Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09:30 on Wednesday 30 April 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month (April 2025)** *Purpose: To **note** the Employee of the Month presentation for April 2025*	Film	Chair *(5 mins)*
09.35	2.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	4.	**TB25/028 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 26 March 2025*	Report	
	5.	**TB25/029 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				
09.45	6.	**TB25/030 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	L Barnes L Neary M Szpakowska G Lawrence *(30 mins)*
Committee Assurance Report				
10.15	7.	**TB25/031 Committee Assurance Reports** 7.1. Executive Committee 7.2. Audit Committee	Report	R Cooper S Connor

		7.3. Quality Committee 7.4. Strategic People Committee 7.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*		G Brown C Spencer obo L Knight C Spencer *(30 mins)*
Other Board Reports				
10.45	8.	**TB25/032 Clinical Strategy Annual Update** *Purpose: To **note** the Clinical Strategy Annual Update*	Report	P Williams *(10 mins)*
10.55	9.	**TB25/033 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
11.05	10.	**TB25/034 Learning from Deaths Quarterly Report (Q2 2024/25)** *Purpose: To **note** the Learning from Deaths Quarterly Report Q2 2024/25*	Report	P Williams *(10 mins)*
11.15	11.	**TB25/035 Patient Experience and Inclusion Strategy** *Purpose: To **approve** the Patient Experience and Inclusion Strategy*	Report	L Barnes *(10 mins)*
11.25	12.	**TB25/036 MWL People Plan** *Purpose: To **approve** the MWL People Plan*	Report	M Szpakowska *(10 mins)*
Concluding Business				
11.35	13.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
11.40	14.	**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 28 May 2025 at 09:30		**11.45 close**

15 minutes 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.

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 26 March 2025
(Approved by the Trust Board on Wednesday 30 April 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
Gareth Lawrence	GL	Director of Finance and Information
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Acting Director of Human Resources
Rani Thind	RT	Associate Non-Executive Director (via MS Teams)
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Neil Fletcher	NF	Designate Associate Non-Executive Director (Observer) (via MS Teams)
Wayne Longshaw	WL	Director of Integration (Agenda Item 9)
Yvonne Mahambrey	YM	Quality Matron, Patient Experience (Agenda Item 2) (via MS Teams)
Naomi Parllaku	NP	Therapy Team Lead, Physiotherapist, Critical Care and Surgery Therapy Team (Agenda Item 2) (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)
Lisa Knight	LK	Non-Executive Director
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	Non-Executive Director

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for March 2025 was Tina Woods, Bereavement Midwife, Whiston Hospital and the Board watched the film of LB reading the citation and presenting the award to Tina. **RESOLVED:** The Board **noted** the Employee of the Month for March 2025 and congratulated the winner
2.	**Patient Story**
	2.1. RF welcomed YM and NP to the meeting. 2.2. LB introduced the Patient Story video in which a patient spoke about his experience of stepping down from critical care. The patient described how he had spent time in critical care following a high speed motor collision in which he had sustained extensive injuries and the impact of being immobilised in a HALO brace for months on his emotional and psychological wellbeing. The patient highlighted the importance of having clear rehabilitation targets that had been listed on his rehabilitation passport and how the continued link with the intensive care team had made him feel less nervous about leaving the security of the Critical Care unit, where he had built up a trust with the staff, when he stepped down to a ward. 2.3. YM reported that she had met with the patient since the recording of the video and advised that he was almost ready to return to work. 2.4. YM reported that the rehabilitation passport was a focused document that facilitated seamless rehabilitation goals for the patient as well as their family members and noted that the patient's fiancée had also felt supported and encouraged by the plan in place. YM commented that it was scary for patients who were stepping down from critical care and the link between this and their ongoing treatment gave a patient confidence. 2.5. RF commented that the rehabilitation passport was a brilliant idea and apart from providing the patient and staff with goals it also involved the patient's family in their recovery. 2.6. RT asked if the idea of a passport for patients transferring between services, could be used in other scenarios to improve communications with patients and their relatives. NP responded that the initial plan was to standardise the passport across the MWL critical care units. RT also reflected on the large numbers of patients receiving some sort of rehabilitation and asked if the passport would be useful to a wider cohort of patients. YM commented that

	the rehabilitation passport followed the guidance set out by the National Institute for Health and Care Excellence (NICE) in Rehabilitation after critical illness in adults' Clinical guideline [CG83] and was bespoke to this patient group but added that the same principles could be beneficial to other patient groups. 2.7. GB asked if the rehabilitation passport also focused on the psychological complications that prolonged stays in critical care could result in or whether it was just about the physical journey. NP confirmed that psychological concerns were included on the passport as the occupational therapy staff on the Critical Care unit included cognitive support, however, if a patient had suffered with long periods of delirium or confusion this was handed over to the ward staff. YM commented that patients were called back to attend follow up clinics in critical care post discharge which supported their psychological recovery. This patient had attended one of these clinics and had been signposted to some additional support. The patient had also gone back to the ward to meet the staff who had cared for him. YM noted that the patient remained optimistic and was looking forward to returning to work in the near future. 2.8. RF thanked YM and NP for sharing the patient's story and asked that they pass on the Board's thanks to the patient as well. *(YM and NP left the meeting)* **RESOLVED:** The Board **noted** the Patient Story
3.	**Chair's Welcome and Note of Apologies**
	3.1. RF welcomed all to the meeting and in particular NF who was attending as an observer. Additionally, RF welcomed WL who would be attending the meeting to present the MWL Health Inequalities Strategy 2025-2028 and Delivery Plan 2025/26. 3.2. RF noted the apologies of AB, LK, LN and HS. 3.3. RF acknowledged the following awards and recognition for Trust staff and services: 3.3.1. MWL was recognised in the latest Patient-Led Assessments of the Care Environment (PLACE) results as the top NHS Trust in the North West. 3.3.2. Alan Sutton, Portering Supervisor won the prestigious 'Lifetime Achievement' Award at the MyPorter awards for his amazing 44 years of outstanding service to the Trust. Additionally, Brian Kennedy, Senior Portering, Transport and Logistics Manager, was shortlisted in the 'Leader of the Year' category.

	3.3.3. Dr Zoe Tattersall, Speciality Diabetes Trainee, Ormskirk Hospital, under Professor May Ng OBE, had been awarded the prestigious International Society for Paediatric and Adolescent Diabetes (ISPAD) Physicians Science School Scholarship, an all-expenses paid week of intensive learning with global diabetes experts in Hanover, Germany in June 2025. Zoe was one of the 20 top global trainees selected from over 100 applicants worldwide. 3.3.4. Gina Rogers, Cardio-Respiratory Manager and Lead Healthcare Scientist for MWL, won the Lifetime Achievement Award at NHS North West Healthcare Science Awards. 3.3.5. The Diabetes and Endocrinology Department at St Helens Hospital received the highest level of accreditation from the Quality Institute for Self-Management Education and Training (QISMET) for their patient education programme. Apologies for absence were **noted** as detailed above
4.	**Declaration of Interests**
	4.1. There were no new declarations of interests in relation to the agenda items.
5.	**TB25/017 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 26 February 2025 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 26 February 2025
6.	**TB25/018 Matters Arising and Action Logs**
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following action was closed: 6.2.1. Action Log number 3 (TB24/084 Trust Objectives Mid-Year Review) – the report on the actions being taken to improve discharges and reduce the time taken to receive To Take Out (TTO) medications had been presented at Quality Committee on 18 March 2025. **RESOLVED:** The Board **approved** the action log
Performance Reports	
7.	**TB25/019 Integrated Performance Report**

	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for February 2025 was presented.
7.1.	**Quality Indicators**
	7.1.1. LB and PW presented the Quality Indicators. 7.1.2. LB highlighted the following: 7.1.2.1. The inpatient Family and Friends Test (FFT) recommendation rate in February 2025 was 94.8% against a target of 90%. 7.1.2.2. Complaints performance was 65.2% against a target of 80% and LB reported that there had been a reduction in the number of first stage complaints received and work was ongoing to further improve response times. 7.1.2.3. The Trust was on target to achieve the NHSE threshold of no more than 113 Clostridioides Difficile (C.Diff) cases for 2024/25 with 94 cases reported year to date (YTD). The MWL rate of 32.2 cases per 100,000 bed days was below the Cheshire and Merseyside (C&M) rate of 38.6 cases. 7.1.2.4. The Nurse staffing fill rate had been 97.3% against a target of 90%. 7.1.2.5. The main themes for reported pressure ulcers related to Emergency care and particularly agency staff's familiarity and access to electronic systems. Education was ongoing to resolve this. Data was presented for December 2024 and there were 0.13 cases reported per 1,000 bed days (0.14 cases had been reported YTD). 7.1.2.6. There had been a reduction in patient falls resulting in harm across all Trust sites. There had been a focus on medication reviews and work was ongoing with the IT team to discuss how the Electronic Prescribing and Medicines Administration (EPMA) system could be used to support further improvements. The decaffeinated drinks programme had been rolled out to additional wards. LB advised that she had commissioned an independent clinical peer review of falls. Additionally, MIAA would be undertaking quality spot check audits which included falls, pressure ulcers and risk assessment documentation. 7.1.2.7. There had been no (0) still births or neonatal deaths reported in February 2025. 7.1.2.8. One Never Event had been reported in February 2025 (wrong site nerve block to the hand) and the initial Patient Safety Incident Review (PSIR) had been undertaken and presented at the Patient Safety Panel with an initial action plan. 7.1.3. PW highlighted the following: 7.1.3.1. The reported Hospital Standardised Mortality Ratio (HSMR) included data up to July 2024 and MWL's latest in-month figures for July was 103.3. This was largely due to a reduction in crude mortality rates at Whiston and St Helens Hospitals to 101.4 in July compared to 110.5 in June. PW noted that the YTD HSMR remained below 100 at 96.7 (97.2 for Whiston and St Helens Hospitals and 95.2 for Southport and Ormskirk Hospitals). PW noted that these changes were within expected in-month variation. PW reported that he had commissioned a review of all diagnosis groups where observed

	deaths had been higher than expected to determine if there had been any avoidable mortality for June 2024, and no concerns had been raised. 7.1.3.2. There had been a reduction in the Summary Hospital-level Mortality Indicator (SHMI) to 1.03 in September 2024. 7.1.4. RT asked if the length of time to respond to complaints, which remained above the 60 day target had any impact on the number of stage two complaints received. LB responded that there had not been an increase in the number of stage two complaints and also noted that reported performance was based on the number of complaints closed in month in the 60 day target. GB asked if there had been an improvement in the quality of complaints responses. LB felt that the quality of responses had been improved and were becoming more standardised and this was also helping to reduce the number of complaints that progressed to stage two.
7.2.	**Operational Indicators**
	7.2.1. GL on behalf of LN, presented the operational indicators and highlighted the following: 7.2.1.1. The 4-hour mapped performance in February 2025 was 74.3% against the national target of 78%. This compared to 73.4% nationally and 73.1% for Cheshire and Merseyside (C&M). 7.2.1.2. NHS England (NHSE) had launched an end of year financial incentive scheme for the Top 10 performing and most improved trusts in respect of the 4 hour access target. 7.2.1.3. Non-Criteria to Reside (NCTR) patient numbers remained a challenge across all hospital sites and GL noted that there had been a significant increase at Southport Hospital in February linked to infection, prevention and control (IPC) issues, which made discharge planning more challenging. 7.2.1.4. There had been a 146% improvement to zero length of stay patients at Southport Hospital from February 2024 to February 2025 which had been driven by the extended use of the Same Day Emergency Care (SDEC) service. SDEC was now a standardised model across MWL. 7.2.1.5. The main focus for the elective care programme remained the reduction of the 65+week waiters to zero by the end of March 2025 and this was monitored weekly at the Executive Committee. The current position was that there were 139 patients waiting 65+ weeks, with 42 attributed to the Trusts capacity to complete the procedures and the remainder due to patient choice. 7.2.1.6. There was continued improvement in Referral to Treatment (RTT) 18-week performance which was 63.1% in February compared to national performance of 58.9% (latest reported data for January) and 56.5% for C&M. 7.2.1.7. Diagnostic waiting time performance in February was 97.5% of patients seen within six weeks against a target of 95% (national performance was 77.6% and C&M performance was 88.8%). 7.2.1.8. Performance against the 28-day cancer standard was 73.6% against a target of 77%.

	7.2.2. RF reflected on a recent news item regarding Huddersfield Royal Infirmary which had introduced weekend operating lists to help reduce waiting times and asked if this was something the Trust had considered. GL responded that this might have been part of the Further Faster 20 programme that was being run by Professor Tim Briggs, NHSE National Director for Clinical Improvement and Elective Recovery. PW advised that the initiative was being led by the Getting It Right First Time (GIRFT) team. GIRFT was a programme focussed on reducing unwarranted variation initially in elective Orthopaedics but had been rolled out to other specialities and benchmarked trusts against each other and best practice to reduce variation and improve productivity. The Further Faster 20 programme was introduced by the new government and aligned with their key focus of reducing waiting times and enabling people to return to work. The programme focused on 20 trusts with the highest rates of unemployment due to ill health in the community. PW noted that MWL was taking part in the project and, where clinically appropriate, was identifying people who were on the waiting list that could benefit from bringing their procedure forward to enable them to return to the workplace sooner. The Trust engaged well with the GIRFT programme which focussed on assessing the Trust's practice against the national standard and peers, which in surgery related to productivity and waiting list management. The Trust already regularly undertook activity during extended days and at weekends but also needed to focus on maximising the productivity from core capacity to reduce the need for Waiting List Initiative (WLI) payments. RF agreed that it was important to maximise the use all the Trust resources including the two new operating theatres at Whiston Hospital and the theatres at Ormskirk Hospital.
7.3.	**Workforce Indicators**
	7.3.1. MS presented the Workforce Indicators and highlighted the following: 7.3.1.1. The compliance rate for appraisals was 85.1% against a target of 85% and MS reported that the 2025/26 appraisal window would be opening shortly and a communication, which highlighted the importance of in-person and self-directed training, would be circulated this week. The quality of the appraisal had been highlighted in the recent NHS Staff Survey results and this would be an area of focus for the coming year. 7.3.1.2. The compliance rate for mandatory training was 88% against a target of 85% and it was noted that there was continued focus on the compliance in specific subjects and staff groups and this was reviewed in depth by the Executive Committee and reported at Quality Committee. 7.3.1.3. Sickness absence had reduced in February to 6.9% against the 5% target which was comparable to the same period in 2023/24. MS assured the Board that reducing absence levels remained a priority, including the focus on preventing ill health. Training was being provided for managers to ensure the Attendance Management Policy was being consistently applied and Welcome Back Conversations were happening after every episode of sickness absence. The Attendance Management Policy was also being reviewed. Regular audits were being undertaken to ensure compliance with the policy overall and to check that welfare meetings with staff on long term

	sick were taking place and that the relevant referrals to Occupational Health were being made. 7.3.1.4. Sickness absence for Health Care Assistants (HCA) remained an area of focus and specific departments, Outpatients at St Helens Hospital, and theatres at Whiston and Southport Hospitals, had been identified for intensive support. Sickness absence was slightly higher on the Whiston and St Helens Hospital sites and additional wellbeing champions had been identified within the teams with the highest sickness absence rates. 7.3.1.5. Staff turnover had been 0.5% in month against a target of 1.1%.
7.4.	**Financial Indicators**
	7.4.1. GL presented the financial indicators and highlighted the following: 7.4.1.1. The final approved MWL financial plan for 2024/25 had been a deficit of £10.9m which assumed: • A Cost Improvement Plan (CIP) target of £48m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 elective activity plan • Non-recurrent deficit funding 7.4.1.2. At month 11 the Trust was reporting a deficit of £14.1m which was £7m better than the revised plan as a result of receiving the advanced payments for deficit support, which had been expected in month 12. 7.4.1.3. The Trust was forecasting delivery of the full plan by the end of the financial year. 7.4.1.4. Agency spend was 3.5% of the pay bill and GL noted that this was a significant improvement. 7.4.1.5. The Trust remained on track to deliver CIP of £48m. At month 11 the Trust had successfully delivered £42.2m of CIP, of which £34m was recurrent with a further £1m recurrent CIP at the finalisation stage. 7.4.1.6. It was anticipated that the Trust would spend the full capital programme allocation. 7.4.1.7. Cash balance at month 11 was £7.7m which was slightly higher than normal, and GL noted that the Trust anticipated a closing balance of circa £2.7m as per plan at the end of the financial year. 7.4.2. RF reflected on the strong CIP performance and stressed the importance of the involvement of staff across the Trust in owning these targets. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB25/020 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. RC presented the Executive Committee Assurance report from the meetings held in February 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 had received Assurance Reports from the weekly vacancy control panel. 8.1.2. RC highlighted the following: 8.1.2.1. The Committee had approved the Supplementary Care Business case to increase the HCA establishment for selected wards where there was a high demand for supplementary care. This would be funded by a reduction in HCA bank and agency usage. 8.1.2.2. The Committee had agreed to stop using agency staff for HCAs with effect from 01 April 2025 and this would be accompanied by a greater focus on the training and support for this group. 8.1.2.3. The Committee had received the monthly Mandatory Training and Appraisal Compliance report. 8.1.2.4. The Committee had been monitoring the 65+week waiters improvement trajectory via weekly reports. 8.1.2.5. The Committee had received a briefing on the implementation of the Procurement Act 2023 and the introduction of NHS England (NHSE) spend controls for the North West region which included new requirements for Cabinet Office approval of procurements or new contracts with a value exceeding £20m. 8.1.2.6. The Committee had received the independent review of the Trust's clinical governance which had been a requirement of the transaction risk rating, to be undertaken 12 months after the completion of the transaction. MIAA had also completed a governance councils review. Both reports had found the Trust's governance processes were operating effectively but had included some recommendations for improvement, the majority of which had already be actioned. GB asked if the independent report could be circulated to all Board members. NB noted the report presented to the Executive Committee was written by the Trust based on the feedback from the independent reviewers, who had for various reasons not been able to complete the full report themselves. **Action:** RC to circulate the post transaction independent Clinical Governance Review. 8.1.2.7. The Committee had considered the Outpatient Transformation Programme plans report and RC noted that was an area of focus to improve productivity and efficiency from core funded capacity. 8.1.2.8. The Committee had received the first Communications and Media quarterly report which summarised the activities in Q3 as well as the plans for the remainder of the financial year. The remainder of the report was **noted.**
8.2.	**Charitable Funds Committee**
	8.2.1. SC on behalf of HS, presented the Charitable Funds Committee Assurance Report for the meeting held on 10 March 2025 and highlighted the following:

	8.2.1.1. The Committee had received an update from the Head of Charity on the activity between November 2024 and March 2025 which included the Christmas campaigns, staff engagement, the roll out of new resources and the launch of the new Charity website. 8.2.1.2. The Committee had approved the following: • The Charity Strategy and annual workplan • The MWL NHS Charity Appeal and SC noted that this was the first big appeal for the new MWL NHS Charity and a target of £60,000 had been set to improve facilities for patients at the Northwest Regional Spinal Injuries Unit. • The MWL Charity's Treasury Management and Reserves Policy, which set out the basis on which the Charity would act in relations to its treasury functions (cash management and investments). • The Committee draft annual workplan and meeting arrangements for 2025/26. 8.2.1.3. The Committee had received a summary of the grant applications received in 2024/25 and noted that 64 projects with a total value of over £270,000 had been supported. The remainder of the report was **noted.**
8.3.	**Quality Committee**
	8.3.1. GB presented the Quality Committee Assurance Report for the meeting held on 18 March 2025 and highlighted the following: <u>Corporate Performance Report</u> 8.3.1.1. Committee has supported the Executive in undertaking some focused support for theatres following the four Never Events that had been reported. The investigation reports from these never events would be presented at the meeting in June 2025, to identify common themes and lessons. <u>Patient Safety Report</u> (including the Patient Safety Council Chair's Assurance Report) 8.3.1.2. The Committee had requested additional assurance in relation to the long term trends of falls per 1,000 bed days. 8.3.1.3. The Committee had requested more information on the timelines of completion of Patient Safety Incident Investigations (PSII) as it appeared that the investigations were taking longer to complete than had been anticipated and there were two reports that had been outstanding for 12 months. The Committee had discussed the reasons for this and noted that the aspiration was that investigations were completed within six months of the incident. LB noted that some of the cases from 2024 were Maternity and Newborn Safety Investigations (MNSI) and these were undertaken independently of the Trust who had no control over the length of time taken for the investigations. The patients /relatives were kept informed of progress with all PSII investigations.

