses (RN) and 113.44% for HCAs. • HCA sickness had increased in December, and this was being analysed to identify improvement actions. • HCA turnover also remained higher than planned and Committee agreed that further work was required on an MWL HCA recruitment and retention plan. • The report was noted.	Assurance
Target to eliminate 65+ week waiters	• The Chief Operating Officer briefed the committee on the revised NHSE target to eliminate all 65+ week waiters by 31 March. • At the end of January MWL had 142 patients that had waited longer than 65 weeks, mainly from Urology, Plastics and Gynaecology. • The Committee agreed to receive a weekly progress report until the end of March.	Assurance
Financial Improvement Plan Update	• The Director of Finance and Information introduced the update on the finance improvement plan. • Actions had been agreed to reduce non-clinical agency staff spend and other variable pay.	Assurance
Critical Incident – Whiston Hospital Emergency Department	• The Committee discussed the step down of the critical incident and actions that would be needed with system partners to maintain improved patient flow, discharges and reduced ambulance handover times.	Assurance
13 February 2025		

Procurement Act 2023	• The Director of Finance and Information introduced the presentation which briefed the Committee on the implications of the new Act which came into force on 24 February 2025. • The purpose of the Act was to introduce shorter, simplified and more flexible procurement rules whilst also increasing transparency and ensuring value for money for the public purse.	Assurance
NHS England Spend Controls	• The Director of Finance and Information introduced the briefing on the new spend controls being applied to the NHS in the Northwest region from 5 February 2025. • This required cabinet office approval for any procurement or new contract with a value exceeding £20m (whole life value). • The paper included details of the types of procurement and contracts that were in-scope for cabinet office review and those that would be out of scope e.g. medicines	Assurance
Quality Account – Improvement priorities for 2025/26	• The Acting Director of Nursing Midwifery and Governance presented the proposals for the 2025/26 Quality Account improvement objectives, including a review of the Q3 position in relation to the 2024/25 objectives. • Although progress had been made it was agreed that the broad themes of the quality improvement objectives would need to be carried forward to 2025/26. • The proposals were supported to present to Quality Committee.	Assurance
Independent Clinical Governance Review	• The Acting Director of Nursing, Midwifery and Governance and Director of Corporate Services presented the outcome of the independent clinical governance review, that had been a transaction risk rating recommendation by NHSE to be undertaken 12 months after the two trusts came together. • Three external and independent experts from other NHS Provider Trusts had been commissioned to undertake the review in July 2024 and had been finalised in January 2025. • The agreed scope of the review covered the Board, Quality Committee, the councils reporting to the Quality Committee and the Risk Management Council.	Assurance

	• In the same timeframe MIAA had also conducted a review of all the governance councils as part of the Trust internal audit programme for 2024/25. • Both reports had found that the Trust's governance processes were operating effectively (MIAA report gave "substantial" assurance). • Both had identified similar recommendations in relation to – streamlining membership, focusing on actions, moving away from legacy Trust reporting as soon as systems allowed. • It was noted that both reviews had been undertaken at a point in time, and many of the recommendations had already been addressed as the new divisional structures had been embedded. • The paper included the Trust response and completion status against each recommendation, with all either being completed or in progress. • The recommendations for each Council were being shared with the Council Chair to disseminate good practice.	
Corporate Benchmarking – Clinical Governance	• The Acting Director of Nursing, Midwifery and Governance presented a review of the corporate benchmarking results for Clinical Governance costs which had been reported as higher than the national average. • There were some areas where costs had been included in the national return, which were clinical services, and several corrections were proposed. • There was agreement to raise with Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) to ensure at least across Cheshire and Merseyside (C&M) all trusts were consistent in how the national definitions were interpreted.	Assurance
Horatio's Garden Charity Update	• The Director of Strategy briefed the Committee that Horatio's Garden was a national charity that had the objective to create a garden at every spinal injuries unit in the country and had approached the Trust about a garden for the North West (NW) Spinal Injuries Centre (NWSIC) at Southport Hospital. • The initial proposal from the charity had been to convert 144 car parking spaces into a dedicated garden for spinal injuries patients. This was not a viable option given the strategic considerations for the hospital site and alternative options were	Assurance

	being explored, including a hybrid option with the NWSIC courtyard and part of the car park, although this would entail re-routing the access road. • The estates team were evaluating the impact on the rest of the site including re-providing car parking spaces. • Once the option appraisal is completed a recommendation will be made to the Committee.	
Integrated Performance Report (IPR)	• The Director of Finance and Information presented the IPR for January and Committee reviewed the headline metrics and commentary to allow the Committee performance reports to be distributed.	Assurance
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the council assurance report from the RMC held on 11 February. • The new InPhase system implementation date had been delayed to March 2025, so the reports to the RMC were based on the separate legacy Datix systems. • The total number of risks on the combined MWL risk register was 1,068 with 19 of these escalated to the Corporate Risk Register (CRR). • The membership of the RMC had been streamlined, in line with the clinical governance review recommendations. • The Quality Impact Assessment (QIA) process had been completed for 158 of the 182 CIP schemes for 2024/25, with 14 progressing through the gateway process and ten outstanding for review. • The RMC had reviewed the terms of reference, and these were recommended to the Executive Committee and approved.	Assurance
Financial Plan 2025/26	• The CEO reported on meetings with the ICB about the 2025/26 financial and operational plan. • The draft plan had to be submitted on 27 February and would be presented to the Trust Board.	Assurance
20 February 2025		
Board Portal Business Case	• The Director of Corporate Services introduced the business case which evaluated the options and benefits of introducing a board portal. • There were several board portals on the NHS framework which were aimed at supporting people who attend meetings from outside the organisation.	Approval

	• Committee felt that there were opportunities to optimise the functionality in existing systems e.g. MS teams and Adobe, and the additional expense for a board portal could not be justified. • The business case was not approved.	
Outpatient Transformation Project	• The Director of Strategy provided an overview of the proposed approach to the Outpatient Transformation Project. • There were legacy site differences that needed to be mapped and then harmonised, and this work had to be completed ahead of the implementation of the new Electronic Patient Records (EPR). • There were interdependencies with the administrative support services improvement programme and the clinic reconfiguration programme. • An approach that mirrored the patient pathway had been agreed to allow the programme to be broken down, and each area had an agreed scope and objectives. • Committee supported the proposed approach and asked that the next update report include more detail on the expected timescales and deliverable benefits.	Assurance
Communications and Media Report – Q3 2024/25	• The Deputy CEO introduced the new report, which summarised the Communications and Media activities in Q3 and plans for the remainder of the year. • The report covered print and social media including the issues that had generated most interest. • A quarterly report will now be presented to the Committee	Assurance
Target to eliminate 65+ week waiters	• The Chief Operating Officer presented the weekly report on actions being taken to eliminate 65+ week waiters by 31 March 2025. • There were 89 urology patients on the list to be seen by 31 March but more patients on the waiting list just under 65 weeks, were expected to increase this number. • The Committee went through each speciality and the specific plans to increase capacity, including options for mutual aid. • The progress would continue to be reviewed weekly.	Assurance

Future of the Mersey Burns App	• The Committee received a presentation on the future options for the provision and potential development of the Mersey Burns App. • It was agreed the options needed to be fully appraised and the routes to delivery explored commercially and legally within the NHS England guidance.	Assurance
27 February 2025		
Target to eliminate 65+ week waiters	• The Chief Operating Officer introduced the weekly update. • The overall position remained static due to new patients with a 65week wait. • The forecast of patients who needed to be seen in March to avoid a 65+ week breach was 294 and committee discussed the need to support resources, such as booking staff to be able to maximise outpatient, diagnostic and theatre capacity to ensure all these patients were seen. • There had been further discussions with Liverpool University Hospitals about the vascular pathway.	Assurance
Corporate Benchmarking Reviews – Informatics and clinical governance	• The Acting Director of Nursing, Midwifery and Governance and Director of Informatics presented an analysis of the 2024 national corporate benchmarking as it related to their portfolios. • The benchmarks had shown the costs for these services were above the national average. • The reviews allowed the committee to understand the drivers and identify actions to address this, where appropriate.	Assurance
Trust Board Agenda - March	• The Director of Corporate Services presented the draft Trust board agenda based on agreed actions and the annual work. • The Employee of the Month was selected from the nominations received.	Approval
Nurse safer staffing report - January	• The Acting Director of Nursing, Midwifery and Governance presented the report. • The overall fill rate for registered and HCAs was above 95%. Registered nurse fill rates for days were just below 95%. • HCA sickness absence levels had reduced from the peak in December. • Bank and agency HCA usage was decreasing as expected, with the implementation of the supplementary care strategy.	Assurance

	• Going forward a rolling approach to the establishment reviews was proposed, which would include the EDs, Theatres and community nursing as well as wards. The proposal was supported by the Committee.	

Alerts:

None

Decisions and Recommendations:

Investment decisions taken by the Committee during February 2025 were:

- Increase in the HCA establishment for selected wards where there was a high demand for supplementary care, which would be funded by a reduction in HCA bank and agency usage.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 March 2025
Agenda Item	**TB25/020 (8.2)**		
Committee being reported	Charitable Funds Committee		
Date of Meeting	10 March 2025		
Committee Chair	Hazel Scott, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Head of Charity update	Updates were provided on the Charity teams activity between November and March, including • Christmas campaigns • Staff engagement • The role out of new resources • Launch of the new Charity Website.	Assurance
Charity Strategy and annual work plan	The Charity Strategy and annual workplan were presented including financial targets and the request to recruit a digital communications officer.	Approval
MWL NHS Charity Appeal	A proposal was presented to select the first appeal for the Charity. A target of £60,000 has been set to refurbish the patient day room based at the North West Regional Spinal Injuries Unit, Southport Hospital.	Approval
Finance Report	An update of MWL NHS Charity's financial performance and financial position (fund balances) as at March 2025. MWL NHS Charity balance was £1,455,300.61 at March 2025	Assurance
Review of Charity Risk Register	No change to the risk register has been made since the previous meeting in November 2024.	Assurance
Review of Policies	MWL Charity's Treasury Management and Reserves policies were presented. Both policies set out the basis on which the Charity will act in relation to its treasury (cash / investment) and reserves activities for 2025.	Approval
Summary of applications received to date	A list of all applications MWL NHS Charity as received since April 2024.	Assurance

	• 64 projects have been supported with a total value of over £270,000	
Committee Terms of Reference (ToR)	The Committee Terms of Reference including membership was noted.	Assurance
Charitable Funds Committee Meeting Arrangements and Workplan	The annual workplan and meeting arrangements for committee were presented.	Approval

Alerts:

Not applicable

Decisions and Recommendation(s):

- The Charity strategy and annual work plan including the recruitment to the Charity team was approved.
- The first MWL NHS Charity appeal for the Spinal Unit patient day room was approved.
- The Treasury management and reserves policy was approved.
- The Charitable Funds Committee meeting arrangements and annual work plan were approved.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 March 2025
Agenda Item	**TB25/020 (8.3)**		
Committee being reported	Quality Committee		
Date of Meeting	18 March 2025		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Matters arising/Action Log	• The outstanding actions were reviewed, and progress noted.	Assurance
Quality Committee Corporate Performance Report (CPR).	• Committee reviewed the Quality performance Report metrics. • Four Never Events Year to Date (YTD) in theatres with investigation reports to be completed and reported by June. • Pressure Ulcers increased in month – corrective actions in place which will be further impacted with a move away from agency staff utilisation. • Nutrition metrics not achieved – to remain as a Trust objectives for 2025/26 with recognised focus on referral to dietitian processes across MWL. • Positive reduction in number of stage 1 complaints. • Mortality data reporting updated to July 2024 – Hospital Standardised Mortality Ratio (HSMR) reduced but higher than expected however within tolerance against monthly variation. YTD HSMR remains below 100 at 96.7. • Medical Director had requested a review of all deaths by the Learning from Deaths group who assured no avoidable deaths in the diagnostic alerting groups with work ongoing with the coding team to address cases of miscoding	Assurance

	affecting the HSMR. HSMR YTD provides assurance the observed deaths are not exceeding expected. • Summary Hospital-level Mortality Indicator - Deaths associated with hospitalisation (SHMI) - reduced to 1.03 slightly over statistically expected position.	
Patient Safety Report (Inc. Chair's Assurance Report).	• One incident reported under the Patient Safety Incident Investigation (PSII) framework for MWL in January 2025 bringing a total number of 11 PSIIs since April 2024. 13 PSIIs remain open. • During January 2025, 20 incidents were identified that required a Patient Safety Incident Review (PSIR). • Total incidents for MWL for January 2025 was 3,053 consistent with numbers reported across the year. • Total number of Pressure Ulcers incidents for January 2025 was 469 (non MWL acquired, and Trust acquired). Committee noted the increase in Hospital Acquired Pressure Ulcers (HAPU) category three identified and awaiting validation. Lapses of care targeted through improvement activity noting increase in Emergency Department (ED). • Total number of patient falls for MWL for January 2025 was 259. Overall numbers reducing however high percentage increase at Southport Hospital of falls with moderate or severe harm. • Committee requested additional assurance in relation to the absolute number of falls as well as the rates per 1,000 bed days, and trends over time. • PSII – Biopsy delay – assurance provided following review and PSIR actions. • Committee sought clarity on timelines for PSII completion noting two that were over 12 months. Committee discussed the reasons for this and	Assurance

	the aspiration for completion within six months, which would be monitored in future reports. Assurance provided that family liaison is put in place when a PSII is commissioned. • The Patient Safety Council Assurance report was received, with no alerts	
Infection, Prevention and Control (IPC) Quarterly Report.	• Report received for quarter 3 (Oct to Dec 2024). • The NHS Standard Contract for 2024/25 outlined the healthcare associated infections and thresholds for the Trust. • The Trust is below NHSE threshold for Clostridium difficile, E-coli and Pseudomonas bacteraemia. • There were five Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia cases year to date, with three cases in Q3. Cases were on the Spinal Injuries Unit at Southport and Wards 4B, and Bevan Court 2 on the Whiston site. Action plans developed from learning. • Ongoing Trust wide Peripheral intravenous catheter (PIVC) (cannula) improvement plan includes harmonisation of Aseptic Non Touch Technique (ANTT) delivery and reliable PIVC care. • Visual Infusion Phlebitis score (VIP) monitoring compliance is a key measure within the plan and a Trust Quality objective for MRSA reduction. Compliance has continued to improve at Southport Hospital throughout the financial year, while compliance at Whiston Hospital is below the Trust target of 90%. • As part of the MWL Mandatory Training project, ANTT harmonised is to be implemented during 2025/26. • ANTT training compliance – focus continues level 2 compliance and promotion of training through the divisions.	Assurance

	• MSRA screening compliance - Southport and Ormskirk sites below 95% (Q3 93%) however assurance provided that this was an improving trajectory. • Committee received assurance universal screening is in place against all hospital admissions including wounds. • MSSA cases have increased significantly with Q3 reporting 26 cases and 71 YTD across MWL. During the same period of 2023/24 there were 39 YTD, which is an increase of 32 cases 2024/25 YTD. A deep dive is near completion with a reduction target of 15% set. Regional peer support being accessed to share best practice. • Clostridioides difficile (C.Diff) 82 cases YTD, below the threshold for MWL which is for no more than 113 cases in year. • Improvement plan in Q1 and Q2 resulted in Trust becoming a low outlier regionally and this remains for Q3. Deep clean of wards remains in place. • Cheshire and Mersey IPC Provider Collaborative (CMAST) - first improvement project completed on C-Diff tool kit to be implemented Q4 with many actions already embedded at Whiston Hospital. • Covid-19-Q3 Whiston sites total of 233 cases compared to 288 cases in Q2. At Southport and Ormskirk sites there were 119 cases, a slight increase compared to 108 Covid cases in Q1. Cases reduced over the quarter as Influenza A started to predominate. • There were 43 outbreaks in Q3 at MWL, 21 outbreaks at Whiston Hospital and 22 at the Southport Hospital. • IPC audit programme - majority of areas scoring less than 90% with improvement focus on	

	clinical practice and environmental audits with areas scoring below 92%. • Committee recognised the improvement work to date and challenges during the winter months.	
Actions to Improve Discharge & Take Home Medication (TTO) Delays (Action 94).	• MWL TTO processes at the legacy trusts are different and were being aligned. • TTO turnaround time at St Helens and Whiston Hospitals reports 92 minutes (electronic data capture). Southport and Ormskirk Hospitals report 40 minutes (manual data capture). • Model presented regarding TTO Discharge process with issues, solutions and benefits and barriers to improvement presented. • Focus on integrated systems and timely reporting. • Committee reviewed the proposed action to reduce TTO times, which will remain a Trust objective for 2025/26.	Assurance
Clinical Effectiveness Report (including Chair's Assurance Report).	• Committee noted positive steps in approved Policies and procedural documents. • Development of a Trauma Support pathway. • A business case is in preparation for the resources required to make the programme permanent. • Increase of 62% in staff on Non-Medical Prescribers (NMP) register since June 2023. • Intensive Care National Audit and Research Centre (ICNARC) - excellent performance with only one area outside of predicted range: Bed-days of care post 4-hour delay. • NICE quarterly report- reviewed evidence published and compliance noting one NICE guidance not achieved related to antiplatelet treatment with no trusts currently using the treatment with plan to discuss at Stroke network meetings and regional investment.	Assurance

	• OPAL (older persons assessment liaison) increase in referrals and bed days saved. Business case required to make service permanent. • Non-Elective Laparotomy Audits (NELA): all patients over 65 to receive care of the elderly review - acknowledge ongoing challenge. • Target of 85% set for improving NELA risk documentation compliance through continuing education. • Committee advised participation in the Advancing Quality programme will now come at a cost with AQuA requesting a financial contribution from all participating trusts from 2025/26. At present MWL participates in the Sepsis and Acute Kidney Injury (AKI) programmes. A paper will come to the Executive Committee for consideration of options moving forwards. • Drug and Therapeutics Group (DTG) - update provided regarding work for Venous Thromboembolism (VTE) assessment and link to Electronic Prescribing and Medicines Administration (EPMA). Positive Roll out plan for EPMA at Southport and Ormskirk sites on-going. Terms of Reference to be updated to support DTG being an authorising body for purely drug related pathways/policies as part of the groups delegated responsibilities. • Acute Kidney Injury (AKI) at MWL continues to be higher than national rates. Promotion of fluid balance monitoring and encouragement of hydration in post-op patients is in place to help reduce this. Reduction in post operative AKI adverse outcomes is a Trust objective. • Sepsis action plan - compliance with sepsis guidance and standards noted with focused presence in ED and resident doctors. Ongoing work in screening for sepsis team to be able to clinically support.	

	• Outlier for consenting Trauma patients at Southport Hospital (consent for information to be added to joint registry). • Histopathology - positive recruitment to histopathologists and work ongoing to reconfigure services regionally.	
Any Other Business	• Reminder to members to complete the annual Committee effectiveness review questionnaire.	
Alerts:		
• None		
Decisions and Recommendation(s):		
The Board is recommended to note the report.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 March 2025
Agenda Item	**TB25/020 (8.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	19 March 2025		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	The Committee reviewed the minutes of the meeting held on the 19 February 2025 and approved them as a correct and accurate record of proceedings.	Approval
Action Log and Matters Arising	The Committee reviewed the outstanding and approved the completed actions.	Assurance
Workforce Dashboard	The MWL combined workforce dashboard reported the following: • Appraisals - appraisal compliance is 85.1% • Mandatory Training - the Trust continues to exceed its target for mandatory training at 88% • Sickness - in-month sickness decreased during February to 6.88% (January 7.11%) against a 5% target. • Vacancies - vacancy rate has positively reduced to 4.5% (January 7%) against a target of 8%. Positive reductions in vacancies are in Registered Nursing and Midwifery at 3.4% against a target of 6% (January 4.5%) and Allied Health Professionals (AHP) at 7.5% (January 8.4%). • The largest vacancy gap is within the Healthcare Assistant (HCA) staff group at 11.3% against a target of 8%. The current pipeline for HCA's is 99.26 Full Time Equivalent (FTE) with a further recruitment event scheduled for 12 April 2025. • Average time to recruit - average time of recruit has decreased in February to 58.4 days (January 63.2 days) against a target of 40 days. Time to Hire (TTH) is still impacted primarily due to the transition from the cohort Occupational Health (OH) system to the new Civica Occupational Health Cloud Management Software System (OPAS) system. The Occupational Health Team	Assurance

	continues to work through its recovery plan. • Turnover - in-month turnover 0.5% against a target of 1.1% with 12-month rolling turnover is 11.3% against a target of 13.2%. • Occupational Health – the key performance indicators (KPI's) reported are from November. Following implementation of OPAS monthly reporting will resume.	
Health, Work & Well Being Operational Plan Annual Assurance Update	The Committee received the Health, Work & Well Being Operational Plan 2022-2025 Year 3 Annual Assurance Update for the final year of the current plan April 2024 to March 2025 which provided information and assurance on the activity and objectives delivered in relation to supporting our people with health and wellbeing. Key achievements and success outcomes on deliverables over the last 12 months were highlighted as follows: • Growth within the wellbeing network from c.170 to now c.240 across key areas. • Over 10,000 visits to ''the wellbeing hub'' support page, • Three Occupational Health Nurses have graduated with a Specialist Community Public Health Nurse (SCPHN) qualification as part of our development programme • Approval and implementation of a new OH Management system ''OPAS G2'' to enable one system of practice for MWL and client service users. **Looking after our People and Wellbeing Support:** • Successful collaborative and the muti-disciplinary team (MDT) response to the Southport Major Incident • Approval of the Business Case to harmonise Health, Work & Well Being (HWWB) services. • Implementation and approval of updated policies and associated support and guidance. • Continued growth in occupational health for the future. • Maintained Safe Effective Quality Occupational Health Services (SEQOHS) Accreditation and harmonisation of HWWB Services. • Implementation of a new staff engagement forum specifically focused on and for Managers.	Assurance

	There was also a presentation on Psychological Safety and the development of a Trauma Support pathway which aims to: • Embed the ‘’Standard Operating Procedure for Take STOCK and Post-Incident Reflection Debrief’’ across MWL • Ensure that all relevant Trust staff are trauma informed and psychologically prepared for traumatic incidents at work. • Offer a structured framework and guidance for managers and leaders to provide appropriate and consistent support to staff following traumatic incidents in work. • Ensure that managers and leaders have support and skills to provide a compassionate response to their staff and knowledge around signposting for further support if required.	
Staff Story – Managers Experience of an Employees Relations Case	The experiences of the staff member, the manager case manger and the investigator involved in employee relations cases were shared with the Committee. It was noted that cases can be difficult for all parties involved and that a kind, timely and supportive approach along implementation of lessons learnt will improve our people practices in the future. It was acknowledged that the timeliness of the formal processes is impacted by employee relations cases being an additional task on top of the day job for case managers and investigators. People focussed actions to implement lessons learnt will include: • Investigating officer training • Investigation agreements • Drop in /lunch and learn training session on HR Policies • Case work oversight • Culture change OD support • Freedom to speak up/’Ask Rob’/Executive team	Assurance
MWL People Plan 2025-28	The Committee received a presentation on the proposed MWL People Plan 2025-28 and noted that a robust engagement process has taken place with a range of stakeholders, groups, councils and committees and builds upon the foundations and achievements from the first Peoples Plan 2022-25. The Strategic People Plan describes what those who work for MWL can expect from us and each other and	Decision

	sets out our ambitions for creating a culture of kindness, inclusivity and openness, where everyone can develop, grow and thrive. The People Plan 2025-28 reflects the strategic direction of the NHS People Plan, national priorities, the NHS People Promise, our Trust values and Equality & Inclusion. It also describes how we will measure progress against our commitments to deliver the four strategic ambitions which are aligned to the NHS people plan pillars: • **Looking after our people** - we will develop a culture that empowers individuals to lead healthy lives and thrive in work by providing holistic wellbeing support. • **Belonging in the NHS** - we will develop an inclusive culture where everyone's voice is represented and celebrated. • **Growing for the Future** - we will embrace new ways of working and create opportunities to enable our people to achieve their potential. • **New ways of working and delivering care** - we will improve outcomes across MWL for health, employment and wellbeing by working with our partners to be the best place to work.	
Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the People Performance Council which included the approval of the Social Media and Media Policy and the Clinical Observation Attachments policy.	Assurance
Strategic People Committee – Annual Work Schedule	The Strategic People Committee – Annual Work Schedule 2025/26 was approved.	Decision
Items for Escalation to Trust Board	There were no items to escalate to the Trust Board.	Assurance
Any Other Business	None	Assurance
Effectiveness of Meeting	The committee indicated this meeting has been effectively chaired.	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
• The MWL People Plan 2025-28 was approved. • The Strategic People Committee – Annual Work Schedule 2025/26 was approved.		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	26 March 2025
Agenda Item	**TB25/020 (8.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	20 March 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Director of Finance Update	• Committee noted the recent changes announced for NHSE and Department of Health and Social Care (DHSC) and the emerging leadership changes in the national teams. • Updates regarding planning picked up throughout meeting.	Assurance
External review of draft plan and Draft plan Integrated Care Board (ICB) /NHSE responses	• Update given to the Committee on the external scrutiny of the Trust draft plan from external partner, ICB and NHSE. • Key lines of enquiry from all shared with the Committee alongside responses provided. • External review feedback shared with the Committee. • No feedback received from ICB/NHSE	Assurance
MWL Plan Paper	• Trust planning approach described along with ongoing work at a system level. • MWL current formal plan paper for 2025/26 including financial statements, workforce and performance metrics was presented building on previous presentations and information shared throughout the year. • Discussion held around known and emerging risks, what mitigations are currently in place and strategic opportunities. • Discussed implications around cash requirements and impact of plans not being accepted by NHSE. • Significant financial challenge across the Trust and System, work ongoing to identify opportunities to improve. • Committee confirmed assurance regarding the detail within the plans and acknowledged the	Approval

	progress on developing required efficiency and strategic developments to deliver the plan. • Recommendation that the current plan be approved by Board subject to emerging system challenge.	
Integrated Performance Report Month 11 2024/25	• Bed occupancy across MWL continues to be significantly higher than the target of 92% at 106.4% in February. General and acute (G&A) bed occupancy averaged 97.7% in February. • Average length of stay for emergency admissions is high at 8.0 days, 10.5 at legacy S&O and 7.1 at legacy STHK, the impact of non-criteria to reside (NCTR) patients remains high in February, being 22.0% at Organisation level (21.5% legacy STHK and 23.0% legacy S&O). • 4-Hour performance increased in February achieving 74.3% (all types), national performance 73.4% and providers across Cheshire & Merseyside (C&M) averaging 73.1%. • 18 Week performance in February for MWL was 63.1%, legacy S&O 65.0% and legacy STHK 62.3%. National Performance (latest month January) was 58.9% and C&M regional performance was 56.5% • The Trust had 2,021 52-week waiters at the end of February, 133 65 week waiters and two 78 week waiters. • Diagnostic performance in February for MWL was above target at 97.5%, legacy S&O 97.1% and legacy STHK 97.7%. • Cancer performance for MWL in February decreased to 73.6% for the 28-day standard but decreased to 78.9% for the 62 day standard.	Assurance
Finance Report Month 11 2024/25	• The Trust is reporting a deficit of £14.1m which is £7m better than the revised plan due to recognition of planned transaction support and additional income; offset by the impact of industrial action, pressures following the critical incident. • The Trust's combined 2024/25 Cost Improvement Programme (CIP) target is £48m of which £11.8m is non-recurrent. As at Month 11, the Trust has transacted CIP of £42.2m in	Assurance

	year and £34.0m recurrently with the remaining balance in finalisation stage. • The Trust has utilised £8.8m non recurrent resources year to date which will be unavailable in future years. • At Month 11, agency spend is £20.3m, 3.5% of total pay costs. Premium Payment Scrutiny Council review and address drivers of agency costs with actions taken to Executive Committee. • The Trust has a closing cash balance of £7.7m at Month 11 due to the timing of capital Public Dividend Capita (PDC) receipts and outgoings. The Trust anticipates a closing cash balance of circa £2.7m as per plan. • Better Payment Practice Code has not been achieved for non NHS suppliers but has been impacted by a large volume of small value agency invoices, however it is on an improving trajectory. • The capital plan for the year is £48.4m (including Public Finance Initiative (PFI) Lifecycle). Spend to date is £31.2m and forecast to meet plan in M12.	
Month 11 2024/25 CIP Programme Update Surgical Division CIP update	• Total targets for 2024/25 is £48m in year and £36.2m recurrently. • At month 11 there is £42.2m transacted with a further £5.8m of delivered/low risk schemes to be transacted (100% of the £48m target) and £34.0m recurrent transacted with a further £2.2m delivered/low risk schemes to be transacted (100% of the £36.2m target). • Schemes identified in 2024/25 to date are £62.0m with £60.4m recurrent. Focus is on delivering remaining balance of the 2024/25 plan. Schemes not delivered in year will be rolled forward as part of the CIP programme to support 2025/26 plans. • Division CIP update provided including overview of governance process to provide assurance.	Assurance
Elective Care recovery review	• 65 week waiters currently under close monitoring, specific action plans in place however unlikely to be zero by the end of March. • Theatres utilisation trajectory improving, tracked through series of internal meetings and	Assurance

	linked into the further faster 20 programme of work. • Improvement actions outlined in detail including cross site working.	
Business Case Benefits Realisation Report	• Total number of benefits identified and mapped is 362 across 42 business cases. 334 are on track with 28 requiring mitigating actions or not yet reporting delivery. • Examples shared of benefits review and discussed.	
Assurance Reports from Subgroups:	• Procurement Council • CIP Council • Capital Planning Council • Estates & Facilities Management Council • IM&T Council update	Assurance
Alerts		
None		
Decisions and Recommendation(s):		
MWL Plan Paper Recommendation that the current plan be approved by Board subject to emerging system challenge.		

