Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 28 May 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (May 2025)** *Purpose: To **note** the Employee of the Month presentations for May 2025*	Film	Chair *(15 mins)*
10.15	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.30	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB25/037 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 30 April 2025*	Report	
	6.	**TB25/038 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
10.40	7.	**TB5/039 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*	Report	L Barnes L Neary AM Stretch obo M Szpakowska G Lawrence *(40 mins)*

Committee Assurance Reports				
11.20	8.	**TB25/040 Committee Assurance Reports** 8.1. Executive Committee 8.2. Quality Committee 8.3. Strategic People Committee 8.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper G Brown L Knight C Spencer *(40 mins)*
Other Board Reports				
12.00	9.	**TB25/041 National Quality Board Establishment Reviews** *Purpose: To **note** the National Quality Board Establishment Reviews*	Report	L Barnes *(10 mins)*
12.10	10.	**TB25/042 Aggregated Incidents, Complaints and Claims Report (Q4)** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for Q4*	Report	L Barnes *(15 mins)*
12.25	11.	**TB25/043 Maternity and Neonatal Services Assurance Report Quarter 4** *Purpose: To **note** the Maternity and Neonatal Services Assurance Report*	Report	L Barnes *(15 mins)*
12.40	12.	**TB25/044 Quality Account 2024/25** *Purpose: To **approve** the Quality Account 2024/25*	Report	L Barnes *(15 mins)*
12.55	13.	**TB25/045 2024/25 Board and Committee Effectiveness Review** *Purpose: To **approve** the updated Terms of Reference following the annual effectiveness review*	Report	N Bunce *(10 mins)*
13.05	14.	**TB25/046 Review of Trust Objectives for 2024/25** *Purpose: To **note** the Review of the Trust Objectives for 2024/25*	Report	R Cooper *(15 mins)*
Concluding Business				
13.20	15.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*

13.25	16.	**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 25 June 2025 at 09:30		**13.30 close**
15 minutes lunch break				

Chair: Steve Rumbelow

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.

Title of Meeting	**Trust Board**		**Date**	28 May 2025
Agenda Item	**TB25/000**			
Report Title	Patient Story - Accident and Emergency Department, Southport Hospital			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Yvonne Mahambrey, Matron, Patient Experience			
Action Required		**To Approve**	X	**To Note**

Purpose

The patient story is told by Joseph who wished to share his experience of the End-of-Life Care that was given to his grandmother, Patricia, in the Accident and Emergency Department at Southport Hospital.

Executive Summary

Joseph wrote into the Trust to share his story and to acknowledge the care and experience he and his family received.

In July 2024 Joseph's grandmother, Patricia, suffered a cardiac arrest. She received care from Northwest Ambulance Service and was then transferred to the Accident and Emergency (A&E) Department at Southport Hospital at 4am in the morning. At this time the department was extremely busy with the hospital site reporting close to Operational Pressure Escalation Level (OPEL) 4.

Joseph describes how on arrival to the department he and his family were given immediate access to the relatives room and despite the department being so busy the staff made sure they were comfortable and had their privacy maintained. However, he felt that the relatives room was not in the best location due to being close to the mental health room.

The initial updates regarding his grandmother's condition were shared with the family by a junior doctor with further discussions being led by a more senior doctor. Joseph felt that he and his family received a compassionate explanation regarding his grandmother's care which was very comforting to the family.

Nursing staff requested spiritual care and chaplaincy support who arranged an urgent visit from the Roman Catholic priest and Patricia died peacefully with her family around her.

On asking Joseph what could be improved he made the following recommendations:

- To consider the location of the relatives room.
- To have dimmed lighting in the relatives room as it is too bright especially at 4am and may have a negative impact on those with additional sensory needs.
- Consideration of adding USB ports for patients/relatives to charge their phones.

There are no immediate plans to move the location of the relatives room. However, Joseph's comments regarding the lighting in the relatives room has led to the purchase of cordless table lamps and a dimmer switch has now been fitted. A further review has also resulted in the purchase of non-clinical crockery and neater storage space with the donation of pocket tissues and colouring books and crayons for families with young children.

A review of possible phone charging facilities within the Accident and Emergency Department will also be undertaken.

Financial Implications	
Not applicable	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Patient Story.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 30 April 2025
(Approved at Trust Board on Wednesday 28 May 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
Claudette Elliott	CE	Non-Executive Director
Neil Fletcher	NF	Associate Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	Non-Executive Director
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Acting Director of Human Resources
Rani Thind	RT	Associate Non-Executive Director
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Dapo Ademolu	DA	Causeway Medical Centre (Observer) (via MS Teams)
Angela Ball	AB	Halton Council Representative (Stakeholder Representative) (via MS Teams)
Katie Hurst	KH	Head of Strategic Relationships, HBSUK (Observer) (via MS Teams)
Steve Rumbelow	SR	Designate Chair (Observer)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
No apologies received		

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for April 2025 was Dr Khalil Wahdati, Consultant, Same Day Emergency Care (SDEC), Southport Hospital and the Board watched the film of LN reading the citation and presenting the award to Khalil. **RESOLVED:** The Board **noted** the Employee of the Month for April 2025 and congratulated the winner
2.	**Chair's Welcome and Note of Apologies**
	2.1. RF welcomed all to the meeting and in particular CE and NF as this was their first MWL Board meeting. Additionally, RF welcomed AD, KH and SR who were attending the meeting as observers. 2.2. RF acknowledged the following awards and recognition for Trust staff and services: 2.2.1. The Indo-UK Breast Forum Annual Scientific Meeting celebrated the work of Consultant Surgeon Leena Chagla for the "remarkable contributions made to breast care in the UK and internationally. '' Leena was recognised for her courageous leadership in breast care on a global scale and her role in leading the Association of Breast Surgery (ABS) in the UK. The Indo UK Breast Forum represents Breast Surgeons of Indian origin working in the UK. 2.2.2. Amy O'Connor, community Nurse, based at Horton Lodge, was recently published in the Cancer Nursing Practice magazine. The article was written for her MSc Adult Nursing dissertation which explored the barriers that trans men and non-binary people face in accessing HPV testing and cervical screening, and the advantages of cervical self-sampling in these population groups. 2.2.3. Adam Gore, Crime Prevention and Reduction Officer, made the final in the Outstanding Leadership category at the recent Workplace Violence Reduction Awards (WVRA). 2.2.4. Reverend Martin Abrams, Spiritual Care and Chaplaincy Manager won the Lifetime Achievement Award / Special Recognition Award at the recent Grand Pride of Sefton Awards. Martin was recognised for his years of dedicated service to patients and the local community. Following the tragic incident in Southport last year, Martin was asked to lead a vigil in the town centre. His perfectly chosen words and calmness on the evening played a huge part in making the vigil a tremendously poignant occasion and since then Martin has continued to support many of those affected. 2.2.5. Tanya Holden, Sister in Critical Care at Southport Hospital, won the Unsung Hero Award at the recent Grand Pride of Sefton Awards. Tanya runs a support group for former Critical Care patient.

	2.2.6. Whiston and St Helens Hospitals achieved Level 1 accreditation with the Diabetes Care Accreditation Programme (DCAP) – the first service in the UK to do this. Apologies for absence were **noted** as detailed above
3.	**Declaration of Interests**
	3.1. There were no new declarations of interests in relation to the agenda items.
4.	**TB25/028 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 26 March 2025 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 26 March 2025
5.	**TB25/029 Matters Arising and Action Logs**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. The following action was closed: 5.2.1. Action Log number 2 (TB24/067 Statutory Pay Gap Report 2023/24) – Following analysis of the staff survey results and subsequent Team Talks, the Strategic People Committee (SPC) in April reviewed an action plan. This included actions to improve the lived experience of staff against the People Promise Theme of "we are compassionate and inclusive". Specific Equality, Diversity, and Inclusion (EDI) actions had also been agreed to improve the experience of staff with protected characteristics and needed reasonable adjustments. Action closed. 5.2.2. Action Log number 4 (TB25/006 Board Assurance Framework) – An update was included in Agenda Item TB25/033 Board Assurance Framework. Action closed. 5.2.3. Action Log number 6 (TB25/016 2023/24 Safeguarding Annual Report (Adults and Children) - 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 harmonised wherever possible. Action closed 5.2.4. Action Log number 7 (TB25/020 Committee Assurance Reports / 8.1 Executive Committee Assurance Report – the Independent Clinical Governance Review was circulated to the NEDs. Action closed 5.2.5. Action Log number 8 (TB25/025 Elimination of Mixed Sex Accommodation Annual Declaration) - 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 closed **RESOLVED:** The Board **approved** the action log
Performance Reports	
6.	**TB25/030 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for March 2025 was presented.
6.1.	**Quality Indicators**
	6.1.1. LB and PW presented the Quality Indicators. 6.1.2. LB highlighted the following: 6.1.2.1. The inpatient Family and Friends Test (FTT) recommendation rate in March 2025 was 94% against a target of 90% and year to date (YTD) was 94.6%. 6.1.2.2. The Nurse staffing fill rate had been 98.1% against a target of 90% and 96.9% YTD. 6.1.2.3. The Trust had exceeded the NHSE threshold of no more than 113 Clostridioides difficile (C.Diff) cases for 2024/25 with 114 cases reported YTD. The MWL rate of 32.2 per 1,000 bed days was below the Cheshire and Merseyside (C&M) rate of 38.6 cases in Q3. 6.1.2.4. MWL remained below the NSHE threshold of no more than 158 Escherichia coli (E-coli) cases for 2024/25 with 12 cases reported in month. 6.1.2.5. Pressure ulcers remained within the normal variation with 0.13 cases reported per 1,000 bed days, YTD was 0.14 cases. There was a slight backlog in the review of pressure ulcers and this was being monitored. A link nurse had been identified to embed the quality improvement project for pressure ulcer prevention in the Emergency Department (ED) and this included a focus on nursing documentation and risk assessment. 6.1.2.6. Patient falls resulting in harm across all Trust sites was 0.12 per 1,000 bed days (0.17/1,000 bed days YTD). An analysis of falls for the preceding three years had been presented at the Quality Committee and it was noted that whilst there had been a decrease in the number of falls overall, there had been a slight increase in numbers at Southport Hospital and further work was being undertaken to understand the reasons for this. 6.1.2.7. Complaints performance was 64.4% against a target of 80% and it was noted that, whilst there had been an increase in the number of complaints received across all sites, the percentage of claims responded to within 60 working days remained consistent. Complaints were now being managed and tracked via the new InPhase system. 6.1.3. PW highlighted the following:

	6.1.3.1. No never events had been reported in March. There had been five never events reported YTD and each incident had undergone or was undergoing a Patient Safety Incident Investigation (PSII). It was noted that a review of these never events had been presented at Quality Committee with the immediate actions and a report outlining further actions being taken to prevent future never events would be presented at Executive Committee. 6.1.3.2. The latest reported Hospital Standardised Mortality Ratio (HSMR) included data up to August 2024 and the in-month figure was 91.2 in August. The YTD HSMR remained below 100 at 95.3 (95.5 for Whiston and St Helens Hospitals and 94.5 for Southport and Ormskirk Hospitals). 6.1.3.3. The Standard Hospital Mortality Indicator (SHMI) - remained unchanged in October 2024 at 1.03. PW reported that he had seen the data for November and this indicated a further reduction to 1.02. 6.1.3.4. There were no (0) still births in month. There had been one neonatal death (baby born at 30 weeks and transferred to Liverpool Women's NHS Foundation Trust (LWH) for specialist care). The Perinatal Mortality Review Tool (PMRT) would be undertaken by LWH as this was where the baby died; however, the rapid review had raised no concerns regarding the care of the baby prior to being transferred.
6.2.	**Operational Indicators**
	6.2.1. LN, presented the operational indicators and highlighted the following: 6.2.1.1. The 4-hour mapped performance for MWL in March 2025 was 79.1% against the temporary national target of 78%. This compared to 75% nationally and 72.6% for C&M. This performance masked significant challenges, including, continued long waits in the Emergency Department (ED) for beds across both Whiston and Southport Hospitals which resulted in an increase in the number of escalation areas being opened including the use of corridor care in both ED departments. 6.2.1.2. Ambulance handover times within 30 minutes had improved to 55.2% of handovers being achieved within the target time in March, against the target of 95%. 6.2.1.3. Bed occupancy across all sites was 105.8% in March (the equivalent of 88 additional patients). 6.2.1.4. Non-Criteria to Reside (NCTR) patient numbers remained a challenge across all hospital sites at 23.8% which equated to 290 beds being occupied by patients who no longer needed to be in a hospital bed. 6.2.1.5. A new Chief System and Improvement Officer had been appointed by the C&M Integrated Care Board (ICB) and the Urgent and Emergency Care (UEC) Recovery Plan would be an area of focus. It was noted that LN and RC had attended a meeting regarding the system support across the ICB including the development of a single point of access. There was a collective focus on preventing hospitalisation of patients over 65 years of age, people from care home patients and mental health patients in crisis, by strengthening the support in the community, as well as the possibility of diverting type 1 A&E patients to Urgent Treatment Centres (UTC). A consistent approach to integrated discharge would also be key, especially to MWL who worked with multiple social care departments. A further

meeting had been scheduled to review the improvement workstreams for reducing the time for ambulance handovers.

6.2.1.6. In March there had been further improvement in the use of the ambulatory care pathways across MWL, including more pathways for Same Day Emergency Care (SDEC) and optimising the use of escalation areas.

6.2.1.7. The Referral to Treatment (RTT) 18-week performance was 64.6% of patients completing their treatment within 18 weeks in March compared to national performance of 59.2% (latest reported data for February) and 57.3% for C&M. The Trust was on track to achieve the improvement target of 70% by the end of 2025/26.

6.2.1.8. In March 2.5% of patients were waiting longer than 52 weeks to be treated, with a trajectory to reduce this to 1% by the end of 2025/26.

6.2.1.9. Improvements in theatre utilisation remained a focus for MWL and as a result of the work to date there was an increase in the number of sessions being used as well as a reduction in late starts and early finishes. The opening of the two new theatres at Whiston Hospital in August 2024 had provided additional capacity. Work was also being undertaken on the waiting list validation, in line with the patient access policy.

6.2.1.10. Performance against the 28-day cancer standards was 77.8% (target of 77%) with national performance at 80.2% and C&M performance at 76.6%. Performance against the 62-day cancer standard was 82.4% (target of 85%) with national performance at 67% and C&M performance at 74.6%. The Trust remained a positive outlier for this target. Tumour site specific action plans had been developed and presented at the Finance and Performance Committee to provide assurance of the steps being taken within each tumour site pathway to reduce waiting times. Increased focus would remain on the tumour sites that had not yet achieved the 28-day standard.

6.2.2. SC referred to the financial plan for 2025/26 and the elements of the Cost Improvement Programme (CIP) that would need to be delivered via system schemes and asked if there was more confidence in the plans for UEC Recovery following the various workshops that had been held. LN responded that the appointment of the Chief System and Improvement Officer was positive and reflected an increased commitment and drive by the ICB to deliver the recovery plan. RC commented that there now appeared to be a different attitude towards moving the recovery plan forward and discussions were more focused with workstreams to rationalise and streamline out of hospital community services and design alternatives for patients who did not need to be in an acute hospital. RC also advised that he had attended a national meeting where it was clear there was a drive for rapid change to ensure the NHS lived within its allocated resources.

6.2.3. CE asked about the management of the elective waiting list and whether this was being done based on clinical need, and if patients were being kept informed. LN responded that each patient on the waiting list was risk stratified and the lists were closely managed, with individual patient tracking. The Trust had performed better than peers in C&M against the 65+ week

	target in 2024/25 and the main reasons for breaches were patient choice, complexity and the reliance on other organisations to complete part of the pathway. In addition to more traditional methods of communicating with patients the Patient Experience Portal (PEP) was being rolled out across MWL, and where it was already in place the patients, were sent regular text messages about appointments and waiting times.
	6.2.4. CS asked if there was standardised reporting across the system in relation to discharge information. LN responded that the UEC Recovery Plan consisted of three workstreams, admission avoidance, admission decisions and discharge. The discharge workstream was where the work to reduce the number of NCTR patients was happening and had agreed metrics with targets for each local authority to reduce the number of patients waiting for a package of care, a step down or a care home bed. As discussed previously MWL worked across six local authorities and each had different challenges and processes so there was an emphasis on reducing these variations and developing a consistent offering, such as the Home First model.
	6.2.5. AMS asked if LN felt the Trust was working optimally to prepare patients for discharge as soon as they were ready to leave hospital. LN reflected that the Trust also had to focus on standardisation and consistency, this included the approach to board and ward rounds, the role of the discharge coordinators and reducing the time to receive to take out (TTO) medications. LN noted that there would always be a cohort of complex discharges for patients with complex needs, that would take time to arrange, but many discharges were routine and if completed efficiently supported better patient flow. RC noted that the current discharge model was being reviewed and different approaches piloted. PW commented on the work that was being undertaken with the Emergency Care Improvement Support Team (ECIST) to improve board rounds and the importance of a multidisciplinary team (MDT) contributing to discharge planning.
	6.2.6. RT asked if patients waiting for diagnostic tests had an impact on delayed discharges. LN agreed that sometimes patients did remain in hospital whilst waiting for tests, and where possible they should be discharged with an appointment to return as an outpatient for these tests.
	6.2.7. RT reflected that there was still a difference in the performance of the legacy sites for the cancer targets and asked when the services would be fully aligned. LN responded that historically the Southport and Ormskirk hospitals had underperformed against some of the cancer metrics and some teams were now working across the MWL footprint and plans were being developed for the rest. The deep dives were taking place with each service to identify the best practices to adopt across MWL.
	6.2.8. RF reflected that the Trust was still on its post transaction integration journey but there were now external changes to the NHS that would also impact