	Infection, Prevention and Control (IPC) Quarterly Report 8.3.1.4. The Committee had received the report for Q3 and noted that the Trust was below the NHSE thresholds for C.Diff, Escherichia coli (E-coli) and Pseudomonas bacteraemia, and the Committee had been assured that the improvement action plans had made an impact. 8.3.1.5. Three cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia had been reported in Q3 (five cases YTD) but there had been a decrease in the number of cases reported that were associated with cannula care. 8.3.1.6. The Trust wide Peripheral Intravenous Catheter Cannula (PIVC) improvement plan included the harmonisation of Aseptic Non Touch Technique (ANTT) care guidance and pathways for PIVC care across legacy Trust sites. Standardised ANTT mandatory training was to be implemented in 2025/26 as part of the MWL Mandatory Training project. 8.3.1.7. There had been a significant increase in the number of Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA) cases reported in Q3 (26 cases in quarter with 71 YTD compared to 39 cases in the same period in 2023/24) and regional peer support was being accessed to share best practice. Actions to Improve Discharge and Take Home Medication (TTO) Delays 8.3.1.8. The Committee had received the report, and the Chief Pharmacist had presented the TTO Discharge model which included the differences in process across the legacy Trust sites and areas for improvement. The Committee had noted the importance of submitting scripts into Pharmacy earlier in the day for TTOs to be available when the patient was ready to be discharged. 8.3.1.9. There were actions in place to roll out the Electronic Prescribing and Medicines Administration (EPMA) electronic prescription ordering system across all Trust hospital sites and to standardise reporting of key metrics. Clinical Effectiveness Report (including the Clinical Effectiveness Council Chair's Assurance Report) 8.3.1.10. The Committee had noted that a business case for the continuation of the Trauma Support Programme was in development to make the programme permanent. The programme provided support for staff who had to deal with difficult situations. 8.3.1.11. There had been a 62% increase in staff on the Non-Medical Prescribers (NMP) register since June 2023. 8.3.1.12. The Intensive Care National Audit and Research Centre (ICNARC) had noted excellent performance for Whiston Hospital with only one area outside of predicted range: Length of Time on Critical Care more than 4hour post discharge. 8.3.1.13. The Non-Elective Laparotomy Audits (NELA) showed that the Trust was still not achieving the recommendation that all patients over 65 received a Care of the Elderly specialist review. A target pf 85% had been set to improve NELA risk document compliance through continued education.

	8.3.1.14. The Council had noted that the continued participation in the Advancing Quality programme would be dependent on the Trust agreeing to increased membership fees for AQuA in 2025/26. 8.3.1.15. The Council had received an update from the Drug and Therapeutics Group (DTG) regarding the work to improve Venous Thromboembolism (VTE) assessments and link to roll out of the EPMA system across all Trust sites. 8.3.1.16. GB noted that there had been a discussions about adding more metrics to the IPR as part of the Sepsis improvement action plan. 8.3.1.17. The Council had noted the positive recruitment of consultant histopathologists as well as the ongoing work to reconfigure pathology services regionally. 8.3.2. RF reflected on the number of high calibre applications that were being received for consultant posts in a number of specialities which had been one of the planned transaction benefits. GB commented that she had been the Non-Executive Director on several consultant appointment advisory panels and it was notable the number of candidates who were attracted by the opportunities of the larger organisation and the Trust's reputation. The remainder of the report was **noted**.
8.4.	**Strategic People Committee**
	8.4.1. CS, on behalf of LK, presented the Strategic People Committee (SPC) Assurance report for the meeting held on 19 March 2025 and highlighted the following: 8.4.1.1. The Committee had reviewed the Workforce Dashboard and noted that whilst the Time to Recruit metric remained challenged, the average time to recruit had decreased to 58.4 days in February 2025 (63.2 days in January) against the target of 40 days. Work was ongoing against the recovery plan. 8.4.1.2. The Committee had received the Health, Work and Well Being Operational Plan Annual Assurance update and noted the breadth and scope of the work being delivered by a relatively small team. 8.4.1.3. The Committee had received a presentation on Psychological Safety and the development of a Trauma Support pathway for staff and had reflected on the outcome of the pilot project. A business case for resources to make the pathway permanent would be presented to the Executive Committee. 8.4.1.4. The Committee had received a staff story presentation on Employee Relation cases and their management. The cases could be difficult for all parties involved and a kind, timely and supportive approach as well as the implementation of lessons learnt would improve the Trust's people practices in the future. A manager, case manager and investigator had shared their experiences with the Committee. 8.4.1.5. The Committee had received the draft MWL People Plan and Strategy 2025 – 2028 and CS noted that the team had worked hard to reframe this to be more about what the HR experts were going to do as well as what employees could deliver. It was noted that the MWL People Plan and Strategy would be presented at a future Board meeting for approval.

	8.4.2. RT asked whether it would be appropriate for staff stories to be presented at Board. MS responded that that Chair of the Workforce Committee at legacy Southport and Ormskirk Hospital NHS Trust (S&O) had wanted to ensure that the staff voice was heard, and this had been carried forward to the MWL SPC meetings as a quarterly agenda item. NB commented that some staff may not be comfortable for their stories to be shared in public and sometimes issues were subject to on-going process, so adding staff stories to the public Board would need careful consideration. 8.4.3. RF reflected on the improvement in the vacancy rate which had reduced to 4.5% in February 2025 (was 7% in January 2025) against a target of 8%) and commented on the impact that this would have on the reducing stress on staff. 8.4.4. RF reflected that the Quality Ward Rounds were an excellent way for Non-Executive Directors to meet staff and understand their concerns. The remainder of the report was **noted**.
8.5.	**Finance and Performance Committee**
	8.5.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 20 March 2025 and noted that this had been her first meeting as Chair of the Committee. The Committee had reviewed the F&P CPR and monthly finance report, but the key points had already been discussed in earlier reports so would not be repeated. 8.5.2. CS reported that since the F&P meeting there had been further amendments to the 2025/26 Financial and Operational Plan and noted that the meeting had approved the overall approach that the Trust had taken with regards to developing the plan. 8.5.3. Other points to highlight from the report were: 8.5.3.1. Diagnostic performance was 97.5% in February 2025 against a target of 95%. This meant the Trust was one of the Top 5 performers nationally for the diagnostic tests reported against this target. 8.5.3.2. The Committee had received the Surgical Division CIP update. The Committee had questioned whether the CIP pipeline was sustainable and the Divisional Director of Operations, Surgery, had provided assurance that there were more opportunities to improve productivity. 8.5.3.3. The Committee had received the Elective Care Recovery Review which outlined the approach being taken and it was noted that this linked into the Further Faster 20 and the GIRFT programmes. 8.5.3.4. The Committee had received the Business Case Benefits Realisation Report, which tracked that the benefits from previous investment decisions that were realised. 8.5.4. RT asked whether the two new theatres at Whiston Hospital were being fully utilised. GL responded that the expected levels of activity were being

	complied in the new theatres and as they had been funded as part of the Targeted Investment Fund (TIF) there was external monitoring of this, and the Trust was currently slightly ahead of the agreed TIF activity plan. GL also noted that theatre utilisation across the Trust was improving, although not yet at target. 8.5.5. The Committee had received council assurance reports from the Procurement Council, CIP Council, Capital Planning Council, Estates & Facilities Management Council, and IM&T Council. There had been no issues escalated to the Committee. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**TB25/021 MWL Health Inequalities Strategy**
	(WL joined the meeting) 9.1. WL presented the draft MWL Health Inequalities Strategy 2025-2028 and year one delivery plan for 2025/26 for approval. WL noted that following consideration of an earlier draft by the Board in October 2024 the Strategy had been revised following engagement with Trust colleagues and system partners. WL provided a brief summary of the engagement process and highlighted that the strategy was more closely linked to the C&M ICB health inequality reduction objectives. 9.2. WL highlighted the following: 9.2.1. It was anticipated that the base line position for the health inequality metrics would be finalised by the end of Q1 2025/26. 9.2.2. Progress against the strategy would be evaluated every six months. 9.2.3. The Trust was in the process of committing to the Anchor Institutional Charter. 9.2.4. A progress report to the Board on the delivery of the year one action plan and year 2 priorities would take place in 12 months. 9.3. WL provided an overview of the different measures of health inequality for the population served by the Trust and noted that the Strategy was designed to impact a number of these by the Trust being a provider of quality health care, being an active system partner, being an employer of choice and being an anchor institution. The 'plan on a page' provided an overview of the Trust's objectives and development work for the first year of the strategy with the anticipated outcomes across the four domains. 9.4. RC reflected on the financial challenges facing the NHS in 2025/26 and hoped that the contribution of services to meeting the health needs of vulnerable people who suffered the greatest health inequality would be considered in any

	of the difficult decisions the NHS may need to make to reconfigure services. RC also asked if there was a cross over with the wider Trust improvement and transformation agenda. WL responded that he had worked with the Director of Strategy regarding some of the transformation work that the Trust was undertaking and commented that all service changes being considered needed to have a robust equality impact assessment, so that impact on groups of patients were recognised and considered. 9.5. WL reported that there was likely to be a focus on reducing health inequalities in the NHS 10 Year Plan that was due to be published and he anticipated that there would be a focus on providing more home or community based care, which might improve access and efficiency in some areas but would not be the solution in all geographies. 9.6. WL reported that the first year of the Strategy was designed to lay the foundations and gain a better understanding of how the Trust could make a difference in this field. RC commented that there was no national data collection in this area for trusts and it would be important to have a level of data and information as an organisation to understand if the impact was as a result of Trust actions or wider impacts on society e.g. from government policy changes. 9.7. AMS reflected on the high levels of deprivation, mortality, risk taking behaviours and child health in the Boroughs served by the Trust and the challenges this presented for the demands for healthcare, in the current financial environment. 9.8. SC agreed that the health inequalities table highlighted the scale and this was very sobering. WL commented that in the North West, Knowsley, St Helens and Liverpool were the most deprived areas and noted that whilst there was a gap between the South of England and the North West, there was also considerable variation between some of the Boroughs that the Trust served. 9.9. NB commented that the challenges for MWL were different to some other trusts, who for example might service an ethnically diverse population, and the table provided a focus on this and would allow the Trust to make decisions that would impact the situation locally. 9.10. SC noted that this was a strategy the Trust could not deliver in isolation and there were a number of things that would require input from the local authorities. WL agreed and explained that he attended partners' Health and Wellbeing Boards and had worked with the Directors of Public Health to develop the strategy, including sharing the Trust's inequalities dashboard. WL commented that the main focus for local authorities was on regeneration of the environment and social care. These both required long term investment, and the current financial challenges faced by local government would potentially limit what could be achieved in these areas.

	9.11. GB commented that as 50% of Trust's staff came from this population it was perhaps not surprising that there were high levels of sickness, and this was another pressure for the Trust. GB commented that the government policy to focus access to healthcare on economically inactive people so they could return to the workforce could have a negative impact on health inequalities. WL noted that the one of the biggest determinants of health was employment and so it could be argued that measures to reduce unemployment would have a positive impact. The Trust could support people ready and able to join or return to the workforce by providing training and opportunities. 9.12. CS commented that primary intervention often started at school to influence lifestyle choices and asked what the Trust was doing to engage with young people. WL responded that local authorities had a duty to look at regeneration to increase jobs and the Trust has been approached to provide assistance around life sciences locally. WL advised that he had been invited to attend a Liverpool City Region workshop around new employment opportunities and the Trust was a contributor rather than a leader in this area. MS commented that the Trust had good links with local schools and colleges and promoted NHS careers. Edge Hill University was one of the few Medical Schools that had a recruitment strategy to recruit undergraduate medical students from the local population and the Trust was one of the local hospitals who supported the practical training for these students. MS reflected that whilst there was a need to provide employment opportunities for individuals who had left school, there was also a need to provide support to those individuals who were the first generation in their family to attend university. 9.13. RF commented that the NHS being free at the point of delivery and based on clinical need remained the guiding principle of the NHS and he hoped this never changed. RF also thanked WL for the excellent piece of work. **RESOLVED:** The Board **approved** the MWL Health Inequalities Strategy *(WL left the meeting)*
10.	**TB25/02 Freedom to Speak Up Board Self-Assessment**
	10.1. AMS presented the annual self-assessment of Freedom to Speak Up arrangements and noted that this formed part of the Board's assurance process for its oversight of the Trust Freedom to Speak up arrangements to ensure the organisation had a culture where staff felt able to raise their concerns. 10.2. AMS noted that the self-assessment had included input from the Chair of the Trust, the Acting Director of Nursing, Midwifery and Governance, the Assistant Director of Learning and Organisational Development, and the Freedom to Speak Up (FTSU) Guardians.

	10.3. The self-assessment covered a range of principles set out by the National Guardians Office and the Trust had scored 4 or 5 for most areas which meant that the Trust was able to provide evidence of areas of strength where best practise was in place. 10.4. An area for further development was being able to provide assurance that there was no detriment to staff for raising a concern and there were process in place to monitor and manage this. AMS assured the Board that any issues raised about detriment were already acted upon and the action was to formalise this. AMS noted that the recent staff survey results were a key indicator of whether staff felt confident to raise concerns. 10.5. RF reflected on the Trust's philosophy of having a range of different FTSU guardians so that a member of staff with a concern could always find somebody that they felt comfortable with. **RESOLVED:** The Board **approved** the Freedom to Speak Up Board Self-Assessment and supporting action plan
11.	**TB25/023 2025/26 Financial and Operational Plan**
	11.1. RF advised that there had been a meeting with NHSE before the Board, at which additional amendments to the draft 2025/26 Financial and Operational Plan had been requested. Further work was required to the draft plan prior to Board approval. A further discussion around these amendments would take place in the Closed Board and the updated 2025/26 Financial and Operational Plan would be presented at the April Board meeting for formal approval. **RESOLVED:** The Board **noted** that the 2025/26 Financial and Operational Plan would be discussed in Closed Board
12.	**TB25/024 Care Quality Commission (CQC) Compliance and Registration**
	12.1. LB presented the CQC Compliance and Registration report which provided a summary of the policies, processes, and practices across the Trust to demonstrate on-going compliance with the 14 CQC fundamental standards . 12.2. The Trust was required to maintain its registration 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. 12.3. LB reported that following the introduction of a new CQC assessment framework the 'should and must do' actions would be referred to as breaches of the regulations going forward. 12.4. There had been two unannounced inspections since the 2024 declaration:

	12.4.1. Urgent and Emergency Care (UEC) was inspected at the Southport Hospital site on 04 March 2024 and the draft report had been received by the Trust for factual accuracy checking in February 2025. LB noted that the Trust had submitted a number of comments, and the final publication was awaited. 12.4.2. UEC was inspected at the Whiston Hospital site on 25 March 2024 and the final report was published 31 January 2025. The service was rated as 'requires improvement' overall, but was rated 'good' for caring, effective and well led. Regulatory breaches had been notified to the Trust against three of the fundamental standards. LB advised that action plans in response to the breaches had been developed and assurance on progress was being given to the Quality Committee and at the regular meetings with the CQC. These breaches did not prevent the Trust from remaining registered with the CQC. 12.5. LB advised that the CQC charged all providers an annual registration fee to cover regulatory activities and this was based on a percentage of the patient care income from the most recent annual accounts and the MWL fee for 2025/26 was £567,748. 12.6. RF reflected on the changes to the CQC and asked if these had been for the better. LB responded that the recent changes had been difficult for CQC staff and this had impacted on the Trust as evidenced by the delay in receiving the reports following the unannounced inspections. LB commented that she preferred the layout of the new CQC reports and felt the assessment methodology made it easier for trusts to understand the rating. 12.7. GB referred to the fundamental standards in Appendix 1 and the premises and equipment standard and asked, based on the description, whether this should be reported to the Executive Committee and not the Quality Committee has indicated in the report. LB responded that many of the standards had cross cutting aspects affecting many areas of the Trust. **RESOLVED:** The Board **approved** the CQC Compliance and Registration annual declaration.
13.	**TB25/025 Elimination of Mixed Sex Accommodation Annual Declaration**
	13.1. LB presented the report and noted that the Trust was 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 would be published on the Trust website. 13.2. LB reported that for 2024/25 to the end of February 2025 MWL had reported 92 breaches. There had been 77 breaches declared at Southport Hospital and these were because of delays in the step down of patients from the Intensive Care Unit (ICU) who met the clinical criteria to be transferred to a ward. There had been 15 breaches declared at Whiston Hospital and these

	were from the Cardiac Diagnostic Centre, which had been used as an escalation area to provide additional beds at times of extreme operational pressures. 13.3. It was noted that the Trust continued to implement the Provision of Same Sex Accommodation Policy to minimise breaches. 13.4. RC commented that mixed sex accommodation breaches were becoming more of an issue for many trusts, due to high bed occupancy rates and asked if there was any benchmarking information available. Respecting the patients right to privacy and dignity were fundamental and RC assured the Board that the Trust continued to take the breaches very seriously and avoid them wherever possible. **Action** LB to report mixed sex accommodation breaches benchmarking information at the next meeting. 13.5. RF agreed that because of increased Accident and Emergency (A&E) attendances and the increased need for beds, the external scrutiny on mixed sex breaches appeared to have reduced. **RESOLVED:** The Board **approved** the Elimination of Mixed Sex Accommodation Annual Declaration
14.	**TB25/026 2024 Staff Survey Report and Action Plan**
	14.1. MS presented the 2024 Staff Survey Report and Action Plan which provided an overview of the results and identified the key outcomes and supporting actions that the Trust would be focusing on during 2025. It was noted that this was the second MWL wide survey since the completion of the transaction in July 2023 but the first reflecting a full 12 months of being MWL, and the data would serve as a baseline for future improvements. 14.2. MS advised that the survey had been conducted between September and November 2024. There had been a response rate of 37% and MS noted that this was 1% below the response rate for 2023 and below the national benchmark of 49% for Acute and Community trusts. 14.3. MS reported that the staff survey had been aligned with the seven themes of the People Promise framework as well as two additional themes of staff engagement and morale. The Trust's results had not shown any real change in the nine theme scores, and this was in line with the national trend. However, there had been a small decline all in scores. MS advised that the national results had returned to pre-Covid-19 levels. 14.4. MS highlighted the following key results for the Trust:

	14.4.1. MWL had scored above the national average in most of the themes including staff engagement, which included the sub themes of advocacy, motivation and involvement, as well as the theme of morale, which included the sub themes 'thinking about leaving', work pressure and stressors. MS noted that prior to the completion of the transaction the legacy S&O staff survey had indicated a low staff morale and job enthusiasm compared to the legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) survey, however the combined results for 2024 had reflected an overall improvement in morale. 14.4.2. The work life balance sub theme has improved from 2023. 14.4.3. Compassionate culture remained above the national average. 14.4.4. The raising concerns sub theme had decreased from 6.72 in 2023 to 6.61in 2024 and this would be an area of focus for improvement in 2025. 14.4.5. It was important that the context of the survey against a backdrop of extensive organisational change was noted; however, it also provided assurance that the amalgamation of teams and services was not having a significant negative effect and that the shared values of MWL remained important to staff. 14.4.6. The line management sub theme had decreased which was reflective of the national picture and the need to invest in this level of leadership had already been recognised by the Executive. 14.4.7. The Trust had ranked third in the North West region for staff engagement and fourth for morale, and 'we are safe and healthy'. 14.4.8. There had been a decline against the 2024 Trust scores for all of the People Promise themes scores, but by less than the 3% significant change range. This provided the areas for improvement in 2025. 14.4.9. 'We work flexibly' had scored below the national average but had had increased slightly from 2023. 14.4.10. Learning and Development had indicated the importance of providing better access to clinical skills and leadership training. Staff from ethnic minorities and lower bands had reported higher concerns about inclusivity and career progression. 14.4.11. There had been a slight increase in the numbers of staff reporting harassment and discrimination from colleagues and managers. 14.5. Community Services had the staff survey highest response rate whilst the Southport and Ormskirk Hospital sites had the lowest response rates. The individual teams with the lowest scores included Pathology, Medical Secretaries, Theatres and Medicine Management. GB asked whether these teams were the same as the 2023 staff survey. MS responded that these results were similar in the 2023 staff survey. 14.6. GB asked how the team were assured the actions taken following the 2023 staff survey were embedded. MS responded that one of the difficulties with the staff survey was that it was based on the Electronic Staff Records (ESR) and how the teams were broken down and noted that as the Trust had gone through a period of organisational change there might be differences at team level between years, which was why it had been proposed that the 2024 staff

survey should be used as the baseline for measuring the impact of any changes. Each area would have their own staff survey feedback and be supported to develop local actions plan. GB commented that the Pathology and Theatres teams were slightly isolated from the rest of the hospital and asked if this influenced the culture in these areas. MS responded that those teams did not have direct patient contact and sometimes felt undervalued and it would be important to ensure that staff from these teams attended the upcoming Team Talks to discuss the staff survey results.

14.7. RT commented that these clinical support teams were dependent on various processes within the organisation and were often held to account for any gaps, e.g. Pharmacy and the TTO process, and it would be important to provide support to these areas. MS responded that, whilst benchmarking against the national staff survey results was available at a high level, the details of the results for the different staff groups across organisations was not available. MS advised that she had requested the C&M O&D group consider local C&M benchmarking to see if there were common themes across other local trusts.

14.8. NB commented that analysing the staff survey results by band/ grade, type of staff and maybe age groups might highlight different issues, however, the teams reporting lower scores all had recruitment issues and experienced staff shortages.

14.9. MS highlighted the following key areas of focus in the for the action plan:

14.9.1. Flexible working – continuing to improve the availability and variety of options available and exploring creative solutions for the clinical workforce as this was the group that had reported the least satisfaction with flexible working opportunities.

14.9.2. Learning and development – continuing to improve access to specific learning opportunities, particularly clinical skills development, leadership and management. Work was underway on leadership skills with a focus on operational colleagues for 2025.

14.9.3. Continuing to embed the Trust's values and to create a Trust wide offer of support and learning for compassionate leadership in practice.