Title of Meeting	**Trust Board**			**Date**	26 March 2025
Agenda Item	**TB25/021**				
Report Title	Health Inequalities Strategy 2025-2028 and Delivery Plan 2025/26				
Executive Lead	Wayne Longshaw, Director of Integration				
Presenting Officer	Wayne Longshaw, Director of Integration				
Action Required	X	**To Approve**		**To Note**	

Purpose

This report introduces Trust's Health Inequalities Strategy 2025-2028 and the Delivery Plan for 2025/26.

Executive Summary

This paper introduces a slightly revised Health Inequalities Strategy from when the Board received the first draft in the Autumn 2024 following and engagement with colleagues the strategy is accompanied by a delivery plan for its first year.

The Strategy provides a route map to reducing to Health Inequalities, it is a call to action that recognises that our geographies are amongst the most deprived in the country. The strategy has developed its approach accordingly with a vision and four objectives:

Health Inequalities Vision:
Reducing health inequalities by ensuring equitable access to our services and promoting preventable support in the community.

Health Inequalities Objectives:
The Trust will use its role to reduce health inequalities in the communities it serves by:

- Being a **provider** of quality health care
- Being an active **partner**
- Being an **employer** of choice
- Being an **anchor institution**

The strategy provides the background and the policy context - NHSE statement on information on health inequalities, CORE20PLUS5 approach and Kings Fund statistics and policy briefings ahead of the NHS 10 Year Plan.

The strategy recognises the challenges our populations face and there is a comparison of the health outcomes across our places. The document provides a framework for action, recognising the good work we have done in this area, but also what further work is required. There is a 'Plan on a Page' which details some priority areas and this has been developed through engagement with colleagues and partners to establish a Delivery Plan for 2025/26.

The need is very real - locally and nationally, there is a decade of difference in life expectancy between the most and least deprived areas. Around half of the population, we serve live in the lowest quintile (20%) for deprivation with health outcomes on many metrics that are well below the national average.

The Strategy captures some of the things we have done to reduce inequalities, for our patients (Inequalities Dashboard, Smoke Free Service, Diabetes, Self Harm pathway) for our workforce and

the local communities (work experience, events, school engagement) which speaks to our role as a good employer as an Anchor Institution.

There is a governance framework to support the further development of this Strategy and ensure the delivery of the work programme. As we learn more about tackling health inequalities it is expected that our delivery plans, metrics and systems will become more sophisticated throughout the life of the strategy. We would also envisage that the Board will provide both support and rigour to the process of providing oversight of the delivery.

Financial Implications

None at this point.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the Trust's Health Inequalities Strategy 2025 – 2028 and the Delivery Plan 2025/26.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust

Mersey and West Lancashire Hospitals NHS Trust

Health Inequalities

3 Year Strategy

2025/26 – 2028/29






March 2025

Contents

1. Introduction

After a little over a year of integrating our two legacy trusts with a combined patient base of around 600,000 and significantly serving 6 local authority places. The time is right to have a greater focus on Health Inequalities and Health Equity for our diverse populations.

We know that chronic, persistent, and unacceptable health inequalities result in poorer health, reduced quality of life, higher costs of care and early death for many people. Marginalised and deprived populations experience health outcomes far worse than the general population. They experience exclusion from services, and economic and social marginalisation.

This strategy has been developed in a context of Covid recovery and cost of living poverty crisis as well as an NHS challenged to address the imbalance of supply and demand for care. We recognise that this journey for the trust to ensure that our approach is rooted in the needs of the diverse communities and their geographies, that we work with local partners and collaboratively with Cheshire and Merseyside colleagues to deliver the very best outcomes for our populations.

The Trust has organised its approach in four priority areas: as a healthcare provider; as a partner; as an employer and as an anchor institution. As a provider of services, we need to shift focus to ensure inclusion, preventative interventions and make every contact count. We will continue to work with partners on the wider determinants of health and develop greater insights on needs. We employ 10,000 and it is important that the welfare and the development of staff is a priority to maximise the quality of care and productivity of services. Finally, as an anchor institution within our communities, we will use our capabilities and economies of scale to positively influence people's lives through employment opportunities and our procurement policies as well as the way we deliver care. This strategy has the following vision and objectives:

Health Inequalities Vision:

Reducing health inequalities by ensuring equitable access to our services and promoting preventable support in the community.

Health Inequalities Objectives:

The Trust will use its role to reduce health inequalities in the communities it serves by:

- Being a **provider** of quality health care
- Being an active **partner**
- Being an **employer** of choice
- Being an **anchor institution**

2. Background and Policy Context

NHS England (NHSE) published a statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) on 27 November 2023. The purpose of the statement is to help trusts and Integrated Care Boards (ICBs) identify key data and information on health inequalities and outline how they have responded to this information within their annual reports.

The National Health Service Act (2006) states that "NHSE must publish a statement setting out a description of the powers available to relevant NHS bodies [trusts, foundation trusts and ICBs] to collect, analyse and publish information relating to inequalities" (section 13SA). This includes inequalities in accessing healthcare services and within health outcomes.

The statement provides NHSE's view on how NHS bodies should use information on health inequalities. NHS bodies are expected to work collaboratively on information collection and analysis to better understand the health and wellbeing needs of their local communities. This involves increasing shared understanding of the demographic profile and geographic distribution of disadvantaged groups, the health and care needs of those in more deprived places, and the wider social, environmental, and economic factors underpinning health inequalities.

The Kings Fund recently cited the statistics below as a case for change:

Infant mortality is twice as high for Black infants and nearly twice as high for Asian infants compared with White infants.
Deaths per 1,000 infants in England and Wales in 2022 = 6.6 Black infants; 5.7 Asian infants; 3.1 White infants.
Source: Office for National Statistics 2024.

People in the most deprived areas are twice as likely to die prematurely from cardiovascular disease than people in the least deprived areas.
111 deaths per 100,000 in the most deprived areas of England compared with 55 in the least deprived areas as of 2022.
Source: Office for Health Improvement and Disparities 2024.

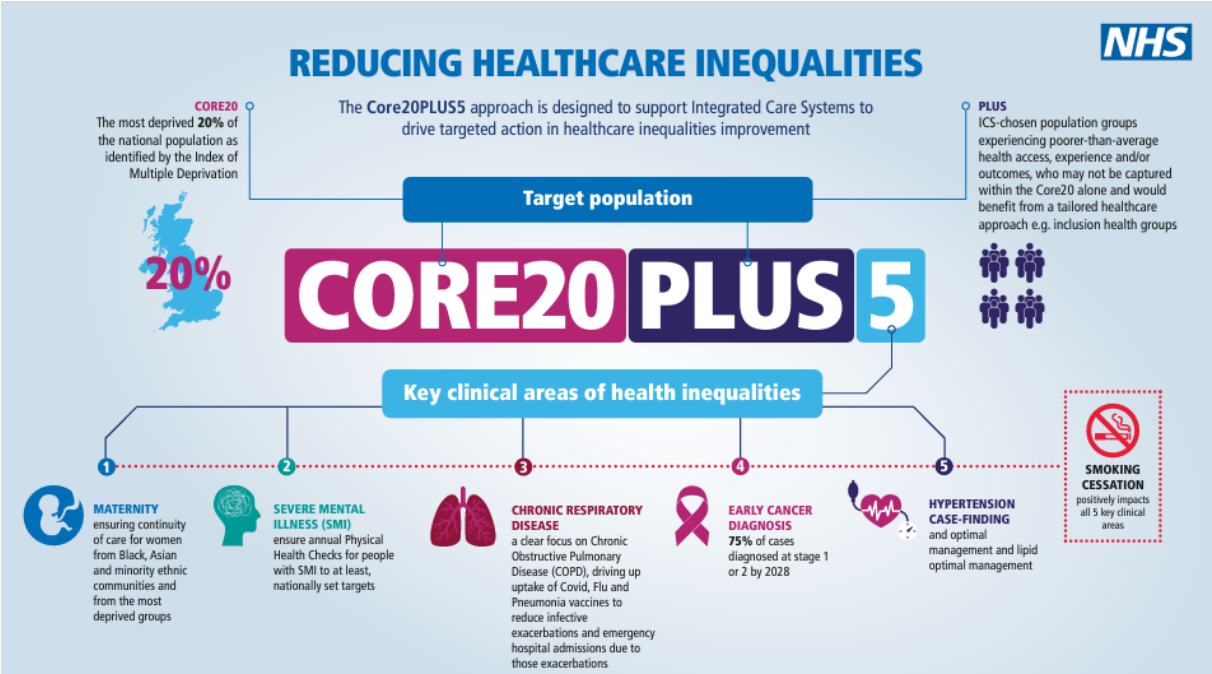
Lesbian, gay and bisexual adults are more than twice as likely to report having a longstanding mental, behavioural or neurodevelopmental condition than heterosexual adults.
16% compared with 6% of heterosexual adults in England 2011–18.
Source: NHS England 2021.

People living in the most deprived parts of England are more than twice as likely to wait over a year for elective care than people living in the most affluent areas in 2022.
Source: Robertson *et al* 2023.

Women experiencing homelessness are less likely to attend breast screening appointments than the general population.
37% had attended a screening compared with 62% in the general population (of those eligible) in England as of 2018–21. Source: Office for Health Improvement and Disparities 2024.

The difference in life expectancy for people living in the most deprived areas of England compared with the least deprived areas is 9.7 years for males and 7.9 years for women.
2018- 2020
Source: Office for National Statistics 2022.

NHS England have also developed the CORE20PLUS5 approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The Infographic below demonstrate this approach:



As part of our plan, the Trust is exploring with partners how we can use the CORE20PLUS framework to have an impact on the services we deliver.

NHSE will publish it's 10-year plan in the Spring 2025, it is likely to place a greater emphasis on preventative services with the aim of reducing health inequalities.

The Cheshire and Merseyside Health and Care Partnership feature health inequalities as the focal point of their strategic plan for 2024-2029. The plan adopts the Professor Sir Michael Marmot's eight themes and converted them in to a set of headline ambitions set out below.

This strategy broadly aligns with the ambitions of Cheshire and Merseyside partners and will be developed as we learn, adapt and tackle the challenges presented by the health inequalities faced by the populations we serve.

3. Definitions

Health inequalities are "avoidable, unfair and systematic differences in health between different groups of people". This means that some population groups have significantly worse health experiences and outcomes than others.

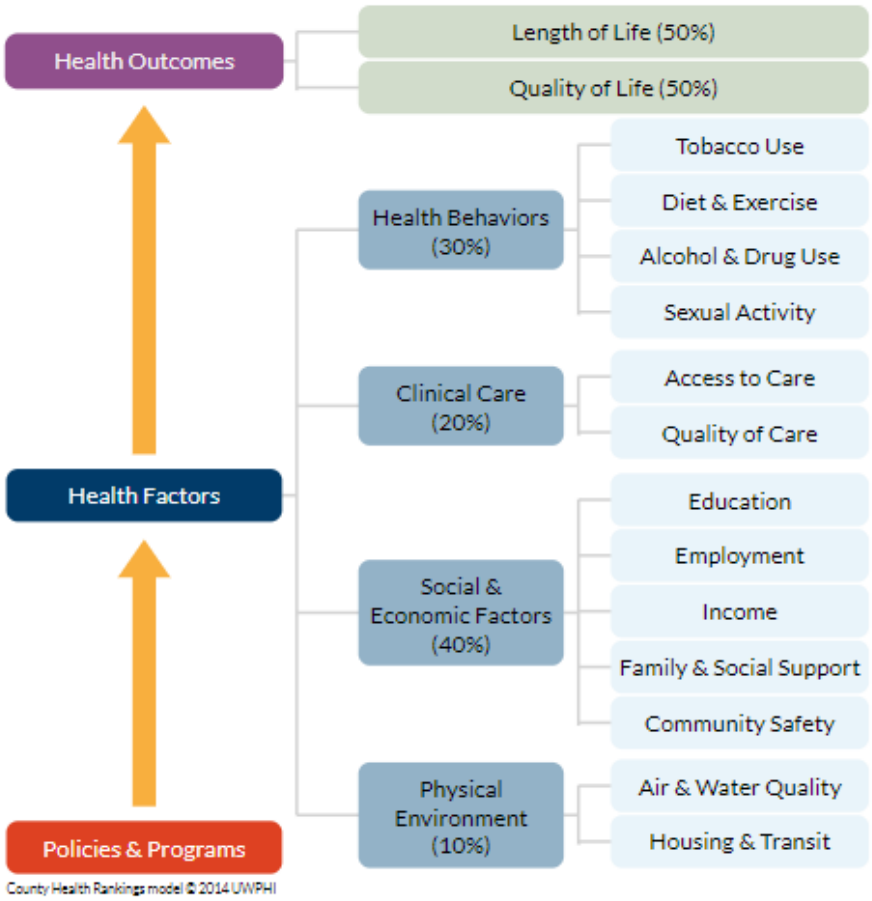
These differences can be due to a range of factors including a person's social, economic, and environmental circumstances – and we know that greater deprivation in any of these factors is associated with an increased risk of becoming ill earlier and dying younger. People with certain characteristics, such as certain ethnicities, sexual orientation, age, and disabilities, also have a lower chance of living a long and healthy life compared to others. This is often due to the exclusion from society that people with these characteristics face.

EQUALITY	EQUITY	BARRIER FREE

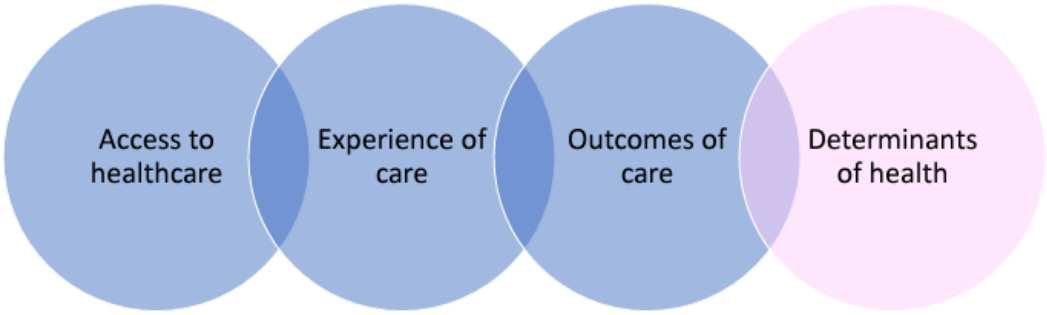
Equality means treating everyone the same or providing everyone with the same resource, whereas **equity** means providing services relative to need. The third image shows the systemic barriers are removed meaning everyone has access without any supports or accommodations because the cause of the inequity was addressed.

Wider determinants are a diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

The health and wellbeing of our population are influenced by a thriving economy, a healthy environment, having good quality housing in a safe place to live, education and skills, job opportunities and positive social networks and leisure opportunities. These are the 'social determinates' of health and wellbeing and they are thought to determine around 50% of health outcomes, see figure overleaf. The second greater is factor is health behaviours which is considered to determine 30% of health outcomes (diet, exercise, habits).



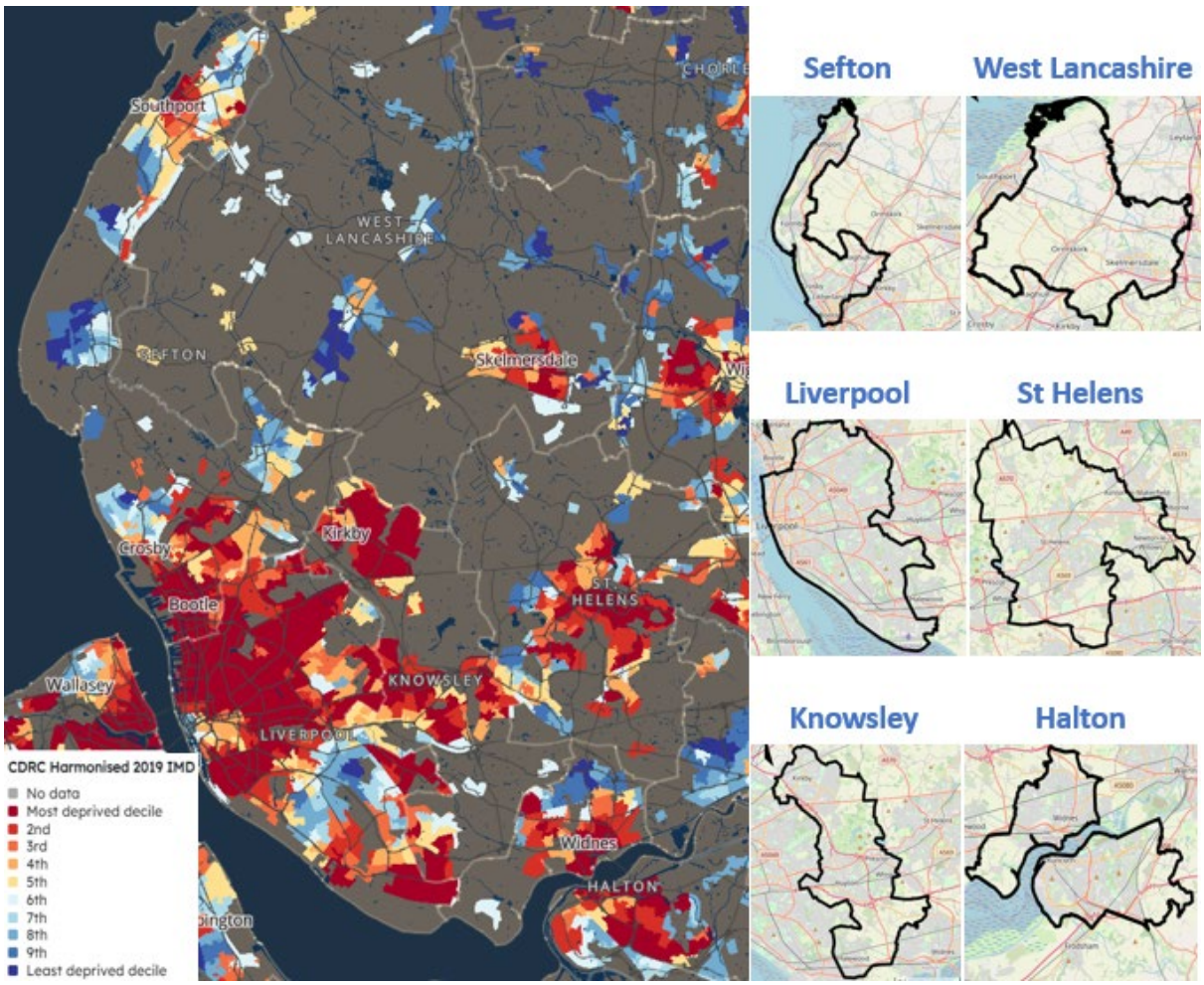
And finally **clinical care** contributes just **20%** to health outcomes, and therefore as a provider of care we also need to consider how we can influence the other factors as a partner, as an employer and as an anchor institution.



The determinants of health can be greatly affected by nationally government policy, the economy and society and locally City Regions, local authorities and ICBs, all commission services and have resources to invest albeit scarce. This strategy explores how we could collectively influence that fourth circle.

4. Our Population

We are a significant provider of services in six local authority areas and our reach stretches into the Lancashire and South Cumbria ICB. Working with such a diverse range of partners has its challenges, but also has benefits in terms of learning and best practice. The figure below reminds us of the geographies we serve and also the levels of deprivation.



Our patient populations come from areas of high deprivation and within the geographies we serve there are communities that endure significant health inequalities, see overleaf.

The table overleaf highlights the extent of the challenges and also within boroughs further inequalities exist:

- in the majority of cases there is a decade between the life expectancy of people living in the worst and least deprived areas in the boroughs
- The Merseyside boroughs have higher mortality rates.
- Behavioural risk factors are much more prevalent.
- Children do not have the best start in life.

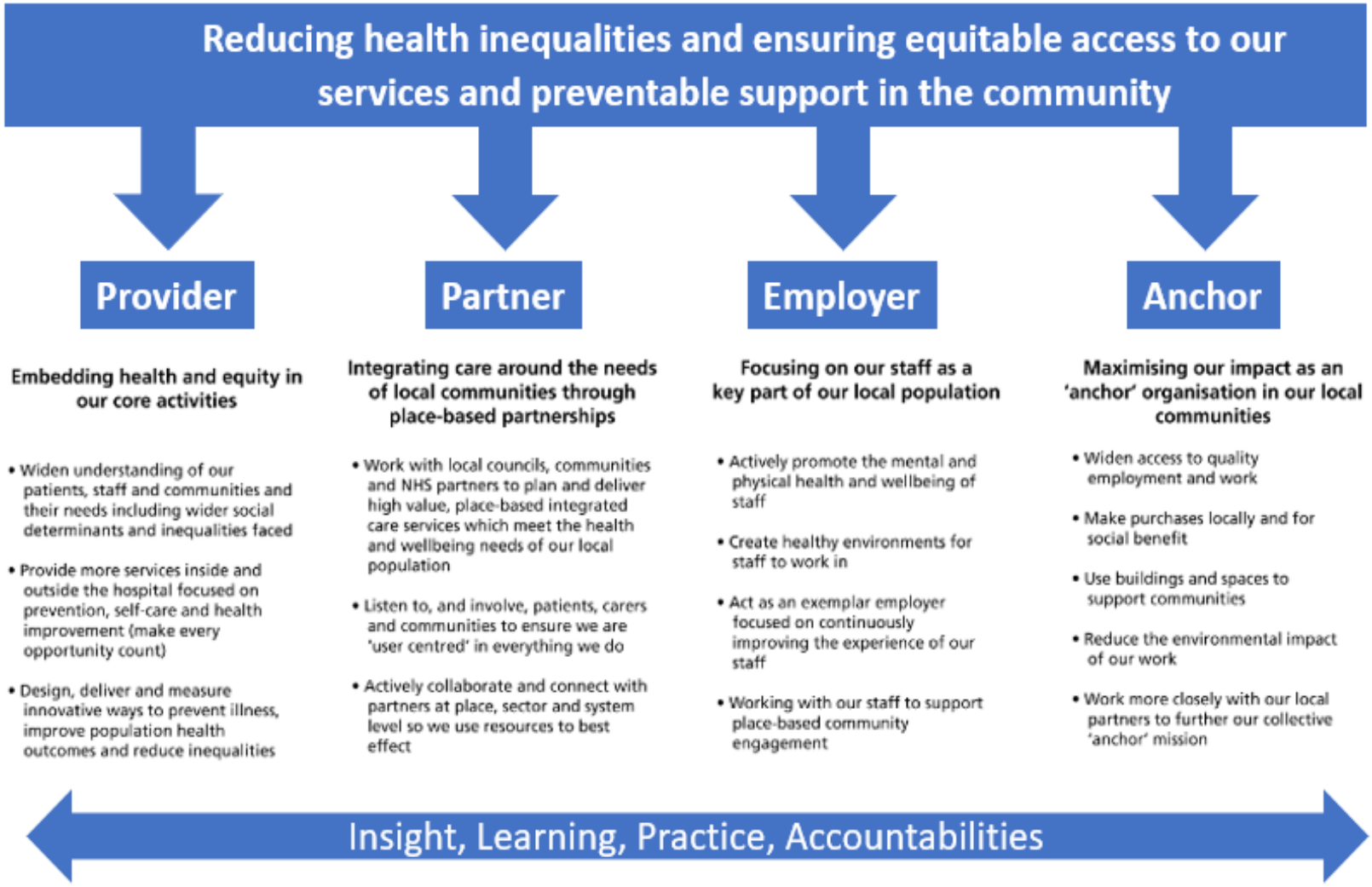
The challenges are quite stark and require a fundamental rethink in how we as a provider, partner, employer, and anchor in the community can play a more influential role in turning the inequalities tide.