	decisions about the future of services, which made the situation even more complex. The newly appointed Chief System and Improvement Officer would be looking at issues across the ICB, but RF noted delayed discharges had been a theme at every Board meeting he had attended in his 15 years working with the NHS, so these issues were not easy to resolve.
6.3.	**Workforce Indicators**
	6.3.1. MS presented the Workforce Indicators and highlighted the following: 6.3.1.1. The compliance rate for appraisals was 83.4% (target 85%), as the 2025/26 appraisal window would open on 01 May 2025. 6.3.1.2. The compliance rate for mandatory training was 88% (target 85%) and there had been an improvement in several of the lower compliance subjects. Work was ongoing with medical staff to improve compliance and the Executive Committee continued to review performance each month, while the Quality Committee received quarterly assurance reports. 6.3.1.3. Sickness absence had reduced to 6.5% (target 5%), this was slightly higher than the same period in 2023/24. The North west region had the highest levels of sickness absence and the rolling 12 month figure for C&M was 5.6%. A deep dive into sickness absence had been presented at the April Strategic People Committee. The three top reasons for sickness remained stress, anxiety and depression (30% of sickness), cough, cold and flu, and musculoskeletal health. There had been a slight reduction in Health Care Assistants (HCA) sickness in month, however, there had been an increase in the admin and clerical workforce sickness. 6.3.1.4. Staff turnover was 0.9% (target 1.1%.)
6.4.	**Financial Indicators**
	6.4.1. GL presented the financial indicators and advised that the financial position report was a provisional position as the figures were still subject to audit. Additionally, GL reported the position had changed due to a late change with a notional charge being applied following a change to the accounting rules for the treatment of Public Finance Initiative (PFI). 6.4.2. GL highlighted the following: 6.4.2.1. The initial MWL financial plan for 2024/25 had been a deficit of £26.7m which assumed: • Payment of the £12m non-recurrent transactional support. • A CIP target of £48m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 elective activity plan • Non-recurrent deficit funding 6.4.2.2. In September 2024 MWL agreed to a revised financial plan on the basis of receiving £15.8m deficit support and the revised financial plan for 2024/25 had been a deficit of £10.9m. The final performance position was a £14.7m deficit which was a £3.8m variation to plan and this was mainly due to the impact of the £5.4m notational charge. However, if the notational charge had not been applied the Trust would have delivered a £9.3m deficit which was an improvement against plan.

	6.4.2.3. The Trust had delivered the CIP target of £48m in full. 6.4.2.4. The closing cash balance at the end of 2024/25 was £10.2m which was slightly higher than expected. 6.4.2.5. The Trust delivered capital expenditure of £45.3m. 6.4.3. GL noted that there was a variation between the performance position and the accounts position, and this was due to the accounts being based on IFRS rules whilst the NHS produced accounts on the UK Generally Accepted Accounting Principles (GAAP). The final accounts which would be reviewed by the Audit Committee were a £48m deficit against a plan of £20m deficit. The main reason for the variation was the revaluation of Trust's assets and it was noted that these were reviewed by external assessors annually. 6.4.4. CE commented on the Trust's financial performance especially the CIP performance and asked if progress was being made on the agreement of control totals for 2025/26. GL responded that the discussions remained ongoing and there was a further update scheduled for the Strategy Board agenda. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB25/031 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. RC presented the Executive Committee Assurance report from the meetings held in March 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. 7.1.2. RC highlighted the following items from the report: 7.1.2.1. The Committee had received the review of the Transition and Transformation Council (TAT) and had approved the recommendation to disband the Council as the original objectives had been delivered or transferred to business as usual governance. 7.1.2.2. The Committee had reviewed the proposals to formalise the Trust's strategy team, the methodology for prioritisation of service improvements to deliver the Trust objectives and strategic plans and governance arrangements and had approved the creation of a Strategy and Transformation Council reporting to the Executive Committee. 7.1.2.3. The Committee had discussed the ongoing financial planning for 2025/26. 7.1.2.4. The Committee had agreed the Trust objectives for 2025/26 for recommendation to the Board.

	7.1.2.5. The Committee had received an update on the 2024/25 Staff Vaccination Programme and the national emphasis on staff vaccination programmes as part of the 2025/26 winter plan had been highlighted. 7.1.2.6. The Committee had discussed the results of the 2024 staff survey and members of the Executive Committee had attended several physical and virtual Team Talk with staff to discuss the results and the changes they wanted to see. The discussions from these events would be woven into the improvement plan for the organisation. 7.1.2.7. The Committee had reviewed the proposals for two development programmes to support Divisional Triumvirate teams and the cohort of operational managers across MWL. 7.1.2.8. The Committee received a report which detailed the benefits of continued membership of the Advancing Quality Programme (AQuA) and it had been agreed to extend the membership for 2025/26. 7.1.3. RC advised that the following investments had been approved in March 2025: 7.1.3.1. The business case to implement seven day dietetics and speech therapy cover at Southport Hospital. 7.1.4. RT was pleased that there was now a plan to implement seven day dietetics and speech therapy cover at Southport Hospital as this had been a recommendation in the Care Quality Commission (CQC) inspection report of Medicine at Southport Hospital. However, RT asked if alternative models of delivery had been considered, given the national shortages of Speech Therapy and Dietitians. RC acknowledged this concern about recruitment, but felt it was important that the service had the resources allocated to be able to run a seven day service, and the importance of appropriate referrals for nutritional support for patients was widely recognised. There were options to develop health support worker roles with specific skills in this area as had already been done for other Allied Health Professional (AHP) groups. LB commented that it would be important to prioritise what the qualified dietetic staff would do and noted that MWL, as a bigger organisation, offered the opportunities for a larger professional group with collaboration and subspecialisation across sites. Nutrition and Hydration remained in the Trust Objectives for 2025/26 as it was recognised that the Trust still had more work to do in this area to improve care. 7.1.4.1. GB asked about the decision to stop using agency HCAs that had been reported at the March Board and asked for an update on HCA recruitment to substantive posts and to the bank. RC responded that the decision to stop using agency HCAs had been accompanied by the decision to move to a larger substantive workforce who were familiar with the Trust and trained in the local system and processes, to support the demand for supplementary care. Recruitment and retention of HCAs continued to be a challenge, as these were difficult jobs, but the benefits were being demonstrated. LB assured the Board that there had been a planned and controlled turn-off of agency usage, initially in the lower use areas. MS

	noted that there was always a healthy pipeline of HCA recruits but turnover and retention remained an issue. The remainder of the report was **noted.**
7.2.	**Audit Committee**
	7.2.1. SC presented the Audit Committee Assurance Report for the meeting held on 16 April 2025 and highlighted the following: 7.2.1.1. The Committee had received the external audit plan for the 2024/25 audit of the accounts. 7.2.1.2. MIAA had issued six internal audit review reports since February 2025. Four reports (Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, Electronic Staff Records (ESR) / Payroll, Risk Management Core Contents and key Financial System Controls) had received high assurance. Two reports (Emergency Preparedness, Resilience and Response (EPRR) and Patient Safety Incident Response Framework (PSIRF) had received significant assurance. 7.2.1.3. The Committee had received and approved the internal audit plan for 2025/26 which covered the key risk areas and strategic risks that linked into the Trust's Board Assurance Framework (BAF). 7.2.1.4. MIAA had presented the Head of Internal Audit Opinion for 2024/25 which assisted the Board in the completion of the Annual Governance Statement (AGS). This was based on three elements; the BAF, core mandated reviews and other risk based reviews undertaken during 2024/25. MIAA provided substantial assurance on the Trust's systems of internal control. It was noted that this was the highest level of assurance that could be achieved. 7.2.1.5. The Committee received the MWL Audit Log which listed all the recommendations from previous internal audit reports and provided assurance that the agreed management actions had been implemented in the planned timescales. 7.2.1.6. MIAA presented the Anti-Fraud Annual Report for 2024/25. The Trust had received a green rating in all areas excluding one; policies and registers for gifts, hospitality and Conflicts of Interest which had received an amber rating. 7.2.1.7. The Committee received Trust Accounts Preparation report which highlighted that there were that there were no major changes to the Trust's accounting policies for 2024/25. The report also included the key deadlines for submission of the 2024/25 accounts as 25 April (draft) and 30 June (final). 7.2.1.8. The Committee had received the Losses and Special Payments report which included a presentation on pharmacy stocks and the work undertaken to reduce wastage and losses during 2024/25. 7.2.1.9. The Committee had received the Aged Debt report and specific attention had been paid to the age and value of the aged debt in the greater than 90 days category, and the Audit Committee had referred this to the Finance and Performance Committee to monitor performance.