14.9.4. Freedom to Speak Up - continuing the work started in 2024 regarding the willingness to speak up and the confidence that the Trust would act upon concerns raised by staff.

14.9.5. The Equality, Diversity and Inclusion (ED&I) team would be targeting the teams that had scored a 15% or higher negative response to the Trust average for the discrimination, harassment, and sexual harassment questions.

14.10. RF commented that there was still an impact following the formation of MWL in July 2023 and this needed to be taken into account when being compared to other trusts. Additionally, the morale of all NHS staff might be further impacted by things outside of the Trust's control, for example the abolition of NHSE.

	RESOLVED: The Board noted the 2024 Staff Survey Report and **approved** the 2025 action plan
15.	**TB25/027 Trust Objectives 2025/26**
	15.1. RC presented the proposed Trust Objectives for 2025/26 and noted that there were 28 proposed objectives in total and the quality objectives were aligned to the Quality Account improvement priorities for 2025/26. The proposed objectives had been developed to support the 5 Star Patient Care criteria, with additional strategic and performance themes. RC reported that there had been a detailed discussion around how each objective would be measured at the recent Executive time-out. RC highlighted that the need to agree with commissioners and regulators a three-year strategy to return the Trust to financial balance had been included as an objective for 2025/26. 15.2. RT reflected on the Safety objectives and asked whether a specific objective to improve VTE risk assessments should be included. PW responded that the number of hospital acquired VTE incidents across MWL was small, and a potential electronic solution to remind staff of the need for VTE risk assessments was a was being trialled. The main area for improvement was focused on Whiston Hospital. RC commented that as this was already an area of focus and monitored via the IPR he did not feel there was also a need for a specific Trust wide objective, but performance would continue to be closely monitored. LB explained that including the VTE risk assessment prompt on prescription charts had been highly successful at Southport Hospital and several other trusts. 15.3. AMS commented that these objectives formed one part of the personal objectives for the Executive Directors and assured the Board that VTE risks assessments would be included as an additional personal objective. 15.4. SC felt that these were a good set of objectives and asked how they would be monitored at the assurance committees to which they were aligned. RC clarified that the Committee was not responsible for delivery of the objective but the workplans should include regular monitoring reports to provide assurance of progress. 15.5. GB commented that it was helpful for each objective to have SMART outcome measures. NB responded that this had been the focus of the discussion at the Executive Timeout and it was hoped that were ever possible each objective had an objective measure of success. 15.6. RF reflected on the possible difficulty in achieving some of the strategic objectives, due to the changes in the NHS that would happen during 2025/26 **RESOLVED:**

	The Board **approved** the Trust Objectives for 2025/26
Concluding Business	
16.	**Effectiveness of Meeting**
	16.1. RF reflected on the last minute amendments to the agenda following the meeting with NHSE before Board and hoped this hadn't been too disruptive to proceedings.
17.	**Any Other Business**
	There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.42 The next Board meeting would be held on **Wednesday 30 April 2025 at 09.30**

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	✓	A
Gareth Lawrence	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Lesley Neary	✓	A	A	✓		✓	✓	✓		A	✓	A
Sue Redfern	A	A	A	A		A	A	A				
Hazel Scott	✓	✓	✓	A		✓	✓	✓		✓	✓	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	A
Richard Weeks	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
✓ = In attendance A = Apologies												

Trust Board (Public)
Matters Arising Action Log
Action Log updated 25 April 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 (SPC) asked to consider what the Trust value 'we are inclusive' means for staff. Update (25/04/2025) Following analysis of the staff survey results and subsequent Team Talks, SPC received a paper on 23 April that provided a summary of the actions that have been identified. This included actions relating to improving the lived experience of our staff in relation to the People Promise Theme of we are compassionate and inclusive. A number of specific EDI actions have also been identified which aim to improve the experience of the members of our workforce with a protected characteristic with specific focus on provided reasonable adjustments and support for colleagues with disabilities and long term health conditions. **Action completed**	MS	~~01/01/2025~~ Apr-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. Update (25/04/2025) Update included in Agenda Item TB25/033 Board Assurance Framework. **Action completed.**	MG	Apr-25		**Completed**

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. Update (25/04/2025) There were separate audit plans for each legacy organisation in 2024/25 with several mirrored between sites, however, learning was shared between sites within divisional governance reports. Audit plans for 2025/26 will be fully harmonised where possible. **Action completed.**	LB	Apr-25		**Completed**
7	26/03/2025	**TB25/020 Committee Assurance Reports** 8.1 Executive Committee	RC to circulate the Independent Clinical Governance Review to the NEDs. Update (27/03/2025) The report was circulated to NEDs. **Action completed**.	RC	Apr-25		**Completed**
8	26/03/2025	**TB25/025 Elimination of Mixed Sex Accommodation Annual Declaration**	LB to review mixed sex accommodation breaches at other trusts and provide feedback at the next meeting. Update (25/04/2025) Within Cheshire and Merseyside the trusts reporting the highest number of mixed sex breaches are Liverpool University Hospitals NHS Foundation Trust and Warrington and Halton Hospitals NHS Trust. MWL had the fourth highest number of mixed sex breaches. **Action completed**.	LB	Apr-25		**Completed**

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
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	LN & MG	Mar-25	**26/03/2025** - The report on the actions being taken to improve discharges and reduce the time taken to receive To Take Out (TTO) medications had been presented at Quality Committee on 18 March 2025. **Action completed.**	**Completed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 April 2025
Agenda Item	**TB25/030**			
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 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
	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

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	Aug-24	91.2	100	95.3	Best 40%
FFT - Inpatients % Recommended	Mar-25	94.0%	90.0%	94.6%	Best 50%
Nurse Fill Rates	Mar-25	98.1%	90.0%	96.9%	
C.difficile	Mar-25	10	113	114	
E.coli	Mar-25	12	171	154	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.13	0.00	0.14	
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.12	0.00	0.17	
Stillbirths (intrapartum)	Mar-25	0	0	0	
Neonatal Deaths	Mar-25	1	0	10	
Never Events	Mar-25	0	0	5	
Complaints Responded In 60 Days	Mar-25	64.4%	80.0%	64.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Feb-25	77.8%	77.0%	74.0%	Worst 30%
Cancer 62 Days	Feb-25	82.4%	85.0%	79.2%	Best 20%
% Ambulance Handovers within 30 minutes	Mar-25	55.2%	95.0%	48.1%	
A&E Standard (Mapped)	Mar-25	79.1%	78.0%	78.1%	Best 20%
Average NEL LoS (excl Well Babies)	Mar-25	3.8	4.0	4.1	Best 30%
% of Patients With No Criteria to Reside	Mar-25	23.8%	10.0%	21.0%	
Discharges Before Noon	Mar-25	18.6%	20.0%	18.6%	
G&A Bed Occupancy	Mar-25	98.4%	92.0%	97.7%	Worst 30%
Patients Whose Operation Was Cancelled	Mar-25	1.1%	0.8%	1.0%	
RTT % less than 18 weeks	Mar-25	64.6%	92.0%	64.6%	Best 30%
RTT 65+	Mar-25	88	0	88	Worst 30%
% of E-discharge Summaries Sent Within 24 Hours	Mar-25	83.2%	90.0%	82.8%	
OP Letters to GP Within 7 Days	Feb-25	49.6%	90.0%	61.7%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Mar-25	83.4%	85.0%	83.4%	
Mandatory Training	Mar-25	88.2%	85.0%	88.2%	
Sickness: All Staff Sickness Rate	Mar-25	6.5%	5.0%	6.2%	
Staffing: Turnover rate	Mar-25	0.9%	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 – There were 10 healthcare-associated CDI cases in March: 8 HOHA and 2 COHA cases. At year end there have been 114 cases (87 HOHA, 27 COHA), one case above the Trust threshold for 2024/25 of no more than 113 cases. In the most recent comparative UKHSA data available, for 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 -There were 12 healthcare-associated cases in March (7 HOHA and 5 COHA). The Trust is below the NHSE threshold by 12 cases, with 158 cases at year end.

Pressure Ulcers - Supportive improvement work with wards by TVN teams based on learning and outcomes from investigations is underway. Tissue viability team led audits are in place to high-risk areas.
Pressure ulcer training for new starters was rolled out in ED in 2025 and a band 7 link nurse has been identified to embed quality improvement projects for pressure ulcer prevention in ED. This will focus on nursing documentation and risk assessment.
A plan is in place to address the backlog of HAPU reviews and it is expected that this will be completed by May 2025.

Patient Falls – Analysis of falls reported at MWL during year 2022/23, 2023/24 and 2024/25, suggests overall number of falls and falls with harms have remained similar, without significant change. An increase in moderate harm falls was reported from SO in 2024/25. Falls lead and wards with increased incidence of harm have targeted improvement actions including training on falls prevention and management. A revised falls prevention strategy and associated action plan is in development, which incorporates learning and themes identified as part of thematic reviews completed biannually by the falls team on all falls of moderate harm and above.

Never event - There were no Never Events reported in March (YTD 5).

Complaints – The number of complaints received has increased overall across all sites. Whilst the % of complaints responded to within 60 working days remains consistent, the number of complaints closed in March significantly increased.

Mortality - Data covers deaths in the Trust until Aug 2024. The latest month (Aug-24) HSMR for MWL was 91.2. All individual diagnosis groups with HSMR alert for this period have had deaths reviewed with none highlighting any areas of concern. The latest 12 months (ending Aug-24) had an overall low HSMR (92.0 for MWL, 93.5 for S&O and 91.4 for STHK). The YTD HSMR remains below 100 (95.3 for MWL, 94.5 S&O and 95.5 for STHK). The latest SHMI data for October has remained at 1.03.

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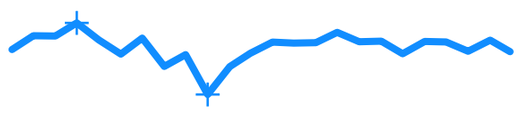
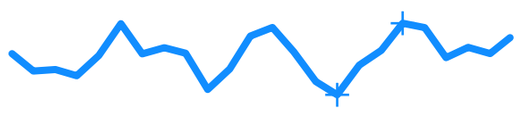
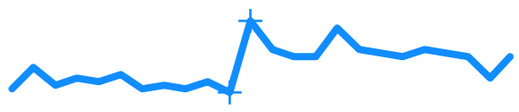
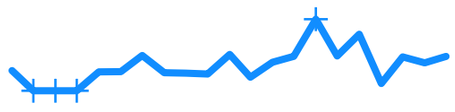
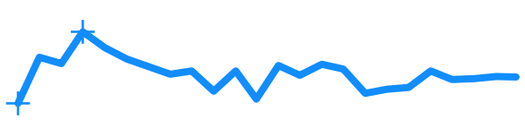
Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Aug-24	91.2	100	95.3	Best 40%	
FFT - Inpatients % Recommended	Mar-25	94.0%	90.0%	94.6%	Best 50%	
Nurse Fill Rates	Mar-25	98.1%	90.0%	96.9%		
C.difficile	Mar-25	10	113	114		
E.coli	Mar-25	12	171	154		
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.13	0.00	0.14		
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.12	0.00	0.17		
Stillbirths (intrapartum)	Mar-25	0	0	0		
Neonatal Deaths	Mar-25	1	0	10		
Never Events	Mar-25	0	0	5		
Complaints Responded In 60 Days	Mar-25	64.4%	80.0%	64.4%		

Board Summary - Operations

Operations

A&E - 4-Hour performance increased in March, achieving 76.7% (all types). Trust performance remained ahead of National (75%), and ahead of C&M (72.6%). The Trusts mapped 4-Hour performance achieved 79.1%.
Patient Flow

RTT - The Trust had 1910 52-week waiters at the end of March, (333 S&O and 1577 StHK), 88 65-week waiters and 2 78-week waiters.
The 52-week position is a decrease of 111 from February and the 65-week waiters have reduced by 33% from February to March. 18-Week performance in March for MWL was 64.6%, S&O 65.5% and StHK 64.2%. This was ahead of national performance (latest month February) of 59.2% and C&M regional performance of 57.3%.

Diagnostics - Diagnostic performance in March was 93.1% for MWL, failing to achieve the 95% target, with S&O achieving 97.3% and StHK 91.2%. MWL performance is ahead of national performance (latest month February) of 82.5% and C&M regional performance of 94.1%.

Patient Flow - Bed occupancy across MWL averaged 105.8% in March equating to 88.1 patients - a slight reduction on the 106.4% reported in February. There was a peak of 129 patients (47 at S&O, 82 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 10% higher than last March, driven by a 29% increase in 0 LOS activity, and a -5% decrease in 1+ day LOS activity. Southport had a 142% increase in 0 LOS from March 24 to March 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 9.3 at S&O and 7.5 at StHK, with an overall average of 8 days, the impact of non CTR patients being 23.8% at Organisation level, 1.8% higher than February but 4.7% higher than March 2024 (20.5% StHK and 29.6% S&O).

Cancer - Cancer performance for MWL in February improved slightly, at 77.8% for the 28 day standard (target 77%), with Southport achieving 67.9% and St Helens performance being 83.5%. Latest published data (February) shows national performance of 80.2% and C&M regional performance of 76.6%. Performance for 62-day increased, achieving 82.4% (target 85%), with Southport achieving 71% and St Helens 87.3%. C&M performance was 74.6% and National 67%.
Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2024/25.

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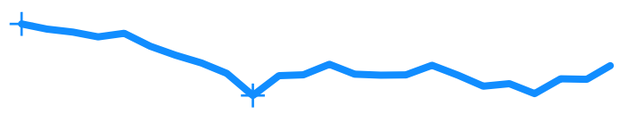
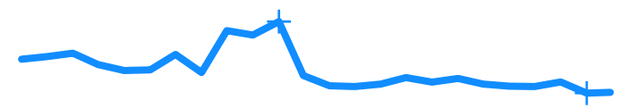
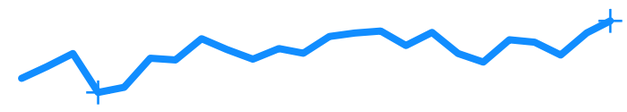
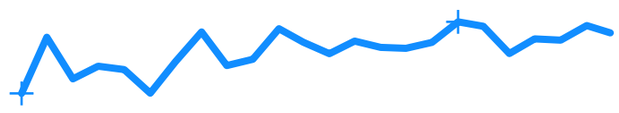
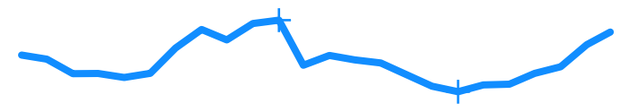
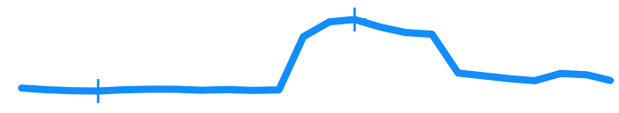
Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Feb-25	77.8%	77.0%	74.0%	Worst 30%	
Cancer 62 Days	Feb-25	82.4%	85.0%	79.2%	Best 20%	
% Ambulance Handovers within 30 minutes	Mar-25	55.2%	95.0%	48.1%		
A&E Standard (Mapped)	Mar-25	79.1%	78.0%	78.1%	Best 20%	
Average NEL LoS (excl Well Babies)	Mar-25	3.8	4.0	4.1	Best 30%	
% of Patients With No Criteria to Reside	Mar-25	23.8%	10.0%	21.0%		
Discharges Before Noon	Mar-25	18.6%	20.0%	18.6%		
G&A Bed Occupancy	Mar-25	98.4%	92.0%	97.7%	Worst 30%	
Patients Whose Operation Was Cancelled	Mar-25	1.1%	0.8%	1.0%		
RTT % less than 18 weeks	Mar-25	64.6%	92.0%	64.6%	Best 30%	
RTT 65+	Mar-25	88	0	88	Worst 30%	
% of E-discharge Summaries Sent Within 24 Hours	Mar-25	83.2%	90.0%	82.8%		
OP Letters to GP Within 7 Days	Feb-25	49.6%	90.0%	61.7%		

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. In addition targeted support is in place to support front line clinical staff to access training

Appraisals - The Trust is no longer meeting its appraisal target of 85% however this is due to us entering into the new appraisals window for 2025/2026. Current appraisal compliance is slightly below target at 83.4%. We have consistently been meeting the target for appraisals since the closure of the 2024/2025 appraisal window in September 2024. The Learning and Development Team are preparing for the launch of the next appraisal window and are supporting teams in preparing to undertake quality appraisals focusing on development and wellbeing with the development of resources and training

Sickness - In-month sickness is above target, at 6.5% against the 5% target which is a slight reduction from last month (6.9%). This is higher than the same time last year but based on benchmarking data available to us it is reflective of absence levels across other acute organisations.

The top 3 reasons for sickness in March were 1) Stress, Anxiety & Depression, 2) Cold, Colds and Flu and 3) MSK. The Trust continues to focus on supporting all employees who are absent, and the HR absence Team are supporting staff and managers with timely support, guidance and access to Health and Wellbeing Support. In addition, we continue to undertake targeted work with our staff groups with the highest levels of absence. A deep dive into sickness absence over the last 12 months has been undertaken and a targeted support plan developed. The Sickness and Absence policy is continuing be reviewing in partnership with mangers and trade union colleagues to further develop how we provide holistic wellbeing support to our workforce

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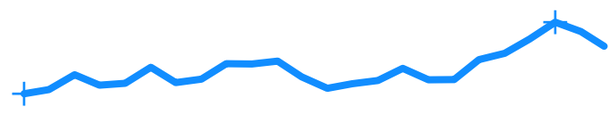
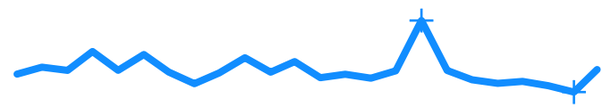
Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Mar-25	83.4%	85.0%	83.4%		
Mandatory Training	Mar-25	88.2%	85.0%	88.2%		
Sickness: All Staff Sickness Rate	Mar-25	6.5%	5.0%	6.2%		
Staffing: Turnover rate	Mar-25	0.9%	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.

The Trust is currently in the process of preparing the annual accounts ready for the draft submission of the 24/25 financial position to NHSE on 25th April. The figures given below are provisional subject to finalising the submission and subsequent matters arising from the audit.

Surplus/Deficit – For the financial year 2024/25 the Trust's reportable position is expected to be a £9.3m deficit, in line with the forecast as at M11 reporting. This represents a £1.6m favourable variance against plan.

CIP - The Trust's combined 2024/25 CIP target was £48.0m of which £11.8m was non-recurrent. These 2024/25 targets have been met in full.

Cash - The Trust finished the year with a closing cash balance of £10.2m.

Capital - Capital expenditure for 24/25 (including PFI lifecycle maintenance and IFRS 16 Lease Remeasurements) totals £45.3m.

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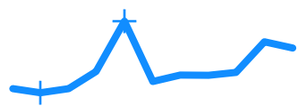
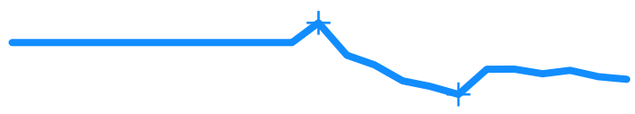
Board Summary - Finance

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...		