A Comparison of Places: Deprivation, Mortality, Risk Factors and Child Health

Place		England	North West	St Helens	Halton	Knowsley	Liverpool	Sefton	West Lancs
Deprivation									
IMD (2019) Rank out of 317		-	-	26	22	2	3	89	155
% of people in lowest quintile		-	-	43.4%	48.6%	62.8%	62.0%		
Health Inequalities									
Life Expectancy: Most	Male	9.7 years	-	12.4 years	10.8 years	11.4 years	11.1 years	11.8 years	8.6 years
v Least deprived areas	Female	7.9 years	-	8.6 years	8.8 years	12.6 years	8.9 years	11.5 years	7.9 years
Causes of Death									
Under 75 mortality rate (all causes)		330.5	388.4	411.9	428.1	476.2	497.6	369.2	332.7
Mortality rate from CVD		71.7	86.6	85.8	88.4	98.9	106.1	76.9	74.3
Mortality rate from cancer		132.3	145.6	143.1	170.9	185.3	179.4	141.6	129.3
Suicide Rates		9.64	10.4	16.1	11.4	11.5	9.54	11.5	13.3
Behaviour risk factors									
Hospital Admission for alcohol specific conditions (under 18 yrs)		31.6	45.9	100.2	58.6	45.4	51.7	52.9	37.8
Hospital Admission for alcohol related conditions (under 18 yrs)		663.7	741.5	882.7	862.7	939.7	997	912.3	648.4
Smoking prevance in adults		14.4	14.7	15.8	17.9	18.1	14.7	11.1	14.1
% of physically active adults		66.3	64.7	61.7	62.8	63.3	66.4	63.7	70.6
% of adults overweight or obese		62	64.3	72.6	74.4	71.2	62.4	71.2	69.5
Child Health									
Teenage conception rate		17.8	21.9	37.1	34.9	27.6	28.1	17.4	19.5
% of smoking during pregnancy		10.6	12.7	16.2	17.3	14.6	13.0	12.9	12.6
% of breastfeeding initiation		74.5	64.5	55.3	54.6	48.4	55.0	57.9	62.4
Infant mortality rate		3.93	4.62	3.50	3.40	3.36	6.12	4.20	4.95
Year 6: Prevalence of obesity		20.2	21.5	23.0	25.0	26.9	24.9	21.3	19.4
% of children in low income families		17.0	18.0	19.5	19.6	25.0	26.3	17.1	13.7

5. Our Approach

Our approach to health inequalities is articulated in the framework below:



The framework will help us draw together the initiatives already underway and, importantly, to spot and address key gaps. Getting the balance right balance between actions to improve equity of access, experience and outcomes in our own, core activities (clinical care, research and education) and those that contribute to wider efforts to improve health and to reduce inequalities due to social determinants of health (such as employment, housing, literacy levels and structural racism).

6. Our Journey?

The Trust is involved in a number of initiatives that have and will reduce health inequalities, below are a few examples of the activities that we do or partner with:

HEALTH EQUALITIES GROUP

Prevention Pledge

14 core commitments, covering key themes including:

- Promoting workforce development, workplace health & wellbeing
- Promoting healthier lifestyles for patients/visitors & making every contact count
- Using Marmot principles to address health inequalities & working with partners at Place
- Signing up to C&M Concordat for Better Mental Health
- Embedding prevention in governance structures

social value BUSINESS

Social Value Award

A quality mark which is centred on providing evidence against and making a pledge for one or all of the 4 themes - **Innovation, Economic, Social and Environment** - the Social Value Award aims to help organisations to recognise the impact that they are making in their community through their social value, deliver social value, and recognises the organisation as an 'Anchor Institution'.

Workforce

- Work Experience Opportunities
- Registered Nurse Degree Parentships Conversion Course
- School Engagement
- Healthcare Science Careers Event

St Helens Skills Academy

Health Inequalities Dashboard

Self-Harm: Prevention & Resolution Service

Smoke Free Service

- Since April we have visited over 1,400 Inpatients
- Of those 52% inpatients wanted to stop smoking
- 73% of those inpatients who wanted to stop smoking, wanted a referral to their community stop smoking service
- We are currently reporting a 40% quit rate of those inpatients who have manged to stay quit 28-days after leaving hospital.

Type 2 Diabetes

Sanofi data interrogation performed, and task and finish group reviewed data

- Diabetic consultant included
- Outcomes from project were fed back to Clinical Directors for St Helens place and associated action plan agreed to review and support changes in service delivery
- Aim to change focus to delivering service in primary care / community reducing pressure on secondary care services
- Organising 'group consultations' for diabetic patients to attend and receive both clinical and educational support

7. Our Plan

The Trust will use its role to reduce health inequalities in the communities it serves by:

- Being a **provider** of quality health care
- Being an active **partner**
- Being an **employer** of choice
- Being an **anchor institution**

This section illustrates how the Trust will convert its strategic intent into a series of deliverables for each objective. This is summarised in the plan on a page overleaf.

The Trust has already been awarded the Cheshire and Merseyside Social Value Award, signed up to the Prevention Pledge and the 14 aspects of the programme, and is in the process of committing to the Anchor Institutional Charter.

The current base year will focus on building the evidence base. MWL has the capability through its data analytics and highly skilled, multi-professional clinical teams who are in contact with 100,000s of patients to risk stratify and understand the needs of its patient population. There is a robust evidence base behind 'make every contact count' to indicate the positive influence clinicians have on the healthy wellbeing behaviours of patients.

Whilst it is recognised that asking about lifestyle issues such as alcohol intake and smoking takes time and adds more of a data collection burden for clinicians, the utility of the data and the impact of the conversation on the patient can be profound.

Likewise, setting up systems to account for how we engage with partnership and the impact we have will have it challenges, but the differences we make can be significant and lasting. We do have a duty to be an exemplar employer and to play a leading role as an Anchor Institution as the biggest employer in the area.

A draft plan on a page has been developed, see overleaf, but we need to do more work with colleagues across the trust and with our partners to help shape a more granular plan that target the agreed priorities.

Plan on a Page to Reduce Health Inequalities

Vision	*Reducing health inequalities by ensuring equitable access to our services and promoting preventative support in the community*					
Objectives To reduce health inequalities	**Development work Year 1 – 2025/26**					**Outcomes**
Being a provider of quality health care	**Embedding Health Equity into Service Delivery**	**Service Transformations with Equity Embedded**	**Making Every Contact Count**	**Data Driven Improvements in Health Inequalities**	**Digitally Enable Services (avoiding exclusion)**	**Patients will have more years in better health. Gain equitable access to services, avoiding crisis interventions through proactive and preventative care**
Being an active partner	**Population Health approach to collaboration and prevention**		**Care Closer to Home**	**Digitally and Data Enable Services**		**Services have adapted to peoples' needs, improved health outcomes and a reduction in the cost of delivery**
Being an employer of choice	**Growing our Future Workforce**		**Equality, Diversity and Inclusion**	**Workforce Health and Wellbeing**		**Staff across the Trust are reflective of the local population with high recruitment and retentions rates and positive satisfaction rates**
Being an anchor institution	**Skills, Employment in Health and Social Care**		**Exploring Development Opportunities with Local Authorities & Partners**	**Leadership within the Places we serve**		**MWL having a net positive impact on the socioeconomic health and wealth of our geography**

1. Provider

Moving from our base year and using the data collected, MWL can then begin to mitigate some of this inequity we may find. Having achieved a dataset, the population groups can be segmented and targeted for a differential approach to care provision that meets their needs. With improved data and some targeted investment, we could begin to explore the priority areas of Core20+5, elective recovery, and urgent and emergency care.

2. Partner

The ICB has been established for over two years and the Trust is an active partner within Cheshire and Merseyside and place-based partnerships are still at varying levels of maturity and capacity. There are opportunities to accelerate efforts to tackle heath inequalities given the mandate set out in the legislation and in NHSE guidance. Places such as St Helens have an Inequalities Commission which researches best practice to be implemented locally.

3. Employer

The third pillar of our health and equity framework is focused on promoting the mental and physical health and wellbeing of our own staff. Over half of our 10,000 staff live locally and many have active roles within their communities - thinking about them as a key part of our local population is essential.

There has been quite a disparity between the quality of the working environment between the legacy STHK buildings and that of legacy S&O. We do have a capital programme of improvements to go some way to levelling up our estate for staff as well as high quality facilities for patients. We also want to act as an exemplar employer focused on continuously improving the experience of our staff.

4. Anchor

Employing a 10,000 strong professionally diverse workforce; caring for 600,000+ residents; and a financial expenditure of around £850m on the provision of healthcare makes the MWL an anchor institution within the communities we serve. The MWL will use this status to positively impact the local economy, society, and economy through:

- purchasing more locally wherever possible, using social value measures in commissioning and procurement
- ensuring access to work, and making sure that job roles are high quality
- supporting families to live healthy, sustainable lives
- supporting the wider transition to a net zero economy, helping to reduce emissions and improve air quality

8. Our Governance

The ongoing development of this strategy and its delivery will need structure and resourcing. The governance structure is shown below:

The Board should approve the development of this strategy and receive assurance for its delivery.

The Executive Committee will monitor progress of the delivery of the strategy and the action plan and improvement metrics and benefits.

A Health Equalities Group should be formed to oversee the shaping of the strategy, engaging with staff and partners as part of its development including a delivery plan. Developing metrics, tracking progress, communicating progress across the organisation and producing an annual report will also be part of their duties.

It is also important to share our ambitions with Partners at the appropriate fora. The table below provides an outline of our approach.

Forum	Role
MWL Board	Approves and monitors delivery of health inequalities of this strategy Receive bi-annual report charting progress and delivering four objectives Reports will align to the requirements of NHS England Health Inequalities Statement
Executive Committee	Will monitor progress and delivery of the strategy including the benefits accruing from the activity
Health Equalities Group	Responsible for the development and co-ordinating the delivery of the strategy and its workplan
Place Partnership Boards/HWB Boards	Engagement with partners, sharing plans and co-ordinating local initiatives

9. Conclusions

It is deeply unjust that some groups of people have significantly worse health and worse experiences of the NHS than others – it is also preventable. The MWL footprint sees some of the country's highest levels of deprivation. The Trust cannot tackle this alone, and it needs to work with partners, particularly with the Local Authority's Directors of Public Health, the ICB and the Voluntary, Faith and Social Enterprise Sector.

Some of the barriers the Kings Fund cited the following barriers to accessing services:

- discrimination and racism

- not being treated with empathy or genuinely listened to
- lack of communication from services
- feeling of powerlessness
- practical barriers, eg, travel costs
- shame and stigma
- services not being flexible, holistic or inclusive enough.
- lack of trust and engagement due to negative experiences in the past.

The new 10 Year NHS Plan is likely to place a greater emphasis on radically transforming the way the NHS works with communities and staff, while reorientating services to focus on prevention.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Health Inequalities Strategy - 2025/26 Delivery Plan

No	Themes	Initiatives	Measurements	Trust Lead	Outcomes
1. PROVIDER – Embedding health and equity in our core activities:					
1.1	**Enabling data driven improvements in health inequalities**	• Core20plus5 dashboard to be made available on CIPHA. This will inform selection of areas to work on. • High Intensity Users/Frequent Flier dashboards available to support refocused interventions. • Commence diabetic amputation audit-intended to identify improvement areas but not started by diabetologist. • Redevelopment of the Health Inequalities dashboard to target improvements and spread the adoption across C&M • Maximise the use of C2AI tool - identifies surgical patients suitable for prehab • 'On an elective wait list and attending ED' by QOF condition tool implementation.	• Commencement of two Pilot projects using Core20plus • Reduction in number of patients repeat attending none • Improvements diabetes treatment • Targeted improvements in DNAs for most deprived patients • Patients most in need will receive timely care and better outcomes • To trial with MWL gynae dept. (requested by St Helens Place)	Deputy Director Information	**Patients will have more years in better health by gaining equitable access to services, avoiding crisis interventions through proactive and preventative care**

1.2	**Making Every Contact Count (MECC)**	• Smoking Cessation Service:
		  ○ Increase compliance of screening inpatients for smoking status
		  ○ Move service closure to frontline
		• MECC Training – Ensure staff have undertaken the training and ensure MECC is practiced
			• Supporting more than 2,500 inpatients to consider stopping smoking.
			• Plan a wider roll out of the service Including ED patients and Pre-Op patients by March 2026
			• Improving Training compliance rates
				Smoking Cessation Lead
				Deputy Director of Nursing (Quality)	

No	Themes	Initiatives	Measurements	Trust Lead	Outcomes
1.3	**Service Transformations**	• Outpatients – Review of current processes to identify populations less likely to attend appointments and implement process to address barriers to attendance; increase utilisation of patient experience portal to manage appointments, enhance clinical validation • Engage with Family Hubs to gain insight into 'was not brought in' children to outpatient appointments • Shaping Care Together – insuring health inequalities considerations are incorporated when proposing change	• Improving DNA rates of patients living in the most deprived neighbourhoods • Reducing waiting time for appointment • Improve DNA/WNB rates • EQIAs are undertaken	Director of Strategy	
1.4	**Digitally Enabled Services without Digital Exclusion**	• Roll-out patient portal using the 'waiting well' feature whilst monitoring the impact on inequalities and take up of the tool. Deploy easy read letters as a standard and ensure the patient portal is setup for easy read as a default. • Build into the patient portal app AI capability to predict DNAs and best forms of communications for that cohort of patients • Commence the implementation of LIMS whist using appropriate communications that meet the needs of neuro divergent staff.	• Improved choice and control for patients to access services and amend appointments • Reducing DNAs • Range and type of communications, management of change process	Deputy Director of Informatics	
1.5	**Embedding Health Equity into Service Delivery**	• Smoking Cessation Midwife and tobacco dependent advisors connects with wider team to ensure best practice for advice and referrals • Breast feeding education programme for women in pregnancy and postnatally • Work with the Neonatal Collaborative for pre-term babies • Dedicated teams (Amethyst and Sapphire) care for most vulnerable women and families	• Lower rates of smoking in pregnancy • Raising awareness of benefits for healthy babies • Vulnerable care plan outcomes • Mitigation of higher risks in most vulnerable mothers	Director of Midwifery	

No	Themes	Initiatives	Measurements	Trust Lead	Outcomes
		• Working across all of the organisation's points of delivery to level out PTL long waits and bring care closer to home where possible	• Development of AMD services at ODGH to bring care closer to home for patients • Development of HOLEP Urology services at SDGH and ODGH • Reopen paediatric squint surgery and repatriate from AHH • Repatriate adult tonsillectomy patients from Aintree	Deputy Director of Operations – Surgical Division	
2. PARTNER – Integrating care around the needs of local communities through place partnerships and the Integrated Care Board:					
2.1	**Population Health approach to collaborative prevention**	• Supporting carers on wait list project • St Helens Suicide audit in train for Public Health • Frailty case finding support given to St Helens PCNs • Provide St Helens PCN Care coordinators with case finding training & support	• Project at scoping stage • Gain insight to prevent future suicides • Enables proactive treatments of patients at risk of frailty avoiding NEL admissions • PCNs become more self-sufficient in using the tool in their practices	Director of Integration/ Director of Public Health	**Services have adapted to peoples' needs, improved health outcomes and a reduction in the cost of delivery**.
2.2	**Care Closer to Home**	• Warm Homes for Lungs – Using the fuel poverty dashboard to 'pull' patients into a community based respiratory service at Lowe House (those with high inhaler usage/multiple ED attends) for clinical review, incl. spirometry and FENO. • Warm Homes for Young Lungs – enhanced localised offer at Parr Children's Community Centre, with mix of clinic appointments and drop-in sessions by all partners. • Expansion of Tongue Tie Service (previously only available at Alder Hey).	• Admission avoidance, immunisation advice, smoking cessation advice, winter support and home grants • Admissions avoidance, more appropriate prescribing - reducing prescribing costs, and referral to the right service • Reducing the waiting time and care closer to home	Director Women and Children's Services	

No	Themes	Initiatives	Measurements	Trust Lead	Outcomes
		• Making greater use of Lowe House and other community sites/family hubs	• Phlebotomy, GP with Extended remit in Paediatrics, Consultant led clinics, Tics & Tourettes service • Implement the birthing suite	Director of Midwifery Services	
2.3	**Digitally & Data Enabled Services**	• Digital Inclusion Team supports Primary Care teams to enable patients to maximise the use of the NHS app. • Send MWL letters from the patient portal to the NHS app so that the patient starts to have all communications in one place. • Utilise the Connected Care Record as it is rolled out to all places	• Greater use of NHS app including ordering prescriptions. • Greater use of the NHS app for viewing letters and appointments – reducing DNAs • Better care as more complete patient record information is available	Deputy Director of Informatics	
3. EMPLOYER – Focusing on our staff as a key part of our local population					
3.1	**Growing our future workforce.**	• Engaging local schools and colleges about careers in healthcare • Designate a work experience window (set number of places for students from deprived areas) • Recruiting Apprenticeships using the levy • Explore programmes with the DWP to attract NEETs and offer opportunities to join the bank	• Define our engagement area and map the High Schools and colleges then identify our key links – Q1 25/26 • Attend careers events identified as part of our engagement work – Q2-Q4 25/26 • Launch work experience programme across MWL – Q2 25/26 • Work with schools and colleges in deprived areas across MWL to fill a minimum of 20% of work experience places with students from deprived areas – Q4 25/26	Assistant Director - HR (Workforce)	**Staff across the Trust are reflective of the local population with high recruitment and retentions rates and positive satisfaction rates**

No	Themes	Initiatives	Measurements	Trust Lead	Outcomes
		• Estates and Facilities: Apprenticeship Scheme	• Identify roles at recruitment authorisation stage that can be recruited as an apprenticeship and work with departments to identify courses and support recruitment – Q4 25/26 • Implement DWP Ways to Work Programme to support local job seekers to experience healthcare careers and access opportunities to gain employment – Q4 25/26 • Expand the Programme across all areas of Estates and Facilities service.	Deputy Director – Estates and Facilities	

3.2	**Equality, Diversity and Inclusion**	• Continue to support disabled staff with reasonable adjustments and removing barriers:
		  ○ Estates
		  ○ Policies
		• Achieve Bronze level anti-racism status. Trust Anti-racist statement in place
		• BME Nurses & Midwives Band 5 Career Progression
			• Implement communication programme on the support available to disabled staff – Q2 25/26
			• Map out and improve the process for implementing reasonable adjustments within MWL with internal stakeholders Q4 25/26
			• Submit an application for Bronze level of the Anti-Racism Framework Q2-3 25/26
			• Review impact of the BME Nursing and Midwifery Band 5 Career Progression Workshops – number of BME applicants for Band 6+ roles, number of BME staff holding Band 6+ roles Q3 25/26
				Assistant Director - HR (Workforce)	

No	Themes	Initiatives	Measurements	Trust Lead	Outcomes
3.3	**Workforce Health and Wellbeing**	• Targeted health inequality initiatives delivered by ''The Wellbeing Hub''; 1:1 appointment, group sessions and events, team and department support and visits • Review the 2022-25 Health and Wellbeing Plan and prepare a future plan that fully incorporates into the wider Trust ''MWL People Plan 2025-2028 • Providing modern updated spaces for staff rest and recuperation, within internal and external areas. • Continue to improve the estate and facilities across the Trust to create a positive work environment.	• Delivering on targeted initiatives and KPIs, reducing sickness lost for specific health inequality conditions • Delivering on year one priorities, ''looking after our people'' pillar as part of the new MWL People Plan to be launched for 2025-2028 • Transforming outdoor garden spaces • Investment to create modern Healthcare environments for example new operating theatres, endoscopy units, IT training rooms etc	Assistant Director – Health, Work and Wellbeing Deputy Director Estates and Facilities	
4 ANCHOR INSTITUTION – Maximising our impact as an 'anchor' organisation in our local communities					
4.1	**Skills and Employment in Health & Social Care**	Skills Academy to open in the Summer 2025 to facilitate: • Changing the perception of a career in care • Making employment opportunities more accessible with simpler processes and a 'work ready offer' for those that need it • Employing more local people in care with a continuing pipeline of talent – good for the sector and good for the economy • Creating a career path to enhance skills of local people to increase incomes and social value • Retaining and retraining people in care through upskilling, advancement and supporting health and well-being	• Completion of the building refurbishment on time and to budget – Q2 25/26 • Core activities commence September 2025 – Q2 – Q3 25/26 • Closure of the 'project expenditure' phase of the Town Deal Board March 2026 • Deliver the outputs required by the Town Deal Board	Assistant Director - HR (Workforce)	**MWL having a net positive impact on the socioeconomic health and wealth of our geography**

No	Themes	Initiatives	Measurements	Trust Lead	Outcomes
4.2	**Explore Development Opportunities with Local Authorities and other partners**	• Complete acquisitions of strategic property and land for opportunities future development. • Explore options and opportunities for regeneration of nearby land for 'life sciences' and related activities. • Operation Cavell – working closely with police forces across boundaries to support staff and patients during the management of untoward incidents • Utilisation of Community based Healthcare spaces to create capacity on acute hospital sites and avoid ICB paying for void accommodation.	• Increase footfall in the local areas will add economic benefits • Significant opportunities to redevelop brownfield sites • Engagement with Merseyside and West Lancs police, resulting in protection arrangements, prosecutions and investigations • Relocation of services that can operate from premises out in the community to create capacity on the acute hospital sites for example sexual health services	Deputy Director Estates and Facilities	
4.3	**Leadership within the Places we serve**	• MWL leadership team plays a leading role for the communities at Place, ICB and the Region • MWL is the Lead Employer for Resident Doctors • MWL is a national payroll provider and continues to grow • Liverpool City Region Shadowing Programme for Ethnically Diverse Individuals • Sign up to the Cheshire and Merseyside Anchor Institute Charter	• Contribution to system developments in all fora • Satisfaction of service provided • Satisfaction and cost of service provided • Medical Director and Director of Integration completing the programme • Demonstration of Anchor practices	Chief Executive	

Title of Meeting	**Trust Board**		**Date**	26 March 2025
Agenda Item	**TB25/022**			
Report Title	Freedom to Speak Up Annual Self-Assessment 2025.			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance.			
Presenting Officer	Anne-Marie Stretch, Deputy Chief Executive			
Action Required	X	**To Approve**		**To Note**

Purpose

The paper presents the latest self-assessment of Freedom to Speak Up arrangements for approval by the Board. The self-assessment forms part of the Trust Board's assurance process for its oversight of the Freedom to Speak Up arrangements.

Executive Summary

Trust Boards are required to have an oversight of their 'Freedom to Speak Up' arrangements and undertake a comprehensive self-assessment in the required template provided by National Guardians Office (NGO).

This year's self-assessment follows a previous self-assessment undertaken in 2024. The requirement is for a self-assessment to be undertaken at least two yearly. The self-assessment completed for 2025 forms part of Board's assurance process of its review of Freedom to Speak Up process.

The Trust's 'Freedom to Speak Up' and 'Raise a Concern' vision is to promote an open and transparent culture across the organisation to ensure that all members of staff feel safe, supported, and confident to speak out and supports the Trust's objective of delivering 5 Star patient care.

Trust Boards are required to have an oversight of their 'Freedom to Speak Up' arrangements and undertake a comprehensive self-assessment at least every two years.

The assessment has had input from the Chair of the Board, Acting Director of Nursing, Midwifery and Governance, Assistant Director of Learning and Organisational Development, and the Freedom to Speak Up (FTSU) Guardians.

Areas for additional development include further direction regarding how detriment will be managed by the Trust given NGO guidance that this is required. Staff survey results are being reviewed to ensure any required actions to support managers in developing the appropriate culture in their work area will be supported by FTSU Guardians. The Freedom to Speak Up strategy will be updated to support the areas for development.

Financial Implications

None

Quality and/or Equality Impact

Not applicable

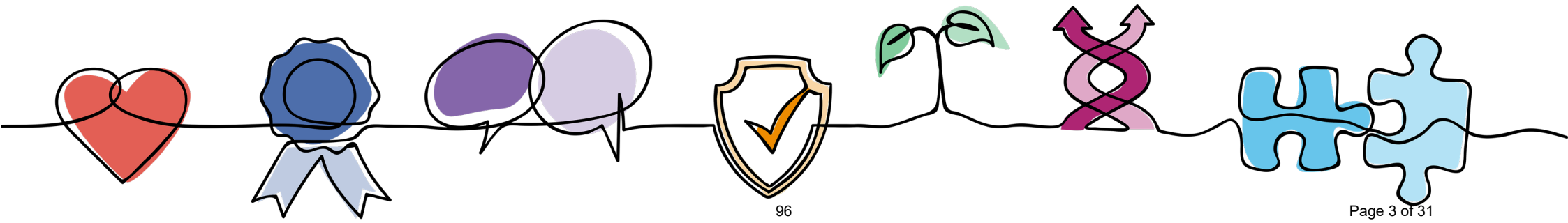
Recommendations	
The Board is asked to approve the Freedom to Speak Up Board Self-Assessment.	
Strategic Objectives	
	SO1 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

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

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks
  2 = concern or risk which warrants discussion to evaluate and consider options
  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach
  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on
  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on: Lynne Barnes - Acting Director of Nursing, Midwifery and Governance 15.01.2025	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5

Enter summarised commentary to support your score.

- Final FTSU structure being agreed post transaction.
- The two legacy Trust's completed a self-assessment in 2023, along with the 2024 self-assessment as a merged organisation enabling the organisation to develop an MWL FTSU forward plan.
- CEO and Chairman are FTSU leads, Medical Director is FTSU Guardian. The best practice suggested that as a lot of FTSUP issues are HR related it was best for the DoHR to attend the quarterly meetings with the Guardians to understand any themes that the Guardians wish to share and Executive Lead for FTSU - Director of Nursing who are knowledgeable and offer direction, advice, support, and challenge in relation to the FTSU culture, structure, systems, and process.

- Organisation has 4 FTSU Guardians, one of whom is a member of the Trust Board. Two of the other dedicated Guardians have been recruited through open advert and fair competition.
- Review of speaking up arrangement is carried out regularly and triangulated with other performance measures impacting speaking up.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Nil

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on Richard Fraser – Chairman 16.02.2025	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	5
I challenge the board to develop and improve its speaking-up arrangements	5
I am confident that our guardian(s) is recruited through an open selection process	4
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	5

Enter summarised evidence to support your score.
• Non-Executive lead is the Trust Chair

• A Trust Board member is an established FTSU Guardian, with knowledge and awareness of FTSU process and NGO guidance.

• Board level engagement and promotion of speaking up agenda with visibility, promotion, role modelling and communication using appropriate forums, including Trust Team Brief Live events and Trust Social media channels.

• Regular review of speaking up process and challenge to improve arrangements through reflective evaluation at Guardians meetings.

• Organisation has a longstanding approach to having several guardians with 4 FTSU Guardians, one of whom is a member of the Trust Board, the second is a senior manager with a clinical background. Two of the other Guardians have been recruited through open advert and fair competition. This provides staff with a number of guardians to choose from.

• A review of FTSU Guardians' structure has been undertaken post-merger and a further Guardian has been appointed. Two of the FTSU Guardians are employed part time to solely deliver the FTSU function and the others, complete their Guardian role, in addition to their main job role. This offers staff a mixture of Guardians to approach.

• In collaboration with the Trust, Guardians will be providing oversight into any investigation that relate to the board.

• Support to Guardians as required in setting speaking up process and systems.

• Facilitative function of Board members being FTSU Guardian in enabling system changes and assurance.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

All future FTSU Guardians to be appointed through a fair and open process in line with national guidance.

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	5
We regularly and clearly articulate our vision for speaking up	5
We can evidence how we demonstrate that we welcome speaking up	5
We can evidence how we have communicated that we will not accept detriment	5
We are confident that we have clear processes for identifying and addressing detriment	5
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	5
We regularly discuss speaking-up matters in detail	5

Enter summarised evidence to support your score.