	The remainder of the report was **noted.**
7.3.	**Quality Committee**
	7.3.1. GB presented the Quality Committee Assurance Report for the meeting held on 22 April 2025 and noted that a curtailed agenda had been presented to allow for members to attend the Senior Leaders Star Conference. 7.3.2. GB highlighted the following items: <u>Corporate Performance Report (CPR)</u> 7.3.2.1. The National Early Warning Score (NEWS) targets had been achieved for inpatient areas, however, further work was required in ED and NEWS2 training was to be made compulsory for all registered nurses (RN). 7.3.2.2. There had been three maternity intensive care admissions in month, two of which were due to pregnancy related issues, and all cases had been reviewed. <u>Patient Experience Report</u> 7.3.2.3. There had been a month-on-month improvement in the number of patients receiving the discharge booklet which was one of the Trust's 2024/25 quality improvement objectives. 7.3.2.4. Local Healthwatch groups had awarded the Trust an average of four stars and positive comments had been received about patient care and treatment from staff. Negative comments had related to communication and the environment, particularly corridor care in the ED. 7.3.2.5. The number of volunteers in the Trust had increased from 377 to 639 and the Committee had reflected on the important and valuable work undertaken by this group. 7.3.2.6. The Southport Critical Care Unit (CCU) has been nominated for Placement of the Year for Nursing by the Nursing Times. <u>Care Quality Commission (CQC) Update Quarterly Report</u> 7.3.2.7. The CQC Report for Southport ED had now been published and it was expected that the CQC would return to carry out a further inspection within 12 months. 7.3.2.8. A focussed Radiology inspection was scheduled for 30 April and a full inspection of St Helens Urgent Treatment Centre (UTC) would take place on 08 May. 7.3.2.9. The Executive Committee had approved funding for a seven-day Dietetic Speech and Language service on the Southport site, which was a 'must do' action from the CQC report of the inspection of Medicine at Southport Hospital. 7.3.2.10. Representatives from the CQC had attended a Quality Ward Round (QWR) and had expressed an interest in visiting other sites and specialties. <u>Patient Safety Report</u> 7.3.2.11. There had been two open Patient Safety Incident Investigations (PSII) reviews in February, however, the team would be applying to external commissioners to deescalate one of these following the coroner's findings.

	7.3.2.12. A pilot project to review patient drug allergies, particularly penicillin, to differentiate between true anaphylaxis and milder reactions that could be easily controlled, was being planned. 7.3.2.13. The Committee received an aggregated review of investigation outcomes of the five Never Events reported since May 2024. It had been agreed that there were several areas that required additional support and these would be discussed at the Executive Committee and feedback would be provide to the Quality Committee. 7.3.3. RF reflected on the welcome increase in the number of volunteers and the importance of their roles in the Trust. The remainder of the report was **noted**.
7.4.	**Strategic People Committee**
	7.4.1. CS, on behalf of LK, presented the Strategic People Committee (SPC) Assurance report for the meeting held on 23 April 2025 and thanked SC for attending to ensure that the meeting retained quoracy. 7.4.2. CS highlighted the following: 7.4.2.1. The Committee had reviewed the Workforce Dashboard and had noted the improvement in the Time to Hire (TTH) which had improved in March 2025 to 50.7 days (64.7 days in February) against the target of 40 days. The differences between professional groups continued to be tracked on the dashboard. 7.4.2.2. The Committee received the 2024/25 Sickness Absence Review and it was noted that the Trust was consistent with the national and regional position. The review had highlighted the importance of 'return to work' discussions for both short and long term absences as a key tool in the management of sickness and absence, to reinforce the importance of the individual to the organisation. This would be reinforced in the Workforce Plan as well as in the response to the staff survey. 7.4.2.3. The Committee received an update on the progress made against the Trust's People Plan and Trust objectives. It was noted that three actions remained outstanding and the completion of these would be a priority for the HR team in 2025/26. 7.4.2.4. The Committee noted the concluding summary of the 2022 to 2025 People Plan and the progress made over the three years in delivering the improvements. 7.4.2.5. The Committee received the Lead Employer People Plan update for quarter four of 2024/25 and was assured by the progress with 14 of the planned actions completed and five ongoing. 7.4.2.6. The Committee reviewed the Annual Workforce Operational Plan 2025/26 and had noted that the plan may need to be updated to align to the final agreed financial plan for 2025/26.

	7.4.2.7. The Committee had received the Trust's Educational Experiences Survey results for students across all professions and the resultant action plan would be incorporated into the operational workplan. 7.4.3. RT reflected on the 1% reduction in the substantive workforce and asked if the impact on other related services had been considered. MS responded that the consequences of any reductions in workforce were being considered as part of the workforce planning process for 2025/26 and reflected on the financial investments that the Trust had made into its workforce in recent years and whether these had delivered the planned benefits. It would be important to continue to balance risks to both clinical and corporate services. A risk assessment and Quality Impact Assessment (QIA) tool was being drafted to understand the impact of any reductions in workforce, and every proposal would be reviewed by the Director of Nursing, Midwifery and Governance, Medical Director and Chief Operating Officer. 7.4.4. CE asked whether the stress, anxiety and depression reported as the biggest reported cause of sickness absence was workplace related. MS responded the ESR system currently only recorded the primary reason for sickness absence, so if this was linked to other issues this was not recorded and could not be analysed. However all staff who were off sick due to stress, anxiety and depression should be referred to Occupational Health, and anecdotally there seemed to be a balance between work and home life stress. Even in situations where an individual's ability to work was being impacted by home life stress, the Trust should still offer support from the Health, Work and Well Being (HWWB) service. CS reflected on the difficulty of these types of conversations and the importance of discussions being honest, open and transparent. MS agreed and noted that there needed to be a holistic approach with many other policies also concerned with supporting the needs of staff, e.g. the flexible working policy. MS also reflected that the reasons for staff struggling with attendance at work were often complex and varied, and on some occasions the needs of the individual were not compatible with the requirements of the service. The remainder of the report was **noted**.
7.5.	**Finance and Performance Committee**
	7.5.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 24 April 2025 and noted that several reports had been deferred due to the ongoing financial and operational planning for 2025/26 with the ICB and NHSE. The Committee had reviewed the Finance and Performance CPR and monthly finance report, but the key points had already been discussed in earlier reports on the Board agenda so would not be repeated. 7.5.2. Other points to highlight from the report were:

	7.5.2.1. GL had provided an update on the 2025/26 financial planning position and the correspondence from the ICB regarding further expenditure instructions, as well as the pressure on the Finance team. 7.5.2.2. The Trust had consistently achieved the 2024/25 financial plan over the preceding three to four months. 7.5.2.3. The Committee had received the month 12 CIP update and it was noted that the Trust had achieved the plan for 2024/25. (£48m of which £36.8m was recurrent). Any schemes that had not been delivered in year had been rolled forward as part of the 2025/26 CIP programme. 7.5.2.4. The Committee had received the Clinical Support Services and Community Division (CSS&C) CIP update and whilst, the plan was not as strong as other divisions, it had still contributed to the overall performance. The Divisional Director had acknowledged the need for improvement in 2025/26. 7.5.2.5. The Committee had received the UEC Performance Delivery Review which had provided an update on the pressures being experienced and the plans to alleviate them. The report highlighted the good relationship with Mersey Care NHS Foundation Trust in dealing with mental health pressures in the ED. The in hospital workstreams included projects to improve access to SDEC, reduced ambulance handover delays reducing and inpatient length of stay had been noted. The Committee had requested a trajectory of improvement so there was a quantitative measurement of the impact of these schemes and the out of hospital workstreams. 7.5.3. 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	
8.	**TB25/032 Clinical Strategy Annual Update**
	8.1. PW presented the Clinical Strategy Annual Update The strategy had set out the clinical priorities for the first two years following the creation of MWL. PW noted that, whilst clinical strategies normally covered a period of five years, this was a two year strategy recognising the period of stabilisation and integration the Trust needed. 8.2. The strategy objectives were : 8.2.1. To ensure that the MWL clinical governance structures were in place to continue to deliver safe and effective clinical care across the Trust. 8.2.2. To review and align pathways to enable integration of clinical services across the Trust.