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Board Summary

S&O

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-24	95.8	100	94.5	
FFT - Inpatients % Recommended	Mar-25	94.0%	90.0%	94.3%	
Nurse Fill Rates	Mar-25	99.0%	90.0%	96.2%	
C.difficile	Mar-25	3		50	
E.coli	Mar-25	3		50	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.16	0.00	0.11	
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.09	0.00	0.19	
Stillbirths (intrapartum)	Mar-25	0	0	0	
Neonatal Deaths	Mar-25	0	0	3	
Never Events	Mar-25	0	0	2	
Complaints Responded In 60 Days	Mar-25	63.6%	80.0%	66.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Feb-25	67.9%	77.0%	68.3%	
Cancer 62 Days	Feb-25	71.0%	85.0%	63.9%	
% Ambulance Handovers within 30 minutes	Mar-25	68.2%	95.0%	60.4%	
A&E Standard (Mapped)	Mar-25				
Average NEL LoS (excl Well Babies)	Mar-25	3.7	4.0	4.9	
% of Patients With No Criteria to Reside	Mar-25	29.6%	10.0%	18.3%	
Discharges Before Noon	Mar-25	18.9%	20.0%	19.3%	
G&A Bed Occupancy	Mar-25	97.9%	92.0%	97.1%	
Patients Whose Operation Was Cancelled	Mar-25	0.9%	0.8%	1.1%	
RTT % less than 18 weeks	Mar-25	65.5%	92.0%	65.5%	
RTT 65+	Mar-25	28	0	28	
% of E-discharge Summaries Sent Within 24 Hours	Mar-25	84.3%	90.0%	80.3%	
OP Letters to GP Within 7 Days	Feb-25	45.8%	90.0%	64.7%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Mar-25	74.2%	85.0%	74.2%	
Mandatory Training	Mar-25	89.2%	85.0%	89.2%	
Sickness: All Staff Sickness Rate	Mar-25	6.2%	5.0%	6.3%	
Staffing: Turnover rate	Mar-25	0.9%	1.1%	0.8%	

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

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Board Summary

STHK

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-24	89.9	100	95.5	
FFT - Inpatients % Recommended	Mar-25	93.9%	94.0%	94.7%	
Nurse Fill Rates	Mar-25	97.2%	90.0%	97.6%	
C.difficile	Mar-25	7		64	
E.coli	Mar-25	9		104	
Hospital Acq Pressure Ulcers per 1000 bed days	Dec-24	0.12	0.00	0.15	
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.13	0.00	0.17	
Stillbirths (intrapartum)	Mar-25	0	0	0	
Neonatal Deaths	Mar-25	1	0	7	
Never Events	Mar-25	0	0	3	
Complaints Responded In 60 Days	Mar-25	65.2%	80.0%	62.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Feb-25	83.5%	77.0%	77.6%	
Cancer 62 Days	Feb-25	87.3%	85.0%	85.6%	
% Ambulance Handovers within 30 minutes	Mar-25	48.7%	95.0%	41.4%	
A&E Standard (Mapped)	Mar-25				
Average NEL LoS (excl Well Babies)	Mar-25	3.9	4.0	3.8	
% of Patients With No Criteria to Reside	Mar-25	20.5%	10.0%	22.5%	
Discharges Before Noon	Mar-25	18.2%	20.0%	17.9%	
G&A Bed Occupancy	Mar-25	98.7%	92.0%	98.1%	
Patients Whose Operation Was Cancelled	Mar-25	1.2%	0.8%	1.0%	
RTT % less than 18 weeks	Mar-25	64.2%	92.0%	64.2%	
RTT 65+	Mar-25	60	0	60	
% of E-discharge Summaries Sent Within 24 Hours	Mar-25	82.9%	90.0%	83.5%	
OP Letters to GP Within 7 Days	Feb-25	51.6%	90.0%	59.9%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Mar-25	87.6%	85.0%	87.6%	
Mandatory Training	Mar-25	87.7%	85.0%	87.7%	
Sickness: All Staff Sickness Rate	Mar-25	6.7%	5.0%	6.1%	
Staffing: Turnover rate	Mar-25	0.9%	1.1%	0.9%	

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**	30 April 2025
Agenda Item	**TB25/031 (7.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in March 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 March 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. There were no team-to-team meetings in March.		
06 March 2025		
Recruitment and Resourcing Update	• The Acting Director HR introduced the report which updated the Committee on the performance of the recruitment and temporary staff resourcing functions. • The Trust level vacancy rate had remained stable throughout 2024/25 at 7%, which was below the target rate of 8%. The Administrative and Clerical staff group had the highest vacancy rate at 12%. • Time to hire targets were not being achieved, due to delays in receiving DBS checks, Occupational Health pre-employment check requirement changes and the time taken to receive references. • Challenges therefore remained to recruit sufficient staff in areas of growth e.g. additional Health Care Assistants (HCA) to support the supplementary care strategy • Recruitment to the staff bank and take up of shifts had improved since September, and the one stop recruitment events for Health Care Support Staff remained successful.	Assurance
65+ week waiters	• The Chief Operating Officer reported on the February position against the revised target to eliminate 65+ week waits by 31 March 2025.	Assurance

	• At the end of February there were 139 patients waiting longer than 65 weeks and this was forecast to increase to 161 in March, through expected tip-ins, with plans being put in place, and progress monitored weekly. • The most challenged specialities were MOHS and vascular. • Corneal grafts remained delayed due to the national availability of appropriate tissue. • The booking team were contacting all patients waiting between 48 and 51 weeks to validate the waiting list.	
Patient Experience Portal (NetCall)	• The Director of Informatics presented the position statement in respect of implementing the Patient Experience Portal across MWL. • This had been implemented at the Southport and Ormskirk Hospital sites with 18 specialities sending appointments via the portal, which had reduced Do Not Attend rates for some specialities. • Other communication options remained accessible for patients who were not digitally enabled. • At the Whiston, St Helens and Newton Hospital sites it had been found that the current booking systems were not compatible with NetCall, so implementation was linked to the outpatient reconfiguration project, to change the booking operational practices. • The benefits and optimisation of the Patient Experience Portal would continue at the sites where it could be operationalised, and these lessons would then be applied when the system could be implemented across the Trust.	Assurance
Disbanding the Transition and Transformation Council (TAT)	• The Director of Strategy presented the review of the TAT confirming that its original objectives had been delivered or been transferred to business-as-usual governance and concluding the council that had been established immediately after the transaction to deliver the post transaction implementation plan was no longer required as a separate part of the Trust governance structure. • Committee approved the recommendation to disband the TAT, which had previously been discussed at Board.	Approval
Proposal to establish the MWL strategy team and a Strategy	• The Director of Strategy presented proposals to formalise the Trust strategy team, the methodology for prioritisation of service	Approval

and Transformation Council	improvements to deliver the Trust objectives and strategic plans and governance arrangements. • The team would incorporate the Shaping Care Together programme team and bring together other existing teams. • A new governance council was proposed – The Strategy and Transformation Council, to report to the Executive Committee. • The Committee approved this proposal	
Financial Plan 2025/26 and Integrated Care Board (ICB) Key Lines of Enquiry (KLOE)	• The Director of Finance and Information briefed the Committee on the latest planning developments and guidance from NHS England and the ICB about the 2025/26 planning process. • The report included proposals for a three-year sustainability plan as well as the 2025/26 position. • There were also draft responses to the ICB financial assurance KLOEs which were reviewed by the Committee ahead of the submission deadline of 07 March 2025. • The latest financial plan to be presented for approval at the March Board meeting was discussed.	Assurance
Draft Trust Objectives 2025/26	• The Director of Corporate Services presented the draft Trust Objectives for 2025/26 for review. • Changes were agreed to the draft to be presented to the March Board for approval.	Approval
Staff Vaccination Programme 2024/25	• The Acting Director of HR reported that when the Covid-19 staff vaccination programme ended in January 2025, 37% of frontline staff and 50% of administrative staff had taken up the Trust's offer. • This was consistent with the uptake across the country and NHS England had commissioned work to better understand the drop off in vaccine take up by the whole population. • The flu vaccination campaign remained live until the end of March 2025 and the final uptake data would be reported at the end of the period.	Assurance
13 March 2025		
65+ Week Waiters	• The Chief Operating Officer presented the position with 161 65+ week waiters to be treated during March to hit the national target to eliminate long waits. • Committee discussed the challenges to treating all the patients during the month and the plans to deliver where patients wished to have their procedures in these timescales.	Assurance

Supporting patient discharge – To Take Out (TTO) drugs	• The Chief Operating Officer introduced a presentation by the Chief Pharmacist which detailed the process from prescribing by the doctor on the ward to dispensing. Most of the data was for the Whiston and St Helens Hospital sites as they had an Electronic Prescribing Medicines Administration (EPMA) system in place, whilst the Southport and Ormskirk Hospital sites still had paper processes. • The current performance was circa 90 minutes, which was the mean when benchmarked against other trusts. • Some areas of improvement would be to ensure TTO reached pharmacy before mid-day for same day discharges. The current average was before 14:00. There was also a lack of data about the time from dispensing to delivery to the ward or discharge lounge, and it was agreed this should be monitored. • It was agreed a task and finish group should be established with all functions involved in the TTO process to try and identify ways to reduce the turnaround times. • Additional metrics would be added to the Integrated Performance Report (IPR) so that performance could be monitored.	Assurance
Draft MWL People Strategy	• The Acting Director of HR introduced the draft People Strategy for review by the Committee. • Comments were also being sought from the Strategic People Committee before the Strategy would be presented for approval by the Trust Board.	Assurance
2024 Staff Survey results and draft 2025 action plan	• The Acting Director of HR presented the results of the 2024 staff survey and the proposed 2025 action plan. • The Committee endorsed the action plan for recommendation to the March Trust Board.	Assurance
Divisional Triumvirate and Operational Manager Development programmes	• The Acting Director of HR introduced proposals for two development programmes to support Divisional Triumvirate teams and the cohort of operational managers across MWL. • The programmes were a combination of team building and practical skills and would facilitate more cohesion across sites. • The proposals were approved, as the priority for existing training and development funding for 2025/26	Approval

Targeted Financial Review	• The Director of Finance and Information presented the report detailing the information submitted in response to the targeted financial review of the draft MWL financial plan for 2025/26 which had been commissioned by NHS England (North West).	Assurance
Freedom to Speak Up (FTSU) – annual self-assessment	• The Deputy CEO introduced the report which detailed the FTSU annual self-assessment against the National Guardian's Office standards to provide assurance that the Trust's FTSU processes align with best practice. • An area of development to ensure there was no detriment for staff who raised FTSU concerns was the focus of the 2025/26 FTSU action plan. • Committee approved the FTSU self-assessment and action plan for presentation to the Trust Board • The Committee also approved the FTSU policy and strategy document.	Approval
Advancing Quality Programme membership 2025/26	• The Medical Director presented the report detailing the benefits of continued membership of The Advancing Quality Alliance (AQuA) and Advancing Quality programme to support benchmarking key quality metrics. • The costs for membership had increased, but the internal expertise or systems did not currently exist to undertake these functions. • It was agreed to extend membership for 2025/26 and evaluate the cost effectiveness of alternatives.	Approval
Draft Health Inequalities Strategy	• The Director if Integration presented the updated draft Health Inequalities strategy that was due to be presented to the March Trust Board for approval.	Assurance
Risk Management Council (RMC) Assurance Report	• The Committee received the RMC's assurance report from the March meeting. • The new InPhase system went live on 03 March 2025 and risks were being transferred from the legacy Trust Datix systems with a target completion date of 31 April 2025. This meant that reporting for March would be delayed. • The RMC reports covered the risk register changes in February 2025. • The total number of risks on the combined MWL risk register was 1,068 (236 @ S&O legacy sites and 832 @ STHK legacy sites) • 20 risks had been escalated to the Corporate Risk Register (CRR) seven from S&O legacy sites and	Assurance

	13 from STHK legacy sites. One new CRR risk had been escalated and no CRR risks have been closed or de-escalated. The new CRR risk related to the end of life decontamination washers at Whiston Hospital. • The RMC received assurance reports from the Claims Governance Group, the Emergency Preparedness, Resilience and Response (EPRR) Operational Group and an update on the Quality Impact Assessment (QIA) completion rates for Cost Improvement Programme Schemes.	
20 March 2025		
The Executive Committee on the 20 March only considered core business – CEO above threshold agency/locum approvals and the vacancy control panel report, due to an Executive Team time out.		
27 March 2025		
Patient Experience and Inclusion Strategy	• The Acting Director of Nursing, Midwifery and Governance presented the updated draft of the MWL Patient Experience Strategy. • Committee noted that this had been discussed at Quality Committee and required formal approval by the Trust Board. • Further comments were made on the draft which the patient experience team agreed to action so the Strategy could be presented for formal approval to the Trust Board.	Assurance
Dietetic and Speech Therapy Weekend Cover Business Case	• The Acting Director of Nursing, Midwifery and Governance presented the business case to respond to the CQC report of Medicine at Southport Hospital. • The CQC report had included “should do” actions to expand provision of the dietetic and speech therapy services to seven days. • The preferred option was to fund four additional sessions two for dietetics and two for speech therapy, to enable one session on each day of the weekend, which the activity modelling demonstrated would be sufficient to meet the current weekend demand. This was an additional cost of circa £45k per annum and allowed for the development of a rota with the existing posts. • There were risks to delivery as both services currently had vacancies and these were hard to fill specialist posts. This was also being discussed with the specialist commissioners as a seven day service was part of the spinal injuries national	Approval

	specification but had not been funded for the Spinal Injuries Unit at Southport. • The business case preferred option was approved.	
65+ week waiters	• The weekly report showed 91 65+ week waiters remained to be treated by 31 March. • Some patients had been offered their surgery at another Trust site, but not all had accepted. • The year end position was likely to have some breaches, but the majority would be because of complex procedures and patient choice.	Assurance
Impact Review – Vacancy Control Process (VCP)	• The Acting Director of HR presented a review of the Vacancy Control Process introduced in October 2024. • There had been learning for the Trust since the introduction of the VCP and several improvements were proposed to streamline the process, clarify the requirements for supporting information and improve communications with recruiting managers (via the Divisions). • The Committee considered the revised draft Terms of Reference for the VCP Group and the revised Vacancy Control Process principles, which helped define what the Vacancy Control Process Group could approve. • The Committee recommended several changes to the draft documents.	Assurance
Trust Board Agenda - April	• The Director of Corporate Services presented the draft Trust Board agendas, based on the agreed annual workplan for review. • The Committee selected the April employee of the month from the nominations received during March 2025.	Assurance
Mandatory Training and Appraisal Compliance	• The Acting Director of HR presented the compliance reports for February. • Appraisal compliance was 85.1% • The 2025/26 appraisal window would launch on 01 May 2025. • Mandatory training compliance was 88% • Compulsory training compliance was 88.2%	Assurance
Alerts:		
None		
Decisions and Recommendations:		
Investment decisions taken by the Committee during March 2025 were: • AQuA membership for 2025/26		

- Approval of the business case to implement seven day dietetics and speech therapy cover at Southport Hospital.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 April 2025
Agenda Item	**TB25/031 (7.2)**		
Committee being reported	Audit Committee		
Date of Meeting	16 April 2025		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
External Audit Plan	Grant Thornton (GT) summarised the Audit Plan for 2024/25. GT outlined the usual checks around anticipated significant audit risks including management override of controls, improper revenue recognition and land and buildings valuation and the specific audit approach. GT also referred to materiality, Value for Money (VfM) audit, audit fees and logistics of the audit in addition to work that will focus on Lead Employer (LE).	Assurance
Internal Audit Report	MIAA summarised the Internal Audit Progress reports key messages section. Six reports have been finalised, four of which have received high assurance, two have received significant assurance. Four reports are currently in progress. MIAA summarised the Internal Audit Charter noting changes resulting from global internal audit standards and MIAA's ongoing compliance with Public Sector Internal Audit Standards. MIAA highlighted that changes were minimal.	Assurance
Internal Audit Plan	MIAA presented a proposed Internal Audit Plan for 2025/26, covering key risk areas and strategic risks that link into the Trust's Board Assurance Framework (BAF).	Assurance
Head of Internal Audit Opinion	MIAA presented the head of Internal Audit Opinion for 2024/25. The opinion helps to assist the Board in the completion of the Annual Governance Statement	Assurance

	(AGS), in addition to organisational performance, regulatory compliance and the wider operating environment. MIAA confirmed that they can provide an overall substantial assurance on the Trust's systems of internal control. MIAA summarised the approach taken to arrive at this opinion throughout the report. MIAA confirmed that there are no high level actions outstanding as at 31 March 2025.	
MWL Audit Log	Committee received the Audit Log report which highlighted key movements on the audit log, both in relation to internal and external audit recommendations.	Assurance
Anti-Fraud Annual Report	MIAA presented the Anti-Fraud Annual Report for 2024/25, which summarised the anti-fraud and investigations activity during the year by referring to specific pages in the report. MIAA referred to the Government Functional Standard for Counter Fraud, noting the Trust was green in all but one area – policies and registers for gifts and hospitality and Conflicts of Interest (COI).	Assurance
Anti-Fraud Annual Workplan	MIAA presented the Anti-Fraud Workplan for 2025/26, with a proposal to deliver 130 anti-fraud plan days at a cost of £47,970 (subject to uplift).	Assurance
Audit Committee Annual Effectiveness Review	The Annual Committee Effectiveness Review report was presented for the Audit Committee. It was noted that Committee documentation was of a generally high standard, with only minor areas identified for improvement.	Assurance
Trust Accounts Preparation	The Trust Accounts Preparation report was presented, which highlighted that there were no major changes to the Trust's accounting policies for 2024/25. The paper also identified key deadlines for submission of the Trust's annual accounts being 25 April (draft) and 30 June (final).	Assurance
Trust Common Seal 2024/25	The report documented the times the Trust's common seal was used in 2024/25 (18 occasions).	Assurance
Financial Reports	The Losses and Special Payments report was presented. Total losses identified as at 31 March 2025 were approximately £372k (compared to £409k for the same period in 2023/24). An additional presentation was received on pharmacy stocks which discussed wastage and losses during 2024/25.	Assurance

	The Aged Debt report was presented. Specific attention was paid towards the age and value of aged debt in the greater 90 day category, and what actions would be needed to help reduce these values down going forward. Future reports will look to separate out Trust debt from LE debt. The Tenders and Quotation Waivers report was presented and its contents noted.	

Alerts:
None
Decisions and Recommendation(s):
Items for escalation to the Board included the positive Internal Audit and Anti-Fraud reports and for Aged Debt to be updated through the Finance and Performance Committee.

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 April 2025
Agenda Item	**TB25/031 (7.3)**		
Committee being reported	Quality Committee		
Date of Meeting	22 April 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. • Additional training has been provided for ED staff regarding pressure ulcers. • There had been four falls with harm in month; these are currently under review. • National Early Warning Score (NEWS) targets had been achieved for inpatient areas, however, further work is required in the Emergency Department (ED). NEWS2 training will now be compulsory for all registered nurses (RN) in ED. • IT colleagues are working to migrate nutrition risk assessments to align with other risk assessment tools to improve compliance. • Methicillin-Resistant Staphylococcus Aureus (MRSA) year-end figures remain in line with previous reports, however, there has been an improvement in cannula related cases. • There had been an increase in the number of enquiries through Patient Advice and Liaison Services (PALS) and complaint activity in month, however, 60-day response compliance had increased to 65%. Improvement is expected to continue following successful recruitment.	Assurance

	• There had been a slight drop in the Friends and Family Test (FFT) for inpatients (pain management) and ED (waiting times). • Maternity - three Intensive Care admissions in month. These have all been reviewed; two were due to pregnancy related issues. • There had been a low harm Never Event related to a wrong site steroid injection. A Patient Safety Incident Investigation (PSII) had been commissioned and an Invasive Procedures working group has been established to review Never Events to identify any themes. • There had been an improvement in Venous Thromboembolism (VTE) compliance at the Whiston site, however, this remained below target. Following a successful pilot the VTE risk assessment tool will be rolled out across the Trust. • Hospital Standardised Mortality Ratio (HSMR) was reported at 91.2, Year to Date (YTD) =95.5. Summary Hospital-level Mortality Indicator (SHMI) for October 2024 was 1.03. • The Business Intelligence (BI) team are reviewing metrics for Sepsis to ensure the most accurate data is included in the CPR.	
Patient Experience Report (Inc. Chair's Assurance Report).	• Patient Experience audits for January and February had shown a slight decrease for inpatient areas. There has been some improvement in March and work is ongoing to encourage engagement with the audit programme. • There had been month-on-month improvement in the number of patients receiving the discharge booklet. • The Patient Experience and Inclusion Strategy had been presented to Executive Committee and will be launched during Patient Experience Week (week commencing 28 April).	Assurance

	• Legacy Friends and Family Test (FFT) platforms have now been merged and went live on 03 February. ED and Birth and Postnatal were above target for negative responses; themes were waiting times in ED and communication with partners following Caesarean Section (C-Section). • There are ongoing improvements within Dementia and Delirium. The Patient Experience Team continue to work with staff to identify training opportunities. • Local Healthwatch groups have awarded the Trust an average of 4 stars, positive comments related to patient care and treatment from staff. Negative comments related to communication and surroundings, particularly corridor care. • The number of volunteers in the Trust had increased from 377 to 639. • Southport Critical Care Unit (CCU) has been nominated for Placement of the Year for Nursing in Nursing Times. • MIAA audit of the 5 Star Accreditation programme reported a high level of assurance.	
Care Quality Commission (CQC) Update Quarterly Report.	• MWL retains its Outstanding rating. • The CQC Report for Southport ED has now been published. This was a narrative-only report, and the previous rating remains in place. CQC will return to carry out a full inspection within 12 months. • There will be a focussed Radiology inspection on 30 April 2025. • There will be a full inspection of St Helens Urgent Treatment Centre (UTC) on 08 May 2025. • The Executive Committee approved funding for a seven-day Dietetic Speech and Language service on the Southport site.	Assurance

	• Representatives from CQC had attended a Quality Ward Round (QWR) and expressed interest in continuing this, visiting other sites and specialties.	
Patient Safety Report (including Chair's Assurance Report)	• Report of patient safety incidents for February 2025. • There were two investigations in progress through the Patient Safety Incident Response Framework (PSIRF). • There had been no Maternity and Newborn Safety Investigations (MNSI) referrals during February. • Plans are in place to bring the pressure ulcer validation processes together across MWL. There will be extraordinary meetings to validate and close the open cases. • There had been a slight decrease in the number of falls in February, however, there had been one fall resulting in severe harm which occurred at Whiston Accident and Emergency (A&E) Department. • A falls comparison over the preceding two years had been undertaken which identified the overall number of falls had remained static, however, there had been a continued decrease in the number of severe harm/deaths as a result of falls whilst the number of moderate harm falls had increased. • There had been two open Patient Safety Incident Investigation (PSII) reviews in February, however, the team will be applying to external commissioners to deescalate one of these following the coroner's report which stated that the aortic injury was unlikely to have been caused by the pacemaker wire. • There is to be a project pilot to review patient drug allergies, particularly penicillin, to differentiate between true anaphylaxis and milder reactions that could be easily controlled.	Assurance