• Members of the Board encourage staff to speak up and this has been raised several times on Trust Brief Live and is also part of the Trust Objectives, relating to developing the organisational culture and workforce.

• High visibility of the Executive Team and Senior Leaders through the Staff Voice Partnership, Staff Network and clinical role encourages staff to speak up.

• Staff networks are in place which supports staff, with protected characteristics to have a safe space to discuss concerns and raise issues.

• Trust participates in the October Freedom to Speak up Month and undertook several activities across the month in 2024.

• Feedback to the Guardians, from staff who have spoken up, is positive.

• Guardians are aware of the NHS England FTSU Support Scheme and how to refer staff, who have reported detriment, to the scheme.

• FTSU Quarterly Reports taken through the Valuing Our People group and then through to Quality Committee for assurance, oversight, and scrutiny to the Trust Board.

• Regular communication with all staff members through forums to inform of the support and mechanism for Freedom to Speak Up

• Periodic communication regarding Freedom to Speak Up using Team Brief Live, Newsletters, Global Emails, Team Talk events and engagement events.

• FTSU Guardians seek feedback, as per national guidance, from all staff who speak up through them.

• Staff who speak up to the guardians are supported through the process and are asked to report any perceived detriment.

• Process in place to identifying detriment experienced because of speaking up.

• Quarterly meetings restarting with new leads following retirement of key Executives

• Highly visible Executive members and senior leadership teams, role modelling of speaking up culture.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

Formalise and refine approach to monitor detriment for staff who have spoken up via the FTSU Guardian

Statements for the person responsible for organisational development Adam Ruddock - Assistant Director of Learning & Organisational Development 15.01.2025	**Score 1–5 or yes/no**

I am knowledgeable about Freedom to Speak Up	5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	5
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	5
We support our guardian(s) to make effective links with our staff networks	5
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	5

Enter summarised evidence to support your score.

• Speaking up culture is integral to the organisations culture and is integrated into the development of compassionate leaders and organisational development plans. The Trust is committed to a Just and Leaning Culture with supportive mechanisms embedded within the organisation.

• Trust has a consistent open and honest reporting culture with high levels of incident reporting, indicative of the existence of a just and learning culture.
The organisation develops its leaders with a compassionate, inclusive an open management style that encourages staff to speak up, that values, recognises and supports the workforce.

• FTSU Guardians have links with and support the full range of staff networks within the Trust.

• Feedback on the FTSU indicators within the staff survey is used to review our presenting culture and plan relevant activities. Staff survey feedback is extremely positive.

• We have undertaken a short FTSU effectiveness and awareness evaluation to measure awareness of FTSU processes, with positive findings.

• We utilise and encourage FTSU Champions to share soft intelligence regarding the FTSU culture at regular meetings as well as formal FTSU concerns. Actions are captured and progress reported at next meeting.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Nil

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	5
We have reviewed the ringfenced time our Guardian has in light of any significant events	5
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians.	5

Enter summarised evidence to support your score.

• 4 Guardians in place across the Trust, two of whom are ring fenced posts as FTSU Guardians. This provides a variety of roles and leadership levels for staff to approach and allows for cross site cover.

• There has been a review undertaken post-merger of FTSU resulting in one additional post, being appointed to and the expansion of the network of FTSU champions across the Trust.

• FTSU Specialist Administrator post provides administrative support to Guardians.

• Trust Executive Team has reviewed FTSU guardian capacity and supported business case to expand capacity by creation of additional part time dedicated FTSU Guardian role and expansion of network of FTSU champions. A further 0.6 WTE 12-month fixed term FTSU Guardian post has been extended after the initial 12 month term, with funding agreed to advertise externally as a permanent position in the near future.

• FTSU champions roles reviewed, development programme is in place and ongoing recruitment in progress at all sites.

• Guardians are supported by a growing network of FTSU Champions.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Review the establishment for FTSU at least annually going forward and adjust if required.
Continue to recruit and support FTSU Champions across all sites of the Trust.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	5

Enter summarised evidence to support your score.

• Harmonisation of FTSU policy in new format, post-merger completed.

• There is a dedicated intranet page for staff to review and read which includes a links to additional information, policy and ways for staff to raise concerns.

• Staff are asked as part of quality walkarounds regarding FTSU and information is shared if staff indicate they are unaware of the processes.

• Pop up stalls, engagement events and awareness sessions are held on a regular basis to support raising staff awareness.

• Evaluation audits on FTSU awareness were undertaken in 2024 and these have informed further work.

• FTSU Guardians has a presence on the staff Facebook page, raising awareness of speaking up.

• There has been an increase in the numbers of staff speaking up in 2024/25 when compared to the year 2023/24.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Continuous review and revision of FTSU policy as required.

Statements about how speaking up is promoted	**Score 1–5 or yes/no**
We have used clear and effective communications to publicise our guardian(s)	5
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	4
We measure the effectiveness of our communications strategy for Freedom to Speak Up	4

Enter summarised evidence to support your score.

• There is a dedicated intranet page for staff/leaders to review and read, which includes links to additional information, resources and ways for staff to raise concerns.

• There are posters placed around throughout the Trust to identify FTSU Guardians and Guardians have been highlighted in the Trust Newsletter.

• Executive and Guardian led briefs on Speaking Up provided through Team Brief Live events.

• Regular meetings with Freedom to Speak Up Guardians to discuss themes and communication requirement.

• There are screen savers on Trust computers describing FTSU support available for staff.

• Electronic notice boards in place, in high visibility public areas with information about speaking up.

• The Trust participated in Octobers Freedom to Speak up Month and held several engagement activities and pop ups to raise awareness.

• FTSU Guardians have a presence on the staff Facebook page, raising awareness of speaking up.

• Reports to Trust committees include what changes have been made because of speaking up, where appropriate, and whilst protecting staff confidentiality.

• Positive changes and 'You Said We Did' summaries shared at engagement events highlighting positive stories and changes as a result of speaking up.

• Guardians have planned pop up stands periodically to raise awareness of speaking up and talk to staff.

• Formal and informal collection of feedback on effectiveness of communication.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Continue to develop and implement plan of engagement events and speaking up profile-raising events

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	5
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	4

Enter summarised evidence to support your score.

• FTSU information is included in both the corporate and clinical inductions.

• All Guardians and FTSU Champions have completed appropriate National Guardian's Office and Health Education England training.

• National Guardian's Office and Health Education England training made available on Moodle platform and ESR for all staff to access.

• Information regarding training shared through engagement events and communications from Guardians.

• FTSU Guardians deliver Transition and Foundation Leadership courses

• FTSU Guardians attend induction for student nurses, junior doctors, international nurses and complete ad hoc sessions for other staff on request.

• All staff who speak up receive a thank you from one of the guardians.

• National staff survey and Pulse survey in place to measure effectiveness of speaking up process and findings reviewed.

• Sample survey of induction programme and contents delivered includes measuring impact of speaking up training. • Positive feedback on awareness sessions delivered by Guardians.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Continue to promote and deliver training to staff members raising awareness and supporting staff.

Statements about support for managers within teams or directorates	**Score 1–5 or yes/no**
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	5
All managers and senior leaders have received training on Freedom to Speak Up	4
We have enabled managers to respond to speaking-up matters in a timely way	4
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	4
Enter summarised evidence to support your score. • Individual managers are offered support by Guardians when receiving and reviewing concerns raised via Guardian. • When raising concerns, Guardians ask for a response from managers and leaders within a timeframe which varies depending on the concern being raised. This approach acknowledges that some areas of concern may take longer to review and offers a flexible and dynamic approach. • National Guardian's Office and Health Education England training for managers 'Listen Up' made available on Moodle platform and ESR for staff to access.	

• All management and leadership development programme incorporates the systems, process and benefits associated with FTSU as part of a compassionate leadership. • All managers and senior leaders have access to learning modules and has been promoted. • Information shared with managers through engagement events and communication on their role in supporting and responding to speaking up. • Reflective improvement and feedback from staff and managers on learning from speaking up and adapting their environments to ensure a safe speaking-up culture. • Guardians have close working relationship with HR and OD team to develop a supportive and learning culture and develop staff members.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Consider delivering relevant Speaking Up Training for all managers through available forums.
Incorporate speaking up as integral part of inhouse course for leaders and managers regarding building and supporting a Speak Up culture.

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	5
We use triangulated data to inform our overall cultural and safety improvement programmes	4

Enter summarised evidence to support your score.

• Guardians are supported via meetings with the Executive lead for FTSU and meet as a collective to discuss emerging or actual areas of concern/themes.

• Guardians follow through on cases raised through them to completion to ensure that any lessons identified are taken forward.

• Regular meetings with all Guardians in place to raise and address any areas of concerns and develop actions to resolve.

• We have highly visible Executive team and Board member involvement as Freedom to Speak Up Guardian.

• We use triangulation of data obtained through various process to inform and develop overall cultural and safety improvement programmes.

• Guardians attend quality and patient safety groups/committees.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	4
We use this information to add to our Freedom to Speak Up improvement plan	4
We share the good practice we have generated both internally and externally to enable others to learn	4

Enter summarised evidence to support your score.

• FTSU Guardians are members of the Northwest FTSU Guardians Network and share and learn from other FTSU Guardians

• Annual assessment has been undertaken by both former Trusts and presented to the Trust Boards

• Gap analysis against reports published by the NGO.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Revise FTSU Strategy and Improvement Plan for the next two years, incorporating gap analysis as identified in reviews and evaluation.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5

Enter summarised evidence to support your score.

• Two of the 4 guardians have been appointed through an open recruitment process. The other Guardians are senior manager/board level.

• FTSU Guardians, who have a dedicated role, follow the national prescribed job description

.

• All the Guardians are registered with the NGO and have completed the training required.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

All Guardians recruited to undertake training from the NGO. Existing guardians will undertake annual refresher training or appropriate development programmes as required by NGO standards or individual requirement.

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

• All guardians have had a PDR and have objectives in place.

• Guardians have regular 1:1 with the Executive lead for FTSU and meet as a collective

• Peer support through Trust Guardians regular network meetings.

• Support from Trust Board members and Trust Executive team to Guardians in advisory and facilitative support.

• Guardians have access to wider range of emotional support mechanism within the Trust.

• Guardians are members of the Northwest FTSU Network and can gain emotional support via this group or via the NGO.

• Multiple Guardians in place to provide mutual support and cross cover in absence.

• Multiple processes in place for staff members to contact Guardians and raise concerns including Confidential Hotline and Anonymous Work in Confidence system.

• Guardians can provide cross site cover when there is annual leave/absence.

• The organisation submits data to the NGO on a quarterly basis.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Nil

Statements about our speaking up process	**Score 1–5 or yes/no**
Our speaking-up case-handling procedures are documented	4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4
We are assured that confidentiality is maintained effectively	5
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	5
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	5

Enter summarised evidence to support your score.

• Case handling procedures are documented in policies.

• When raising concerns, Guardians ask for a response from managers and leaders within a timeframe which varies depending on the concern being raised. This approach acknowledges that some areas of concern may take longer to review and offers a flexible and dynamic approach.

• There is a dedicated intranet page for staff to review and read which includes a links to additional information, resources and ways for staff to raise concerns.

• Regular updates given through Team Brief, Newsletter and other engagement events on the role managers and other key

stakeholders in handling speaking-up cases.

• Speak Up and Listen up modules available on education portal for all staff to access

• Staff can raise concerns openly or confidentially via a Guardian or anonymously through the “work in confidence system”.

• Guardians maintain confidential files for all cases open to them and are only accessible by the FTSU Team.

• Soft intelligence suggests that most people asked, feel able to speak up in their teams, however further work is required in those areas where confidence can be higher.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Incorporate speaking up as integral part of inhouse course for leaders and managers regarding building and supporting a Speak Up Culture.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation’s speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	5
We know who isn’t speaking up and why	4
We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	4
Enter summarised evidence to support your score.	

• Barriers to speaking up have been identified through networking and engagement. Identified barriers mitigated by creation of new dedicated Guardian role and expansion of Champion network.

• FTSU strategy to be revised based on organisational need.

• Engagement of Guardians in staff network, EDI forums and international recruitment support process to develop understanding of barriers from speaking up.

• Champions are given training on recruitment and work to the NGO guidelines issued in 2023.

• Champions are supported via monthly meetings and one to one meeting, with a Guardian, as required.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Analysis of Staff Survey data, once received to identify individual areas where staff feel unable to speak up and provide some targeted support.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	4
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	5
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	5

Enter summarised evidence to support your score.

• We carry out regular engagement events on understanding what speaking up looks and feels like, along with detriment.

• FTSU Guardians discuss detriment with staff who raise concerns through them, and staff are asked to report if they feel they are experiencing detriment. • Where possible, Guardians follow up on staff who have raised concerns to monitor whether workers feel they have suffered detriment after they have spoken up. • Guardians are aware of the FTSU support scheme run by NHSE England and can refer staff to the scheme as required. • Non-executive Director for Freedom to Speak Up is regularly attends Guardians meeting and scrutinises instances of detriment.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
FTSU Policy to define how detriment will be monitored and reviewed as part of the FTSU process in line with NGO guidance.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	4
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	4
Our improvement plan is up to date and on track	4
Enter summarised evidence to support your score.	

• Legacy Trusts had a FTSU Strategy, a draft strategy for the newly merged organisation is awaiting approval/ finalisation

• Strategy is aligned and fits with organisational objective and overall cultural improvement.

• Trust continuously evaluates the Speaking Up process and effectiveness, using a range of qualitative and quantitative measures like Annual Staff Survey, Pulse Surveys, feedback from staff, review of concerns by Guardians and regular Guardians meetings.

• Continual evaluation of speaking up process and improvements made

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Develop a formal and dynamic improvement plan reflective of continuous evaluation.

Statements about evaluating speaking-up arrangements	**Score 1–5 or yes/no**
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	4
Our speaking-up arrangements have been evaluated within the last two years	4

Enter summarised evidence to support your score.

• Completion of an annual self-assessment.

• Staff survey results are reviewed in relation to FTSU and triangulated with other relevant information applicable to speaking up.

• Continuous evaluation of speaking up arrangements by Trust Board members, Executive Team, and Guardians

• High staff satisfaction results in staff surveys

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Implement a recognised quality improvement approach in evaluation of speaking up arrangements.

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	5
We have evaluated the content of our guardian report against the suggestions in the guide	5
Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	4

Enter summarised evidence to support your score.

• Both legacy Trust Boards received regular reports relating to FTSU and as a merged organisation, reports will be produced quarterly

• A variety of qualitative and quantitative information is used to evaluate Freedom to speak up arrangements, including staff surveys results, direct feedback.

• Assurance of positive impact of speaking up, with learning and improvement from senior leaders shared at appropriate forms.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Nil

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Formalise and refine approach to monitor detriment for staff who have spoken up via the FTSU Guardian.	30 June 2025	FTSU Guardians Exec Lead
2. Continue to develop and implement plan of engagement events and speaking up profile-raising events.	31 March 2025	FTSU Guardians Exec Lead
3. FTSU Policy to define how detriment will be monitored and reviewed as part of the FTSU process.	30 June 2025	FTSU Guardians
4. Develop a formal and dynamic improvement plan reflective of continuous evaluation	31 March 2025	FTSU Guardians
5. Implement a recognised quality improvement approach in evaluation of speaking up arrangements.	31 March 2025	FTSU Guardians
6. Revise FTSU Strategy and Improvement Plan for the next two to three years, incorporating gap analysis as identified in reviews and evaluation.	31 March 2025	FTSU Guardians
7. Monitor and evaluate speaking up as integral part of in-house course for leaders and managers regarding building and supporting a Speak Up Culture.	30 June 2025	FTSU Guardians/ Organisational development team
8. Analysis of new Staff Survey data, once received to identify individual areas where staff feel unable to speak up and provide targeted support.	31 March 2025	FTSU Guardians/ Organisational development team

Development areas to address in the next 12–24 months	Target date	Action owner
1. All future FTSU Guardians to be appointed through a fair and open process in line with national guidance.	Ongoing	FTSU Guardians Exec Lead
2. Continue to recruit and support FTSU Champions across all sites of the Trust.	Ongoing	FTSU Guardians
3. Deliver relevant Speaking Up Training for all managers through available forums.	Ongoing	FTSU Guardians
4. Continue to promote and deliver training to staff members raising awareness and supporting staff.	Ongoing	FTSU Guardians
5. All guardians recruited to be undertaken training from NGO. Existing guardians will undertake annual refresher training or appropriate development programmes as required by NGO standards or individual requirement.	Ongoing	FTSU Guardians
6. Review the establishment for FTSU at least annually going forward and adjust if required.	30 December 2025	FTSU Guardians
7. Continuous review and revision of FTSU policy as required.	30 June 2025	FTSU Guardians

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1. Continue to recruit and support FTSU Champions across all sites of the Trust.	Ongoing	FTSU Guardians

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	26 March 2025
Agenda Item	**TB25/023**				
Report Title	2025/26 Operational Plan/Opening Budgets				
Executive Lead	Gareth Lawrence, Director of Finance and Information				
Presenting Officer	Gareth Lawrence, Director of Finance and Information				
Action Required	X	**To Approve**		**To Note**	

Purpose

To present the Operational Plan and associated workforce, performance and financial statements for the 2025/26 Financial Year

Executive Summary

Formal planning guidance for the 2025/26 year was received by the Trust on 30 January 2025.

The Trust has prepared a financial and operational plan in line with the Trust planning paper approved by Finance and Performance Committee in November. It incorporates the formal planning guidance and emerging details from Integrated Commissioning Board (ICB) and NHS England (NHSE).

There is a significant amount of work ongoing across the system and NHSE and any further updates will be included and brought to the Finance and Performance Committee and Board.

Final plans due to be submitted on Thursday 27 March to NHS England.

Based on current information the Trust will submit a plan of a £59.5m deficit based on the current income and expenditure estimates and includes the following:

- Recurrent Cost Improvement Programme (CIP) of £51.2m (5% of operating expenditure)
- A deterioration of £7.6m relating to income the ICB have removed (capital charges; convergence).
- £6m planned spend in relation to the Transaction Business Case.
- Capital Expenditure of £52.6m
- Cash requirements of £82m (£60m revenue support, £22m capital schemes)
- Elective/Variable activity increased on 24/25 due to the additional theatres.

Financial Implications

None as a direct consequence of this paper

Quality and/or Equality Impact

None as a direct consequence of this paper

Recommendations

The Board is asked to approve the plan as the opening budget for 2025/26 and sign off the Board assurance statements in Appendix F.

Strategic Objectives

	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety

	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

1. Executive Summary

1.1. The purpose of this paper is to provide an update to the Committee on the financial plans for Mersey & West Lancashire Teaching Hospitals (MWL) for the 2025/26 financial year.

1.2. Formal planning guidance for the 2024/25 year was received by the Trust on 30 January 2025. This was delayed by over a month however this has not been reflected in the timeframes for submission which have remained high level draft plan 27 February 2025, detailed final plan 27 March 2025.

1.3. The Trust has submitted a financial plan of a £59.5m deficit. For the Trust to deliver this plan it will need to deliver CIP of £51.2m of Cost Improvement Schemes (CIP) which equates to c5% of operating expenditure. The plan does not include any resources for the unfunded growth on fixed elements of the contract such as non-elective that the Trust has delivered since 19/20, or inflation over and above funded levels as set out in this paper.

1.4. The Trust has been offered an indicative income value from the ICB for 2025/26. This value does not reflect the ongoing work being undertaken across the ICS to rebase contracts and remove all top ups. The value fixes elective recovery income at 2024/25 month 8 forecast outturn (FOT) levels and does not take into account the full year effect of schemes partly delivered in year i.e. the theatres business case which was a supported and agreed TIF scheme. With negotiations ongoing, this plan assumes all planned activity is funded.

1.5. The following elements have not been concluded or confirmed by external partners:

- No formal contract has been issued by the ICBs/NHSE nor have discussions concluded.
- While the National NEL tariffs have been significantly increased, this is not reflected in this plan.
- Health Education England contracts.

2. National Priorities

2.1. Formal planning guidance for the 2025/26 year was received by the Trust on 30th January 2025. The financial and operational plan has been created following four National priorities:

1. Reduce the time for people wait for elective care:

   - The percentage of patients waiting for treatment more than 18 weeks to improve to 65% and to first appointment to 72%
   - People waiting more than 52 weeks for treatment is to be less than 1% of the total waiting list
   - Need to improve performance against the 62-day cancer standard and 28-day faster access standard to 80%

2. Improve A&E waiting times and ambulance response times:

- 78% of patients to be admitted, discharged and transferred from ED within 4 hours
- Cat 2 ambulance response times to be an average of 30 minutes

- Deliver hospital handovers within 15 minutes
- Improve access to urgent care services at home or in the community
- Improve urgent care by using the principles of same day emergency care (SDEC)

3. Improve patient access to GPs and urgent dental care

4. Improve mental health and learning disability care:

- Improved patient care through mental health crisis and acute pathways
- Improve access to children and young people's (CYP) mental health services

3. Proposed changes to System Allocations, Contracts and the National Payment System

3.1. The 2024/25 commissioner income and associated contracts were set on a fixed and variable basis, with a significant proportion (around 70%) of the Trusts commissioner income being fixed and the remainder being variable and paid based on volumes of activity.

3.2. The national team have consulted on changes to this process for 2025/26 including a cap on the amount of variable income to be paid to a provider. The consultation has ended but the results are not yet known.

3.3. System variable allocations have been set based on the 2024/25 M8 forecast outturn plus inflation with an expectation that contracts will be capped at this level. Negotiations are continuing in this area, this plan assumes the Trust will be paid for all variable activity undertaken within the current system allocation. Changes to this value will have an impact on the Trust position.

3.4. Within the fixed elements of the 2024/25 contracts there were a number of 'top ups' allocated by the ICB. For 2025/26 the ICB set out an approach to review these alongside Trust activity plans to rebase the contracts across the system ensuring that funding flows follow the patient. This work has not concluded.

3.5. For MWL the impact of this rebasing work has been shared with the ICB and will be reviewed by Board in March. This plan assumes that fixed elements of the contract remain as per 2024/25 plus inflation where appropriate.

4. The Trust Planning Process

4.1. The planning process set out in the committee paper in November detailed the approach for 2025/26. Divisions have worked since November to set out their plans for 25/26 including planned performance, workforce and associated financial figures. This detailed work has formed the basis of the Trust plan.

4.2. Plans have been developed on a detailed 'bottom up approach' with updated activity and workforce plans alongside known cost pressures informing the income, expenditure and performance metrics for 2025/26.

4.3. Weekly meetings have been in place since January with key leads from across HR, Finance & Information to ensure planning is fully triangulated and all assumptions made are reflected in each part of the plan. Division plans have undergone two check and challenge reviews, a draft in December and a final in February post national guidance.

4.4. The Trust continues to engage with all budget holders and Senior Leaders through various forums, which include:

- Finance and Performance Committee
- Executive Committee
- Team to Team
- Division Finance and Performance Committees
- Finance Improvement Group
- Capital Planning Council
- CIP Council
- Premium Payment Scrutiny Council
- Budget review meetings with key leads and heads of service within each Division

4.5. National planning guidance has been reviewed alongside Trust plans and incorporated in the Division strategies on an ongoing basis, from informal national feedback in December, to the Elective Reform Plan and the National Planning Guidance. This information has been shared with committee alongside draft planning information.

4.6. Each sub section below will set out the planning process in more detail across the key headers of:

- Activity/Performance
- Workforce
- Finance

4.7. **Activity / Performance specific assumptions/process**

4.7.1. From a performance perspective, the headline performance metrics required are set out below.

- ED mapped performance at 78% (All types 72.4%)
- RTT 18 week performance to improve by 5%
- Time to first outpatient appointment 77%
- Cancer 28 day Faster Diagnosis Standard 80%
- Cancer 62 day wait for first treatment at 82%

4.7.2. Divisions have reviewed activity plans and ensured that they reflect the funded capacity within their expenditure plans. As a result they incorporate the full year effect of part year schemes such as Theatres and the impact of industrial action is not continued into the new financial year.

4.7.3. Calculation of the Trusts performance metrics has been undertaken based on the detailed activity plans, in line with the improving trajectory reported in 2024/25, the Trust is planning to meet (or exceed) these targets in 25/26.

4.7.4. The income and associated expenditure have been included on the basis of this activity as part of the Divisional planning process to ensure the resources triangulate with the performance metrics.

4.8. Workforce specific assumptions/process

4.8.1. From a workforce perspective the planning requirements for 2025/2026 stipulated.

- achieving close to 100% delivery of planned core capacity before accessing premium capacity, including the use of agency and premium bank rates, waiting list initiatives, and insourcing arrangements, managing to tariff prices
- reducing agency expenditure, as far as possible as part of optimising cost and productivity. As a minimum all systems are expected to deliver a 30% reduction based on current spending
- reducing bank use, with all systems expected to deliver a minimum 10% reduction. Bank rates should be optimised as far as possible with collaborative arrangements in place across and between systems
- conducting a robust review of establishment growth and reduce spend on support functions to April 2022 levels

4.8.2. The Trust workforce planning process has been informed through a robust analysis of workforce data including core drivers for variable pay. This data has been cross referenced with divisional priorities and challenges to ensure that the workforce plan is triangulated and reflective of the operational needs of our services and our financial position.

4.8.3. In addition, we have reviewed our workforce profile to ensure a robust understanding of our current workforce, determine future needs and to identify workforce gaps

4.8.4. The workforce plan prioritises frontline care and the focuses on recruiting and retaining staff across all staff groups whilst also reducing sickness and turnover

4.8.5. There is a continuous focus on continuing to deliver against our 4 people priorities and the national People Promise actions: including being compassionate and inclusive, safe & healthy and working flexibly

4.8.6. Any changes in workforce numbers are reflected in financial CIP

4.9. Finance specific assumptions/process

4.9.1. Financial budgets that have formed the building blocks of the financial plan have been developed on a detailed “bottom-up approach”, re-costing pay budgets and working to ensure all costs within the forecast outturn have been considered.

4.9.2. The following assumptions have been made within the plan to continue the strong financial management that is already in place within the Trust:

- All vacant posts funded at the bottom of the scale.
- No additional funding allocated for avoidable cost pressures.
- Inflation and incremental increases have been calculated on their own specific rates.

The above principles should help to ensure that the Trust has set a reasonable yet challenging budget to ensure the best possible value for money within the resources that are available.

5. Activity / Performance plan

5.1. The Trust has planned for elective activity in 2025/26 based on the funded capacity within the operational team's expenditure plans. As per the planning guidance this assumes that the impact of industrial action will not continue into the new financial year.

5.2. Due to the full year effect of schemes partially delivered in 2024/25 (e.g. Theatres business case) the additional activity planned for in 2025/26 delivers the required improvements in RTT and time to first outpatient appointment. There is scope for further waiting list reductions however this would require additional funding.

5.3. Emergency Care continues to be funded on a block contract basis, with activity levels set at historic levels. This is a significant risk to the Trust as NEL activity has increased by significantly (Whiston site only). Since 2019/20 Whiston site has delivered:

- 14% increase in NEL bed days (from 209,232 to 239,301)
- 2.8% reduction in NEL LoS (from 3.6 to 3.5 days)

While the activity figures below include planned activity regardless of funding, this activity reflects an overperformance against the assumed fixed contract. In 24/25 this was valued at £16m however the draft national prices for 2025/26 increase this value significantly (circa £65m). The financial figures included in the plan are the 24/25 fixed values uplifted by the standard 2.15% tariff uplift as per commissioner guidance.