	8.2.3. To complete the stabilisation of fragile clinical services and address any inequalities, delivering high quality and effective care to patients at all sites. 8.2.4. To achieve the national regional and local NHS priorities relating to ED, turnaround times, reduction in waiting times for elective and diagnostic tests and to reduce the time to diagnose or exclude cancer in patients who were referred to the hospital. 8.3. PW highlighted the achievements in the period since the strategy had been launched: 8.3.1. The clinical governance structures including the Trust-wide divisional leadership and patient safety structures were in place. The Patient Safety structure was delivering the PSIRF, with weekly patient safety panels and incident review groups. The actions for the next 12 months included the appointment of a Trust-wide Assistant Medical Director for Patient Safety and the appointment of Trust-wide Clinical Directors for each speciality (June 2025). 8.3.2. The review and alignment of Trust-wide clinical pathways had been achieved in several key areas including Resuscitation and Advanced Care Planning. The actions for the next 12 months would be led by Trust-wide Clinical Directors. Clinical Policies and Standard Operating Procedures for each specialty would continue to be harmonised as services became more integrated. 8.3.3. Progress had been made in the stabilisation of some fragile clinical services and PW noted that these fragile services had been identified by the former Southport and Ormskirk Hospital NHS Trust (S&O) Board prior to the transaction and had been one of the driving forces for the transaction. New consultant appointments had been made to Medicine for Older People and Ophthalmology and work was ongoing with the Liverpool Vascular and Endovascular Service (LiVES) service to agree a service specification for vascular services at Southport Hospital. Work was ongoing for the C&M Ear, Nose and Throat (ENT) service as this was a fragile service across several organisations in the system. Work had also been undertaken to provide on-call services for Ophthalmology within MWL to reduce the reliance on Service Level Agreements (SLA). 8.3.4. Work on the UEC Recovery Programme, to optimise theatre utilisation and to address cancer waiting time variations, would continue to be areas of focus. 8.4. PW advised that work would start on the new Clinical Strategy later in the year and this would align to the overarching Trust strategy and other supporting strategies including IT, workforce and nursing. The draft Clinical Strategy would be presented to Board for approval. 8.5. RT asked for more information about the progress on developing a C&M ENT service. PW noted that, whilst the Trust was currently delivering a safe service, it needed to be delivered differently to meet demand but progress had been slow. RT suggested that ENT should be listed as a fragile service. PW responded that the report had noted that two out of three services had shown

	progress and that it was anticipated that there would be progress with the other. 8.6. HS asked whether any of the objectives would not be achieved over the next 12 months. PW responded that, as the Board discussed, some of the issues around the ED pressures would be challenging to resolve and were not resolvable by the Trust alone. However, it was anticipated that the objectives for cancer targets and diagnostic tests, as well as the alignment of clinical pathways and the integration of clinical services would be achieved. There were several aspects around the stabilisation of fragile clinical services which were outside of the Trust's control as there was a reliance on other organisations for the delivery of services, for example the LiVES service was delivered by NHS University Hospitals of Liverpool Group, however, the Trust would move forward with things that were within its control. 8.7. NF asked if there were other fragile services that had not been included in the report. PW responded that ENT, Vascular and Ophthalmology services were the most at risk services as there was a reliance on locums, single practitioners, SLAs or were closed to referrals. There were several other fragile services which had moved into a stabilisation phase. PW noted that the Ophthalmology service at Southport Hospital had reopened to cataract referrals and now was able to offer an age-related macular degeneration (AMD) service. 8.8. GB reflected on the conciseness and clarity of the strategy and commented that the report had been easy to understand. GB also commented that the themes and issues highlighted in the strategy were woven into questions and discussions with candidates at Consultant interviews which provided assurance that the strategy was being embedded in the organisation. 8.9. RC commented that the Trust was still in a period of change and stressed the importance of having a clinical workforce that was dynamic enough to adapt to these changes and having a clinical strategy in place would support potentially difficult decisions that would need to be made around where care would or would not be delivered and to ensure the best use of resources. 8.10. CS asked how primary care interfaced with the Clinical Strategy, and if the GP practice delivered by MWL would be used as a test for change. PW responded that there was a primary and secondary care interface forum that included mid and north Mersey as well as Lancashire and the forum had been consulted on the original Clinical Strategy. The Trust would continue to utilise the forum to build good relationships with primary care. Marshall Cross was perceived as a normal GP primary care service; however innovations were tested there and the surgery was heavily involved in research. It was noted that one of the challenges with primary care was the number of single handed practitioners and this meant that some changes did not work for all practices. PW noted that a symposium meeting had been held recently and had been attended by

	GPs and consultants from the Trust, where ways to improve the urgent care interface had been discussed. 8.11. CE reflected on the level of clinical engagement, which had been evidenced at the recent Senior Leadership Conference. 8.12. RF reflected on the Trust's reliance on other organisations or the wider system to work with us to resolve some of the long standing issues faced, particularly in relation to the fragile services for the populations of Southport and Ormskirk. **RESOLVED:** The Board **noted** the Clinical Strategy Annual Update
9.	**TB25/033 Board Assurance Framework**
	9.1. NB presented the Board Assurance Framework (BAF) and noted that each BAF risk has been reviewed by the lead Executive and updates provided in relation to closed and new actions. 9.2. NB advised that normally the Corporate Risk Register (CRR) was presented at the same time as the BAF, however, the Trust had transitioned to the new InPhase system in March 2025 and there had been some difficulties transferring the risks from the two legacy Trust Datix systems, which had meant that the CRR could not be generated at the current time. The risks were in the process of being manually transferred and once this was completed normal reporting would resume. NB assured the Board that existing risks continued to be monitored and new risks reported to InPhase, and there were no new approved risks that had been escalated to the CRR that the Board needed to be made aware of at this time. 9.3. NB noted that several of the BAF risks had been updated to reflect the year end position and the start of the new financial year, with new actions to fill any gaps in assurance. 9.4. SC reflected on the target score of 5 in respect of BAF 1 (Systematic failures in the quality of care) which had remained consistently high and asked whether a target score of 5 was achievable. NB responded that the Trust should always aspire to not have any systematic failures of care and noted that the risk score had been lower in the past but had been elevated throughout 2024/25. RF agreed with aspirational target score for this risk, as it was a fundamental issue for the NHS, but the systemic issues with UEC and NCTR patients did risk the quality of patient care. **RESOLVED:** The Board **approved** the Board Assurance Framework

10.	**TB25/034 Learning from Deaths Quarterly Report (Q2 2024/25)**

10.1. PW presented the Learning from Deaths Quarterly Report (Q2 2024/25) and advised that the Learning from Deaths programme was introduced about eight or nine years ago at all trusts to provide assurance to the Board that any deaths that had occurred in hospital were undergoing a robust review and that lessons learnt were identified and shared across the organisation. This process sat alongside two other processes that also reviewed deaths or harm to patients. The first was the Medical Examiner's process which was slightly removed from the organisation and any lessons learnt was feedback into the organisation. The second was the PSIRF process which reviewed any harm, including death, where appropriate.

10.2. PW noted that there was a discrepancy between the figures included on the front sheet and in the main report. The tables in the report were correct and a new front sheet would be issued.

10.3. PW highlighted the following:

10.3.1. There had been 76 deaths that met the criteria for a Structured Judgement Review (SJR) at the Whiston, St Helens and Newton Hospital sites, of which 18 had been completed this quarter. None of the cases reviewed had been graded as amber or red.

10.3.2. At the Southport and Ormskirk Hospital sites 192 deaths had been reviewed by the Medical Examiner Scrutiny and 12 SJRs had been completed, of which three were graded as amber and none (0) were graded as red. There were still different processes in place across the legacy Trust sites but these were in the process of being harmonised.

10.4. The review of cases that had been graded as amber had not suggested that the deaths were preventable or were anything other than natural causes. However, there were some lessons identified from the review of the care and these had been shared across the Trust.

10.5. The reported included details of a case that had been graded as green (85 year on chemotherapy presented with chest pain) as the patient's wife had requested a second opinion under Martha's rule, which was a pilot being run at Southport Hospital, as she had not been in agreement with the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision. The Critical Care team had reviewed the patient and had been in agreement with the DNACPR decision. It was noted that there was learning from this case which would be shared throughout the organisation.

10.6. No prevention of future death orders had been passed down following the coronial inquests that had taken place in this period.