Never Events Presentation.	• The presentation provided an aggregated review of investigation outcomes for five Never Events reported since May 2024. • The review identified a lack of adherence to procedural guidance across all five cases. • Two of the cases reported a noisy environment had contributed to distractions. • Work demand had been a contributory factor in two cases. • Communication at safety huddles had been limited and the quality of discussions had been variable. • Actions to improve adherence to policies, staff training, consent processes, distractions in theatre, safety checks and documentation audits have been put in place. • A cross divisional Invasive Procedures Working Group has been established to review the Trust's position against National Safety Standards for Invasive Procedures (NatSSIPS 2) guidance and established workstreams for improvement. • An aggregated Patient Safety Investigation is being undertaken to identify learning from the individual events and support the workstreams. • Local processes have been reviewed in theatres to address immediate issues identified within the Never Event investigations; actions are being monitored through the Divisional Safety and Governance Groups and Theatre Improvement Group. • Local education for staff has been put in place through departmental training and wider learning shared through the Trust. • A review of on-call for orthopaedic services is being undertaken by the Clinical Director to ensure rest days following an on-call weekend.	Assurance

	• Presentation referred to Executive Committee for additional discussion.	
Any Other Business	• None discussed.	
Alerts:		
• None		
Decisions and Recommendation(s):		
The Board is recommended to note the report.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 April 2025
Agenda Item	**TB25/031 (7.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	23 April 2025		
Committee Chair	Carole Spencer, Non-Executive Director in the absence of Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	The Committee approved the minutes of the meeting held on the 19 March 2025.	Assurance
Action Log and Matters Arising	The outstanding actions had either been completed or were in progress.	Assurance
Workforce Dashboard	The Committee noted the following performance: • Mandatory Training - the Trust continued to exceed its mandatory target at 88% against a target of 85%. • Appraisals - the appraisal target was not met in March at 83.4% as we approached the new appraisal window for 2025/26 which opens on 01 May 2025 • Sickness - in-month sickness is above target, at 6.5% against the 5% target. This was a reduction from February (6.9%), but higher than the same month in 2023/24. Based on the benchmarking data available the Trust is reflective of absence levels across other acute organisations. The top three reasons for sickness in March continued to be stress, anxiety and depression, coughs, colds and flu and musculoskeletal (MSK). • Vacancies - the Trust continues to be below target for vacancies at 6.7% against the target of 8%. It was noted at the meeting that there was an error in the March report (February data) and that the vacancy rate for the Southport and Ormskirk hospital sites was 11.5%. • Time to hire (TTH) - has improved in March and has reduced from 64.7 days to 50.7 days. This is still above the Trust target of 40	Assurance

	days. This is a significant improvement from previous months where TTH had been impacted due to the new Occupational Health IT system implementation. Recovery plans had been put in place and the performance was recovering. It was noted that due to the enhanced scrutiny of workforce numbers there may be a further impact in our TTH position in the coming months • Turnover - in-month turnover was 0.9% against a target of 1.1% and 12-month rolling turnover was 11.3% against a target of 13.2%. • Occupational Health – the key performance indicators (KPI's) reported were from November and was suspended while the new Occupational Health IT system was implemented. Normal monthly reporting will resume from April.	
Sickness Absence Review	The Committee received the sickness absence review of 2024/2025 which including the analysis of trends and themes in comparison to the national and regional picture and provided assurance on the actions being taken. The following key points were highlighted to the Committee: • Sickness absence has increased during 2024/25 with the main reported reasons being stress, anxiety and depression, cough colds and flu and MSK. • Overall sickness has increased on average from 5.9 % in 2023/2024 to 6.2% in 2024/2025 • The sickness absence trends for the Trust were consistent with the national and regional position. • Most of the sickness absence was long term in nature, lasting on average 72.2 days • The staff groups with the highest levels of absence on average during 2024/25 were Additional Clinical Services (9.13%); Estates and Ancillary (8.13%); Nursing and Midwifery (6.58%) • Welcome back (Return to Work)	Assurance

	conversations being consistently undertaken had been shown to have the greatest impact on sickness absence levels, and increasing compliance in this area will be a key area of focus for 2025/26. • During 2024/25 the HR Department introduced a dedicated absence support team and further developments to the wellbeing hub to support staff and managers. • The Committee reviewed and supported the proposed improvement actions for 2025/26 and agreed that progress would be monitored via People Performance Council and assurance provided to the Committee via the Council Assurance reports.	
Trust People Plan and Trust Objectives 2024/25 Q4 Update and the People Plan 2022-25 Concluding Summary	The Committee noted the Q4 2024/25 summary of progress made against the Trust people plan and the 2024/25 Trust objectives led by the Director of HR. Significant progress has been made and at the end of Q4 20 out of 63 actions had been completed. The Committee noted that three actions remained incomplete including the harmonisation and standardisation of workforce policies. This would continue to be a priority in line with the HR Trust objectives for 2025/26 The Committee also noted the concluding summary of the 2022-2025 People Plan. There has been a significant amount achieved over the three years including the delivery of meaningful improvements in wellbeing, inclusive recruitment, leadership development, and workforce innovation. Challenges for 2025/26 were noted and progress against the 2025/2028 People Plan will form part of SPC workplan for the next 12 months.	Assurance
Lead Employer People Q4 Update 2024/25	The Committee noted the update on the year-end 2024/25 position for achievement of the Trust People Plan for Lead Employer. In total 14 of the planned actions had been completed and five were ongoing.	Assurance
Annual Workforce Operational Plan 2025/26	The Committee noted the submitted workforce plan for 2025/26 in line with national planning guidance. The committee was assured that the	Assurance

	workforce plan is underpinned by core principles: • Frontline care as a priority • The total workforce Whole Time Equivalent (WTE) plans for a total reduction of 4% driven by reduction in bank (-26.7%) and agency usage (-38.8%) which meets the national targets. • Reducing sickness absence • Reducing turnover • Delivery of the People Plan and national People Plan Priorities including being compassionate and inclusive, safe and healthy and working flexibly. In summary the plan outlines: • A reduction in total workforce WTE of 4% • A reduction in bank usage of 26.7% • A reduction in agency usage by 38.8% • A 1% reduction in substantive workforce The Committee were provided with a summary of the current opportunities identified to support the achievement of the plan but noted that the specific proposals to achieve the 1% reduction in substantive WTE were still in development. The Committee also noted challenges for achievement including the impact on staff wellbeing. The Committee also noted that the workforce plan may need to be updated to align to the final agreed financial plan for 2025/26.	
Staff Survey Action Plan	The Committee received the report analysing the staff survey 2024 results. Special Team Talks had taken place across the organisation and virtually, led by Chief Executive and Directors to discuss the results with staff and hear what is important for our workforce. Actions had been identified in response to the Staff Survey and these were also reflected in the 2025/26 Trust objectives. Actions included improving the lived experience of staff in relation to the People Promise Theme of “we are compassionate and inclusive”. Specific equality, diversity, and inclusion (EDI) actions had also	Assurance

	been identified to improve the experience of staff with a protected characteristic with specific focus on reasonable adjustments to support colleagues with disabilities and long term health conditions.	
Education experience Survey Action Plan (NETS/ GMC)	The Committee received a report on the Trust's Educational experiences survey results for students across all professions. This was the first time this information has been received by SPC and would be incorporated into the workplan going forward. The survey results showed stable trainee satisfaction with improvements in key areas like Obstetrics and Gynaecology and surgery. However, challenges remained in relation to workload, rota design, and wellbeing, particularly in acute medicine and advanced practice. The Committee was assured by the proposed actions, including improved rota planning, educator support, and a focus on learner experience. These are aligned with the NHS England Education Quality Framework to drive sustainable, high-quality training and workforce development.	Assurance
Assurance Reports from Subgroup(s)	The SPC noted the Assurance Reports from the People Performance Council, HR Commercial Services Council, Valuing Our People Council, and Employee Relations Oversight Group.	Assurance
Terms of Reference review for recommendation for approval by the Trust Board	Deferred pending the completion of the Annual Committee Effectiveness review	Assurance
Terms of Reference approval	Deferred pending the completion of the Annual Committee Effectiveness review.	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 April 2025
Agenda Item	**TB25/031 (7.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	24 April 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Director of Finance (DoF) Update	• At the time of meeting Cheshire and Merseyside (C&M) Integrated Care Board (ICB) do not have an approved financial plan and further correspondence is anticipated. • Several items remain outstanding relating to contracts, and these link to the Trust plan and represent significant risks to delivery. • Cash remains a priority and there is work ongoing across the system to identify ways to help mitigate issues, however this has not concluded. • Committee noted the recent correspondence received from the ICB regarding further expenditure instructions and noted the workstreams being set up by the new Chief System Improvement and Delivery Officer.	Assurance
Integrated Performance Report Month 12 2024/25	• Bed occupancy across MWL continued to be significantly higher than the target and in March averaged 105.8%. • Average length of stay for emergency admissions was high at 8.0 (9.3 at legacy S&O sites and 7.5 at legacy STHK sites, the impact of non-criteria to reside (NCTR) patients remained high in March, being 23.8% at organisational level (20.5% at legacy STHK sites and 29.6% legacy S&O sites). • 4-Hour performance remained at 74.3% in March, national performance was 75% and C&M 72.6%. Mapped performance was 79.1%. • 18 week referral to treatment (RTT) performance in February for MWL was 64.6% (legacy S&O sites 65.5% and legacy STHK	Assurance

	sites 64.2%). National Performance (latest month February) was 59.2% and C&M performance was 57.3% • The Trust had 1,910 52 +week waiters at the end of February, 88 65 +week waiters and 2 8 week +waiters. Majority of breaches were as a result of patient choice. • Diagnostic performance for March was below target at 93.1% (legacy S&O sites 97.3% and legacy STHK sites 91.2%.). Cancer performance in February increased to 77.8% for the 28-day standard and increased to 82.4% for the 62 day standard.	
Finance Report Month 12 2024/25	• The Committee received draft figures for Month 12 as the Trust was in the process of preparing the draft Annual Accounts for submission on 25 April. • The Trust was reporting a draft adjusted deficit of £9.3m which is £1.6m better than the revised plan due to recognition of additional income. • An update was given on a technical adjustment that is being re-instated on Public Finance Initiative (PFI) organisations that ceased in 2014/15. This will have an impact on the adjusted financial position. • The Trust's combined 2024/25 Cost Improvement Programme (CIP) target was £48m of which £11.8m was non-recurrent. These targets had been fully met. • The Trust position includes £10m of non-recurrent resources which will be unavailable in future years. • 2024/25 agency spend is expected to be c£22m. Premium Payment Scrutiny Council reviews and address drivers of agency costs as reports to the executive committee. • The Trust had a closing cash balance of £10.2m. • The capital expenditure for the year totalled £45.3m which included PFI Lifecycle and IFRS16 Lease Remeasurement.	Assurance
Month 12 2024/25 CIP Programme Update Clinical Support Services & Community Division (CSS&C) CIP update	• Targets for 2024/25 was £48m in year and £36.2m recurrently. • At month 12 this plan had been achieved, £48m in year and £36.2m recurrently. • Schemes identified in 2024/25 but not delivered in year have been rolled forward as	Assurance

	part of the CIP programme to support delivery of 2025/26 plans. • CSS&C Division CIP update provided including overview of governance process to provide assurance.	
Urgent and Emergency Care (UEC) Performance Delivery Review	• Update received on C&M wide UEC Improvement plans including integrated discharge team, single point of access, review of the Urgent Treatment Centre (UTC) model, mental health within UEC, local plans to reduce NCTR and ambulance handover delays. • Current in hospital workstreams include projects around same day emergency care, ambulance handovers and inpatient length of stay. • Focus to be added around direct admissions/Emergency Department (ED) avoidance and reduction of corridor care and reduced unnecessary delays for non-admitted patients. • Further work to be undertaken regarding system approach and quantification of the planned improvements across the whole patient pathway, in and out of hospital.	Assurance
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):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**MWL Trust Board**		**Date**	30 April 2025
Agenda Item	**TB25/032**			
Report Title	Clinical Strategy Annual Update			
Executive Lead	Dr Peter Williams, Medical Director			
Presenting Officer	Dr Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

The purpose of this report is to inform the Board on the progress which has been made to deliver the clinical strategy since its publication

Executive Summary

The MWL Clinical Strategy was published in August 2024 and set out the clinical priorities for the organisation following the creation of the new Trust.

The Clinical Objectives outlined in the strategy were based around the local and national healthcare system challenges and the priorities for delivery of care. They reflected the strategic direction for the Trust to standardise pathways and to improve quality, safety and accessibility for those using our services.

This report details the clinical objectives, and the progress made against their delivery, along with examples of how the underlying principles have been followed.

Financial Implications

None

Quality and/or Equality Impact

None

Recommendations

The Board is asked to note the Clinical Strategy Annual Update

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**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
X	**SO9** Strategic Plans

1. Background

The MWL Clinical Strategy was published in August 2024 and set out the clinical priorities for the organisation following the creation of the new Trust. The purpose of the strategy was to guide the development of clinical services over the initial post-transaction period, allowing time for engagement with both our medical workforce and local healthcare system.

The Clinical Objectives outlined in the strategy were based around the local and national healthcare system challenges and the priorities for delivery of care. They reflected the strategic direction for the Trust and the patient centred care delivered by clinical staff, in order to improve quality and safety for those using our services. The Clinical Objectives are underpinned by priorities which describe how the objectives will be achieved while maintaining quality and safety services for patients.

The purpose of this report is to inform the Board on the progress which has been made to deliver the clinical strategy since its publication.

2. Clinical Principles and Objectives

The clinical objectives are priorities for clinical services to deliver in the next two years and are detailed below. The objectives were developed to align with the national, regional and local priorities alongside the Trust vision to provide 5 Star Patient Care.

Objective	Status – Year 1	Actions for next 12 months
Ensure clinical governance structures are in place to continue to deliver safe and effective clinical care across the Trust	Achieved Trust-wide divisional leadership structure in place Trust-wide patient safety structure in place	Trust-wide Assistant Medical Director for Patient Safety to be appointed (June 2025) Trust-wide Clinical Directors to be appointed (June 2025)
Review and align pathways to enable integration of clinical services across the Trust	Partially achieved Trust-wide clinical pathways have been approved in several key areas including Resuscitation and Advanced Care Planning.	Trust-wide Clinical Directors to be appointed (June 2025) New policies approved by councils will apply to the whole Trust to enable integration of services (Ongoing)
Complete the stabilisation of fragile clinical services and address any inequalities, delivering high quality and effective care across to patients who use any of our hospitals	Partially achieved Appointments have been made to fragile services including Medicine for Older People and Ophthalmology. Work ongoing with LiVES to identify service specification for Vascular services at Southport Hospital	Work with system to provide solution to ENT workforce and service delivery problems across C&M (May 2025 and ongoing) Provide on-call services for Ophthalmology within MWL, reducing need to rely on SLA (September 2025)

Objective	Achieved?	Actions for next 12 months
Achieve national, regional and local NHS priorities to: • Improve Emergency Department waiting and ambulance turnaround times • Reduce waiting times for elective treatments and diagnostic tests • Reduce the time to diagnose or exclude cancer in patients who are referred to hospital	Partially achieved ED 4h performance – 78.1% (Target 78%) 30 min Ambulance handover – 48.1% (95%) 18 week RTT – 64.6% (95%) 88 patients > 65 week wait 6 week diagnostic target – 93.1% (95%) Cancer FDS 74% (77%) Cancer 62 Day standard 79.2% (85%)	Work alongside system partners to deliver improvements in NCTR to reduce ED crowding and improve ambulance handover to national standard (Ongoing) Continue work with GIRFT and Productive Partners to optimise theatre utilisation to improve RTT (Ongoing) Outpatient services review to improve efficiency and reduce wait (Ongoing) Appointment of new Trust Caner Lead (June 2025)

The Trust Clinical Objectives are underpinned by the clinical principles which ensure that the priorities are delivered in the best way for patients and staff. Listed below are examples of how the principles have been followed in the delivery of the clinical objectives since the publication of the Clinical Strategy.

Principle	Example
Best Practice, Policy, and Guidance	
Services will operate to a common set of clinical standards, quality metrics, policies and guidelines across the new Trust, wherever they are delivered	Divisional Finance and Performance meetings to ensures that services are measured against common set of metrics and standards
Good practice will be shared to ensure that services achieve the best of what is currently delivered by the two Trusts and comply with standards set by national professional bodies	Single audit and quality meetings in some specialities (eg. Urology) to ensure sharing of best practice
Closed services will re-open to referrals and enhance the care delivered to the population of Sefton and West Lancashire where this is clinically and financially viable	Ophthalmology service at Southport reopened to referrals for cataract surgery
Utilisation of estate and clinical facilities will be optimised across the four main hospital sites	Use of existing theatres and clinical areas at Southport Hospital to allow additional plastic surgery theatre sessions to take place in order to optimise theatre utilisation and reduce waits.

Principle	Example
Improvement practice will be embedded in each clinical service and developments will be supported where these will enhance the health of the local population	Improvement Team to become part of transformation team in order to work with divisions to embed NHS IMPACT best practice for service improvement
Service Delivery and Workforce	
Clinical services will continue to be delivered as close to patients as possible	Ophthalmology service at Southport reopened to referrals for cataract surgery
System and National Responsibilities	
Report performance and outcome measures as a single organisation	Single IPR, National Joint Registry and Advancing Quality reporting
Provide timely and accurate information about activity, performance and outcomes to allow clinical teams to continuously improve.	Divisional Finance and Performance meetings ensure that services are using performance and outcomes to continue to improve.
Clinical Leadership, Education and Research	
Clinical Leadership will feature prominently in the workforce strategy as we develop a clinical leadership programme for new and aspirant clinical leaders	Trust-wide Clinical Leadership Team Meetings taking place with Clinical Leaders from across the Trust to ensure consistent information sharing and support Development programme attended by Clinical Leaders from across the Trust to ensure everyone has an opportunity to access training and build a peer network
Clear, visible and easily accessible reporting and escalation structures will be embedded across the new Trust with an integrated, compassionate approach to leadership	Divisional Medical Directors in place across the Trust's four divisions with Deputy Divisional Medical Director appointments imminent.
We will continue to develop undergraduate and postgraduate education services, with closer links between the Trust and our partner Educational Institutions ensuring that every clinical service is able to maximise the educational offer for all healthcare learners	Education Teams working together closely with consultant based at Whiston working as Foundation Programme Director for Southport. Edge Hill University approved as a Medical School in part due to support from MWL
The Trust will continue to expand its portfolio of research studies and will work with University colleagues to develop relationships which will enable increased collaboration between the Trust and partner academic institutions.	Research, Development and Innovation Team working collaboratively across the Trust to maximise research opportunities. More patients have been recruited to research trials than the previous total for the individual Trusts combined.

The medical leadership team will continue to deliver the clinical strategy alongside the annual Trust objectives following the clinical principles within the strategy document.

3. Next Steps

Work will commence later this year on the new Clinical Strategy, which will be developed in partnership with the Divisional Teams, Director of Strategy, patients and partner organisations. The new clinical strategy will align with the overarching Trust strategy along with other organisational strategies including IT, workforce and nursing. The new clinical strategy will be brought to the Board for approval prior to its publication.

ENDS

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Title of Meeting	**Trust Board**		**Date**	30 April 2025
Agenda Item	**TB25/033**			
Report Title	Board Assurance Framework (April 2025)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

For the Board to review and agree updates to the MWL Board Assurance Framework (BAF).

Executive Summary

The MWL BAF is reviewed four times a year, the last review was in January 2025, and this review captures the changes that have occurred during Q4 (2024/25).

The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to the delivery of its statutory duties, strategic plans and long term objectives.

Each BAF risk is assigned a lead Executive, who is responsible for ensuring the risk is updated at each quarterly review.

The Executive Committee then review the proposed changes to the BAF in advance of its presentation to the Trust Board and proposes changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite.

Key to proposed changes (appendix 1):
~~Score through~~ = proposed deletions/completed
Blue Text = proposed additions
Red = overdue actions

Proposed changes to risk scores.

No changes have been proposed to the BAF risk scores this quarter.

Financial Implications

None directly because of this report.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board asked to approve the changes to the Board Assurance Framework.