	MWL Activity Plan			Growth %	
Metric	19/20	24/25 FOT	25/26 Plan	19/20 - 25/26	24/25 - 25/26
Elective	8,384	9,252	10,435	24%	13%
Daycase	67,799	78,444	81,891	21%	4%
Outpatient First	196,638	232,883	251,248	28%	8%
Outpatient Procedures	158,309	162,895	160,330	1%	-2%
Advice and Guidance	1,252	8,849	11,250	799%	27%
Elective variable total	**432,382**	**492,322**	**515,155**	**19%**	**5%**
Non-Elective specific acute	106,253	114,569	123,393	16%	8%
ED Attends	198,579	202,745	208,818	5%	3%
Walk in centre	17,531	50,499	51,290	193%	2%

5.4. Emergency care targets for legacy S&O sites continues to be set at 19/20 levels as per the transaction agreement.

5.5. The activity plan assumes that the proportion of no criteria to reside patients does not increase throughout the year and that all current bed capacity remains open.

5.6. The Trust has been set a stretch target of treating 82% Cancer within 62 days, against a national target of 75% within the activity plans.

6. Workforce Plan

6.1. The Trust has planned for workforce in line with the closing funded establishment for 2024/25 cross referenced against our actual workforce position reported through our Provider Workforce Return.

6.2. The plan accounts for existing pressures such as cover for sickness, maternity leave and urgent care pressures. This includes investment in our Health Care Support workforce (HCSW) to address challenges with supplementary care and changes to national role profiles for this staff group

6.3. The total workforce WTE plans for a total reduction of 3.7% driven by reduction in bank (-26.7%) and agency usage (-38.8%) which meets the national targets outlined above. This is underpinned by increases in our substantive workforce (by 0.3%) reflecting investment in HCSW, recruitment to vacant posts and a reduction in turnover. It also reflects the appropriate treatment of services hosted by the organisation.

6.4. Workforce productivity, reductions in temporary staffing usage and support services have been included within CIP plans.

6.5. High level table showing projected Staff in post vs EST (full breakdown in Appendix E):

Annual Workforce Plan 2025/26 (WTE)	Baseline		Plan	
	Staff in Post	EST	Staff in Post	EST
	Year End (31-Mar-25)		Year End (31-Mar-26)	
Total Substantive	9,636.07	10,297.54	9,559.07	10,173.88
Total Bank	801.59		587.65	
Total Agency	237.51		145.45	
Total Workforce (WTE)	**10,675.17**	**10,297.54**	**10,292.17**	**10,173.88**

7. Income and Expenditure plans

7.1. The Trust plans to deliver a £9.3m deficit in 2024/25. This deficit position has been underpinned by £17.4m deficit and other funding alongside a significant amount of non-recurrent mitigations, and some of which have been utilised in year as a result of increases in inflation. As a result of the underlying challenges and new pressures identified in year the Trust has submitted a draft deficit plan of £59.5m including technical adjustments.

7.2. Bridge from 24/25 plan to 25/26 draft plan (Broken down by type in Appendix B):

	£m	
24/25 MWL plan	**-26.7**	**Notes**
Items included within plan:		
Less Transaction support - ICB/NHSE/Trust	(12.0)	Non recurrently identified by all in 24/25
Less Non Recurrent CIP	(11.8)	Planned non recurrent CIP delivery
Less Non Recurrent funding	(5.0)	Year end adjustment in agreement with national team
Emerging issues:		
Less Inflation above funded levels	(4.5)	Trust part of national group reviewing impact of inflation
Less Pay Award costs above funded levels	(0.6)	Identified gap between national funding and costs
Less Urgent Care additional resource	(6.8)	This includes 5th in a bay/ post take cover/ cath lab/ 4E
Less Elective Care underperformance	(12.1)	Currently mitigated non recurrently
Underlying 24/25 position	**(79.5)**	
25/26 additions:		
24/25 Transaction business case	(6.0)	Planned spend in 24/25 linked to Transaction business case
RTT target	0.0	FYE of part year activity based business cases (Theatres) and additional activity income offset with associated cost
PFI remeasurement	0.0	National technical adjustment not released so no offset included yet
System income adjustments	(7.6)	ICS removed system convergance, capital charges and other smaller NR income
Total 25/26 additions	**(13.6)**	
Inflation:		
Income inflation	19.2	Funded inflation is included based on the NHS long term plan. Inflation over and above funded has been included where unavoidable and measurable.
Tariff funded inflation	(41.2)	
Inflation over and above funded (PFI/CNST)	(6.8)	
Total impact of Inflation	**(28.8)**	
National CIP (2%)	21.0	This is based on the NHS long term plan
Transaction saving	6.0	Save to invest from business case
Local	14.2	This brings the total CIP to 4% of turnover
Total CIP	**41.2**	
24/25 Board Draft Plan February	**(80.7)**	
Amendments since plan paper written:		
CNST income	1.2	Additional income identified by the ICB
Additional CIP	10.0	Requested stretch CIP
Strategic Opportunities	10.0	Linked to strategic opportunities discussed at Board
Total amendments	**21.2**	
25/26 Plan paper position	**(59.5)**	

7.3. During 2024/25 the Trust utilised £52.8m of non-recurrent resources, which are described above and are a mix of planned and unplanned items.

7.4. The income within the activity plan has been calculated utilising the funded capacity within the respective Divisions. The plan also includes the opening of the new theatres on the Whiston site.

7.5. The Trust has been working with commissioner leads on the breakdown of the respective plans, however all discussions have not concluded, and no contracts are currently signed, or final offers received.

7.6. National pay and prices have been set at 4.15% with an expected efficiency saving of 2% giving a net increase of 2.15%.

7.7. The Trust has included all income assumptions agreed as part of the Transaction case. The Trust had agreed that all legacy S&O income values (excluding those attributable to ERF) will remain blocked until the strategic goals outlined in the business case were realised however this has yet to be agreed for the 2025/26 financial year.

7.8. The Trust is awaiting the outcome of the ICB rebasing exercise and so this plan currently includes fixed elements of income as per 2024/25 plans.

8. Cost Improvement Plans (CIP)

8.1. The 2025/26 plans require the delivery of a £51.2m CIP, this represents c5% of the Trusts planned operational expenditure. The CIP % calculation is not adjusted within the forms for:

- PFI payments
- Commercial contracts
- Pass through costs

8.2. When these elements are excluded from the operational expenditure the CIP % increases to 5.5% which is a more reflective representation of the challenge to the Trust.

8.3. The Trust has made significant progress in identifying schemes to deliver this target with 123 individual schemes valued, a further 30 being worked up and 23.7% RAG rated as green or amber.

Division Risk Rating	£m
Green	4.9
Amber	18.8
Red	27.5
Total Identified	**51.2**

Type	£m
Premium pay including Agency, Bank, WLI's and outsourcing	16.8
Productivity	10.3
Non pay including drugs	2.0
Service redesign	12.0
Other	10.0
Total	51.2

8.4. As in previous years schemes are identified by the respective Divisions and back office functions and then assessed to ensure that there are no patient safety or quality concerns via the quality impact assessment (QIA) process.

8.5. The cost improvement plans are embedded within the income and expenditure plans; therefore any non-delivery of the savings target will manifest itself within the I&E performance throughout the year.

8.6. There is a rolling CIP tracker – MWL have successfully achieved 4% recurrent CIP over the past 4 years.

8.7. There is no CIP mitigation reserve included within the plan. As a result the Trust will be looking to identify schemes of c£73m in year to allow for a 70% conversion rate. As in previous years any schemes that are not delivered will remain as potential opportunities for future years to contribute to a rolling programme.

8.8. To support delivery of the priorities and actions the National team have provided a productivity pack which incorporates the national tools they expect us to use to improve the financial position and live within our means. These tools are available in Model Hospital and include the National Cost Collection data, Implied Productivity metrics and corporate benchmarking returns.

8.9. The national productivity pack for MWL outlines an opportunity of £50.4m across the themes of clinical & operational productivity and efficiency. As described above the Trust CIP plan has been developed utilising all of the tools available to the Trust and at £51.4 exceeds the opportunity outlined.

8.10. An area the Trust has not been able to improve has been the £11.5m efficiency linked to non-elective overnight stays. The urgent care pressures faced by the Trust since 2019/20 have increased length of stay due to increasing demand and the significant volume of ready for discharge patients within our wards. Despite this the Trust has continued to work towards improving length of stay by incorporating best practice and working with external partners on discharges.

8.11. The Trust regularly reports on these tools through Finance & Performance Committee and the source information is used by the Divisions. The Divisions are supported by the Division based Business Partners/Service Transformation team in using the data and incorporating it into part of their CIP workstreams.

8.12. Historically the Trust also utilised Service Level Reporting to map income against costs, this identified services making less of a contribution to Trust overheads allowing for deep dives to be undertaken to resolve the gaps. However due to income not being rebased for a number of years we have not been able to utilise this.

8.13. The Trust has not incorporated efficiencies to fully offset the current deficit. The Trust has successfully delivered 4% recurrent CIP for the past three years and it is unlikely to be successful in delivering a higher proportion than the 5% included recurrently in year.

8.14. To reduce the deficit the Trust has set out a number if high level strategic opportunities and will continue to work with commissioners and local leads to realise these opportunities so that MWL is a financially sustainable organisation going forward. Delivery of these strategic opportunities will require significant support from local and national leads.

9. Capital planning, Statement of Financial Position (Balance Sheet) and Cash

9.1. The latest forecast closing cash balance for 2024/25 is c. £2.7m. During 2024/25, the Trust received cash support of £17m, PDC revenue support of £17m and PDC funded capital support of £4.5m.

9.2. The current plans will mean that the Trust will require a significant value of cash support during 2025/26. The current plan assumes c. £82m of cash (£60m revenue support, £22m capital schemes) will be required to deliver the agreed capital programme and support the revenue deficit.

9.3. The national team has not yet outlined the process for requesting cash support however in 2024/25 cash has been constrained and so it is likely there will need to be further discussions regarding this cash requirement across the system, region and nationally.

9.4. The plans assume no deterioration in the wider health economy's ability to service its debt to the Trust. An environment of arguably increasing cash pressures on organisations renders this a risk. The summarised cash flow statement can be found within Appendix C of the paper.

9.5. This plan breaches the Trusts statutory break even duty, the same was true of the plan in 2024/25.

9.6. The Trust's land and buildings are valued using the alternative single site methodology and VAT is excluded from PFI valuations. The Trust has currently no surplus estate and therefore does not anticipate any sales of surplus assets.

9.7. The Statement of Financial Position and Cash flow can be found in Appendices B and C.

10. Interest, Tax, Depreciation and Amortisation (ITDA)

10.1. Depreciation and amortisation has been based on the current 2024/25 forecast outturn. During 2024/25 the Trusts capital programme was in excess of £50m (incl. PFI), which has increased the depreciation charges in year.

10.2. The Trust is assuming no deterioration or improvement in the aged debt relating to Lead Employer contracts. This will continue to be managed separately in order to understand and respond to any changes within the working capital.

11. Accounting treatment for PFI / Technical adjustments

11.1. In 2024/25 the PFI has been accounted for on an IFRS16 basis and then adjusted out back to UK GAAP in the national templates.

11.2. Within the Trust 2024/25 plan there was an I&E pressure of c£7m reflecting the move from IAS 17 to UK GAAP The 2025/26 planning guidance is consistent and requires PFI to be accounted for under IFRS 16 and then adjusted back out to UK GAAP.

11.3. The technical adjustment is not an accounting methodology, it is a national notional adjustment to the Trusts accounts intended to remove the significant pressure the change in accounting standards introduced. Along with other Trusts with a PFI, MWL has queries outstanding with the national team with regards to this technical adjustment and associated funding streams. At the time of planning these have yet to conclude.

11.4. We are working with the national team to ensure the Trust is not financially penalised by changes to accounting standards and long term PFI arrangements.

12. Capital

12.1. There are four key elements to the funding of the capital plan:

- Internal depreciation capped at £12.4m by ICB
- IFRS 16 leases (excluding PFI) £2.3m
- Backlog maintenance agreed as part of the S&O transaction £8m
- Additional capital support for Southport and Ormskirk sites £8m
- Externally funded frontline digitisation £14m

12.2. The Capital Plan includes PFI lifecycle replacement costs deferred from previous year's UP funding. It also includes a small amount for finance lease renewals, an allowance set aside for other expenditure including new and replacement equipment and essential developments. PFI lifecycle costs are recognised at actual replacement costs at the time of delivery; the figures below are only estimated costs and are therefore subject to potential change.

12.3. Indicative capital requests include:

Capital Plan 25/26	Forecast 2024/25 £m	Plan 2025/26 £m
Internally Funded Consisting of:	**9.7**	**12.0**
Estates	5.2	5.4
Estates Safety	0.0	2.9
CSR Diagnostics	0.0	0.1
IT General	1.1	1.5
Equipment	3.3	2.0
PDC consisting of:	**11.5**	**14.4**
DDCP PACS	0.1	14.4
LIMS	7.4	0.0
Opthamology Hub	1.9	0.0
Cyber Improvement	0.1	0.0
ePR Frontline Digitisation	0.6	0.0
CAMRIN/i-Refer	0.5	0.0
Connecting Care	0.5	0.0
Diagnostics Microtome	0.5	0.0
ePR Readiness	0.0	14.4
PFI Lifecycle	**10.6**	**7.8**
Routine maintenance (non-backlog) - Land, Buildings and dwellings	6.3	5.9
Equipment - clinical diagnostics	4.3	1.9
System Capital Support (incl. PDC funded)	**16.0**	**16.0**
S&O Backlog	8.0	8.0
S&O Transformation	8.0	8.0
Leases	**4.2**	**2.3**
Lease Remeasurements	4.2	2.3
Total	**52.0**	**52.6**

12.4. The approach for capital planning will be managed via the Capital Planning Council which will report back to F&P Committee and the Executive Committee.

12.5. The Trust will continue to work with its partners on the respective PFI sites to deliver enhanced assets. As a result of the elongated process of approvals, this process sometimes involves pre-payments to ensure the best possible value.

13. Drivers of Deficit/Mitigations

13.1. The Trusts adjusted financial position has deteriorated from a planned £26.7m deficit in 2024/25 to a proposed £59.5m deficit for 2025/26 as set out in this document.

13.2. As part of the planning process the Trust has outlined a number of drivers of this deficit, principally being the underfunding of fixed elements of the contract, premium costs associated with urgent care pressures due to full capacity and ongoing inflation over and above nationally funded levels (particularly relating to PFI contract).

13.3. The Trust is committed to addressing the deficit and has worked to set out the historical financial position to commissioners, providing detailed activity breakdowns to support the assertions regarding the fixed elements of the contract. The Trust has also participated in

national working groups to understand inflation pressures and has worked with local and national partners to embed all best practice with regards to urgent care.

13.4. Rebasing the main commissioner contract to reflect the activity in this plan would result in an increase in income of £65m and for the associate contracts a further £18m

13.5. In addition to this, and in conjunction with the Transaction Business Case, the Trust has developed a set of high level strategic opportunities and has shared them with local leads to take them further. These opportunities could result in a financial improvement of circa £50m over the next three years.

13.6. The mitigations described above would result in a break even plan for the organisation at the end of the three year period, with no income top ups and a plan wholly based on delivery of activity.

13.7. Reflecting the true financial position of the organisation and realising these improvement opportunities is reliant on active participation and leadership at both a local and national level from ICB and NHSE.

14. Risks

14.1. There are a number of risks and outstanding issues which may impact on the plans:

- Commissioner income: As outlined in this paper there are a number of areas where the ICS/NHSE income/ contract negotiations are yet to be concluded. This includes caps on variable elective activity, rebasing of the fixed elements of the contract and funding of items removed by the ICB including capital charges. Changes from the Trust assumptions in these areas could have a material impact on the plan for 2025/26.

- Significant cash borrowing within the plan c£82m, this will require approval by the national team and increase PDC costs. The ICB has had cash requests rejected in the last quarter of 2024/25 and this may impact on 2025/26.

- Final plan puts the Trust into a cumulative deficit (B/Even duty).

- No industrial action impact is assumed in 2025/26, any IA may impact on the Trust workforce and therefore the Trusts ability to deliver this plan.

- Plan underpinned by delivery of significant elective activity assumed to be paid for on a per procedure basis; under delivery will result in a financial pressure.

- The plan includes ongoing use of variable staffing. In line with national planning requirements the Trust is working to reduce the usage of variable staff but this is reliant on recruitment pipelines which are affected by national shortages and improved retention compounded by national living wage decisions impacting on our lowest banded staff.

- The Trust has an ongoing query with the national team regarding the notional PFI adjustments, changes to this could have a negative impact on this plan.

- The impact of the recent announcements regarding System/ National cuts on Trust is not yet known however in conjunction with the significant financial challenges faced by the system is likely to impact on the Trusts plan including the long term delivery of the Transaction and Shaping Care Together principles as leadership changes could result in gaps in understanding of agreements.

- Given the significant financial challenge this plan is unlikely to be accepted by the national team.

15. Conclusion and Next Steps

15.1. The Trust has produced a financial plan that delivers a deficit of £59.5m

15.2. The plan is underpinned by delivery of the respective Division activity plans and a 5% CIP target.

15.3. The Trust will require cash support of c.£82m (£60m revenue support, £22m capital schemes) to deliver the proposed plan and will progress this with the relevant local/national leads.

15.4. The Trust will work with external partners to conclude the ongoing issues including contract negotiations and PFI queries and update committee/Board as appropriate.

15.5. The Trust will submit this plan including the information described in this paper along with any emerging details. The final submission to NHSE is on the 27 March.

16. Recommendations

16.1. The Committee are asked to approve the proposed plan for 2025/26 and next steps as described.

Appendix A – I&E Plan

	Plan 2024/25 £m	Deficit Support 2024/25 £m	Amended Plan 2024/25 £m	Forecast 2024/25 £m	Plan 2025/26 £m
Operating Income from Patient Care activities	817.7	15.9	833.6	838.9	822.3
Other Operating Income	117.1		117.1	113.2	106.8
Total Income	**934.8**	**15.9**	**950.7**	**952.1**	**929.1**
Employee Expenses	(633.8)		(633.8)	(637.7)	(633.8)
Operating Expenses	(268.6)		(268.6)	(267.4)	(291.8)
Total Operating Expenses	**(902.4)**	**0.0**	**(902.4)**	**(905.1)**	**(925.6)**
EBITDA	**32.4**	**15.9**	**48.3**	**47.0**	**3.4**
ITDA	(69.6)		(69.6)	(69.0)	(65.3)
Surplus/Deficit	**(37.2)**	**15.9**	**(21.3)**	**(22.0)**	**(61.9)**
Technical Adjustment	10.5		10.5	11.1	2.4
Surplus/Deficit	**(26.7)**	**15.9**	**(10.8)**	**(10.9)**	**(59.5)**

Appendix B – I&E Bridge by type

	£m Income	£m Exp.	£m EBITDA	£m ITDA	£m Net Surplus/ (Deficit)	£m Tech Adj	£m Surplus/ (deficit)	
24/25 MWL plan	**936.0**	**(904.8)**	**31.2**	**(69.0)**	**(37.8)**	**11.1**	**(26.7)**	**Notes**
Items included within plan:								
Less Transaction support - ICB/NHSE/Trust	(12.0)	0.0	(12.0)	0.0	(12.0)	0.0	(12.0)	Non recurrently identified by all in 24/25
Less Non Recurrent CIP	(1.8)	(10.0)	(11.8)	0.0	(11.8)	0.0	(11.8)	Planned non recurrent CIP delivery
Less Non Recurrent funding	(5.0)	0.0	(5.0)	0.0	(5.0)	0.0	(5.0)	Year end adjustment in agreement with national team
Emerging issues:								
Less Inflation above funded levels	0.0	(4.5)	(4.5)	0.0	(4.5)	0.0	(4.5)	Trust part of national group reviewing impact of inflation
Less Pay Award costs above funded levels & NR income	0.0	(0.6)	(0.6)	0.0	(0.6)	0.0	(0.6)	Identified gap between national funding and costs
Less Urgent Care additional resource	0.0	(6.8)	(6.8)	0.0	(6.8)	0.0	(6.8)	This includes 5th in a bay/ post take cover/ cath lab/ 4E
Less Elective Care underperformance	(7.1)	0.0	(7.1)	(5.0)	(12.1)	0.0	(12.1)	Currently mitigated non recurrently
Underlying 24/25 position	**910.1**	**(926.7)**	**(16.6)**	**(74.0)**	**(90.6)**	**11.1**	**(79.5)**	
25/26 additions:								
24/25 Transaction business case	0.0	(6.0)	(6.0)	0.0	(6.0)	0.0	(6.0)	Planned spend in 24/25 linked to Transaction business case
FYE of part year business cases	5.0	(5.0)	0.0	0.0	0.0	0.0	0.0	
RTT target	14.9	(14.9)	(0.0)	0.0	(0.0)	0.0	(0.0)	Additional activity and the associated costs
PFI remeasurement	0.0	0.0	0.0	8.7	8.7	(8.7)	0.0	National technical adjustment not released - no income offset included
System income adjustments	(10.4)	2.9	(7.5)	0.0	(7.5)	0.0	(7.5)	ICS removed system convergance, capital charges and other smaller NR income
Total 25/26 Changes:	**9.5**	**(23.0)**	**(13.6)**	**8.7**	**(4.9)**	**(8.7)**	**(13.6)**	
Inflation								
Income inflation	19.2	0.0	19.2	0.0	19.2	0.0	19.2	Funded inflation is included based on the NHS long term plan.
Tariff funded inflation	0.0	(41.2)	(41.2)	0.0	(41.2)	0.0	(41.2)	
Inflation over and above funded (PFI/CNST)	0.0	(6.8)	(6.8)	0.0	(6.8)	0.0	(6.8)	Inflation over and above funded has been included where unavoidable and measurable.
Total National Pressures	**19.2**	**(48.0)**	**(28.8)**	**0.0**	**(28.8)**	**0.0**	**(28.8)**	
Cost Improvement:								
National CIP (2%)	0.0	21.0	21.0	0.0	21.0	0.0	21.0	This is based on the NHS long term plan
Transaction saving	0.0	6.0	6.0	0.0	6.0	0.0	6.0	Save to invest from business case
Local	0.0	14.2	14.2	0.0	14.2	0.0	14.2	This brings the total CIP to 4% of turnover
Total CIP	**0.0**	**41.2**	**41.2**	**0.0**	**41.2**	**0.0**	**41.2**	
25/26 Draft Plan February	**938.8**	**(956.5)**	**(17.8)**	**(65.3)**	**(83.1)**	**2.4**	**(80.7)**	
Amendments since previous draft:								
CNST income	1.2	0.0	1.2	0.0	1.2	0.0	1.2	Additional income identified by the ICB
Additional CIP	4.0	6.0	10.0	0.0	10.0	0.0	10.0	Requested stretch CIP
Strategic Opportunities	0.0	10.0	10.0	0.0	10.0	0.0	10.0	Linked to strategic opportunities discussed at Board
Remove additional RTT activity	-14.9	14.9	0.0	0.0	0.0	0.0	0.0	Remove additional activity
Total amendments	**-9.7**	**30.9**	**21.2**	**0.0**	**21.2**	**0.0**	**21.2**	
25/26 Plan paper position	**929.1**	**(925.6)**	**3.4**	**(65.3)**	**(61.9)**	**2.4**	**(59.5)**	

Appendix C – Summarised Statement of Financial Position (Balance Sheet)

Sumarised Statement of Financial Position (Balance Sheet)	Forecast 2024/25 £m	Plan 2025/26 £m
Non Current Assets	**545.7**	**552.9**
Current Assets		
Inventories	9.4	9.4
Receivables & Other Current Assets	77.3	91.8
Cash at Band and in Hand	2.7	2.8
Total Current Assets	**89.4**	**104.1**
Current Liabilities		
Payables & Other Current Liabilities	(70.6)	(40.0)
Borrowings	(19.5)	(23.4)
Provisions	(2.0)	(2.0)
Total Current Liabilities	**(92.1)**	**(65.4)**
Net Current Assets/ (Liabilities)	**(2.6)**	**38.7**
Non Current Liabilities	**(472.0)**	**(464.4)**
Total Assets Employed	**71.1**	**127.2**
Taxpayers Equity		
Public Dividend Capital	333.1	415.7
Retained Earnings Reserve	(290.5)	(317.0)
Revaluation Reserve	28.5	28.5
Total Taxpayers Equity	**71.1**	**127.2**

Appendix D – Summarised Cash Flow

Summarised Statement of Cash Flows	Forecast 2024/25 £m	Plan 2025/26 £m
Operating Surplus/(Deficit)	**14.3**	**(26.5)**
Excluding non-cash items	32.4	32.4
Movement in working capital		
Receivables	(5.7)	(1.7)
Inventories	0.1	0.0
Trade and Other Payables	(15.3)	1.0
Cash Flows from Operating Activities	**25.7**	**5.1**
Investing		
Interest Received	4.7	0.0
Capital Payments net of Dispossals and Donations	(53.4)	(50.0)
Cash Flows from Investing Activities	**(48.8)**	**(50.0)**
Financing		
PDC Receipts	36.0	82.6
Capital and Other Loan/Liability Repayments	(17.6)	(19.9)
Interest on Loans/Liabilities	(17.3)	(17.7)
Cash Flows from Financing Activities	**1.1**	**45.0**
Net Cash Inflow/(Outflow)	**(22.0)**	**0.1**
Opening Cash Balance	**24.7**	**2.7**
Closing Cash Balance	**2.7**	**2.8**

Appendix E – Annual Substantive Workforce Plan

Annual Workforce Plan 2025/26 (WTE)	Baseline		Plan	
	Staff in Post	EST	Staff in Post	EST
	Year End (31-Mar-25)		Year End (31-Mar-26)	
Medical & Dental	1,172.44	1,153.42	1,141.16	1,137.76
Registered Nursing, Midwifery & Health Visiting Staff	3,034.05	3,191.23	3,074.83	3,191.23
Reg/ Qual Scientific, Therapeutic and Technical Staff	1,121.79	1,232.39	1,167.30	1,232.39
Clinical Support	1,963.57	2,141.16	2,115.65	2,141.16
Infrastructure	2,341.58	2,577.20	2,057.49	2,469.20
Other Staff	2.64	2.14	2.64	2.14
Total Substantive	**9,636.07**	**10,297.54**	**9,559.07**	**10,173.88**

Broken down where possible:

Adult nursing	2,371.33	2,498.31	2,412.11	2,498.31
Children's nursing	213.32	224.80	213.32	224.80
Registered Midwives	284.84	287.28	284.84	287.28
Community Nursing	159.36	174.84	159.36	174.84
Mental Health Nursing	5.20	6.00	5.20	6.00
Registered Nursing, Midwifery and Health visiting staff	**3,034.05**	**3,191.23**	**3,074.83**	**3,191.23**

Reg/Qual Allied Health Professionals	680.81	743.15	723.32	743.15
Reg/Qual Other S, T & T	217.31	239.48	220.31	239.48
Reg Qual Healthcare Scientists	223.67	249.76	223.67	249.76
Registered/ Qualified Scientific, Therapeutic and Technical Staff	**1,121.79**	**1,232.39**	**1,167.30**	**1,232.39**

Registered/Qualified Healthcare Scientists	223.67	249.76	223.67	249.76
Support and Trainees to Healthcare Science	239.12	264.62	239.12	264.62
Healthcare science (Registered/Qualified + Support)	**462.79**	**514.38**	**462.79**	**514.38**

Support to Nursing & Midwifery	1,468.88	1,626.82	1,609.28	1,626.82
Support to AHPs	164.52	167.97	167.97	167.97
Support to Other S, T & Ts	91.05	81.75	99.28	81.75
Support to Clinical staff	**1,724.45**	**1,876.54**	**1,876.53**	**1,876.54**

All Consultant	445.89	495.93	445.89	495.93
Non-Con Career Grades (excl Resident Drs)	271.10	256.39	271.10	256.39
Resident Drs (excl. Foundation Trainees)	246.10	246.10	230.44	230.44
All Foundation Trainees	209.35	155.00	193.73	155.00
Medical & Dental	**1,172.44**	**1,153.42**	**1,141.16**	**1,137.76**

Appendix F – Board Assurance statements

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.		
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.		
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.		
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.		
The organisation's plan was developed with appropriate input from and engagement with system partners.		