10.7. A review of the Assistant Medical Director (AMD) for Patient Safety roles had been undertaken and consultation on the Job Descriptions for the new AMD role and responsibilities was currently underway with the appointment of a single lead for the Learning from Deaths (LFD) process anticipated in May

	2025. The new Learning from Deaths Lead would also be responsible for the oversight of the Mortality Surveillance Group and for standardising the LFD process across MWL. 10.8. RT commented that the current Mortality Surveillance Group was not always well attended and reviews sometimes took a long time to be completed, therefore it might be necessary to review the support to the Chair. 10.9. AMS commented on the length of time being taken to complete Patient Safety Learning Reviews which had been discussed at Quality Committee. PW responded that the length of time taken depended on the depth of review required and noted that all cases underwent an immediate review and some cases required a brief patient safety review whilst others required an extended learning review or PSII. The PSII was a detailed review and took a long time to complete. The Mortality Surveillance Group only met bi-monthly, which was being reviewed. **RESOLVED:** The Board **noted** Learning from Deaths Quarterly Report (Q2 2024/25)
11.	**TB25/035 Patient Experience and Inclusion Strategy**
	11.1. LB presented the Patient Experience and Inclusion Strategy for 2025 to 2028 and the strategy implantation plan. LB thanked the patient experience team for their hard work in drafting the Strategy and noted that it had previously been presented and reviewed by the Executive Committee, Quality Committee, and Patient Experience Council. 11.2. The Strategy, which was the first integrated Patient Experience and Inclusion Strategy for MWL, had been designed around the Trust's values and aligned to the Trust objectives. The information that had informed the strategy had been taken from multiple routes of patient feedback, concerns/complaints, incidents, results of the National Patient Experience Surveys, national guidance and legislation and the need for a different approach since becoming a much larger Trust. 11.3. A full consultation had taken place with amendments made in line with feedback from both internal and external partners including patients and their representatives. 11.4. LB advised that the Patient Experience and Inclusion Strategy, if approved, would be launched as part of National Patient Experience week. 11.5. CE commented on the level of engagement with the different groups and communities which she found encouraging. CE could see that the patients views had been taken into account. RF commented that he considered this to be one of the Trust's strengths.

	11.6. NF commented that Lancashire and South Cumbria ICB had not been listed as one of the organisations that had supported the development of the strategy. LB undertook to check this and if necessary, would update the document. **Action** LB to check whether Lancashire and South Cumbria ICB had been one of the organisations that had supported the development of the strategy and, if so, update the document to reflect this. **RESOLVED:** The Board **approved** the Patient Experience and Inclusion Strategy.
12.	**TB25/036 MWL People Plan**
	12.1. MS presented the MWL People Plan 2025 to 2028 which aimed to create a supportive, inclusive and thriving workplace where staff felt valued, empowered and motivated to deliver 5 Star Patient Care. MS highlighted that the plan was for three years and noted that this had been done purposefully given the changing landscape of the NHS and its workforce. 12.2. The Plan was based on the NHS People Plan and was underpinned by four key ambitions namely: • fostering a Culture of Wellbeing and Support • developing an Inclusive and Diverse Workforce • embracing Innovation and Career Development • enhancing Workforce Planning and Partnerships 12.3. MS highlighted the following: 12.3.1. The plan had been created with support from the HR governance councils and had previously been reviewed by the Executive Committee, the Strategic People Committee and by the divisional leadership teams. 12.3.2. There was not a specific Equality, Diversity, and Inclusion (EDI) section as it had been felt to be important to ensure that EDI was at the heart of all aspects of the strategy. 12.3.3. The priorities would form part of the Trust Objectives over the next few years to address workforce risks. 12.3.4. Success would be measured against the four key ambitions and assurance would be reported via the Strategic People Committee. 12.4. RF commented that this was a strategy that would be of interest to everyone who worked at the Trust. **RESOLVED:** The Board **approved** the MWL People Plan 2025-2028
Concluding Business	

13.	**Effectiveness of Meeting**
	13.1. RF invited CE and NF to reflect on the effectiveness of the meeting. CE commented that she had found the discussions interesting, the meeting had been effectively run, and she had been assured by the level of detail in the papers received prior to the meeting which had reflected the work behind each of the reports. RF commented that the engagement of the Executives and NEDs made it a better organisation for staff and patients which was especially important. NF commented that he felt that it had been an open meeting with appropriate challenge when required and he had felt welcomed and supported. RF thanked CE and NF for their contributions to the meeting.
14.	**Any Other Business**
	14.1. RF advised that as this was his last Board meeting; he would like to record his thanks to the Board and to the Trust's wonderful staff. He commented that the last ten years at the Trust had been a joy for him and he reflected on the achievements of the Trust (and its predecessors) in this time, which included an outstanding CQC rating, being voted as the best acute Trust in England by the Health Service Journal, the best in the patient-led environmental assessments (PLACE), a gold award as an employer for supporting staff from the Armed Services from the MOD, the best acute Trust in England based on the NHS staff surveys, the best patient experience in the NHS in CHKS Hospital awards, the volunteers received the Queens Award, which was the highest award that any voluntary group could receive, awards for cleanliness, Top 100 places to work and a leader in disability confidence scheme. RF thanked everyone, both old and new and commented that there had been several recent changes to the team, and the Trust had a great future, thanks to the new Chief Executive supported by lots of experience in the executive team. It has also been great to see the new NEDs (SC and CS) as they have developed their confidence as non-executive members of the Board. RF commented that he was confident in the future of the Trust thanks to the team in place which would be led by RC and SR. 14.2. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.13 The next Board meeting would be held on **Wednesday 28 May 2025 at 10.00**

Meeting Attendance 2025/26												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)	✓											
Steve Rumbelow (Chair)												
Anne-Marie Stretch	✓											
Lynne Barnes	✓											
Gill Brown	✓											
Nicola Bunce	✓											
Steve Connor	✓											
Rob Cooper	✓											
Claudette Elliott	✓											
Neil Fletcher	✓											
Malcolm Gandy	✓											
Lisa Knight	✓											
Gareth Lawrence	✓											
Lesley Neary	✓											
Hazel Scott	✓											
Carole Spencer	✓											
Malise Szpakowska	✓											
Rani Thind	✓											
Peter Williams	✓											
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball	✓											
Richard Weeks	✓											
✓ = In attendance A = Apologies												

Trust Board (Public)
Matters Arising Action Log
Action Log updated 23 May 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
9	30/04/2025	**TB25/035 Patient Experience and Inclusion Strategy**	LB to check whether Lancashire and South Cumbria ICB had been consulted about the development of the strategy and, if so, update the document to reflect this. Update (21 May 2025) LB confirmed Lancashire and South Cumbria ICB had been asked to comment on the draft strategy but no feedback had been received.	LB	May-25		

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	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.	MS	~~01/01/2025~~ Apr-25	**30/04/2025** - Following analysis of the staff survey results and subsequent Team Talks, the Strategic People Committee (SPC) in April reviewed an action plan. This included actions to improve the lived experience of staff against the People Promise Theme of "we are compassionate and inclusive". Specific Equality, Diversity, and Inclusion (EDI) actions had also been agreed to improve the experience of staff with a protected characteristics and needed reasonable adjustments. Action closed	Closed

4	29/01/2025	**TB25/006 Board Assurance Framework**	MG to review BAF 8 to include the implementation of the maternity information system for Whiston or the expansion of the Electronic Prescribing and Medicines Administration (EPMA) system at Southport as actions.	MG	Apr-25	**30/04/205 -** Update included in Agenda Item TB25/033 Board Assurance Framework. Action closed.	**Closed**
6	26/02/2025	**TB25/016 2023/24 Safeguarding Annual Report (Adults and Children)**	LB to provide further information on how the safeguarding audits were being undertaken in 2024/25.	LB	Apr-25	**30/04/2025** - 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 harmonised wherever possible. Action closed.	**Closed**
7	26/03/2025	**TB25/020 Committee Assurance Reports** 8.1 Executive Committee	RC to circulate the Independent Clinical Governance Review to the NEDs.	RC	Apr-25	**30/04/2025** - The report was circulated to NEDs. Action closed.	**Closed**
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.	LB	Apr-25	**30/04/2025** - 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 closed	**Closed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	28 May 2025
Agenda Item	**TB25/039**				
Report Title	**Integrated Performance Report**				
Executive Lead	Gareth Lawrence, Chief Finance Officer				
Presenting Officer	Gareth Lawrence, Chief Finance Officer				
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 ten metrics, Operations 13 metrics, Workforce four metrics and Finance three 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 ten metrics for Quality provide an overview for summary across MWL
Recommendations
The Trust Board is asked to note performance for assurance.