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

Board Assurance Framework Quarterly Review – Q4 2024/25

BOARD ASSURANCE FRAMEWORK 2024-25									
BAF Dashboard 2024-25 – Quarter 4 Review									
BAF	**Risk Description**	**Exec Lead**	**Risk Score**						
			Inherent	**July 24**	**Oct 24**	**Jan 25**	**April 25**	**Target**
1	Systemic failures in the quality of care	Medical Director/ Director of Nursing	**20**	**20** ↔	**20** ↔	**20** ↔	**20** ↔	**5**
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Director of Finance and Information	**20**	**20** ↔	**20** ↔	**20** ↔	**20** ↔	**10**
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	**16**	**16** ↔	**20** ↑	**20** ↔	**20** ↔	**12**
4	Failure to maintain patient, partner and stakeholder confidence in the Trust	Deputy CEO	**16**	**12** ↔	**12** ↔	**12** ↔	**12** ↔	**8**
5	Failure to work in partnership with stakeholders	Director of Human Resources/Deputy CEO	**16**	**12** ↔	**12** ↔	**12** ↔	**12** ↔	**8**
6	Failure to attract and retain staff with the skills required to deliver high quality services	Director of Human Resources	**20**	**15** ↔	**15** ↔	**15** ↔	**15** ↔	**10**
7	Major and sustained failure of essential assets and infrastructure	Director of Corporate Services	**16**	**12** ↔	**12** ↔	**12** ↔	**12** ↔	**8**
8	Major and sustained failure of essential IT systems	Director of Informatics	**20**	**16** ↔	**16** ↔	**20** ↑	**20** ↔	**8**

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

Mission: To provide high quality health services and an excellent patient experience

BAF Ref	Long term Strategic Risks	Strategic Aims					
		We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
1	Systemic failures in the quality of care	✓		✓	✓	✓	✓
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	✓		✓		✓	✓
3	Sustained failure to maintain operational performance/deliver contracts	✓	✓		✓	✓	✓
4	~~Failure to protect the reputation of the Trust~~ Failure to maintain patient, partner and stakeholder confidence in the Trust			✓			✓
5	Failure to work in partnership with stakeholders	✓	✓	✓	✓		✓
6	Failure to attract and retain staff with the skills required to deliver high quality services	✓				✓	✓
7	Major and sustained failure of essential assets, infrastructure	✓	✓	✓			✓
8	Major and sustained failure of essential IT systems	✓	✓	✓			✓

Risk Scoring Matrix

Impact Score	Likelihood /probability				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible (very low)	1	2	3	4	5

Likelihood – Descriptor and definition
Almost certain - More likely to occur than not, possibly daily (>50%)
Likely - Likely to occur (21-50%)
Possible - Reasonable chance of occurring, perhaps monthly (6-20%)
Unlikely - Unlikely to occur, may occur annually (1-5%)
Rare - Will only occur in exceptional circumstances, perhaps not for years (<1%)
Impact - Descriptor and definition
Catastrophic – Serious trust wide failure possibly resulting in patient deaths / Loss of registration status/ External enquiry/ Reputation of the organisation seriously damaged- National media / Actual disruption to service delivery/ Removal of Board
Major – Significant negative change in Trust performance / Significant deterioration in financial position/ Serious reputation concerns / Potential disruption to service delivery/Conditional changes to registration status/ may be trust wide or restricted to one service
Moderate – Moderate change in Trust performance/ financial standing affected/ reputational damage likely to cause on-going concern/potential change in registration status
Minor – Small or short term performance issue/ no effect of registration status/ no persistent media interest/ transient and or slight reputational concern/little financial impact.
Negligible (very low) – No impact on Trust performance/ No financial impact/ No patient harm/ little or no media interest/ No lasting reputational damage.

Key to proposed changes:

~~**Score through**~~ **= proposed deletions/completed**

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Medical Director/Director of Nursing

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	1	5	5

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets. • Failure to deliver CQUIN element of contracts, if required • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care. • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness, or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints. • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Midwifery Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • Maternity Incentive Scheme. • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family scores • Quality Ward Rounds • Ward accreditation programme • Patient survey action plans **LEVEL 2** Board Assurance • IPR/CPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing & Midwifery Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework **LEVEL 3** Independent Assurance • National clinical audits • Annual CQUIN Delivery (if required) • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • Maternity Incentive Scheme/Saving Babies Lives	Embedded divisional performance management/governance systems. Complete implementation of post transaction corporate nursing and medical management structures. Completion of Quality Impact Assessment and Board Assurance Checklist for the system led financial savings schemes for 2025/26 Close regulatory breaches identified in the CQC UEC Reports (December 2025)	Routinely achieve 30% of discharges by midday 7 days a week to improve patient flow. Single set of key clinical and quality policies for MWL (March 2026) ~~Fully integrated MWL quality governance structure (revised to March 2025)~~ Recovery actions post ED/UEC critical incident with internal and external stakeholders (June 2025). ~~MIS assurance and Board approval (February 2025)~~ ~~Recruitment of Deputy Divisional Director of Nursing (Children's Services)~~ Agree corporate nursing and quality governance structures (Revised to April 2025) Finalise N&M strategy on appointment of DON (July 2025)	Achieve new complaints response time of 60 days (Revised to September 2025) ~~Achieve quality improvement objectives for 2024/25 (March 2025).~~ Achieve 2025/26 agreed quality improvement Trust Objectives (March 2026) ~~Implement the new incident and risk reporting system for MWL following approval of the new system (February 2025)~~ Implement outstanding actions from the Maternity, ED and SII CQC inspections (June 2025) Delivery of the GMC trainee survey results action plan (September 2025) Review of medical bed base and non-elective pathways following clinical summit (December 2025) Review of MWL ward accreditation programme (August 2025) Review the role of the Maternity and Neonatal Safety Champions (September 2025) ~~Review CPR/IPR Quality Indicators for 2025/6 (March 2025)~~ Optimise use of and reporting capability of the MWL InPhase Incident and Risk management system (June 2025)

BAF 2 Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Exec Lead: Director of Finance

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty. • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders. • Failure to deliver strategic financial plans. • Failure to control costs or deliver CIP. • Failure to implement transformational change at sufficient pace. • Failure to continue to secure national PFI support. • Failure to respond to commissioner requirements. • Failure to respond to emerging market conditions. • Failure to secure sufficient capital to support additional equipment/bed capacity. • Failure to obtain sufficient cash balances. • Failure to obtain on going transaction support. • Failure to deliver financial plans. **Effect:** • Failure to meet statutory duties. • NHSE/I Single Oversight Framework rating. **Impact:** • Unable to deliver viable services. • Loss of market share External intervention	• Clinical Strategy • Nursing and Midwifery Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • Maternity Incentive Scheme. • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Monthly CBU Finance and Performance Meetings • CIP Council Meetings • Agency and locum spend approvals and reporting process. • Operational planning • Premium Payment Scrutiny Council • Vacancy control panel **LEVEL 2** Board Assurance • Finance and Performance Committee and reporting Councils • Annual Financial Plan • Audit Committee • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT, corporate benchmarking, ERIC) • Internal Audit Programme • CQUIN Monitoring **LEVEL 3** Independent Assurance • ICB & NHSE monthly reporting and review meetings • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit reports including VfM Assessment • Head of Internal Audit Opinion • NHSE scrutiny of cash applications	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, considering current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites.	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances. At the earliest opportunity move back to longer term financial planning with rolling plans for 3 – 5 years. ~~Delivery of the 2024/25 financial recovery actions to reduce run rate (revised to March 2025)~~	~~Deliver the agreed 2024/25 financial and activity plans, including CIP targets, reduction in bank and agency spend and delivery of minimum national activity targets (March 2025)~~ ~~Deliver the agreed 2024/25 capital programme (March 2025).~~ ~~Compliance with ICB/NHSE enhanced financial monitoring requirements for the 2024/25 financial outturn.~~ ~~Develop 2025/26 financial, activity and performance plans (March 2025)~~ Deliver the agreed 2025/26 operational and financial plans, including the CIP target (March 2026) Deliver the 2025/26 Capital Programme (March 2026)

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	5	4	20	3	4	12

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Failure of external parties to deliver required social care capacity **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Patients treated in ED or escalation beds. **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Negative impact on patient outcomes and experience	• NHS Constitutional Standards • Divisional activity profiles and work plans • System Winter Plan • Divisional Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Tumour specific cancer waiting time recovery plans • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events • Bed occupancy rates • Number of super stranded /patients who no longer meet the criteria to reside	**LEVEL 1** Operational Assurance • Winter resilience plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans • Weekly performance review meetings • Monthly Executive Committee Divisional Performance Reviews **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance monthly oversight meetings	Implementation of routine capacity and demand modelling A defined preferred option and capital secured for Shaping Care Together programme. Implementation of CDC at Southport and Ormskirk sites. ~~Complete step down/recovery and reset following the UEC critical incident at Whiston Hospital (March 2025).~~ Undertake lessons learnt review – internal and system wide, following the UEC critical incident, to be presented at Executive Committee and system wide workshop in May 2025.	Assurance that there is sufficient system response to operational pressures and reducing the number of patients who no longer meet the criteria to reside. ~~Progress against 2024/25 waiting list reduction and recovery targets.~~ UEC/ED – GIRFT and ECIST support continues (Revised to June 2025) Continue to deliver Productive Partners recommendations to improve elective activity productivity and maximise capacity (Revised to June 2025)	~~Deliver the agreed 2024/25 activity and access time performance improvements (April 2025)~~ ~~Implement cancer performance improvement plans across MWL (April 2025)~~ ~~Continue to work to support the MWL UEC Improvement Programme and ensure trajectories agreed for each of the three workstreams so all parties can be held to account for the improvement needed for winter 2024/25 (March 2025)~~ ~~Actions plan to achieve 2024/25 RTT reduction targets across all specialties (March 2025)~~ Deliver the internal transition and transformation programme to address fragile services by service integration and alignment across MWL (July 2025) Deliver the 2025/26 elective recovery, and ED, diagnostic and cancer waiting time targets set out the national planning guidance (March 2026)

BAF 4 Failure to maintain patient, partner and stakeholder confidence in the Trust — Exec Lead: Deputy CEO

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff. • Increased external scrutiny/review. **Impact:** • Reduced financial viability and sustainability. • Reduced service safety and sustainability • Reduced operational performance. • Increased intervention	• Communication, Media and Public Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR/FOI • Board media roundups and flash briefings • Work with ICB and NHSE communications teams	**LEVEL 1** Operational Assurance • Winter plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • Daily/weekly media briefings and board flash reports for urgent issues **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways • Provider representative at Place quarterly ICB performance meetings		Creation of good working relationships with new Healthwatch/PBP areas post transaction. ~~SCT pre-consultation engagement report and Pre-Consultation Business Case being reviewed by SCT Board and ICBs in January 2025~~ Complete the stage 2 NHSE assurance process for the SCT Pre-Consultation Business Case (PCBC) and plan for period of public consultation May – August 2025 (September 2025)	Develop the MWL Communications, Media, and Public Engagement strategy for approval by the Trust Board (revised to October 2025) ~~Monthly media activity reports to Executive Committee (draft report developed and first report for Q3 activity – January 2025)~~ ~~Issue 1 of the MWL stakeholder newsletter to be published by the end of January 2025.~~

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Deputy CEO/Chief Operating Officer

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media. • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. **Effect:** • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff. **Impact:** • Unable to reach agreement on collaborations to secure sustainable services. • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff. • Failure to win new contracts. Increase in complaints and claims	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • Place Director Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board • Involvement in Halton and Knowsley PBP development • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • MWL Hospitals Charity annual objectives • Regular meetings with local MPs, OSCs etc. • Equality impact assessments • Anchor institution development plan	**LEVEL 1** Operational Assurance • LUHFT Partnership Board • North Mersey Ophthalmology Steering Group • Shaping Care Together Programme • Membership of CMAST • Capital Assurance Group • ED&I Steering Group • Monitoring of NHS Choices comments and ratings • Review of digital media trends • Healthwatch feedback **LEVEL 2** Board Assurance • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • Quality Account • Annual staff engagement events programme **LEVEL 3** Independent Assurance • NHSE review meetings • Participation in C&M ICB leadership and programme Boards • Collaborative working with Place Directors to develop plans for PBPs • Membership of St Helens People Board • OSC attendance/presentations	Health inequalities improvement objectives to be agreed with each Place and the ICBs	**C**&M Integrated Care System performance and accountability framework ratings and reports Develop and maintain good working relationships with each Place Partnership, ICB and Primary Care Network Maintain effective working with Place leads to take forward the UEC improvement programme workstreams and reduce the % of NCTR patients in acute beds.	~~Re start the Shaping Care Together Programme to develop a new PCBC for the configuration of services between the Southport and Ormskirk Hospital sites (revised to January 2025)~~ Continue to work with the SCT programme and other system partners to reduce the number of legacy S&O Trust fragile services (On-going)

BAF 6 Failure to attract and retain staff with the skills required to deliver high quality services — Exec Lead: Director of HR

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	5	15	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation Loss of market share	• Trust brief live • MWL News • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Workforce & Development Operational Plan • Learning and Organisational Development Operational Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Operational plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • Trust Values • Medical Workforce OD plan • Talent Management action plan • Equality, Diversity, and Inclusion Operational plan	**LEVEL 1** Operational Assurance • Premium Payments Scrutiny Council • Monitoring of bank, agency and locum spend • Workforce operational plans • Vacancy control panel **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council and HR Commercial Services Council • Finance and Performance Committee • Committee Performance Report • Staff Survey • Monthly monitoring of vacancy rates Labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report	Improve ease with which staff can move roles internally (March 2025). Review of education structure across MWL and complete Integration (revised to April 2025) Monthly Provider Workforce Returns (PWR) Development of a workforce information dashboard to support divisional oversight of key workforce metrics (Revised to June 2025) ~~Optimise utilisation of the apprenticeship levy to attract and retain staff (March 2025)~~ ~~Delivery of the NHS EDI Improvement Plan high impact actions (March 2025)~~ Achieve bronze level North West Anti-Racism Framework (revised to September 2025) Delivery of the Sexual Safety charter action plans and policy (Revised to September 2025)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (On-going) ~~C&M Endoscopy bank pilot completed, operating as BAU until 31st March 2025. The long-term requirements for the bank to be reviewed in February 2025.~~ ~~Achieve 2023/24 targets for international medical recruitment and Nurse Associate expansion (March 2025)~~ Approval of the MWL People Plan 2025 – 2028 (April 2025)	Continue to provide the necessary support for organisational change to implement the remaining management structure for the MWL integrated operating model (continues into 2025/26) ~~Achieve the mandatory and compulsory training target of 85% (April 2025)~~ ~~Achieve 85% compliance with staff appraisals (April 2025)~~ ~~Delivery the 2023 staff survey action plan (March 2025)~~ Delivery of the 2024 staff survey action plan and engagement events (March 2026) ~~Deliver the HR Operational plans for 2024/25 (March 2025)~~ Continue Healthcare Support Worker quarterly recruitment events for each hospital site for substantive and bank staff (on-going) Complete single temporary workforce resourcing solution for MWL (July 2025) Deliver the agreed 2025/26 workforce plans to support the operational and financial targets set out in the National Planning Guidance (March 2026) Deliver the agreed Trust EDI priority developments 2025-2028 (March 2029)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • S&O safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data **LEVEL 3** Independent Assurance • Authorising Engineer Appointments • Authorising Engineer Audits • Condition surveys • Premises Assurance Model (PAM) benchmarking • Model Hospital • PLACE Audit Results and benchmarking • Building Safety Act	Maintain up to date 10-year strategic estates development plans for MWL n to support the Trusts service development and integration strategies. Development of an Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	Develop the final business case to fully implement National Standards of Cleaning across MWL (re based budgets to be agreed for 2025/26) Implementation of the national Hospital Food Review recommendations and mandatory standards (Gap analysis being undertaken) Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 and draft legislation not yet published.	~~Deliver the S&O sites backlog maintenance programme for 2024/25.~~ ~~Deliver the MWL capital works plans for 2024/25.~~ Deliver the agreed capital programme for 2025/26 (March 2026) Deliver the agreed backlog maintenance reduction programme for 2025/26 (March 2026) Deliver the PFI lifecycle programme for 2025/26 agreed with NewHospitals (March 2025/26)

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	5	4	20	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register • Service improvement plans • MWL Digital Strategy 2024-2027 • Microsoft Defender for Endpoints • MFA protection for confidential data – enforced on non-Trust devices • Annual DSPT self-assessments	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Information security dashboard • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring • Monthly cyber security operational meeting **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • IM&T Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Groups • Information Governance Steering Group • Quarterly Board Cyber Security Reports **LEVEL 3** Independent Assurance • Internal/External Audits • CareCert, Cyber Essentials, External Penetration Testing • Cyber Essentials Plus accreditation - MMDA. • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments	Annual IT Corporate Governance Structure review Technical Development of staff Mitigation plans to be agreed with current EPR supplier (revised to April 2025) Approval of EPR procurement and implementation timetable to deliver a single EPR for the Trust.	~~Compliance with ISO27001 – with gap analysis being in progress (March 2025)~~ IT communications strategy Digital Maturity assessment Cyber Essential Certification/Accreditation (revised to March 2026) Migration from end-of-life operating system at S&O sites	Achieve HIMMS Level 5 2018 standards and core digital capabilities and WGLL standards (revised to September 2028 due to impact of extended EPR replacement programme) Windows Server 2008 and 2012 Servers are gradually being retired and will be fully replaced (Revised to May 2025). Delivery of the Frontline Digitisation Programme to optimise Careflow EPR and implement new functionality to meet the core digital capability standards (full implementation will only be delivered when the new single EPR is in place) Review of Digital Maturity Benefits that can be delivered within existing system capability Plan to be finalised (June 2025). Delivery of Community EPR (revised to March 2026 – system issues now resolved but needs programmed IT capacity) ~~Deliver the 2024/25 IT capital expenditure plan (March 2025)~~ Cyber Essentials Plus for MWL - cannot be fully achieved until the end-of-life operating systems are removed from the network (March 2026) Implementation of Maternity Information System (revised to March 2026) Implement EPMA at the Southport and Ormskirk Hospital sites (October 2025) Deliver the 2025/26 IT Capital expenditure plan

Title of Meeting	**MWL Trust Board**		**Date**	30 April 2025
Agenda Item	**TB25/034**			
Report Title	Learning from Deaths Q2 2024/2025			
Executive Lead	Dr Peter Williams, Medical Director			
Presenting Officer	Dr Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

To describe mortality reviews which have taken place throughout the Trust; to provide assurance that deaths occurring in hospital undergo a robust review to identify lessons which can be learned to prevent similar incidents occurring again.

Executive Summary

The following mortality case reviews have taken place across the Trust for deaths occurring in Q2 2024/25:

At Whiston and St Helens Hospitals:

Total Number of Deaths Q2	412
Total cases with Structured Judgement Review (SJR) Q2	45
Total outstanding review Q2	27
Total Red SJRs Q2	0
Total Amber SJRs Q2	0

At Southport and Ormskirk Hospitals

Total Number of Case Record Review (CRR)	Q2192
Total Red CRR Q2	0
Total Amber CRR Q2	3

All cases rated as Amber or Red will undergo more detailed review at their respective Mortality Groups with learning and additional actions fed back to the respective Divisions and across the Trust

Financial Implications

None

Quality and/or Equality Impact

Learning from deaths seeks to promote continuous learning in order to foster a culture that leads to ongoing improvement of care, pathways and services.

Recommendations

The Trust Board is asked to note the Learning from Deaths Q2 2024/25 report.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**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
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

"*Learning from deaths of people in our care can help us improve the quality of the care we provide to patients and their families and identify where we could do more*"

NHSI 2017.

1. Outcome from reviews undertaken

Whiston and St Helens Hospitals - Reviews carried out Q2 July 2024 – September 2024

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
45 *(27)*	13	1	4	0	0

DATIX	Summary	SJR Rating	Comments
205183	77 year old female, cardiac arrest death. Myocardial infarction, Ischaemic heart disease, Basal ganglia infarct, heart failure, T2DM	AMBER	Discussed at December Mortality meeting – has been escalated to the Patient Safety Team for PSIR – learning will come back to our group on completion of the investigation for review of grading and any learning.
205184	79 year old male, concern death. Referred to coroner	AMBER	Discussed at December Mortality meeting – has been escalated to the Patient Safety Team for PSIR – learning will come back to our group on completion of the investigation for review of grading and any learning.

Southport and Ormskirk Hospitals - Reviews carried out Q2 2024/2025

No. of reviews	Green	Green with learning	Green with positive feedback from the bereaved	Amber	Red
SJR *12*	9	2	0	1	0
Medical Examiner Reviews *180*	142	9	24	2	0

DOD	Ward	Summary	CRR Rating	Comments
22/10/23	9b	86y. Admitted with spontaneous bruising and bleeding. Patient developed abdominal pain, deteriorated and felt not fit for further intervention.	AMBER	Initial delay in Medical plan being put in place. Patient was not reviewed by a haematologist face to face during stay but advice provided over phone Feedback given to Haematology Team to ensure that face to face haematology review occurs if delay to transfer.
2/8/24	14b	98y. Discharged following MI. Referred back by GP with chest infection.	AMBER	Family raised concerns regarding discharge. Patient Safety Learning Review (PSLR) ongoing to identify any potential learning regarding discharge planning and safety netting.
20/4/24	A&E	89y Admitted with abdominal pain & vomiting. Surgical review delayed due to other cases requiring attention. Surgical Consultant reviewed and felt they were	AMBER	Coroners' post-mortem performed. Cause of death: 1a Ischaemic bowel. Coroner's investigation discontinued. Conclusion: Natural causes Medical and Critical Care team involved in patient's care but DATIX

		not suitable for any intervention. End of Life Care given.		raised following difficulty in obtaining surgical opinion. PSLR ongoing.
7/9/24	14b	85y on chemotherapy presented with chest pain and treated for CAP Ceilings of care put in place. Second opinion requested by wife under Martha's rule as not in agreement with DNACPR decision. Critical Care team in agreement made not to escalate and End of Life Care given	GREEN	Wife's concerns about end-of-life care and resuscitation discussions noted. Ceilings of intervention medically appropriate and lawful DNACPR decision made. Working with complaints team to help resolve any outstanding concerns from patient's family.

Nb. CRR stands for Case Record Review and includes all techniques with a defined methodology which includes SJR and medical examiner scrutiny.