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.		
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.		
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.		
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	26 March 2025
Agenda Item	**TB25/024**			
Report Title	Care Quality Commission (CQC) Compliance and Registration			
Executive Lead	Lynne Barnes Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes Acting Director of Nursing, Midwifery and Governance			
Action Required	X	**To Approve**		**To Note**

Purpose

This paper provides a summary of policies, process and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards (2024) required by the CQC (Appendix 1) to provide assurance to the Board.

Executive Summary

The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009.

This report provides a summary for 2024/25.

Following the transaction and the formation of Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) on 01 July 2023, the original ratings from the former St Helens and Knowsley Teaching Hospitals NHS Trust 2018 inspection remain in place; therefore, the overall Trust rating remains Outstanding.

There have been two unannounced inspections since the last report to Trust Board:

- Urgent and Emergency Care (UEC) were inspected on Southport site on 04 March 2024, draft report received for factual accuracy in February 2025 and final publication awaited.
- UEC were inspected on Whiston site on 25 March 2024 and the final report published 31 January 2025. Service rated as requires improvement overall however rated good for caring, effective and well led. Regulatory breaches have been notified to the Trust against three of the fundamental standards. Action plans are progressing.

There have been no enforcement actions taken during 2024/25.

Appendix 1 provides a high level summary of compliance against the 2024 CQC fundamental standards and regulations.

Financial Implications

The CQC charges all providers an annual registration fee to cover its regulatory activities based on a percentage of the patient care income from the most recent annual accounts.

- MWL 2024/25 fee - £567,748

Quality and/or Equality Impact

Not applicable to this assurance report.

Recommendations

The Board is asked to review the information provided to confirm compliance with the fundamental standards and on-going CQC registration requirements and to determine if further information or evidence is required.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Appendix 1

Trust Compliance with CQC Regulations and Fundamental Standards

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
1. Person-centred care	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, Caring, Responsive	Quality	DoNMG, MD	All patients are assessed on admission or when commenced on caseload and have comprehensive treatment/care plans in place. Mental Capacity Act included in mandatory training. Compliance with nursing care indicators is regularly audited and reported to each ward using the audit app, Tendable. The Trust received an overall rating of outstanding for the caring domain, with examples of compliance cited in the CQC inspection report. MWL maintains its Outstanding CQC rating for Caring. The recent CQC inspections have received praise from the inspectors stating our staff were "exceptionally caring'' as they "treated patients, their relatives, and carers with compassion, kindness and understanding while respecting people's individual needs, privacy.
2. Visiting and accompanying	9A – Visiting and accompanying in care homes, hospitals and hospices	Patients should have visitors and be able to visit the hospital without difficulty.	Caring	Quality	DoNMG	Visiting Policy in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts, health passports, side-rooms, additional staffing where needed, supplementary care model in place and promotion of John's Campaign to support carers who wish to stay with patients/carer beds, hearing loops & communication aids. In addition, the Trust has carer passports in place to support those closest to patients. Interpreters can be accessed as required. In outpatients, double, early, and late appointments are used along with desensitising visits to clinics. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
3. Dignity and respect	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy at all times, including when sleeping, toileting and conversing.	Safe, Caring, Responsive	Quality	DoNMG, MD	The Trust's values include We are KIND, OPEN and INCLUSIVE and these are reiterated at interview, on induction and during appraisals. Values based recruitment is in place for all staff. Privacy and dignity is assessed as part of the CQC inspections, external PLACE assessments and comprehensive internal audits remain in place (which have continued during 2024-25). In February 2025, the Trust was recognised as the top NHS Trust in the Northwest in the latest Patient-Led-Assessments of the Care Environment (PLACE). The 2023 inpatient survey (reported in 2024) results state 95% of patients reported that they were given enough privacy when being examined or treated across all sites. The 2024 National Inpatient Survey currently open with expected CQC publication date of August 2025, however, privacy and dignity is continually monitored within the aligned Tendable and Five Star accreditation audits scoring above 95% on average. Privacy and dignity consistently score highly in the Nursing Care Indicators. Provision of Single Sex Accommodation Policy in place, with breaches reported. Annual mixed sex declaration submitted to the Board each March.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
4. Consent	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	Safe, Responsive	Quality	MD	Trust Consent Policy in place. Annual consent audit undertaken as part of the clinical audit programme which is reported to the Clinical Effectiveness Council. Consent training provided, with additional sessions provided by Hill Dickinson (Trust legal representatives). Reported incidents where consent issues are identified, including through claims and complaints, are investigated through Trust Patient Safety Incident Response Framework (PSIRF) and actions taken to deliver improvements. Consent is included in Mental Capacity Act training regarding patients who lack capacity to consent and the need for best interest decisions.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
5. Safety	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/ equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	Safe	Quality; Strategic People, Executive	DoHR, DoNMG, MD, COO, DoCS,	Health and safety (H&S) risk assessments in place and outlined in H&S Policy & supporting documents. Workplace inspections reported to Health and Safety committee which reports to the Estates and Facilities Governance Council Annual appraisals confirm staff have maintained knowledge and expertise to undertake roles and responsibilities. Trust Five Star Accreditation process re-launched in June 2024 providing assurances against health and safety standards, equipment and medical device maintenance, staff competence, skills and safe management of medicines and Infection Prevention and Control (IPC). Improvement plans support ongoing actions. All medicine safety incidents and maintenance of medical devices are reported through Patient Safety Council to Quality Committee. Compliance with infection prevention is regularly audited and root cause analysis undertaken on any incidents or outbreaks. Ongoing improvement actions reported regularly to the Quality Committee and remain within the Trust Objectives for 2025/26. Regulatory breaches x 2 received for UEC Whiston – delays with triage and ambulance handover, and audit compliance. Action plans in development to return to CQC by 15 April.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
6. Safeguarding from abuse	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	Safe	Quality, Strategic People	DoNMG, DoHR	The Trust has a zero-tolerance approach to abuse, discrimination and unlawful restraint. The Trust has a Management of Allegations of People in Positions of Trust Policy, Raising Concerns Policy, and a Disciplinary Policy in place for any staff who fail to meet the Trust's values, or where a concern regarding a staff members conduct has been notified to the Trust internally or externally. There are polices in place for Safeguarding Adults and Children, and a Restrictive Practice and Interventions Policy. There is a policy for Mental Capacity and Deprivation of Liberty. The Trust has Freedom to Speak Up Guardians in place. All staff undertake safeguarding training at a level relevant to their role and all clinical staff undertake Mental Capacity and Deprivation of Liberty Training. The Trust provides training in conflict resolution. Mandatory training is reported to the Executive and Quality Committees. The Trust has Safeguarding Adults and Children's Teams covering all sites. The Teams oversee all Deprivation of Liberty Safeguards (DoLS) authorisations and undertake regular audits to ensure the levels of restrictions are reasonable and proportionate, and the mental capacity has been followed accordingly. Staff complete daily restrictive practice reviews for patients with a DoLS in place, and the Safeguarding Teams provide regular communication and updates to the relevant Local Authority should there be an increase in the level of restrictions. CQC inspection report highlighted that the relevant policies and procedures were in place, with robust training and support from the Safeguarding Team to ensure patients receive appropriate care. In 2024 MIAA provided substantial assurance.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
7. Food and drink	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	Effective	Quality	DoNMG	The Trust uses the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance. Patients are required to have a MUST risk assessment within 24 hours of admission, which is repeated every 7 days. Patients identified as at risk of malnutrition have appropriate care plans in place. All inpatient wards are required to operate protected mealtimes. Patients are regularly assessed to note any changes in nutrition and hydration status. Regular audits are conducted to maintain focus on high standards of hydration and nutrition throughout the Trust and nutrition remains within the Trust Objectives. Mersey Internal Audit Association (MIAA) completed in 2023 supported ongoing improvements throughout 2024 which have been monitored through quality and safety walkabouts reportable to Quality Committee and through divisional governance meetings. There are Trust Quality Improvement (QI) initiatives in place including Nutrition is a MUST lead by the Dietetic service and Corporate Quality Matrons.
8. Premises and equipment	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	Safe	Quality	DoCS	In February 2025 the Trust was recognised as the top NHS Trust in the Northwest in the latest Patient-Led-Assessments of the Care Environment (PLACE). A comprehensive internal environmental audit is undertaken to maintain these exceptionally high standards. Cleaning standards are monitored closely to ensure high standards are maintained. The cleanliness scores for the PLACE 2024 were 99.94% (2nd best in the northwest and 5th in the country). Workplace inspections and COSHH risk assessments in place. Waste Management Policy in place with regular awareness raising and training provided for staff. Security service provided 24 hours per day and Lone Worker Policy in place. Body cameras are in place for clinical staff within areas identified.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
9. Complaints	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	Responsive	Quality	DoNMG	MIAA review completed in 2024 with a rating of substantial assurance. Trust has reviewed its patient concerns process up to executive level. Staff aware of how to manage complaints at a local level, including local resolution where possible, with involvement of Trust PALS and complaints team. Work remains ongoing to increase the response times for complaints, with effective system in place via Datix and InPhase for recording and monitoring each complaint. Themes and actions taken identified and reported to Patient Experience Council, the Quality Committee and the Board, to support Trust-wide lessons learned.

10. Good governance	17 - Good governance	Robust assurance and auditing processes in place to drive improvement in quality and safety, health, safety and welfare of patients and staff. Effective communication system for users/staff/ regulatory bodies/ stakeholders so they know the results of reviews about the quality and safety of services and actions required.	Well-led, Responsive	Board	CEO	An annual Board effectiveness review is undertaken, including a review of the Board Committees and the outcomes are considered by the whole Board. Progress in delivering the Trust's objectives is reported to the Board annually. The Board and its committees review key performance indicators via the corporate performance report (CPR) monthly, identifying areas where compliance could be improved to target actions appropriately. MIAA review the governance arrangements within the Trust, including compliance with the CQC processes. External Audit review the annual governance statement. Five-star accreditation scheme launched in June 2024 in place that is aligned to CQC standards - MIAA undertook a review in 2025 rated as high assurance. The comprehensive Ward to Board review of each clinical area through the annual Quality Ward Rounds continued during 2024/25. Monthly Chief Executive Blog launched in January 2025. Trust Team Brief Live weekly provides update to all MWL staff. Monthly Team Talk sessions in place for all staff with Non-Executive and Executive colleagues. Annual Staff Survey 2024 - response rate of almost 4000 staff with the Trust scoring higher than the national average in 6 out of 9 areas: • we are compassionate & inclusive. • we are safe & healthy. • we are recognised & rewarded. • we each have a voice that counts. • staff engagement, and • staff morale. Regulation received following Whiston UEC inspection regarding inter-speciality review and referral times. Action plans in development to return to CQC by 15 April.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
11. Staffing	18 - Staffing	Sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	Safe, Effective	Strategic People	DoHR	Comprehensive workforce strategy in place supported by Recruitment and Retention Strategy, including targeting workforce hotspots and proactive international recruitment for both medical and nursing staff as required. There is an active recruitment programme for the medical, nursing and midwifery workforce, on-going throughout the year. The Trust continues to explore all opportunities to attract and retain all groups of staff. 2 regulatory breaches received for UEC Whiston – nurse staffing and mandatory training for medical staff. Action plans in development to return to CQC by 15 April.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
12. Fit and proper staff	19 - Fit and proper persons employed	Staff to be of good character with appropriate qualifications, competence, skills and experience ie all staff are fit and proper – honest, trustworthy, reliable and respectful	Well-led	Strategic People	DoHR, DoNMG	Acting Director of Nursing, Midwifery and Governance is the nominated individual (accountable person) registered with the CQC. Effective procedures in place for pre-employment and on-going revalidation of relevant staff. The Trust has a range of HR policies and procedures in place. Staff are aware of the requirement to raise any concerns about patient care and anything that may affect them personally in fulfilling their duties. Staff are required to provide examples of how they have demonstrated a positive commitment to the Trust's shared values and behaviours and to equality, diversity and inclusion.
13. Duty of candour	20 - Duty of candour	Open and transparent with people who use services/people acting lawfully on their behalf. Promote culture of openness, transparency at all levels, with focus on safety to support organisational and personal learning. Actions taken to ensure bullying, and harassment is tackled in relation to duty of candour.	Safe	Quality Committee	DoNMG, MD	Electronic reporting system, Datix/InPhase, includes mandatory field to confirm compliance with Duty of Candour. Compliance included in Patient Safety Quality Committee report and Patient Safety Incident Investigation Report to Board. Training is provided to staff within the following training programmes: • Trust's induction. • Mandatory training • PSIRF training. • InPhase training. There are several routes for raising concerns across the Trust readily available on the Trust Intranet including speaking in confidence electronic system as a route for staff to report concerns anonymously and directly by telephone to the Trust Freedom to Speak up Guardians. Regular reports in relation to Freedom to Speak Up are presented to the Quality Committee to provide assurance that issues raised are addressed.

Appendix 1

Fundamental Standard	Regulation	Summary	Domain	Committee	Exec Lead	
14. Display of ratings	20A - Requirement as to display of performance assessments	Notify via all websites and in each premise where services are provided the latest CQC rating, including principal premises. The information is to include the CQC's website address and where the rating is to be found and for each service/premise the rating for that service/premise.	Responsive, Well-led	Executive	DoCS	Ratings available on MWL internet with links to the full reports.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	26 March 2025
Agenda Item	**TB25/025**				
Report Title	Elimination of Mixed Sex Accommodation Annual Declaration				
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance				
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance				
Action Required	X	**To Approve**		**To Note**	

Purpose

To provide information to the Board that the Trust (MWL) has complied with the national guidance to eliminate mixed sex accommodation

Executive Summary

All trusts are required to make an annual declaration confirming compliance with the guidance in relation to elimination of mixed sex accommodation and the provision of appropriate single-sex facilities. The annual declaration must be published on the Trust website.

For 2024 to the end of February 2025, MWL reported 92 breaches,77 from the Southport site and 15 from the Whiston site.

- All 77 of the Southport site breaches were as a result of delays in step down of patients from the Intensive Care Unit (ICU) who met the clinical criteria to be transferred to a ward.
- All 15 breaches on the Whiston site were from Cardiac Diagnostic Centre, which was opened due to delayed availability of beds as part of the Trusts risk assessed response.

The Trust continues to implement the Provision of Same Sex Accommodation Policy in order to prevent any breaches.

Financial Implications

None noted

Quality and/or Equality Impact

None noted

Recommendations

The Board is asked to approve the Elimination of Mixed Sex Accommodation Annual Declaration for uploading to the Trust's website.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce

	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Eliminating Mixed Sex Accommodation Declaration

1. Background

1.1. In November 2010, the Chief Nursing Officer (CNO) and Deputy NHS Chief Executive wrote to all NHS Trusts. The letter (PL/CNO/2010/3) set out the expectations that all NHS organisations 'are expected to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient, or their personal choice'. The CNO letter included detailed guidance on what was meant by 'overall best interests', including situations, for example, when a patient is admitted in a life-threatening emergency.

1.2. This was followed by another letter from the Chief Nursing Officer and Deputy NHS Chief Executive in February 2011 (Gateway ref 15552) setting out expectations regarding annual declarations of compliance.

1.3. Further guidance, 'Delivering same-sex accommodation' was issued by NHS England and NHS Improvement in September 2019 which provided clarification about what constitutes a breach.

1.4. Covid-19 Response, a letter dated 28 March 2020 from NHSE/I provided the trust with guidance relating to reducing burden and releasing capacity for staff so that emergency planning can be undertaken as part of the local NHS response to the Covid-19 pandemic. The letter stipulated that MSA breaches did not need to be returned to NHS Digital from 1 April 2020 to 30 June 2020.

1.5. Trust Boards are required to declare compliance annually and if they are not able to do so, they may declare non-compliance however significant financial penalties may apply under such a circumstance.

2. Declaration of Compliance

2.1. The Trust Board of Mersey and West Lancs Teaching Hospitals NHS Trust confirms that mixed sex accommodation has been virtually eliminated within all its hospitals, except where it is in the overall best interest of the patient or reflects their personal choice.

2.2. We have the necessary facilities, resources, and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen by exception based on clinical need, for example, where patients need specialist equipment such as in critical care areas.

2.3. Sleeping accommodation does not include areas where patients have not been admitted, such as cubicles in the Emergency Department or assessment areas.

2.4. If our care should fall short of the required standard, the Trust will report it. Mersey and West Lancashire Teaching Hospitals NHS Trust have assurance mechanisms in place to monitor compliance, the management structure to manage any breaches and the desire to ensure we are communicating to patients and the public that we are continuing to meet our commitment to providing same-sex accommodation.

2.5. The Trust board monitors compliance with mixed sex accommodation compliance monthly as reported in the integrated performance report (IPR).

3. Data collection and performance

3.1. There were 92 breaches across MWL in 2024/25. 77 were related to delayed transfer of patients out of ICU who met the clinical criteria to be transferred to a ward. All 15 breaches on the Whiston site were in Cardiac Diagnostic Centre, which was opened due to delayed availability of beds as part of the Trust's risk assessed response.

4. Current Situation

4.1. Gender mixing is reflective of the national guidance and routinely only occurs within critical care units and the emergency department. This is in line with the overall best interests' criteria stated by the CNO.
4.2. All adult in-patient wards are either single sex, or where they are mixed sex, areas within the ward are designated as male or female, with separate designated toilets and bathrooms. Where admissions and transfers may potentially cause a mixed sex breach ward teams are able to move patients to prevent this.
4.3. Children, young people, and their parents will be asked at time of admission if they wish to be cared for with others of a similar age in a single sex bay or in a single room. This preference is used to determine where to place a child or young person in our children's wards.
4.4. Any changes proposed to the ward environment include a risk assessment to ensure that the requirements for single sex accommodation can continue to be met.
4.5. The Trust's Provision of Same Sex Accommodation Policy is available for staff on the Trust's intranet for review 2026.

5. Patient experience

5.1. Year to date the Trust has not received any feedback of concerns regarding privacy and dignity in relation to mixed sex accommodation via the patient experience feedback methods.

6. Recommendation

6.1. The Trust Board are asked to approve the annual statement of compliance. This will then be published on Trust website and submitted to NHS England.

ENDS

Title of Meeting	**Trust Board**		**Date**	26 March 2025
Agenda Item	**TB25/026**			
Report Title	Staff Survey Report and Action Plan			
Executive Lead	Malise Szpakowska, Acting Director of Human Resources			
Presenting Officer	Malise Szpakowska, Acting Director of Human Resources			
Action Required	X	**To Approve**		**To Note**

Purpose

To provide the Board with an overview of the results of the 2024 Staff Survey, the second for MWL as one Trust. It identifies the key outcomes and supporting actions that the Trust will be focusing on during 2025.

Executive Summary

The 2024 Staff Survey was conducted between September and November 2024. Full national results were published on 13 March 2025. As this is the second MWL survey since the completion of the transaction in July 2023, the data will serve as a baseline for future improvements.

Key Findings:

- Positive feedback from staff at MWL was above the national average in all themes except 'We Work Flexibly', though this did show improvement from last year.
- Overall scores declined slightly across People Promise themes, but sub-themes including Work-Life Balance improved.
- Staff Engagement was above national average, except in the sub theme Involvement.
- Morale was above national average, but some areas did report a lower satisfaction than the average across MWL.
- Compassionate Culture was above national average, but leadership aspects require development.
- Flexible Working was below national average.
- Learning and Development was below MWL average, with specific requests for improved clinical skills and leadership training.
- Equality and Diversity - some groups reported lower experiences of inclusivity and career progression.

MWL ranked third across the North West and Cheshire & Merseyside for the Staff Engagement theme and fourth for Morale and We are Safe and Healthy.

Financial Implications

None directly from this paper

Quality and/or Equality Impact

This report supports the Trust's duties under the NHS Workforce Plan (People Promise), Equality Act 2010, the NHS contract.

Recommendations

The Board is asked to note the report Staff Survey Report and approve the Action Plan

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Mersey and West Lancashire Teaching Hospitals NHS Trust
2024 NHS Staff Survey Report

1. BACKGROUND

The NHS Staff Survey which ran between 2 October and 24 November 2023, is the world's largest annual workforce survey, with 747,288 NHS staff participating in 2024.

The survey is aligned with the 7 themes of the **People Promise** framework, plus 2 additional themes of **Staff Engagement** and **Morale**.

The MWL had, 3,944 responses from a workforce of 10,614 (a 37% response rate), 1% **below that for 2023 and the national benchmark of 49%** for Acute and Community Trusts. A separate survey was conducted for **Bank Workers**, and its results are under review by the Temporary Workforce team.

Staff could complete the survey online or via paper questionnaires distributed through Staff Survey Champions. Two reminders were issued to encourage participation. Results were published nationally on **13 March 2024** following the embargo lift.

All results are available through the Survey Coordination Centre website.

2. QUESTIONNAIRE CONTENT

2.1 Results are reported both as individual question responses and against the People Promise themes. The People Promise from part of the NHS People Plan and sets out, in the words of NHS staff, the things that would most improve their working experience and is made up of seven elements:

The themes are scored on a 0 to 10-point scale. A higher score indicating a more positive (better) result.

Some questions change each year and the changes to the question set for 2024 are outlined in **Appendix 1**.

The list of questions feeding into each People Promise theme and the additional themes of Staff Engagement and Morale and the sub themes are presented in **Appendix 2**.

In addition to the themes, question-level data is presented in the updated benchmark reports for all questions included in the core questionnaire. The question-level results are reported as percentages.

As part of the survey staff are given the opportunity to provide free text responses to two additional questions. This information is not yet available from the survey provider.

2.2 Bespoke Questions.

Trusts can add bespoke questions tailored to their specific needs. This allows them to gather more detailed and relevant insights from their staff, which can be crucial for addressing unique challenges and improving overall staff satisfaction and engagement.

Bespoke questions added included for 2024 supported the following themes: -

- Development
- Culture
- Flexible working

Full list of bespoke questions is in **Appendix 3.**

2.3 Equality, Diversity and Inclusion (ED&I)

Appendix 5 provides a summary of the Equality, Diversity & Inclusion (ED&I) analysis, highlighting key findings related to discrimination, harassment, and inclusivity across different staff groups.

The key findings:

- **Physical Violence & Harassment**:
  - Incidents of physical violence from patients slightly increased (11.84% to 11.93%), but remain below the NHS average (14.14%).
  - Harassment from patients decreased (21.92% to 19.99%), as did incidents from colleagues (14.54% to 14.38%).
  - Harassment from managers, however, slightly increased (7.82% to 7.95%).
- **Discrimination**:
  - Discrimination from patients dropped (5.16% to 4.58%), while discrimination from managers/colleagues increased (5.42% to 6.48%).
  - BAME staff reported the higher rates of discrimination, particularly from managers.
- **Fairness in Career Progression**:
  - The percentage of staff who believe the Trust offers equal career progression while above the NHS average of 54.484% has fell from 59.88% to 58.08%.
  - Disabled and lower-banded staff were the least likely to perceive fairness in career progression.
- **Sexual Harassment**:
  - Reports of sexual harassment from patients increased (6.19% to 6.76%), while from managers/colleagues it decreased (3.26% to 2.94%).
- **Reasonable Adjustments for Disabled Staff**:
  - The percentage of staff receiving disability adjustments improved (73.22% to 75.84%), exceeding the NHS average (73.49%).

The ED&I team are using this data to inform actions in regard to the WDES and WRES metrics and to support network activity across the Trust.

3. RESPONSE RATE

3.1 MWL

3944 completed questionnaires were returned from a workforce of **10712** which is an increase for both figures – in 2023 there were 3924 responses from 10397 sent questionnaires. A response rate of **37%.** This was a **1%** decrease against MWL 2023 response rate.

When looking at the national picture, the average national response rate for was 49% for the benchmarking group of Acute and Acute & Community Trusts.

3.2 Respondent Demographics

The 3944 respondents comprised the following groups:

Gender	%
Female	77.4%
Male	19.3%
Non-binary	0.2%
Prefer to Self-describe	0.2%
Prefer not to say	3.0%

Age	%
16-20	0.4%
21-30	12.9%
31-40	22.3%
41-50	24.2%
51-65	37.7%
66+	2.4%

Ethnicity	%
White	87.6%
Mixed/Multiple ethnic background	1.1%
Asian/Asian British	8.7%
Black/African/Caribbean/Black British	2.0%
Arab	0.4%
Other	31.0%

Sexual Orientation	%
Heterosexual or Straight	90.7%
Gay or Lesbian	2.8%
Bisexual	1.5%
Other	0.3%
Prefer not to say	4.7%

Occupational group	%
Registered Nurses and Midwives	27.5%
Nursing or Healthcare assistants	7.5%
Medical and Dental	6.5%
Allied Health Professionals	12.2%
Scientific and Technical	7.5%
Social Care	0.1%
Public Health	0.2%
Commissioning	0.0%
Admin and Clerical	18.5%
Central Functions	8.1%

Religion	%
No religion	37
Christian	57
Buddhist	0.5
Hindu	2
Jewish	0.03
Muslim	1.1
Sikh	0.1
Other	1.0
Prefer not to say	5.1

Physical or mental health conditions or illnesses lasting or expected to last for 12 months or more	%
Yes	28.15

When you joined this organisation, were you recruited from outside of the UK?	%
Yes	5.0
No	93.8
Prefer not to say	1.7

Division/Corporate Division	Head count	Respondents	Response %
Clinical Support Services and Community Division	2907	1297	45
Corporate Services Division	1796	1025	57
Medicine and Urgent Care Division	2645	734	28
Medirest	318	69	22
Surgery Division	2133	556	26
Women and Children's Division	913	263	29

Corporate - Chief Executive	47	37	79
Corporate - Estates and Facilities	401	156	39
Corporate - Finance & Information	307	178	59
Corporate - Human Resources	496	350	71
Corporate - IM&T	276	143	52
Corporate - Medical Director	35	20	57
Corporate - Non-Clinical Support	45	30	67
Corporate - Nursing Director	189	111	59

When compared with the demographic makeup of MWL, these percentages are equivalent to those as reported in ESR.