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

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	Sep-24	87.2	100	92.5	Best 30%
FFT - Inpatients % Recommended	Apr-25	93.6%	90.0%	93.6%	Best 50%
Nurse Fill Rates	Mar-25	98.1%	90.0%	96.9%	
C.difficile	Apr-25	6		6	
E.coli	Apr-25	12		12	
Hospital Acq Pressure Ulcers per 1000 bed days	Jan-25	0.08	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.12	0.00	0.17	
Stillbirths (intrapartum)	Apr-25	0	0	0	
Neonatal Deaths	Apr-25	0	0	0	
Never Events	Apr-25	0	0	0	
Complaints Responded In 60 Days	Apr-25	46.5%	80.0%	46.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-25	74.0%	77.0%	74.0%	Worst 30%
Cancer 62 Days	Mar-25	85.7%	85.0%	79.7%	Best 20%
% Ambulance Handovers within 30 minutes	Apr-25	56.1%	95.0%	56.1%	
A&E Standard (Mapped)	Apr-25	79.5%	78.0%	79.5%	Best 30%
Average NEL LoS (excl Well Babies)	Apr-25	3.8	4.0	3.8	Best 30%
% of Patients With No Criteria to Reside	Apr-25	21.7%	10.0%	21.7%	
Discharges Before Noon	Apr-25	21.6%	20.0%	21.6%	
G&A Bed Occupancy	Apr-25	98.3%	92.0%	98.3%	Worst 30%
Patients Whose Operation Was Cancelled	Apr-25	1.0%	0.8%	1.0%	
RTT % less than 18 weeks	Apr-25	64.3%	92.0%	64.3%	Best 30%
18 weeks: % 52+ RTT waits	Apr-25	2.7%	1.0%	2.7%	Worst 40%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-25	77.0%	85.0%	77.0%	
Mandatory Training	Apr-25	89.2%	85.0%	89.2%	
Sickness: All Staff Sickness Rate	Apr-25	6.1%	5.0%	6.1%	
Staffing: Turnover rate	Apr-25	0.6%	1.1%	0.6%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Apr-25		5,200	666	
Cash Balances - Days to Cover Operating Expenses	Apr-25	1.0	10		
Reported Surplus/Deficit (000's)	Apr-25		-6,665	-6,665	

Board Summary - Quality

Quality

MRSA - There was 1 healthcare-associated MRSA case in April on the Southport Site. The IPLR panel concluded that the case was unavoidable but organisational lessons for improvement were identified. Reducing MRSA bacteraemia remains a Trust Quality objective in 2025-26.

Clostridium difficile infection - There were 5 HOHA and 1 COHA cases at MWL in April. The CDI Improvement Plan will continue into the new financial year, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training.

E coli - There were 12 healthcare-associated cases in April, 8 HOHA and 4 COHA, which is 2 cases below NHSE threshold.

Never Events - There were no never events in April

Complaints: There has been a 22.2% reduction in new complaints received by the Trust, it can be noted all sites have seen a reduction in new complaints received through the month of April in comparison to the previous month. The reduction in complaints responded to within 60 working days against Trust policy has had a marked reduction. This is due to an increased focus on responding to complaints that have breached the 60 working day timeframe. Additionally there has been a 16.2% increase in the number of complaints closed in April (43 resolved overall) compared to March (37 complaints resolved).

Inpatient FFT: April positive score 93.6%, 0.4% below target of 94% (National average score Jan-25 - 95%). Main themes aligned to negative comments were staff attitude and communication (also main themes attached to positive comments). National Inpatient Survey (2023) action plan in place.

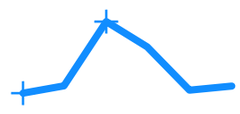
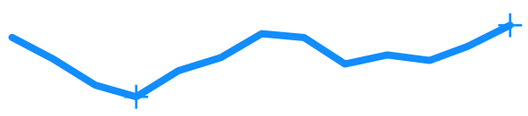
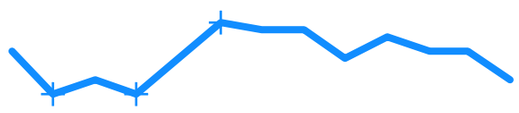
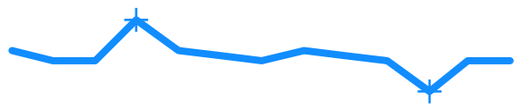
Mortality - Data covers deaths in the Trust until Sep 2024. The latest month (Sep-24) HSMR for MWL was 87.2. All individual diagnosis groups with HSMR alert for this period have had deaths reviewed with none highlighting any areas of concern. The latest 12 months (ending Sep-24) had an overall low HSMR (90.8 for MWL, 90.5 for S&O and 91.7 for STHK). The YTD HSMR remains below 100 (92.5 for MWL, 90.1 S&O and 93.3 for STHK). The latest SHMI data for December is 1.02.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Sep-24	87.2	100	92.5	Best 30%	
FFT - Inpatients % Recommended	Apr-25	93.6%	90.0%	93.6%	Best 50%	
Nurse Fill Rates	Mar-25	98.1%	90.0%	96.9%		
C.difficile	Apr-25	6		6		
E.coli	Apr-25	12		12		
Hospital Acq Pressure Ulcers per 1000 bed days	Jan-25	0.08	0.00	0.13		
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.12	0.00	0.17		
Stillbirths (intrapartum)	Apr-25	0	0	0		
Neonatal Deaths	Apr-25	0	0	0		
Never Events	Apr-25	0	0	0		
Complaints Responded In 60 Days	Apr-25	46.5%	80.0%	46.5%		

Board Summary - Operations

Operations

A&E - 4-Hour performance increased in April, achieving 74.8% (all types). Trust performance remained ahead of National (74.8%), and ahead of C&M (72.7%). The Trusts mapped 4-Hour performance achieved 79.5%.

RTT - The Trust had 2012 52-week waiters at the end of April, (355 S&O and 1657 StHK), 119 65-week waiters and 4 78-week waiters. The 52-week position is an increase of 102 from February and the 65-week waiters have increaesd by 35% from March to April. 18-Week performance in April for MWL was 64.3%, S&O 66% and StHK 63.4%. This was ahead of national performance (latest month March) of 59.8% and C&M regional performance of 58%.

Diagnostics - Diagnostic performance in April was 87.3% for MWL, failing to achieve the 95% target, with S&O achieving 92.6% and StHK 84.6%. MWL performance is ahead of national performance (latest month March) of 81.6% and C&M regional performance of 93.3%.

Patient Flow - Bed occupancy across MWL averaged 105.9% in April equating to 70.9 patients - similar to the 105.8% reported in March. There was a peak of 123 patients (42 at S&O, 84 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 13% higher than last April, driven by a 13% increase in 0 LOS activity, and a 12% increase in 1+ day LOS activity. Southport had a 92.4% increase in 0 LOS from April 24 to April 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 10 at S&O and 7.5 at StHK, with an overall average of 8.2 days, the impact of non CTR patients being 21.7% at Organisation level, 2.1% lower than March and 0.2% higher than April 2024 (21.9% StHK and 21.3% S&O)

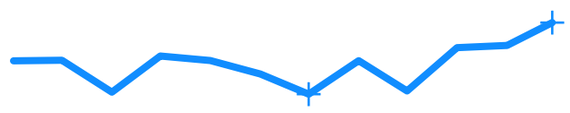
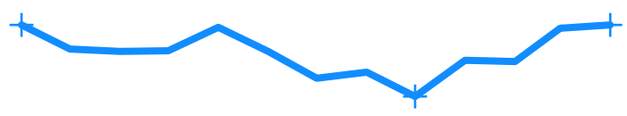
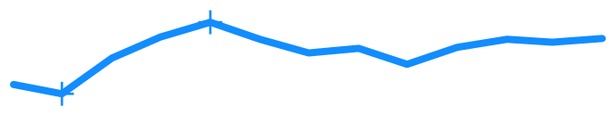
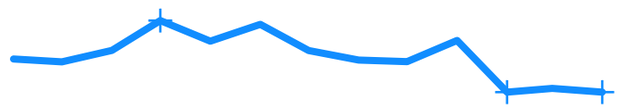
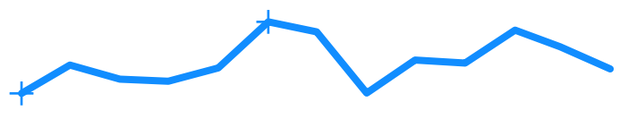
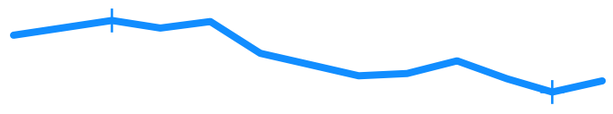
Cancer - Cancer performance for MWL in March deteriorated slightly, at 74% for the 28 day standard (target 77%), with Southport achieving 63.2% and St Helens performance being 79.7%. Latest published data (March) shows national performance of 78.9% and C&M regional performance of 76.6%. Performance for 62-day increased, achieving 85.6% (target 85%), with Southport achieving 78.1% and St Helens 88.5%. C&M performance was 76.4% and National 71.4%. 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.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Mar-25	74.0%	77.0%	74.0%	Worst 30%	
Cancer 62 Days	Mar-25	85.7%	85.0%	79.7%	Best 20%	
% Ambulance Handovers within 30 minutes	Apr-25	56.1%	95.0%	56.1%		
A&E Standard (Mapped)	Apr-25	79.5%	78.0%	79.5%	Best 30%	
Average NEL LoS (excl Well Babies)	Apr-25	3.8	4.0	3.8	Best 30%	
% of Patients With No Criteria to Reside	Apr-25	21.7%	10.0%	21.7%		
Discharges Before Noon	Apr-25	21.6%	20.0%	21.6%		
G&A Bed Occupancy	Apr-25	98.3%	92.0%	98.3%	Worst 30%	
Patients Whose Operation Was Cancelled	Apr-25	1.0%	0.8%	1.0%		
RTT % less than 18 weeks	Apr-25	64.3%	92.0%	64.3%	Best 30%	
18 weeks: % 52+ RTT waits	Apr-25	2.7%	1.0%	2.7%	Worst 40%	

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 89% against a target of 85%. Targeted support is in place to support front line clinical staff to access training.