2. Key learning points

Update 26	**Sepsis of uncertain origin** When patients preset with sepsis of uncertain origin, it is essential to do a thorough assessment to identify the source of their infection as this allows antibiotics to be tailored appropriately. Assessment should include a skin survey, including removal of any wound dressings / compression bandages. It is also important to consider whether there are any indwelling devices (including prosthetic joints, pacemakers, etc, that may have become infected.	**Careflow Alerts** It is important to review all Careflow alerts when patients are admitted to hospital. MRSA/VRE/CPE alerts should trigger review of antibiotic prescribing to ensure that there is appropriate cover for resistant organisms. Failure to do so risks delay to appropriate antibiotic prescription.
Update 25	**Know your Pathways** Trust pathways have been developed following local and national guidance of significant events and learning within the healthcare environment. It is imperative that staff familiarise themselves with what pathways are available within their field of practice, then follow them accordingly. They are there to protect our patients and you.	**Communication with families / carers** At times of high emotion and distress families and carers may not take in what is happening to their loved one and or understand the poor prognosis. Staff must remain aware of verbal of physical cues from families/carers suggesting key messages haven't been fully appreciated, so changes to method of communication can be made.
Update 24	**Imaging with contrast** Inpatients who receive imaging with contrast are at a higher risk of renal complications if their fluids are not correctly managed. Please consider IV fluids for these patients as they are particularly vulnerable	**Observe caution in the use of Lorazepam in the elderly.** Guidance is given in the Delerium assessment and management pro-forma under the elderly & frail, medication, ED section of the intranet ***Start low and go slow*** Haloperidol or Lorazepam if haloperidol contraindicated
Update 24 Cont.	**DNACPR communications on Transfer** On a transfer form there is a specific box to indicate a DNACPR in place, this must be ticked and ensure the lilac form is prominent at the front of case notes	

Learning into Action

- Following each quarterly submission to Board, examples of learning are reported and shared throughout the organisation to ensure that all staff are given the opportunity to determine how this could impact on their practice and try and make things better. The leaning is shared at team brief and via all Trust councils. The learning also appears on the intranet. http://nww.sthk.nhs.uk/about/learning-into-action

3. Coronial Inquests

Whiston and St Helens Hospitals – Q2 2024/25

Inquests	56
PFD orders	0

Southport and Ormskirk Hospitals – Q2 2024/25

Inquests	12
PFD	0

4. Learning From Deaths Lead

A review of the Assistant Medical Director for Patient Safety roles was undertaken following a change to guidance around Medical Examiners and the retirement of one of the previous post holders. Consultation on the draft Job Descriptions for the new AMD roles and responsibilities is currently underway with the appointment of a single lead for the Learning from Deaths (LFD) process anticipated in the next month. The new Learning from Deaths Lead will be responsible for the oversight of the Mortality Surveillance Group and the standardisation of the LFD process across the Trust

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 April 2025
Agenda Item	**TB25/034**			
Report Title	Learning from Deaths Q2 2024/2025			
Executive Lead	Dr Peter Williams, Medical Director			
Presenting Officer	Dr Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

To describe mortality reviews which have taken place throughout the Trust; to provide assurance that deaths occurring in hospital undergo a robust review to identify lessons which can be learned to prevent similar incidents occurring again.

Executive Summary

The following mortality case reviews have taken place across the Trust for deaths occurring in quarter 2 Q2 2024/25:

At Whiston and St Helens Hospitals:

- Total Number of Deaths Q2 412
- Total cases with Structured Judgement Review (SJR) Q2 45
- Total outstanding review Q2 27

- Total Red SJRs Q2 0
- Total Amber SJRs Q2 2

At Southport and Ormskirk Hospitals

Total Number of Case Record Review Q2 192
Total Red CRR Q2 4
Total Amber CRR Q2 3

All cases rated as Amber or Red will undergo more detailed review at their respective Mortality Groups with learning and additional actions fed back to the respective Divisions and across the Trust.

Financial Implications

None

Quality and/or Equality Impact

Learning from deaths seeks to promote continuous learning in order to foster a culture that leads to ongoing improvement of care, pathways and services.

Recommendations

The Trust Board are asked to note the Learning from Deaths Q2 2024/25 report.

Strategic Objectives

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

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

"Learning from deaths of people in our care can help us improve the quality of the care we provide to patients and their families and identify where we could do more"

NHSI 2017.

1. Outcome from reviews undertaken

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		not suitable for any intervention. End of Life Care given.		raised following difficulty in obtaining surgical opinion. PSLR ongoing.
7/9/24	14b	85y on chemotherapy presented with chest pain and treated for CAP Ceilings of care put in place. Second opinion requested by wife under Martha's rule as not in agreement with DNACPR decision. Critical Care team in agreement made not to escalate and End of Life Care given	GREEN	Wife's concerns about end-of-life care and resuscitation discussions noted. Ceilings of intervention medically appropriate and lawful DNACPR decision made. Working with complaints team to help resolve any outstanding concerns from patient's family.

Nb. CRR stands for Case Record Review and includes all techniques with a defined methodology which includes SJR and medical examiner scrutiny.

2. Key learning points

Update 26	**Sepsis of uncertain origin** When patients preset with sepsis of uncertain origin, it is essential to do a thorough assessment to identify the source of their infection as this allows antibiotics to be tailored appropriately. Assessment should include a skin survey, including removal of any wound dressings / compression bandages. It is also important to consider whether there are any indwelling devices (including prosthetic joints, pacemakers, etc, that may have become infected.	**Careflow Alerts** It is important to review all Careflow alerts when patients are admitted to hospital. MRSA/VRE/CPE alerts should trigger review of antibiotic prescribing to ensure that there is appropriate cover for resistant organisms. Failure to do so risks delay to appropriate antibiotic prescription.
Update 25	**Know your Pathways** Trust pathways have been developed following local and national guidance of significant events and learning within the healthcare environment. It is imperative that staff familiarise themselves with what pathways are available within their field of practice, then follow them accordingly. They are there to protect our patients and you.	**Communication with families / carers** At times of high emotion and distress families and carers may not take in what is happening to their loved one and or understand the poor prognosis. Staff must remain aware of verbal of physical cues from families/carers suggesting key messages haven't been fully appreciated, so changes to method of communication can be made.
Update 24	**Imaging with contrast** Inpatients who receive imaging with contrast are at a higher risk of renal complications if their fluids are not correctly managed. Please consider IV fluids for these patients as they are particularly vulnerable	**Observe caution in the use of Lorazepam in the elderly.** Guidance is given in the Delerium assessment and management pro-forma under the elderly & frail, medication, ED section of the intranet ***Start low and go slow*** Haloperidol or Lorazepam if haloperidol contraindicated
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3. Coronial Inquests

Whiston and St Helens Hospitals – Q2 2024/25	
Inquests	56
PFD orders	0

Southport and Ormskirk Hospitals – Q2 2024/25	
Inquests	12
PFD	0

4. Learning From Deaths Lead

A review of the Assistant Medical Director for Patient Safety roles was undertaken following a change to guidance around Medical Examiners and the retirement of one of the previous post holders. Consultation on the draft Job Descriptions for the new AMD roles and responsibilities is currently underway with the appointment of a single lead for the Learning From Deaths (LFD) process anticipated in the next month. The new Learning from Deaths Lead will be responsible for the oversight of the Mortality Surveillance Group and the standardisation of the LFD process across the Trust

ENDS

Title of Meeting	**Trust Board**			**Date**	30 April 2025
Agenda Item	**TB25/035**				
Report Title	Patient Experience and Inclusion Strategy 2025-2028				
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 present and seek approval for the MWL Patient Experience and Inclusion Strategy 2025-2028 and supporting strategy implementation plan.

Executive Summary

This is the first MWL patient experience strategy which will be implemented over the next three years and is supported by a full implementation plan.

The three-year strategy (2025-2028) is designed around the Trust's Values; We are Kind, We are Open and We are Inclusive. The strategy describes the ambition of Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) to improve patient experience and acknowledges that patient experience is fundamental to quality healthcare. Information that has informed this strategy has been taken from multiple routes of patient feedback, concerns/complaints, incidents, results of National Patient Experience Surveys, national guidance and legislation and the need for further collaboration since becoming Mersey and West Lancashire Teaching Hospitals NHS Trust. The strategy is also informed by initiatives such as the Equality Diversity System 2022, Veteran Accreditation and Equality Impact Assessments maintaining our commitment to inclusivity.

A full consultation has taken place with amendments made in line with feedback from both internal and external partners including patients and their representatives.

The strategy will be implemented and measured on an incremental basis over the next three years. The Trust Patient Experience Council (PEC) will provide formal monitoring and evaluation throughout this time and report upwards to the Quality Committee (QC) and Trust Board.

It is proposed that a full launch of the strategy will be undertaken from April 2025 to coincide with the national Patient Experience week.

Financial Implications

Not applicable

Quality and/or Equality Impact

A full supporting Equality Impact Assessment (EIA) has been completed by the Equality and Inclusion manager.

Recommendations

The Board is asked to approve the Patient Engagement Strategy.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
	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
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Patient Experience and Inclusion Strategy 2025-2028

This is the first MWL patient experience strategy which will be implemented over the next three years and is supported by a full implementation plan. Our three-year strategy (2025-2028) is designed around the Trusts Values; We are Kind, We are Open and We are Inclusive. Within the strategy there are a total of three commitments, 13 objectives with 46 actions.

The strategy describes the ambition of Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) to improve patient experience and inclusion and acknowledges that patient experience is fundamental to quality healthcare. We want to build upon the successes of the St Helens and Knowsley Teaching Hospitals NHS Trust Patient Experience Strategy 2022-2025 and the Southport and Ormskirk NHS Trust Patient Experience Strategy 2020-2024.

Information that has informed this strategy has been taken from multiple routes of patient feedback, concerns/complaints, incidents, results of National Patient Experience Surveys, national guidance and legislation and addresses the need for further collaboration since becoming Mersey and West Lancashire Teaching Hospitals NHS Trust. The strategy is also informed by initiatives such as the Equality Diversity System 2022, Veteran Accreditation and Equality Impact Assessments maintaining our commitment to inclusivity.

We know that patient experience is more than just meeting our patient's physical needs, but also about treating each patient as an individual with dignity, compassion and respect, whereas inclusive healthcare involves creating an environment where every individual irrespective of their background, identity or circumstances, access and benefit from healthcare services equitably. Effective engagement enhances services and care, improves health outcomes, strengthens public accountability and supports the Trust's reputation. We do not want to just meet expectations; we want to exceed them. This means we are committed to working in partnership with our staff, patients, carers, local communities including inclusion health communities and stakeholders to improve the quality of care that we provide. We also want to commit to continue to actively be seeking, listening to, and acting on feedback received from our patients, staff, and other key stakeholder groups and involving them in the design and delivery of our services.

A full strategy consultation has taken place (page 5 of the strategy), including via Trust social media platforms, Healthwatch, Patient Participation Group, Deafness Resource Centre and Carer networks. Amendments to the strategy have made in line with feedback from both internal and external partners including patients and their representatives. The strategy was presented and approved by the Patient Experience Council in December 2024 to be shared to the Quality Committee in February 2025 prior to seeking approval by the Executive Team. All feedback from the Quality Committee members has been actioned. A supporting equality impact assessment has been completed by the Patient Experience and Inclusion manager.

It is proposed that once approved a full launch of the strategy will be undertaken from April 2025 to coincide with the National Patient Experience Week. This will be supported by a 'strategy on a page'

to enable staff, patients and members of the public to gain a quick understanding of what the strategy sets out to achieve.

The strategy will be implemented and measured on an incremental basis over the next three years. The Trust Patient Experience Council (PEC) will provide formal monitoring and evaluation throughout this time and report upwards to the Quality Committee (QC) and Trust Board. Progress will also be tracked via the use of a quality dashboard which will be accessible across the patient experience and inclusion team and divisions.

Mersey and West Lancashire Teaching Hospitals
NHS Trust

Patient Experience and Inclusion Strategy

2025-2028

We are KIND

We are OPEN

We are INCLUSIVE

All of our patient information can be translated into various languages. Please speak to a member of staff or email patientexperienceandedi@sthk.nhs.uk who can arrange for information to be translated for you.

Wszystkie nasze informacje dla pacjentów są tłumaczone na różne języki. Aby otrzymać przetłumaczone informacje, prosimy porozmawiać z członkiem personelu lub wysłać wiadomość e-mail na adres: patientexperienceandedi@sthk.nhs.uk

كل المعلومات للمريض لدينا مترجمة إلى مجموعة متنوعة من اللغات المختلفة. يرجى التحدث إلى أحد الموظفين أو إرسال بريد إلكتروني إلى patientexperienceandedi@sthk.nhs.uk الذي يمكنه ترتيب ترجمة المعلومات لك.

Toate informațiile destinate pacienţilor sunt traduse într-o varietate de limbi diferite.Vă rugăm să luaţi legătura cu un membru al personalului sau să ne trimiteţi un e-mail la patientexperienceandedi@sthk.nhs.uk dacă doriţi ca aceste informaţii să fie traduse în limba dvs

Contents

Foreword

At Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), we know that patient experience is more than just meeting our patients' physical needs but also about treating each patient as an individual with dignity, compassion and respect whereas inclusive healthcare involves creating an environment where every individual irrespective of their background, identity or circumstances can access and benefit from healthcare service equitably. Effective engagement enhances services and care, improves health outcomes, strengthens public accountability and supports the Trust's reputation.

We do not want to just meet expectations; we want to exceed them. This means we are committed to working in partnership with our staff, patients, carers, local communities including inclusion health communities and stakeholders to improve the quality of care that we provide. We commit to actively seeking, listening to and acting on feedback received from our patients, staff and other key stakeholder groups and involving them in the design and delivery of our services.

The purpose of the Patient Experience & Inclusion Strategy 2025-2028 is to set out the Trust's commitment to improving patient experience by meaningfully engaging with our patients, key stakeholders and local communities to remove any barriers to access. We will do this by building on our current engagement activities; and ensuring people from all our local communities are included and able to help shape our services.

The Trust acknowledges that a positive experience leads to better patient outcomes and improved morale for staff. The three commitments and associated objectives in this strategy will support a continuous cycle of engagement throughout every step of the patient journey and embody the Trust's 5 Star patient care vision and our values. The Trust expects all staff to embrace this strategy and demonstrate the key principles through the care and services delivered while demonstrating the Trust's values in all that we do. By creating a culture of continuous improvement that strives to provide excellent, quality, patient-driven services, we can achieve our ambition.

We thank our patients, local community and stakeholders who have been involved in developing this strategy and look forward to working with you all to deliver it.

Developing our strategy

Our three year strategy (2025-2028) is designed around the Trust's values; We are Kind, We are Open and We are Inclusive. The strategy describes Mersey and West Lancashire Teaching Hospitals NHS Trust's ambition to improve patient experience and acknowledges that patient experience is fundamental to quality healthcare. Information that has informed this strategy has been taken from multiple routes of patient feedback, concerns/complaints, incidents, results of national patient experience surveys, national guidance and legislation and the need for further collaboration since the forming of Mersey and West Lancashire Teaching Hospitals NHS Trust.

We are KIND

We:

- Treat every individual with respect
- Are compassionate in our support of patients and colleagues
- Are friendly and welcoming and always introduce ourselves
- Care for each other as we care for our patients
- Are polite and value each other's thoughts and ideas

We are OPEN

We:

- Are always listening and learning
- Encourage and support two-way communication
- Are honest, fair and open with others
- Take responsibility for our actions and always aim to improve
- Develop our services in the best interests of our communities

We are INCLUSIVE

We:

- Value everyone's cultural, social and personal needs
- Celebrate our differences and support each other
- Listen to all voices
- Work as a team and learn from each other
- Challenge prejudice and promote acceptance

Consultation with our partners

This strategy is aimed at MWL staff and volunteers, patients and the public, local service providers, commissioners and the voluntary sector. The development of this strategy was supported by several individuals and organisations from within MWL and across St Helens, Knowsley, Halton, Sefton and West Lancashire.

- Patients
- Families
- Carers
- Executive Team
- Quality Committee
- Patient Experience Council
- Patient Experience & Inclusion Champions
- Frontline staff
- Trust volunteers
- Patient Participation Group
- Lay Readers Group
- MWL staff networks
- Local Healthwatch organisations
- Local carers network
- Chaplaincy Champions
- St Helens Deafness Resource Centre
- The public via MWL social media pages and website
- Cheshire & Merseyside Integrated Care Board
- Maternity & Neonatal Voices Partnership Group
- West Lancashire Armed Forces Covenant Network
- St Helens Armed Forces Covenant Network




Patient experience achievements

We developed our strategy in partnership with our patients, key stakeholders, local communities, and staff and built upon the successes of the St Helens and Knowsley Teaching Hospitals NHS Trust Patient Experience Strategy 2022-2025 and Southport and Ormskirk Hospital NHS Trust Patient Experience Strategy 2020-2024.

Achievements:

- We improved our engagement with members of protected community groups. Feeding back findings to relevant committees and services to help address any inequalities and developed best practice equality, diversity and inclusion guidance.
- Continued to work in collaboration with other Trusts on the Equality Delivery System (EDS22)
- Implemented the 'what matters to me' engagement events with members of protected groups, including inclusion health groups and those groups whose first language is not English and engaged with the relevant groups to identify any barriers they may face when accessing Trust services.
- Developed feedback from engagement with patients and service users who may have a learning disability, autism or acquired brain injury.
- Increased membership for the Trust Patient Participation Group (PPG) and the Patient Experience and Inclusion Champions Group (PEICG).
- The complaints service and Patient Advice and Liaison Service (PALS) are accessible to all patients/relatives with monitoring methods in place to ensure that the complaints and concerns relating to a patients protected characteristic can be identified. We developed a satisfaction survey to inform, develop and demonstrate an effective PALS service. PALS is now fully embedded at Southport and Ormskirk sites.
- We have seen a reduction in the number of concerns raised by St Helens Deafness Resource Centre (DRC) regarding patients whose communication needs are not met.
- We developed a library of digital stories that are accessible electronically and ensure shared learning throughout the Trust and patient stories are delivered monthly to Trust Board. We created a robust process for areas to share stories with the Patient Experience & Inclusion Team.
- We expanded digital feedback mechanisms within the Trust, redesigned the 5 a day programme and developed a carers satisfaction survey.
- We revamped the ward patient experience boards and incorporated auditing boards
- Digital audit tool now includes patient feedback.
- Substantive Specialist Learning Disability Nurse in place across Southport and Ormskirk sites.
- 'Keep me here' initiative in place to reduce the number of bed moves for those patients with enhanced care needs.
- New way finding signage in place.
- Launched the new Carers' Passport.
- Discharge booklet reviewed to incorporate all hospital site information and the discharge support volunteer role embedded at Southport and Ormskirk sites.

Commitment 1 - We are Kind

We:

- Treat every individual with respect
- Are compassionate in our support of patients and colleagues
- Are friendly and welcoming and always introduce ourselves
- Care for each other as we care for our patients
- Are polite and value each other's thoughts and ideas

Objective 1 - Patients, families, and carers report that they have received kind and compassionate care.

How we will demonstrate this

- Implementation of quality measurement tool in Emergency Department.
- Monitor & improve the "Hello My Name Is" campaign and kindness and compassion results from local Trust surveys.
- Work with the Communication team on an initiative to acknowledge staff who go the 'extra mile' when delivering kind and compassionate care.

Objective 2 - Demonstrate improvement where we have listened to and learned from patients.

How we will demonstrate this

- Results from feedback mechanisms in the Trust demonstrate patients feel safe and cared for.
- Patient stories to be shared widely across the organisation and available externally.

Objective 3 – Patient Experience and Inclusion Team (PEI) at MWL to provide an equitable service across all Trust sites.

How we will demonstrate this

- Results from feedback mechanisms in the Trust demonstrate patients feel safe and cared for.

Commitment 2 - We are Open

We:

- Are always listening and learning
- Encourage and support two-way communication
- Are honest, fair and open with others
- Take responsibility for our actions and always aim to improve
- Develop our services in the best interest of our communities

Objective 1 – To work in partnership with other staff groups to improve the patient experience.	How we will demonstrate this • Work closely with teams across the Trust to support feedback and demonstrate improvements. • Refresh the usage of the discharge booklet across MWL and use results from feedback mechanisms in the Trust to demonstrate usage.
Objective 2 - Maintain and develop our knowledge regarding regional and national initiatives.	How we will demonstrate this • Evidence of team attendance at meetings and collaborative working.
Objective 3 - Review and improve survey usage and questions based on previous feedback. Review and harmonise existing surveys.	How we will demonstrate this • Review and improve/harmonise overarching Trust surveys and local surveys. Increase compliance with You Said We Did.
Objective 4 – Continue to improve collaborative working across MWL via the Patient Experience and Inclusion Team Champions.	How we will demonstrate this • Increase in membership and evidence of collaborative working with Patient Experience and Inclusion Team Champions.
Objective 5 – The Patient Experience and Inclusion Team are to continue to provide prompt responses to any feedback received.	How we will demonstrate this • Evidence of Patient Experience and Inclusion Team response rates to feedback.