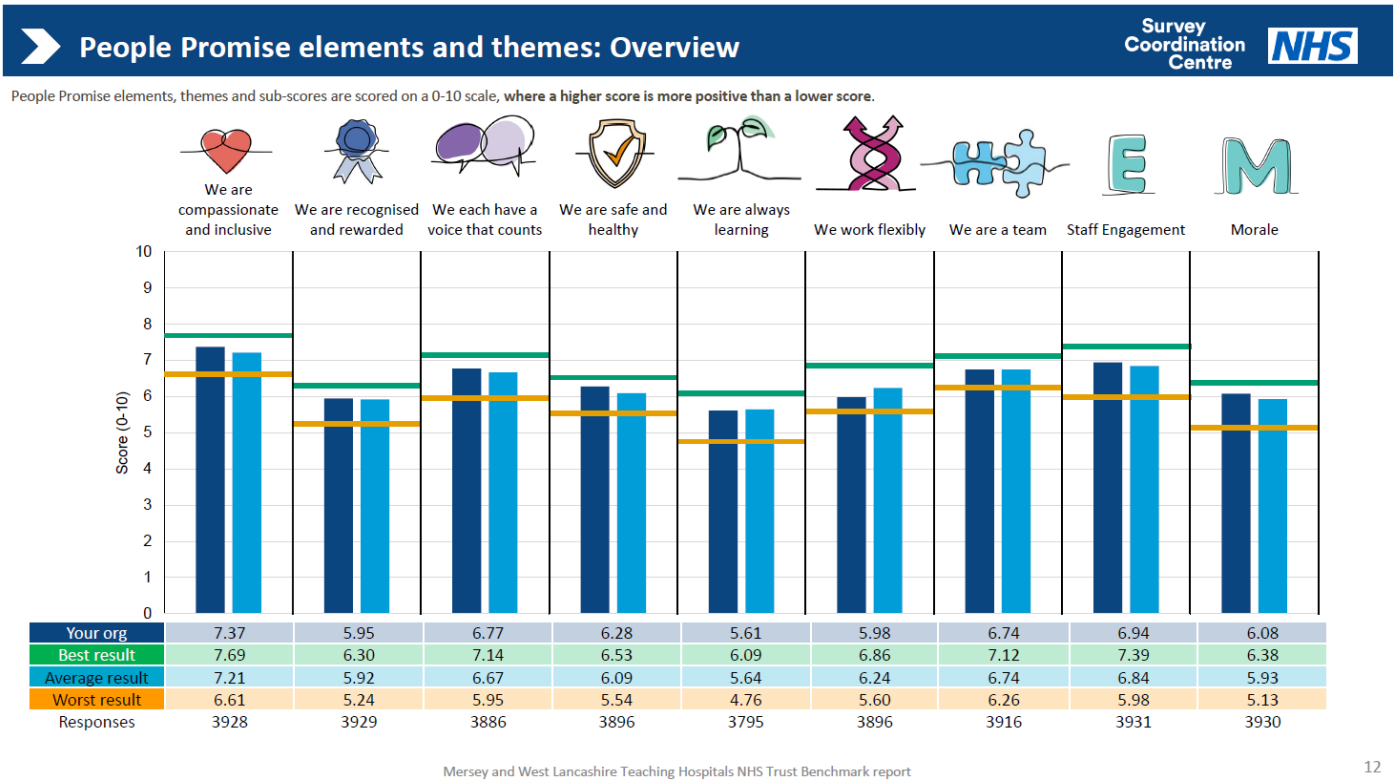
4.0 RESULTS

To support benchmarking of performance, the results for all organisations are presented within one of the following ten national benchmarking groups:

- Acute and Acute & Community Trusts
- Acute Specialist Trusts
- Mental Health & Learning Disability Community Trusts
- Community Trusts
- Ambulance Trusts
- Integrated Care Boards
- Commissioning Support Units
- Social Enterprises - Mental Health
- Social Enterprises - Community
- Community Surgical Services

Each group comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. MWL are in the group Acute and Acute & Community Trusts. The number of organisations in this group is 122.

Performance of the Trust against its benchmark group for all themes is shown below:



Mersey and West Lancashire Teaching Hospitals NHS Trust Benchmark report 12

4.1 Theme Comparison 2023 – 2024

A comparison of positive responses from 2023 to 2024 is shown below.

While positive responses to all People Promise themes have declined since 2023 these changes are very marginal (within a 3% range) and not statistically significant.

Some sub-themes have however shown slight increases.

Note also that the language and designations of specific teams relates to their titles in ESR which forms the basis of the data submitted to IQVIA on 1 September 2024 to allow them to operate the staff survey for MWL.

PP Element / Theme	MWL 2023	MWL 2024	Difference
We are compassionate and inclusive	7.44	7.37	-0.07
We are recognised and rewarded	6.00	5.95	-0.05
We each have a voice that counts	6.86	6.77	-0.09
We are safe and healthy	6.29	6.28	-0.01
We are always learning	5.66	5.61	-0.05
We work flexibly	5.99	5.98	-0.01
We are a team	6.78	6.74	-0.04
Staff engagement	7.05	6.94	-0.11
Morale	6.11	6.08	-0.03

Sub-theme scores

PP Element / Theme	Sub-theme	MWL 2023	MWL 2024	Difference
We are compassionate and inclusive	Compassionate culture	7.43	7.31	-0.12
We are compassionate and inclusive	Compassionate leadership	6.93	6.94	0.01
We are compassionate and inclusive	Diversity and equality	8.4	8.33	-0.07
We are compassionate and inclusive	Inclusion	7	6.91	-0.09
We each have a voice that counts	Autonomy and control	7	6.93	-0.07
We each have a voice that counts	Raising concerns	6.72	6.61	-0.11
We are safe and healthy	Health and safety climate	5.7	5.67	-0.03
We are safe and healthy	Burnout	5.17	5.15	-0.02
We are safe and healthy	Negative experiences	8	8	0
We are always learning	Development	6.46	6.32	-0.14
We are always learning	Appraisals	4.84	4.89	0.05

PP Element / Theme	Sub-theme	MWL 2023	MWL 2024	Difference
We work flexibly	Support for work-life balance	6.14	6.18	0.04
We work flexibly	Flexible working	5.85	5.79	-0.06
We are a team	Team working	6.79	6.72	-0.07
We are a team	Line management	6.77	6.77	0
Staff engagement	Motivation	7.1	7.03	-0.07
Staff engagement	Involvement	6.86	6.79	-0.07
Staff engagement	Advocacy	7.21	7.03	-0.18
Morale	Thinking about leaving	6.34	6.26	-0.08
Morale	Work pressure	5.56	5.56	0
Morale	Stressors	6.45	6.42	-0.03

Staff Group

Looking at average scores across all questions for staff groups, the lowest positive responses were found in:

- Additional Professional and Technical
- Additional Clinical Services
- Estates and Ancillary

The staff groups with higher positive responses were:

- Administrative and Clerical
- Medical and Dental

Site

Whiston Hospital, with the highest number of responses, sets the Trust average for comparison. Southport Hospital follows with 862 responses. The highest positive response rates were seen at Jubilee Court, Knowsley Community College, and Newton Hospital, while the lowest were at Southport and Ormskirk Hospitals. St Helens Hospital had a higher proportion of positive responses than Whiston, particularly within Community Services, which led in positive feedback across clinical divisions. Southport and Ormskirk sites scored lower in Advocacy, Compassionate Leadership, Autonomy and Control, Raising Concerns, and Line Management.

The table below identifies departments and teams that have returned lower numbers of positive responses within particular sub-theme areas.

<u>Staff Engagement Theme</u>

Motivation: Most staff remain enthusiastic, but lowest satisfaction in Pathology, General Medicine, Medical Division Admin, and Medical Outpatients.

Involvement: Decreased nationally and within MWL; lowest satisfaction in Pathology, Medical Secretaries, Catering, and Domestic Services.

Advocacy: Declined in line with national trends; lowest scores in Capital & Facilities, Medicine, ED Southport, Occupational Therapy, Pathology, Anaesthetics, Patient Flow Southport, Surgery, and Medical Division Admin.

Morale Theme

Thinking about leaving: Scores higher than the national average; lower positive responses in Pathology, COE & Stroke Southport, Occupational Therapy, and Medicines Management.

Work pressure: Higher than national average; lowest positive responses in Pathology, COE & Stroke S&O, General Medicine, and Medicines Management.

Stressors: Managers are generally supportive, but lowest positive responses in Pathology, COE & Stroke S&O, Medicine & Urgent Care Mgt, Catering, and Medicines Management.

Promise element 1: We are compassionate and inclusive

Compassionate Culture: Above average, but lowest positive responses in Occupational Therapy, Pathology, Information Services, Anaesthetics, Surgery Division Admin, and Theatres.

Compassionate Leadership: Slight improvement but still below national average; lowest scores in Pathology, Obstetrics, Theatres, General Medicine S&O, and Estates Admin Services.

Diversity and Equality: Lowest scores in Anaesthetics, Burns Nursing, Medical Diversion, Surgical Wards, and Radiology Southport.

Inclusion: Slight improvement but below national average; lowest scores in Anaesthetics, Burns Nursing, Surgical Wards, and Radiology Southport.

Promise element 2: We are recognised and rewarded

No sub-themes, but lowest positive scores in Pathology, COE & Stroke, Theatres, General Medicine STHK & S&O, and Medical Secretaries.

Promise element 3: We each have a voice that counts

Autonomy and Control: Decreased across all sites; lowest positive responses in Pathology, Medical Outpatients, Catering, and Medical Secretaries.

Raising Concerns: Above national average, but lowest responses in Pathology Histology, Orthopaedic Nursing, Obstetrics, and Dermatology.

Promise element 5: We are always learning.

Development: Staff seek Clinical Skills and Management/Leadership Development; lowest responses in Pathology S&O, COE & Stroke S&O, Medical Outpatients S&O, Domestic Services Whiston, and Wheelchair Services.

Appraisals: High completion rates, but concerns about quality; lowest responses in Occupational Therapy, Paediatrics Ormskirk, Anaesthetics, and Plastics Nursing Theatres, especially at Southport and Ormskirk sites.

Promise element 6: We work flexibly

Support for Work-Life Balance: Improved perception, but lowest responses in Pathology S&O, Pathology Biochemistry, Wheelchair Services, Medicines Management, and Obs & Gynae Medical.

Flexible Working: Below national average. Lowest responses in Pathology, Portering, Obs & Gynae Medical, Catering, and Radiology Southport.

Promise element 7: We are a team

MWL Scores is equal to the national average.

Team Working: Scores match the national average, but lowest positive responses in Pathology S&O, Medicines Management, Catering, and Pharmacy.

Line Management: Slightly below national average; lowest responses in Pathology S&O, Obstetrics, Medical Division Admin, and General Medicine S&O**.**

5.0 CONCLUSIONS AND NEXT STEPS

The results for MWL's second staff survey as a new Trust remain broadly positive, although scores have slightly declined across all People Promise themes. The Trust has performed close to or above the national average in most themes, with the exception of 'We Work Flexibly,' which remains an area for improvement.

A key finding is that staff survey results were generally lower at the Southport and Ormskirk Hospital sites, whereas Community Services scored more positively. Several of the teams that frequently appeared in the lower-scoring areas are based at these sites.

Corporate Services, including HR, Finance, and IM&T, had the highest response rates and scored positively, particularly in relation to flexible working. This trend is consistent with previous surveys and highlights the different workforce challenges across staff groups. However, even within these departments, pockets of dissatisfaction were identified which is being reviewed by leadership teams.

Certain teams consistently scored lower across multiple sub-themes, including Pathology, Medical Secretaries, Care of the Elderly, Theatres, and Medicines Management. In discussions with Deputy Directors of Operations and Corporate departments, other teams have emerged as outliers within their own divisions.

The results suggest that ongoing change processes within MWL have impacted some areas more significantly than others, but other factors may also be contributing to dissatisfaction in certain teams. To address these concerns, the L&OD team is working with leadership teams to identify specific areas requiring targeted support and interventions. In collaboration with AffinaOD, suitable teams will be selected for an intensive team development programme based on the compassionate leadership research of Michael West.

Although certain teams have been highlighted as returning lower positive scores, many of these challenges are shared across the Trust workforce. The analysis, along with discussions with leadership teams, has led to the identification of several Trust-wide actions to address the staff survey outcomes.

Trust-wide actions highlighted from the analysis of the Staff Survey data are:

Theme or Action area	Action
We work flexibly	Continue to improve the availability and variety of Flexible Working options and look creatively to offer opportunities in clinical areas.
We are always learning	1. Improve the access to specific learning opportunities, particularly clinical skills development and leadership and management. 2. Continue to embed the appraisal process across the whole of MWL during the 2025 appraisal window with an emphasis on improving quality. Appraisal training has increased to improve the quality elements of the conversation. 3. Continue to develop career pathways for a wider range of roles across the Trust.
We are compassionate and inclusive	Embed the new values and behaviours and create a Trust wide offer of compassionate leadership and management training to improve the skills sets and behaviours of line managers. Additional bespoke questions indicate that the new Trust values are well known and are making a difference to behaviour and expectations, but this work needs to continue across the organisation.
We are a team	Develop line management skills consistently across MWL with a range of interventions and opportunities for learning.
We each have a voice that counts - Freedom to speak up	The Trust will continue to support the work begun in 2024 regarding the willingness to speak up and the confidence that the Trust will act on this information.
Equality and Diversity	We will work with each Team identified in the survey as having 15% or more negative response rate compared to the Trust average, for the discrimination, harassment, and sexual harassment questions.

5.1 Sharing and publicising the Staff Survey results

The timeline for sharing and distribution of the staff survey results is below.

Action	Date
Initial communication issued to Divisional Directors & Chief Operating Officer to inform of upcoming data release and expectations around next steps.	20.12.24
Initial High-Level results released by IQVIA under embargo. Data Analysed by OD Team.	20.12.24
Meeting with Director of HR & Deputy Chief Executive to share Initial High-Level results.	18.12.24
Data shared with ED&I Team.	18.12.24
Creation of Divisional information and data packs.	03.01.25
High-Level Results sharing with: Chief Operating Officer, Divisional Directors. *Postponed to w/b 13/01/25 due to Trust activity escalation.*	24.01.25
High-Level Results sharing with: Heads of HR Operations, Communications, relevant Subject Matter Experts (SMEs).	10.01.25

Action	Date
Trust Brief Live item from Director of HR - confirm receipt of High-Level results and next steps. *Postponed to w/b 13.01.25 due to Trust activity escalation.*	16.01.25
10 Jan 25 - Detailed results available to MWL. L&OD detailed analysis and BI team create Staff Survey dashboard by 24.01.25 (testing for release 13.03.25 when embargo lifted).	24.01.25
Meeting with CEO to discuss High Level results, first cut of department level results and staff survey actions.	15.01.25
Presentation to SPC on High Level results and actions.	22.01.25
OD team meet with COO to present key staff survey results for clinical divisions	21.02.25
Detailed Results shared with Divisional Directors to support identification of 3 key priority actions, HR Ops and SMEs.	21.03.25
Divisional Directors to share detailed results with their SLT.	21.03.25
Weighted Data report received including Benchmark group Best and Worst Score.	28.02.25
Theme Benchmarking Analysis shared with CEO, Director of HR, Deputy Chief Executive, Dep Dir of HR and Comms.	28.02.25
Anticipated release of Qualitative (Free Text) results and Thematic Analysis by the L&OD team and shared with leadership teams. Released 10.03.25, analysis underway.	10.03.25
Analyse local benchmark comparisons and share with CEO, Director of HR, Deputy Chief Executive and Comms.	07.03.25
BI Dashboard launched and made available to all staff.	10.03.25
CEO message to Trust re staff survey results general release	13.03.25
Trust Brief Live update.	13.03.25
National publication of results **- Embargo lifted 13 March.**	13.03.25
Benchmarking Best in Class shared with Divisional SLTs & SMEs.	13.03.25
Staff Survey paper to Executive Committee.	13.03.25
Analyse national benchmark comparisons and share with CEO, Director of HR, Deputy Chief Executive and Comms.	21.03.25
CEO presentation: Mon 31 Mar 2.30pm – Southport, CMO	31.03.25
CEO presentation: Tue 1 Apr 11.30am – Whiston, Nightingale House	01.04.25
CEO presentation:	01.04.25

Action	Date
Tue 1 Apr 2.00pm – St Helens, Café area	
CEO presentation: Fri 11 Apr 2.00pm – Ormskirk, Education Centre	11.04.25
Staff Survey paper to Trust Board.	28.03.25
Comms to share results in News N Views, MWL News, Posters, Intranet Pages, Trust Brief Live, roadshows.	28.03.25
Divisions present progress against actions on 3 key priority areas to VOPC/SPC.	June/ September
SMEs present progress against actions on 3 key priority areas to VOPC/SPC.	June/ September

6.0 GOVERNANCE AND MONITORING OF THE STAFF SURVEY RESULTS

The Staff Survey results, and associated actions developed by the Divisional leadership teams and the SMEs will be reported and monitored on a quarterly basis through the HR Governance process.

7.0 ACTION REQUIRED BY THE BOARD

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

Appendix 1

Changes to the 2023 NHS Staff Survey questionnaire

This Appendix summarises the changes made to the 2023 NHS Staff Survey questionnaire from the previous year (2022). This is for both the main survey and the survey for Bank only workers.

Main Survey

INTRODUCTION PAGE
Updates made to the following sentences on the introduction page:

- Other organisations, including NHS commissioners, the Care Quality Commission, the Department of Health and Social Care, and NHS England, will make use of the anonymised results.
- If you work at more than one NHS organisation, please complete the survey for the organisation which sent you the invitation letter/email.
- The bar code / number below is only used by Contractor Name to identify which staff should be sent a reminder.
- The survey is conducted by Contractor Name and the NHS Staff Survey Coordination Centre on behalf of your organisation and NHS England, in partnership with trade unions.
- The survey findings will be analysed by Contractor Name and the NHS Staff Survey Coordination Centre, and the results will be presented in summary reports in which no individual can be identified.

YOUR PERSONAL DEVELOPMENT
24f. To what extent do these statements reflect your view of your organisation as a whole? I am able to access clinical supervision opportunities when I need to.

BACKGROUND INFORMATION
27a. New wording; Which of the following best describes you?
35. Update on option 35 to be as follows: Social workers

PERMISSION TO RECONTACT QUESTION (ONLINE VERSION ONLY)

Part A: The NHS Staff Survey is coordinated on behalf of NHS England by the NHS Staff Survey Coordination Centre, based at Picker, an independent health and social care charity. As part of the ongoing development of the survey, the NHS Staff Survey Coordination Centre may wish to conduct research to test and develop new survey questions.

Would you like to hear about any opportunities to get involved in testing and developing the questions used in the NHS Staff Survey?

If you select yes, you will be asked to provide your name and email address. By providing your name and email address, you agree to these details being shared with the NHS Staff Survey Coordination Centre at Picker only.

Your contact details will not be shared with your organisation, NHS England, or any other third party, and will not be linked to any of the responses you have given in this survey. The NHS Staff Survey Coordination Centre will retain your contact details for a maximum of 12 months and will not use them for any purpose other than to let you know about opportunities to help with the development of the survey questions.

1. Yes
2. No

Part B [Shown if respondents answer Yes for Part A]:

Please provide your name and email address below.

Name: _____

Email address: _____

Appendix 2: People promise elements and themes

People Promise elements, themes and sub-scores

Survey Coordination Centre NHS

People Promise elements	Sub-scores	Questions
We are compassionate and inclusive	Compassionate culture	Q6a, Q25a, Q25b, Q25c, Q25d
	Compassionate leadership	Q9f, Q9g, Q9h, Q9i
	Diversity and equality	Q15, Q16a, Q16b, Q21
	Inclusion	Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	No sub-score	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
	Raising concerns	Q20a, Q20b, Q25e, Q25f
We are safe and healthy	Health and safety climate	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
	Burnout	Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
	Negative experiences	Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
	Other questions [Not scored]	Q17a*, Q17b*, Q22* *Q17a, Q17b and Q22 do not contribute to the calculation of any scores or sub-scores.
We are always learning	Development	Q24a, Q24b, Q24c, Q24d, Q24e
	Appraisals	Q23a*, Q23b, Q23c, Q23d *Q23a is a filter question and therefore influences the sub-score without being a directly scored question.
We work flexibly	Support for work-life balance	Q6b, Q6c, Q6d
	Flexible working	Q4d
We are a team	Team working	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
	Line management	Q9a, Q9b, Q9c, Q9d
Themes	**Sub-scores**	**Questions**
Staff Engagement	Motivation	Q2a, Q2b, Q2c
	Involvement	Q3c, Q3d, Q3f
	Advocacy	Q25a, Q25c, Q25d
Morale	Thinking about leaving	Q26a, Q26b, Q26c
	Work pressure	Q3g, Q3h, Q3i
	Stressors	Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a
Questions not linked to the People Promise elements or themes		
Q1, Q10a, Q10b, Q10c, Q11e, Q16c, Q18, Q19a, Q19b, Q19c, Q19d, Q24f, Q26d, Q31b		

Appendix 3. MWL 2024 Bespoke Questions.

The following questions were added to the MWL staff survey to gain further insight into specific areas of interest. The results are shown below.

Culture

Are you familiar with the MWL Trust Values: Open/Kind/Inclusive?
To what extent do you think the MWL values contribute to a sense of belonging and inclusivity?
What impact does the MWL values and behaviours have on your job satisfaction and overall job experience?
Do you believe that the MWL values and behaviours have a positive impact on staff morale and motivation?

Development

If you responded Strongly disagree or Disagree to the statement 'I am able to access the right learning and development opportunities when I need to', please indicate which types of learning and development opportunities you are referring to.

Options:
Functional Skills (Maths and / or English)
Apprenticeship
Conference / Seminar / Masterclass
IT Skills
Coaching and / or Mentoring
Management and / or Leadership Development
Clinical Skills Development

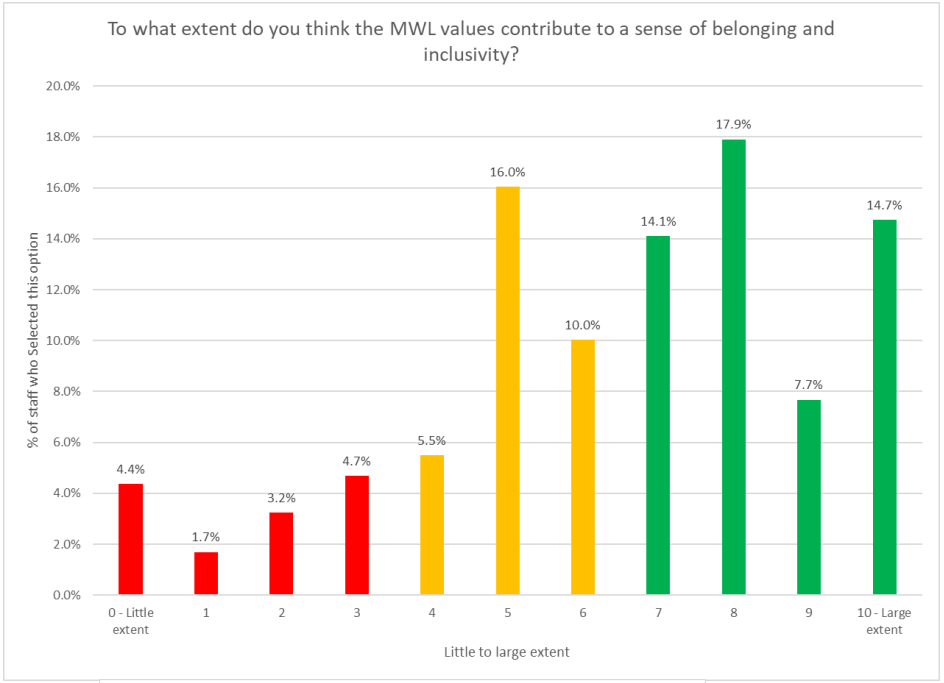
Flexible Working

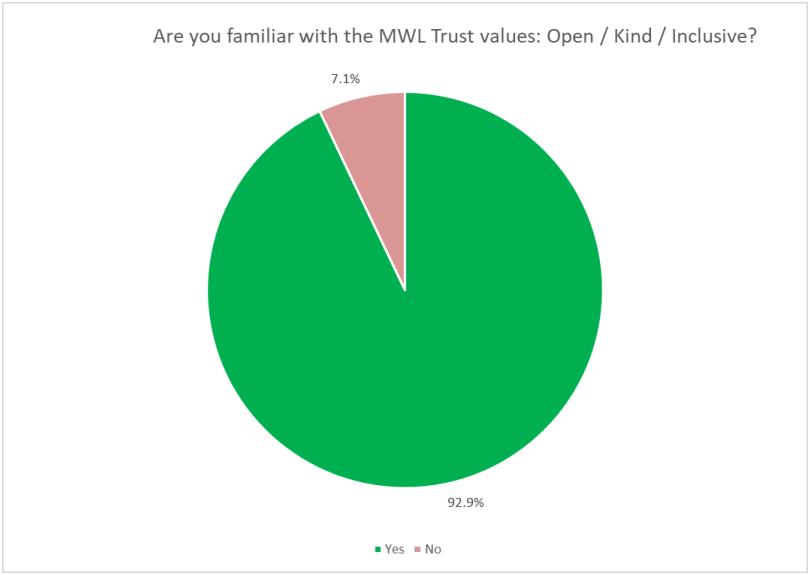
If you selected Strongly disagree or Disagree to being satisfied with the opportunities for flexible working, what type of flexible working opportunities would you like to have access to?

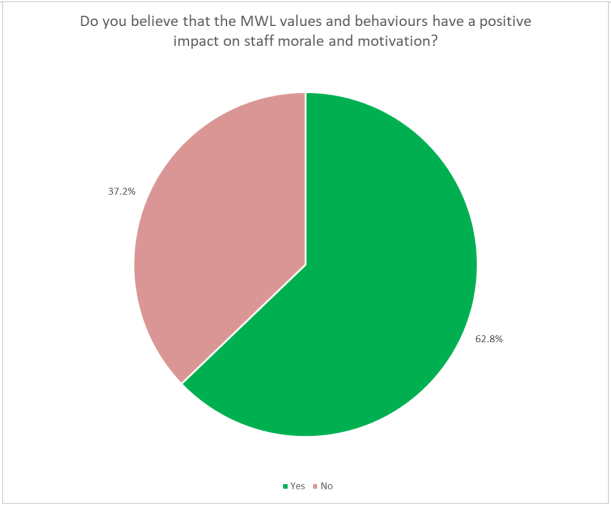
Options

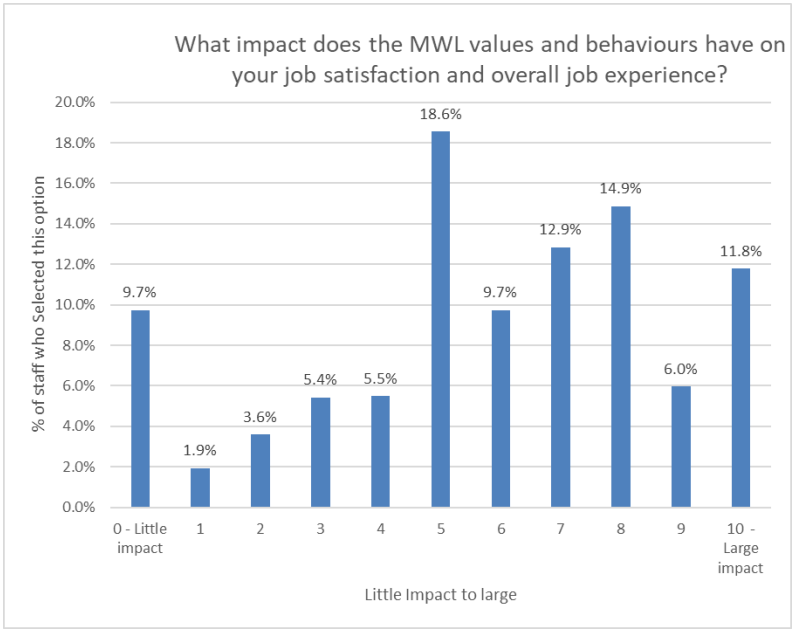
Flexible hours, Flexi-time, Part-time hours, Job sharing, Annualised hours, Zero-hours contract, Compressed hours, Term-time working, Weekend only, Monday - Friday hours only, Fixed shifts, Rotating shifts, Split shifts, Phased retirement, Home working, Sabbaticals, Temporary rota changes, Other (please specify)

Bespoke Culture Questions Results

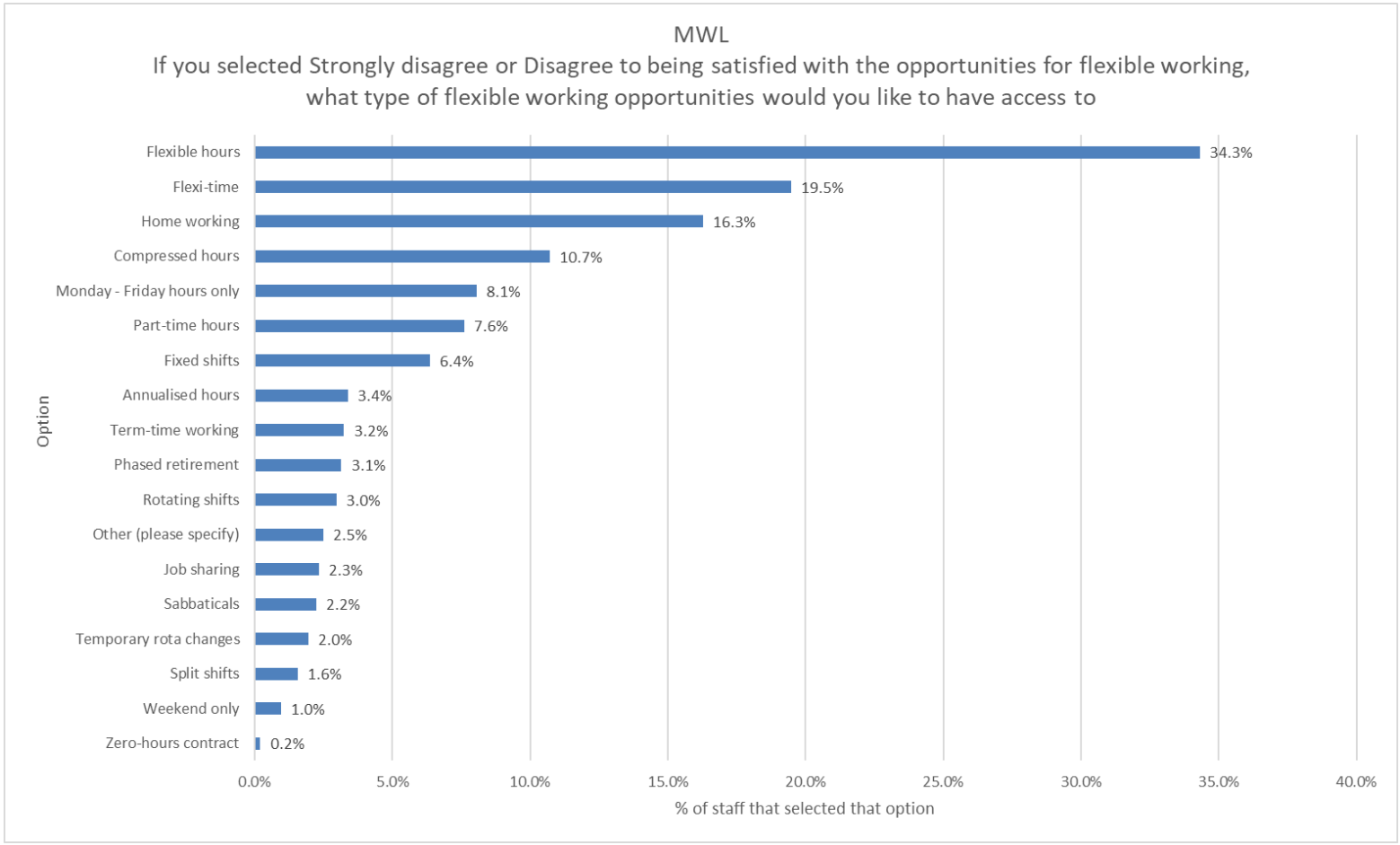




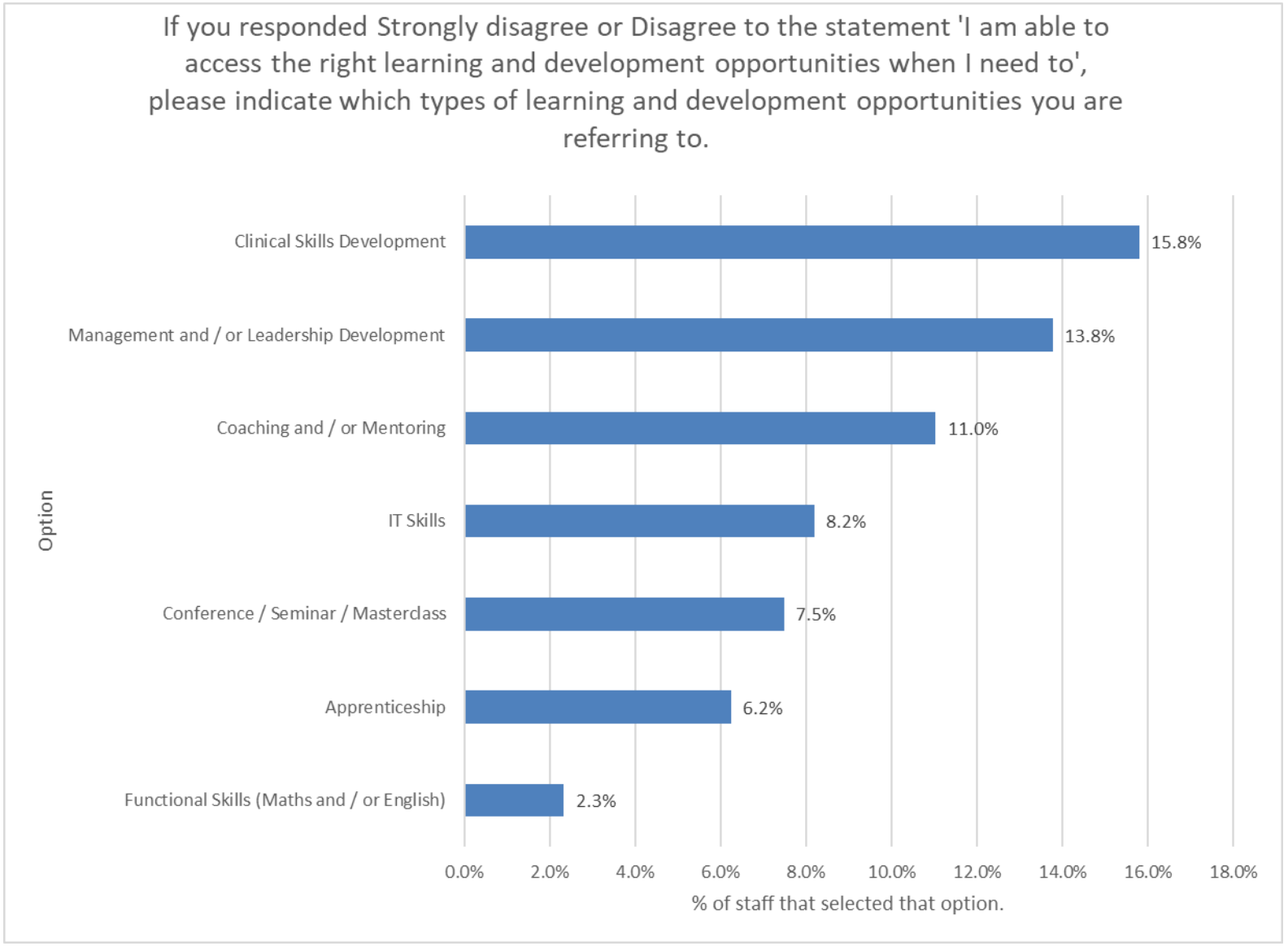




Bespoke Flexible Working Question Results



Bespoke Development Question Results



Appendix 4. Theme performance at Regional and ICB level (no. of Trusts in brackets).

		NW (18)		C&M (8)	
PP Element / Theme	MWL Score	Best in NW	MWL RANKING	Best In C&M	MWL RANKING
We are compassionate and inclusive	7.37	7.69	5th	7.69	4th
We are recognised and rewarded	5.95	6.22	9th	6.22	5th
We each have a voice that counts	6.77	7.06	6th	7.06	5th
We are safe and healthy	6.28	6.44	4th	6.44	4th
We are always learning	5.61	5.83	7th	5.83	5th
We work flexibly	5.98	6.6	15th	6.6	6th
We are a team	6.74	6.98	9th	6.95	4th
Staff engagement	6.94	7.28	3rd	7.28	3rd
Morale	6.08	6.25	4th	6.25	4th

Appendix 5

Summary of Equality, Diversity and Inclusion Analysis by Equality Questions

A summary of the main equality, diversity & inclusion questions is provided, including by the response rates by equality groups, staff groups, AfC banding, and divisions. Full details are available in the detailed analysis from the ED&I team.

- Physical Violence from Patients el al (Q13a): Overall there was an increase from 11.84% to 11.93%, lower than the NHS comparator of 14.14%. 7/15 equality groups saw an increase in incidents with LGBO most likely to experience incidents, followed by 21-30 and BAME groups. Staff groups most likely to experience physical violence were Additional Clinical Services, followed by Nursing & Midwifery; staff who are Band 2, 5 and 6; and staff working in Medicine & Urgent Care, with the department of 'General Medicine (STHK)' having the highest experienced incidents.

- Physical Violence from Managers (Q13b): Overall there was a decrease from 0.60% to 0.23%, lower than the NHS comparator of 0.87%. 13/15 equality groups saw a decrease in reported incidents with LGBO staff most likely to experience incidents (1.12%). Staff groups most likely to experience physical violence from a manager were Medicine & Dental; Band 2 staff; and staff working in Medicine & Urgent care.

- Physical Violence from Colleagues (Q13c): Overall there was a decrease from 1.25% to 1.01%, lower than the NHS comparator of 2.16%. 12/15 equality groups saw a decrease in incidents with BAME most likely to experience incidents (2.51%), Staff groups most likely to experience physical violence from a colleague were in Medicine & Urgent Care, followed by Women & Children's.

- Reported Physical Violence (Q13d): Overall there was a decrease in reporting of incidents from 70.42% to 68.46%, bringing MWL's average lower than the NHS comparator at 69.97%. 10/15 equality groups saw a decrease in reporting with 21-30 year olds least likely to report (59.74%), and Disabled staff being most likely too (76.00%). Staff groups least likely to report incidents were Allied Health Professionals, Band 8a, and staff working in Clinical Support & Community.

- Harassment from Patients et al (Q14a): Overall there was a decrease from 21.92% to 19.99%, lower than the NHS comparator of 25.23%. 15/15 equality groups saw a decrease in incidents with LGBO staff most likely to experience Harassment (26.11%) and 66+ year old the least likely too (7.69%). Staff groups most likely to experience incidents were Medical & Dental, Band 6 and 2, and staff working in Medicine & Urgent Care, with the department of 'General Medicine (STHK)' and 'Burns Nursing' (Surgery) having the highest incidents.

- Harassment from Managers (Q14b): Overall there was an increase from 7.82% to 7.95%, lower than the NHS comparator of 9.62%. 5/15 equality groups saw a decrease in incidents with LGBO staff most likely to experience Harassment (12.92%) and 66+ year old the least

likely too (7.69%). Staff groups most likely to experience incidents were Additional Prof, Sci & Tech, Band 8c, and staff working in Medicine & Urgent Care,

- Harassment from Colleagues (Q14c): Overall there was a decrease from 14.54% to 14.38%, lower than the NHS comparator of 18.44%. 8/15 equality groups saw a decrease in incidents with Disabled/Long Term Condition staff most likely to experience Harassment (21.17%) and 21-30 year old the least likely too (4.99%). Staff groups most likely to experience incidents were Medical & Dental, Band 8d, and staff working in Medicine & Urgent Care, with the department of 'Frail & Elderly' (Medicine) and 'Pathology Microbiology' (CSSC) having the highest incidents.

- Reported Harassment (Q14d): Overall there was a decrease in reporting of incidents from 51.03% to 50.36%, bring MWL's average lower than the NHS comparator at 51.48%. 9/15 equality groups saw a decrease in reporting with 66+ year olds least likely to report (47.06%), and 21-30 year olds being most likely too (56.82%). Staff groups least likely to report incidents were Medical & Dental, Band 8b, and staff working in Surgery.

- Fairness in Career Progression (Q15): Overall there was a decrease from 59.88% to 58.08% of staff believing the Trust offers equality of opportunity in career progression, higher than the NHS comparator of 54.48%. 12/15 equality groups saw a decrease in satisfaction with Disabled/Long Term Condition staff least likely to believe the Trust does (52.92%) and 21-30 year old most likely too (67.74%). Staff groups least likely to believe the Trust provides equality of opportunity were Estates & Ancillary, Band 5, and staff working in Medirest.

- Discrimination from Patients et al (Q16a): Overall there was a decrease from 5.16% to 4.58%, lower than the NHS comparator of 9.97%. 12/15 equality groups saw a decrease in experiences incidents with BAME staff most likely too (19.33%) and 66+ year olds the least likely too (0.00%). Staff groups most likely to experience discrimination were Medical & Dental, Band 5, and staff working in Medicine & Urgent Care, with the department of 'General Medicine (STHK)' (Medicine) having the highest experienced incidents.

- Discrimination from Manager/Colleague(Q16b): Overall there was an increase from 5.42% to 6.48%, lower than the NHS comparator of 9.88%. 1/15 equality groups saw a decrease in experiencing incidents with BAME staff most likely too (14.32%) and 21-30 year olds the least likely too (4.58%). Staff groups most likely to experience discrimination were Medical & Dental, Band 6, and staff working in Medicine & Urgent Care.

- Sexual Harassment from Patients at al (Q17a): Overall there was a increase from 6.19% to 6.76%, lower than the NHS comparator of 7.90%. 6/15 equality groups saw a decrease in experienced incidents with 21-30 year old staff most likely to experience incidents

(12.38%). Staff groups most likely to experience incidents were Allied Health Professionals; Band 2 staff; and staff working in Medicine & Urgent Care, with the department of ‘General Medicine STHK’ (Medicine) having the highest incidents.

- Sexual Harassment from Manager/Colleague (Q17b): Overall there was a decrease from 3.26% to 2.94%, lower than the NHS comparator of 3.71%. 12/15 equality groups saw a decrease in experienced incidents with LGBO staff most likely to experience incidents (8.47%). Staff groups most likely to experience incidents were Healthcare Scientists; Band 6 staff; and staff working in Surgery.

- Providing Disability Reasonable Adjustments (Q31b): Overall there was a increase from 73.22% to 75.84%, higher than the NHS comparator of 73.49%. 12/15 equality groups (intersectional) saw a increase in provided adjustments. Staff groups least likely to have adjustments were Medical & Dental, Band 8b, and staff working in Medicine & Urgent Care.

END

Title of Meeting	**Trust Board**			**Date**	26 March 2025
Agenda Item	**TB25/027**				
Report Title	Trust Objectives 2025/26				
Executive Lead	Rob Cooper, Chief Executive				
Presenting Officer	Rob Cooper, Chief Executive				
Action Required	X	**To Approve**		**To Note**	

Purpose

For the Trust Board to agree the proposed Trust objectives for 2025/26.

Executive Summary

The Executive Team have developed proposed Trust objectives for 2025/26, for consideration by the Board. The objectives are aligned to the Trust vision to deliver Five Start Patient Care: five overarching objectives representing the Five Star Patient Care criteria of care, safety, pathways, communication, and systems. A further four categories cover: organisational culture and support for the workforce; operational performance; financial performance, efficiency, and productivity; and strategic planning.

There are 28 objectives proposed (appendix 1). Some of the objectives are adapted or rolled over from 2024/25 where the mid-year review indicated they would not be fully delivered by year end. Others are new objectives for the coming year.

The 2025/26 Trust objectives will be converted into the poster format and launched at the Trust Leadership Start of the Year event on 22 April.

Financial Implications

Included in 2025/26 budgets

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the Trust objectives for 2025/26.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Appendix 1

Mersey and West Lancashire Teaching Hospitals NHS Trust

2025/26 Trust Objectives

No	Objective	Lead Director	Measurement	Governance Route	Comments
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**					
1.1	Improve measurable success in areas where our patients told us we didn't get it right first time including inpatient areas, ED, maternity with a focus on antenatal.	DoN	• Improvement against previous year's national survey results in relation to: ○ Management of pain ○ Kindness and compassion whilst in hospital ○ Experience of waiting time information • As a minimum, conduct quarterly local surveys based on national survey indicators • Maintain and embed the patient experience score from 5* Ward Accreditation Programme	Quality Committee	Quality Account
1.2	Ensure improvement and sustainability of nutritional standards for patients.	DoN	• Achieve 95% of adult inpatients screened for malnutrition on admission using the MUST tool • Achieve 95% of patients with a score of 2 or more who receive an appropriate care plan • Improve the processes to ensure 95% of high-risk patients are referred to a dietician • Achieve and maintain 90% for nutrition score consistently across all wards for the 5* Ward Accreditation Programme	Quality Committee	Quality Account
1.3	Improve measurable success for people that birth have told us we didn't get it right first time who access antenatal services	DoN	• Improvement against previous year's national survey results via quarterly surveys	Quality Committee	

No	Objective	Lead Director	Measurement	Governance Route	Comments
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**					
2.1	Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.	DoN	• Achieve 95% of appropriate patients triaged in the emergency departments in line with the national standard of triage within 15 mins • NEWS – 80% of observations completed on time or within tolerance • All patients with a working diagnosis of sepsis receive antibiotics in line with the NICE guidance	Quality Committee	Quality Account
2.2	Improve the Trust's compliance with IPC standards.	DoN	• Eliminate methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia infections as a result of lapses of care • Implement action to reduce avoidable hospital onset MSSA bacteraemia • Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for Level 2 across MWL (practical) • 90% compliance with visual infusion phlebitis (VIP) monitoring • Achieve 90% for the IPC and indwelling devices standard for the 5* Ward Accreditation programme	Quality Committee	Quality Account
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**					
3.1	Continue to improve the effectiveness of the discharge process for patients and carers.	COO	• Achievement of 20% target for patients discharged before noon by March 2026 • 10% improvement in discharges by 6pm and 8pm during the week against 2024/25 position • 10% reduction in the number of patient bed moves after 9pm (core wards) against 2024/25 position	Finance & Performance Committee	Quality Account

No	Objective	Lead Director	Measurement	Governance Route	Comments
			• 10% improved utilisation of the discharge/transfer lounges against the 2024/25 position. • Improve average discharge prescription dispensing turnaround time by 10 mins (from 92 to 82 mins) by March 2026 to below the national average • Reduce average take home prescription arrival time to pharmacy by 60 minutes.		
3.2	Implement standardised clinical pathways across MWL.	MD	• Implement a unified clinical leadership structure for all specialties • Implement single clinical pathways for key conditions including sepsis and #NOF • Reduction in unwarranted variation of clinical outcomes across sites • Implement Trust professional standards for inter speciality referral in the ED and audit performance against the agreed standards.	Quality Committee	
3.3	Improve cancer pathways to deliver the national cancer performance cancer standards	COO	• 80% of patients to receive diagnosis or ruling out of cancer within 28 days of referral by March 2026.	Finance and Performance Committee	
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1	Enhance internal communication efficiency.	DoI	• Enable Switchboard to work as a single team via harmonisation of the telephone operating system. • Reduce administration burden on clinicians by piloting and evaluating an AI tool in patient consultations to support real-time documentation, automate order placement within the EPR (Electronic Patient Record), and reduce administrative burden on clinicians.	Finance & Performance Committee	

No	Objective	Lead Director	Measurement	Governance Route	Comments
4.2	Improve patient communication and engagement.	DoI	• Improve patient support and reduce missed appointments by expanding digital waiting list management solutions across all sites. • Pilot and evaluate an AI-driven Did Not Attend (DNA) or Was Not Brought (WNB) prediction tool. • Enable patients to view their outpatient letters on the NHS App through implementation of Phase 1 of the Patient Engagement Portal (PEP).	Finance & Performance Committee	
4.3	Implement a new speech recognition system to improve the turnaround times for clinic letters.	DoI/ MD	• Implement the new system and train staff in its use to consistently achieve a 48-hour (working week) turnaround for urgent letters and 7 days for routine letters	Finance & Performance Committee	
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**					
5.1	Drive Digital System Convergence and Integration to ensure collaborative working across MWL.	DoI	• Launch the single EPR re-procurement process, ensuring alignment of clinical and operational processes across legacy systems. • Deploy a single maternity information system (BadgerNet) across MWL • Deploy Electronic Prescribing and Medicines Administration (EPMA) system at the Southport & Ormskirk Hospitals sites	Finance & Performance Committee	
5.2	Continue to embed service improvement techniques and the culture of improvement across MWL	DoS	• Complete the cascade of training of staff in the MWL service improvement methodology • Embed the consistent approach to service improvement and transformation.	Executive Committee	
6. DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**					
6.1	Develop and embed a culture that empowers individuals to lead healthy lives and thrive at work by providing holistic wellbeing support.	DoHR	• Develop a communications and engagement strategy to support and champion a cultural shift around flexible working and improve performance against the national	Strategic People Committee	

No	Objective	Lead Director	Measurement	Governance Route	Comments
			average for 'We work flexibly' in the national staff survey.		
6.2	Create an environment where all staff feel supported, valued, and able to perform at their best.	DoHR	• Complete the harmonisation of all workforce policies across MWL • Ensure that all divisions are demonstrating adherence to the attendance management policy by proactively reviewing and managing absences in compliance with policy.	Strategic People Committee	
6.3	Foster a workplace that champions equity, diversity, and inclusion to create a culture of belonging, respect, and opportunity for all.	DoHR	• Improvement in the national staff survey theme "We are compassionate and inclusive" • Improvement in the national staff survey theme "We each have a voice that counts"	Strategic People Committee	
6.4	Strengthen core management and leadership skills within our workforce to ensure our leaders are equipped with the required skills and techniques.	COO	• Create a common set of tools and techniques for all operational managers in year 1	Strategic People Committee	
7. OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**					
7.1	Deliver 2025/26 elective/outpatient recovery targets	COO	• Deliver 5% improvement from 2024/25 position in referral to treatment (elective/day case and outpatients) targets for consultant led services • 1% reduction in 52 weeks + waiters	Finance & Performance Committee	
7.2	Deliver the NHS urgent and emergency care performance standards/targets	COO	• Improve A&E waiting times so that no less than 78% of patient are seen within 4 hours by March 2026 • Achieve 30 minute average ambulance handover target	Finance & Performance Committee	
7.3	Deliver cancer improvement targets	COO	• 82% of patients treated within 62 days	Finance & Performance Committee	
8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**					

No	Objective	Lead Director	Measurement	Governance Route	Comments
8.1	Deliver the agreed financial plan including outturn, cash balances and capital resourcing limits.	DoF	• Achieve the approved financial plan for 2025/26 • Deliver the agreed Cost Improvement Programme • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme, to progress the strategic estates delivery plan, equipment replacement and IT investments	Finance & Performance Committee	
8.2	Work with partner organisations across the ICS to develop and deliver opportunities for collaboration at scale and increased efficiency.	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration with system partners e.g., payroll and Eastern Pathology Hub	Executive Committee	
8.3	Deliver the agreed capital schemes to deliver the capacity needed to meet service demand and a safe, high-quality environment for patients and staff.	DoCS	• Deliver the planned estates capital developments for 2025/26 to optimise capacity/space utilisation and improve patient experience • Deliver year three of the backlog maintenance reduction programme at Southport and Ormskirk Hospitals, including options for decant spaces where required • Deliver the planned PFI lifecycle programme for St Helens and Whiston Hospitals to maintain the quality of the environment	Finance & Performance Committee	
9. STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**					
9.1	Deliver the key milestones of the Shaping Care Together Programme for 2025/26 in collaboration with ICB partners and NHS England.	CEO	• Achieve the 2025/26 milestones for the Shaping Care Together Programme – including approval of the Pre-Consultation Business Case and completing public consultation	Executive Committee	
9.2	Work with the ICS and each of the Place Based Partnerships within the MWL footprint to improve patient flow and increase timely discharge from	DoInt	• Urgent Care Recovery Programme – work with Places to improve the discharge from hospital process, principal measures include: -	Executive Committee	

No	Objective	Lead Director	Measurement	Governance Route	Comments
	hospital to appropriate community /social care settings or home-based support.		○ Reducing patients who are non-criteria to reside to < 15% ○ Reducing the patients ready for discharge days in line with best practice		
9.3	Working with NHSE and the ICB to develop a long-term plan for financial and clinical sustainability for MWL	CEO	• Agree a three-year financial recovery plan • Develop strategic service reconfiguration options and delivery plans to support long term clinical sustainability	Executive Committee	
9.4	Develop a Community Services strategy to support the improved effectiveness and outcomes for patients and staff.	DoS	• Implementation of a Community Services strategy including service outcome measures, leadership structure, digital solutions, reporting and estates requirements	Executive Committee	
9.5	Co-ordinate the implementation of the Trust Health Inequalities Strategy and delivery plan	DoInt	• Develop the Health Inequalities dashboard to meet the requirements of the strategy and delivery plans • Work with system partners to create a shared Health Inequalities dashboard for the ICB which is shared on the CIPHA platform • Demonstrable Trust contribution and improvements in the delivery of Core20plus5 for Adults and Children and Young People • Continue to maximise the potential of the Trust as an anchor institution in our communities to improve health, education and employment.	Executive Committee	