Commitment 3 - We are Inclusive

We are INCLUSIVE

We:

- Value everyone's cultural, social and personal needs
- Celebrate our differences and support each other
- Listen to all voices
- Work as a team and learn from each other
- Challenge the prejudice and promote acceptance

Objective 1 – Expand our engagement with local communities to ensure they are consulted promptly when changes to Trust services or estate are planned.	**How we will demonstrate this** • Evidence of engagement with local communities. • Evidence to demonstrate improvement in Equality Impact Assessments being completed. • Expand the number and diversity of patient groups across MWL. • Utilise staff networks to contribute to any consultation needed.
Objective 2 – Improve accessibility across all areas of all sites of MWL.	**How we will demonstrate this** • Evidence of accessibility project to support areas in improvements to meet our statutory Equality Duties. • Evidence of improvements to the Trust interpreter service via video interpreting and increase in training.
Objective 3 – Implementation of the NHS reasonable adjustments flag.	**How we will demonstrate this** • Evidence of working alongside teams required to implement flag and develop training. • Review patient information and increase the provision of Easy Read leaflets, particularly for core leaflets.
Objective 4 – Participate in Equality Delivery System 22. A toolkit to make services more accessible and inclusive for all patients.	**How we will demonstrate this** • Evidence to demonstrate Equality Delivery System 22 compliance and outcome to be reported to Equality, Diversity & Inclusion Committee and Executive Team.
Objective 5 – Maintain/improve on relevant accreditations.	**How we will demonstrate this** • Evidence of achievements and actions to demonstrate improvements made with Trust accreditations.

Monitoring of the strategy

This strategy is applicable to all areas of the organisation. The Trust expects that all staff will embrace the strategy and demonstrate the key objectives and Trust values through the care and services that are delivered.

Assurance monitoring:

The strategy will be implemented and measured on an incremental basis over the next three years. The Trust's Patient Experience Council (PEC) will provide formal monitoring and evaluation throughout this time and report upwards to the Trust Quality Committee (QC) and Trust Board.

Trust Board

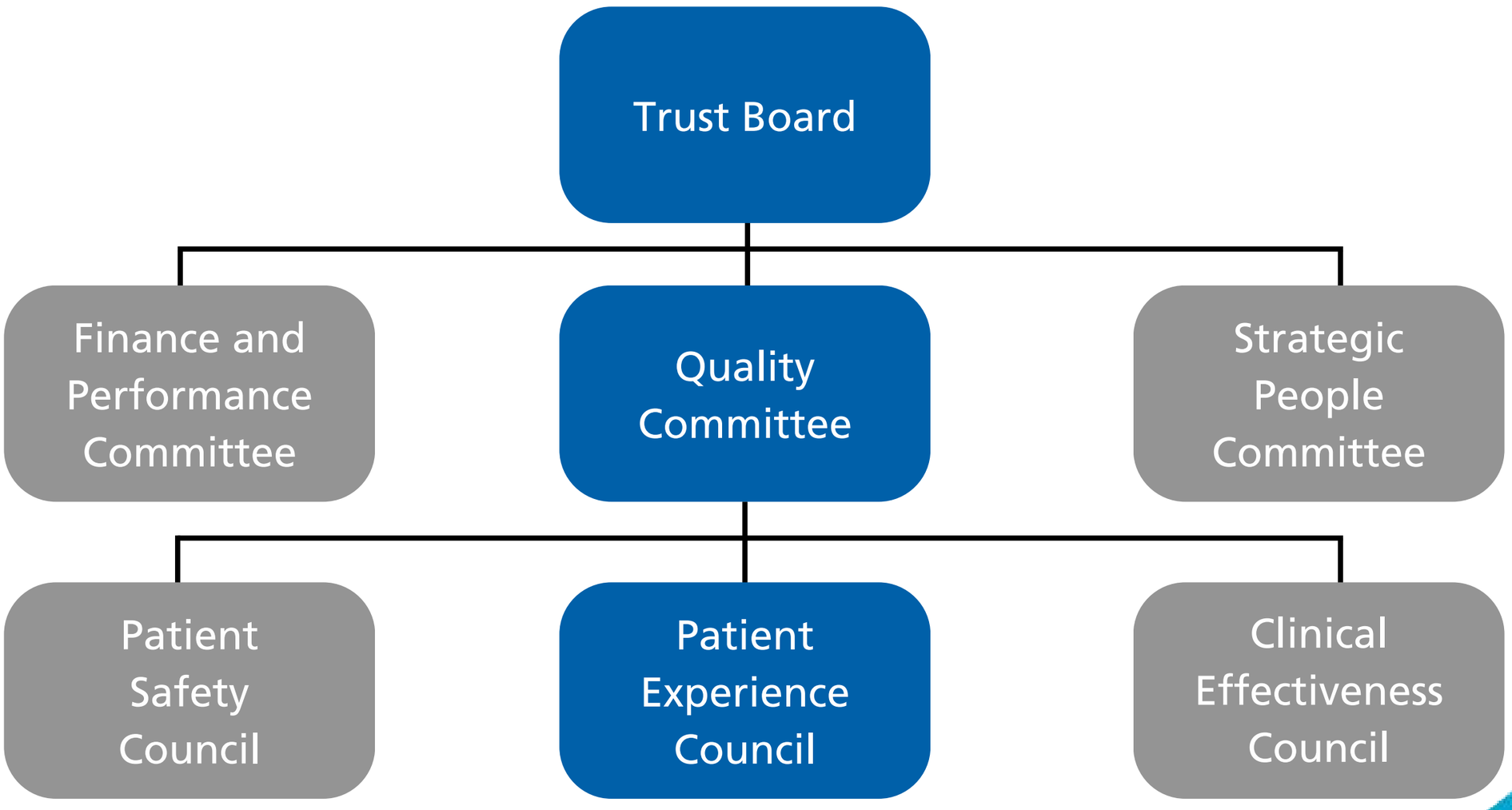
The Board is collectively responsible for establishing a system of internal control and for putting in place arrangements for gaining assurance about the effectiveness of that system. The governance structure in the Trust is based on procedures from Trust Board level and below to ensure the quality of our services and systems to monitor and assure the Trust Board of Directors.

Quality Committee

Quality Committee provides assurance to the Board on quality governance. Quality performance within the Trust is measured against a range of parameters, including patient safety, patient experience and clinical effectiveness.

Patient Experience Council

The Patient Experience Council is established to ensure that the Trust has a robust process for patient experience and investigation of any potential patient experience issues. It supports the aim to embed a positive patient experience culture throughout the organisation.



Glossary of terms

Accessible – able to be reached or entered

Accreditation - the action or process of officially recognising someone as having a particular status or being qualified to perform a particular activity

Audit – An internal inspection of processes and systems to ensure compliance

Champion – a person who vigorously supports or defends a person or cause

Collaborative – Two or more people or groups working together

Commitment – an agreement or pledge to do something in the future

Communities – a group of people that have a particular characteristic in common

Digital - Electronic technology

Diversity – is about taking account of the differences between people and groups of people, and placing a positive value on those differences

Equality – is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics

Equality Delivery System (EDS) 22 assessments – a toolkit that can help NHS organisations improve the services they provide for their patients and service users to ensure that they are accessible and inclusive as possible

Equality Duties - duty on public authorities to consider or think about how their policies or decisions affect people who are protected under the Equality Act

Equality Impact Assessment (EIA) – a tool to help ensure that services, policies, practices and decisions are fair, meet the needs of their staff and patients and that they are not inadvertently discriminating against any protected group

Equitable – Recognising that we do not all start from the same place and must acknowledge and make adjustments to imbalances

Evidence – the available body of facts or information indicating whether a belief or proposition is true or valid

Feedback – the transmission of evaluative or corrective information about an action, event, or process to the original or controlling source

Friends and Family Test (FFT) – created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment

Healthwatch – an independent body, they have the power to make sure NHS leaders and other decision makers listen to patient and carer feedback and improve standards of care

Health inequalities – are the unjust and avoidable differences in people's health across the population and between specific population groups

Implementation plan – outlines the steps to take when accomplishing a shared goal or objective

Inclusion – the action or state of including or of being included within a group or structure

Integrated Care Board (ICB) – a statutory body with responsibility for NHS functions and budgets

Interpreter – a person who interprets, especially one who translates speech orally or into sign language

Objective – a thing aimed at or sought, a goal

Patient engagement – the facilitation and strengthening of the role of those using services as co-producers of health, and health care policy and practice

Patient Experience – is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care

Protected Characteristic - in the Equality Act 2010, nine characteristics were identified as 'protected characteristics'. These are the characteristics where evidence shows there is still significant discrimination in employment, provision of goods and services and access to services such as education and health

Reasonable Adjustment - changes made to remove or reduce a disadvantage related to someone's disability

Stakeholder – a person with an interest or is affected by something, an employee, patient, customer, supplier or investor

Strategy – a plan of action designed to achieve a long-term or overall aim

Survey – a method of gathering information using relevant questions

You Said We Did (YSWD) – a poster that displays feedback and the Trust's action in response to it

Authors:	Head of Patient Experience & Inclusion Quality Matrons - Patient Experience Patient Experience Manager Patient Equality & Inclusion Manager Patient Experience Facilitator
Accountable Director:	Chief Nurse
Approving Body:	Patient Experience Council (04/12/2024) Executive Committee (10/04/2025)
Consultation dates:	24/09/2024 - 25/10/2024 18/03/2025 - 04/04/2025
Date approved:	10/04/2025

Patient Experience and Inclusion Strategy on a page 2025-2028

Mersey and West Lancashire Teaching Hospitals NHS Trust

Commitment 1

We are KIND

We:

- Treat every individual with respect
- Are compassionate in our support of patients and colleagues
- Are friendly and welcoming and always introduce ourselves
- Care for each other as we care for our patients
- Are polite and value each other's thoughts and ideas

Objective 1

Patients, families, and carers report that they have received kind and compassionate care.

Objective 2

Demonstrate improvement where we have listened to and learned from patients.

Objective 3

Patient Experience and Inclusion Team (PEI) at MWL to provide an equitable service across all Trust sites.

Commitment 2

We are OPEN

We:

- Are always listening and learning
- Encourage and support two-way communication
- Are honest, fair and open with others
- Take responsibility for our actions and always aim to improve
- Develop our services in the best interest of our communities

Objective 1

To work in partnership with staff groups to improve the patient experience.

Objective 2

Maintain and develop our knowledge regarding regional and national initiatives.

Objective 3

Review and improve survey usage and questions based on previous feedback. Review and harmonise existing surveys.

Objective 4

Continue to improve collaborative working across MWL via the Patient Experience and Inclusion Team Champions.

Objective 5

The Patient Experience and Inclusion Team are to continue to provide prompt responses to any feedback received.

Commitment 3

We are INCLUSIVE

We:

- Value everyone's cultural, social and personal needs
- Celebrate our differences and support each other
- Listen to all voices
- Work as a team and learn from each other
- Challenge the prejudice and promote acceptance

Objective 1

Expand our engagement with local communities to ensure they are consulted promptly when changes to Trust services or estate are planned.

Objective 2

Improve accessibility across all areas of all sites of MWL.

Objective 3

Implementation of the NHS reasonable adjustments flag.

Objective 4

Participate in Equality Delivery System 22.
A toolkit to make services more accessible and inclusive for all patients.

Objective 5

Maintain/improve on relevant accreditations.

Title of Meeting	**Trust Board**			**Date**	30 April 2025
Agenda Item	**TB25/036**				
Report Title	**MWL People Plan**				
Executive Lead	Malise Szpakowska, Director of HR				
Presenting Officer	Malise Szpakowska, Director of HR				
Action Required	X	**To Approve**		**To Note**	

Purpose

The MWL People Plan 2025-2028 aims to create a supportive, inclusive, and thriving workplace where staff feel valued, empowered, and motivated to deliver 5 Star Patient Care.

Executive Summary

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) serves a population of over 600,000, supported by approximately 10,500 dedicated staff across five hospitals and 16 community sites.

The MWL People Plan 2025-2028 builds on previous successes and outlines the Trust's commitment to fostering a culture based on our values of kindness, inclusivity, and openness where staff can thrive while delivering 5 Star Patient Care.

Strategic Ambitions

The plan is aligned with national NHS priorities, including the NHS Long Term Workforce Plan 2023 and the NHS People Promise, and focuses on four key ambitions:

1. **Fostering a Culture of Wellbeing and Support**
2. **Developing an Inclusive and Diverse Workforce**
3. **Embracing Innovation and Career Development**
4. **Enhancing Workforce Planning and Partnerships**

Measuring Success

Progress will be tracked through staff surveys, wellbeing metrics, leadership development initiatives, and recruitment outcomes, ensuring MWL remains an employer of choice.

The Trust is committed to continuous improvement, staff engagement, and excellence in patient care.

This plan reaffirms MWL's commitment to its people, ensuring a supportive environment where staff can grow, develop, and continue delivering 5 Star Patient Care.

Financial Implications

None in this paper

Quality and/or Equality Impact

None in this paper

Recommendations	
The Trust Board is asked to approve the MWL People Plan	
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
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

Mersey and West Lancashire Teaching Hospitals
NHS Trust

MWL People Plan

Introduction

Serving a population of over 618,000, with a workforce of c.10,500 dedicated and skilled staff, Mersey and West Lancashire Teaching Hospitals NHS Trust is one of the UK's largest Trusts.

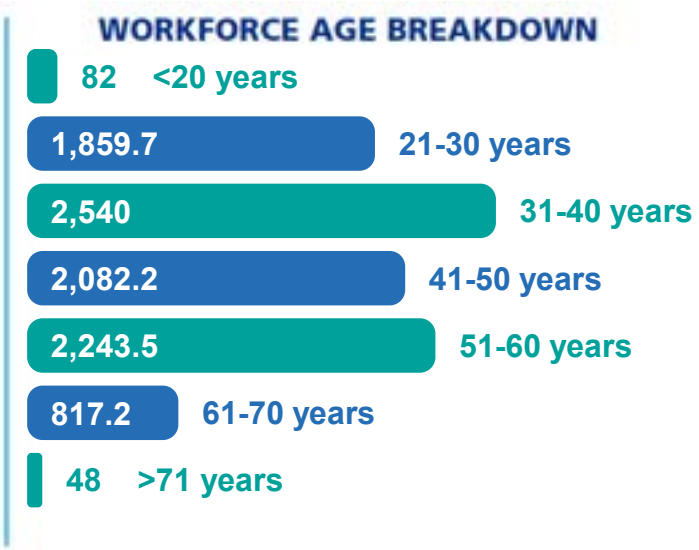
Our valued workforce is recognised for their expert skills and talents in providing 5 Star Patient Care across our 5 hospitals and 16 community sites to people across St Helens, Knowsley, Halton, Southport, Ormskirk, parts of Liverpool and the surrounding areas.

We know that to continue to provide 5 Star Patient Care, we need to continue to support our colleagues to thrive in work.

This strategic plan indicates what those who work MWL can expect from us and each other, and sets out our ambitions for creating a culture of kindness, inclusivity and openness, where everyone can develop, grow and thrive.

This is the second version of our People Plan, which was first published in 2020. In the first 5 years of the Plan, we have achieved great things and are proud of the progress we have made against our objectives.

Our Workforce



National context

Our vision will be delivered through four strategic ambitions for our people. In developing this plan, the Trust has considered both local and national people priorities, including the NHS Long Term Workforce Plan 2023, the NHS People Plan 2020/21 and the seven NHS People Promises. In addition, we have also considered the priorities set out in the Future of HR and OD report (2021), NHS IMPACT (Improving Patient Care Together) and Our Leadership Way.

The NHS People Plan and Our Leadership way sets out what the people of the NHS can expect – from their leaders and from each other. Our People Plan 2025-28 reflects the strategic direction in the NHS People Plan and the NHS People Promise and our four strategic ambitions reflect the national priorities.

Our Values

Developed by MWL staff for MWL staff, our values underpin everything we do at MWL and outline our expectations for fostering a supportive workplace culture and delivering 5 Star Patient Care. By consistently prioritising both "what" we do and "how" we do it, our values help create an environment where everyone can thrive and deliver excellent patient care.

Equality and inclusion

Equality, Diversity, and Inclusion is at the heart of everything we do. We understand the importance of ensuring our workforce reflects our local community and celebrating diversity.

Where diversity – across the whole workforce – is underpinned by inclusion, staff engagement, retention, innovation and productivity improve. Inclusive environments create psychological safety and release the benefits of diversity – for individuals and teams, and in turn efficient, productive and safe patient care (NHS EDI Improvement Plan 2023).

Our staff survey results and experiences shared by colleagues demonstrate that we have more to do.

Our People Plan outlines our dedication to fostering an open, diverse, and inclusive culture where everyone is treated with civility, respect, and dignity, and where their contributions are recognised and valued.

By continuing to champion equality, diversity, and inclusion, we aim to:

- Positively impact the experience of our staff;
- Create an environment where staff feel safe to speak up and raise concerns; and
- Ultimately enhance the services we provide to our patients.

We are committed to promoting equality, diversity, and inclusion, while actively addressing all forms of discrimination, harassment and bullying to create an open, inclusive environment for everyone.

Our Key priorities

We will promote equality, diversity and inclusion for all staff, tackling all forms of discrimination, bullying and harassment and strive to remove all forms of inequality.

We will foster an open, kind and inclusive culture, where staff feel valued and recognised for their contribution to 5 Star Patient Care and feel empowered to raise concerns.

We will promote learning and continuous improvement by ensuring fair and transparent processes.

We will promote and maintain the health and wellbeing of our workforce to enable staff to thrive.

We will enhance and develop leadership skills across all levels of the Trust.

We will recruit the best people to support the delivery of 5 Star Patient Care.

We will continue to develop new roles and new career pathways.

We will provide a comprehensive reward and recognition package that recognises and values the contribution of everyone to Team MWL.

Through our excellence and expertise in education and training, we will continue to achieve 5 Star patient care and service delivery.

Mersey and West Lancashire Teaching Hospitals
NHS Trust

Our People Plan

Fostering a culture of kindness, openness and inclusivity, where everyone can grow, develop and thrive and are recognised for their contribution to 5 Star Patient Care

We will develop a culture that empowers individuals to lead healthy lives and thrive in work by providing holistic wellbeing support

Our commitments;

- Continue to embed health and wellbeing support and initiatives that champion a safe and healthy environment for all
- Continue to harness a culture of kindness, openness and inclusivity where everyone is treated with civility and respect
- Continue to develop compassionate and inclusive leaders that champion a culture of learning and improvement
- Ensuring our leaders and managers have the knowledge, skill and expertise to support wellbeing in the workplace
- Empower our staff to work flexibly, allowing them to balance both professional and personal commitments
- Embed and enhance our reward and recognition offer to support the retention of our workforce

How we will measure progress

- Improve staff sickness levels year on year
- Undertake the Health and Wellbeing Diagnostic tool and implement improvement actions
- Improvements in staff survey results for health and wellbeing
- Improvements in staff survey theme ‘We are Compassionate and Inclusive’
- Improvements in staff survey theme ‘We are Recognised and Rewarded’
- Ensure compliance with the Sexual Safety Charter

We will develop an inclusive culture where everyone's voice is represented and celebrated

Our commitments;

- Celebrate diversity and promote an environment of openness and inclusion
- Tackle all forms of discrimination, harassment and bullying.
- Ensure that every person has a voice that counts by acting on feedback and involving staff in decision making
- Champion an environment that encourages and enables all staff to 'speak up', raise concerns, make changes and shape learning.
- Continue to develop and embed Values and Behaviours into everything that we do
- Improve the experience of those people with a protected characteristic as identified by the Equality Act 2010

How we will measure progress

- The Trust to be in the top 25% for People Promise of 'we are compassionate and inclusive'
- Launch reciprocal mentoring programme
- Continue to increase the percentage of staff sharing their disability status within the Trust
- Implement all 6 high impact areas under the NHS EDI Improvement Plan
- Reduce number of colleagues experiencing harassment, bullying or abuse at work
- Promote our Staff Survey results and actions at a Trust and team level

We will embrace new ways of working and create opportunities to enable our people to achieve their potential

Our commitments;

- Grow our relationships with local communities, schools and colleges to develop health workers of the future.
- Continue to develop and improve our recruitment practices and processes
- Develop and embed training and development pathways across all levels and professions.
- Develop a flexible and adaptive workforce fit for the future
- Deliver comprehensive, accessible, and innovative education opportunities that support the ongoing development of students and staff

How we will measure progress

- 70% of staff recommending the Trust as a place to work
- Increase in the number of people undertaking apprenticeships as part of new recruitment or Continuous Professional Development (CPD)
- Review and improve our exit interviews processes
- Successfully pilot a best practice approach to succession planning
- Continue to achieve compliance for appraisals across all staff groups
- Improvements in staff survey theme ‘We are always learning’

We will improve outcomes across MWL for health, employment and wellbeing by working with our partners to be the best place to work

Our commitments;

- Develop workforce plans for all services that are fully integrated with clinical strategies and financial plans
- Embed digital workforce solutions and technology to support our people to become digitally enabled and connected
- Develop Organisational Development (OD) and change management support for the Trust and its staff to facilitate new ways of working and delivering care
- Continue to develop new roles and career pathways including extended and advanced practice roles to support new ways of providing care.

How we will measure progress

- Develop and launch MWL's approach to temporary workforce
- Monitor and review the OD model in supporting new ways of working and delivering care
- Introduce a simplified workflow for workforce processes such as starters, leavers and changes
- Achieve the workforce plan year on year
- Improve utilisation and compliance for e-roster and e-job planning