Appraisals - The Trust is no longer meeting its appraisal target however this is due to us entering into the new appraisal window for 2025/2026. Current appraisal compliance is slightly is 77%. We have consistently been meeting the target for appraisals since the closure of the 2024/2025 appraisal window in September 2024. The 2025/2026 appraisal window opened on 1st May and support, training and guidance is available to support Indvidual's receiving quality appraisals.
Sickness - In-month sickness continues to be above target, at 6% against the 5% target. This is a slight reduction of 0.5% compared to March. All divisions continue to be above target with the exception of Corporate Services

The top 3 reasons for sickness in April continue to be 1) Stress, Anxiety & Depression, 2) Cold, Colds and Flu and 3) MSK. A sickness absence deep dive was presented to Strategic People Committee in April 2025 that reviewed all metrics related to sickness absence over the last 12 months against national and regional benchmarking trends. A sickness absence improvement plan has been developed and progress will be monitored through People Performance Council and Strategic People Committee. In addition a number of targeted initiatives have been developed as part of the Looking After our People Pillar of the Trust People plan. Targeted support continues to be provided to our teams and departments with the highest levels of sickness through the Absence Support Team.

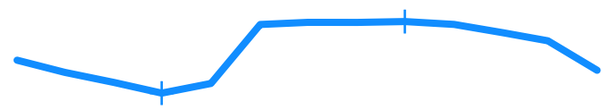
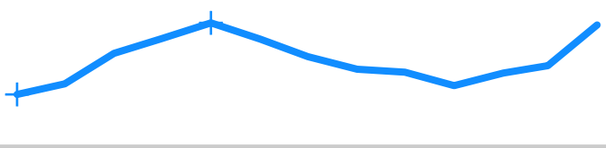
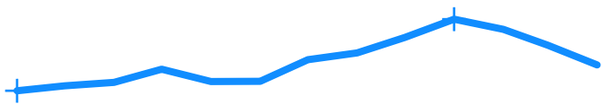
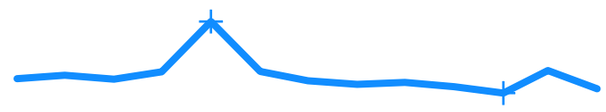
Turnover- In month turnover continues to be below our targe of 1.1% at 0.6%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Apr-25	77.0%	85.0%	77.0%		
Mandatory Training	Apr-25	89.2%	85.0%	89.2%		
Sickness: All Staff Sickness Rate	Apr-25	6.1%	5.0%	6.1%		
Staffing: Turnover rate	Apr-25	0.6%	1.1%	0.6%		

Board Summary - Finance

Finance

The approved MWL financial plan for 2025/26 submitted in April 2025 gives a deficit of £22.2m, assuming:
-Non-recurrent deficit support of £18.8m.
-Delivery of £48.2m recurrent CIP
-Realisation or reallocation of strategic opportunities of £8m
-Realisation or reallocation of system led cost reductions of £27m

The current plan breaks the Trust's statutory break even duty.

Surplus/Deficit – At the end of Month 1, the Trust is reporting an adjusted deficit position of £6.7m deficit, in line with plan.

CIP - The Trust's CIP target for financial year 2025/26 is £48.2m, all if which is to be delivered recurrently. As at Month 1, the Trust has successfully transacted CIP of £3.7m year to date, in line with plan. The recurrent full year effect of delivered schemes is £4.3m (9% of the £48.2m recurrent target).

Cash - At the end of M1, the Trust's cash balance was £3.2m. The Trust anticipates a closing cash balance of c.£22.2m at the end of the financial year. The plan includes £30m PDC revenue support funding and £30m deficit support funding.

Capital - The capital plan for the year is £64.6m (including PFI lifecycle and lease remeasurements). Capital expenditure for the year to date [including PFI lifecycle maintenance and lease remeasurements] totals £0.7m, which is £4.5m below plan. At M1, the plan assumes expenditure of £2.8m for several system/PDC funded schemes which is yet to materialise. As a result, PDC funding is yet to be drawn down for these schemes.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Apr-25		5,200	666		
Cash Balances - Days to Cover Operating Expenses	Apr-25	1.0	10			
Reported Surplus/Deficit (000's)	Apr-25		-6,665	-6,665		

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Southport & Ormskirk

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Sep-24	85.3	100	90.1	
FFT - Inpatients % Recommended	Apr-25	95.1%	90.0%	95.1%	
Nurse Fill Rates	Apr-25	100.3%	90.0%	100.3%	
C.difficile	Apr-25	2		2	
E.coli	Apr-25	2		2	
Hospital Acq Pressure Ulcers per 1000 bed days	Jan-25	0.08	0.00	0.10	
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.09	0.00	0.19	
Stillbirths (intrapartum)	Apr-25	0	0	0	
Neonatal Deaths	Apr-25	0	0	0	
Never Events	Apr-25	0	0	0	
Complaints Responded In 60 Days	Apr-25	35.0%	80.0%	35.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-25	63.2%	77.0%	67.9%	
Cancer 62 Days	Mar-25	78.1%	85.0%	65.0%	
% Ambulance Handovers within 30 minutes	Apr-25	62.2%	95.0%	62.2%	
A&E Standard (Mapped)	Apr-25				
Average NEL LoS (excl Well Babies)	Apr-25	4.0	4.0	4.0	
% of Patients With No Criteria to Reside	Apr-25	21.3%	10.0%	21.3%	
Discharges Before Noon	Apr-25	21.1%	20.0%	21.1%	
G&A Bed Occupancy	Apr-25	98.1%	92.0%	98.1%	
Patients Whose Operation Was Cancelled	Apr-25	0.8%	0.8%	0.8%	
RTT % less than 18 weeks	Apr-25	66.0%	92.0%	66.0%	
18 weeks: % 52+ RTT waits	Apr-25	1.5%	1.0%	1.5%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-25	67.0%	85.0%	67.0%	
Mandatory Training	Apr-25	89.4%	85.0%	89.4%	
Sickness: All Staff Sickness Rate	Apr-25	5.5%	5.0%	5.5%	
Staffing: Turnover rate	Apr-25	0.4%	1.1%	0.4%	

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

St Helens & Knowsley

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Sep-24	87.9	100	93.3	
FFT - Inpatients % Recommended	Apr-25	93.1%	94.0%	93.1%	
Nurse Fill Rates	Mar-25	97.2%	90.0%	97.6%	
C.difficile	Apr-25	4		4	
E.coli	Apr-25	10		10	
Hospital Acq Pressure Ulcers per 1000 bed days	Jan-25	0.08	0.00	0.15	
Falls ≥ moderate harm per 1000 bed days	Feb-25	0.13	0.00	0.17	
Stillbirths (intrapartum)	Apr-25	0	0	0	
Neonatal Deaths	Apr-25	0	0	0	
Never Events	Apr-25	0	0	0	
Complaints Responded In 60 Days	Apr-25	56.5%	80.0%	56.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-25	79.7%	77.0%	77.8%	
Cancer 62 Days	Mar-25	88.7%	85.0%	85.8%	
% Ambulance Handovers within 30 minutes	Apr-25	52.5%	95.0%	52.5%	
A&E Standard (Mapped)	Apr-25				
Average NEL LoS (excl Well Babies)	Apr-25	3.7	4.0	3.7	
% of Patients With No Criteria to Reside	Apr-25	21.9%	10.0%	21.9%	
Discharges Before Noon	Apr-25	22.0%	20.0%	22.0%	
G&A Bed Occupancy	Apr-25	98.4%	92.0%	98.4%	
Patients Whose Operation Was Cancelled	Apr-25	1.0%	0.8%	1.0%	
RTT % less than 18 weeks	Apr-25	63.4%	92.0%	63.4%	
18 weeks: % 52+ RTT waits	Apr-25	3.2%	1.0%	3.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-25	81.6%	85.0%	81.6%	
Mandatory Training	Apr-25	89.0%	85.0%	89.0%	
Sickness: All Staff Sickness Rate	Apr-25	6.3%	5.0%	6.3%	
Staffing: Turnover rate	Apr-25	0.6%	1.1%	0.6%	

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	28 May 2025
Agenda Item	**TB25/040 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in April 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 April 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 April.		
03 April 2025		
NHS National Uniform	• The Acting Director Nursing, Midwifery and Governance introduced the proposal for the Trust to adopt the NHS National Uniform. • Committee agreed to establish a working group to oversee the introduction of the national uniform, noting that the national proposals were for nurses and Allied Health Professionals and there were other groups of staff, such as doctors and Physicians Associates, and some facilities staff etc. that needed to be covered to ensure different roles could be easily identified by patients. • The introduction of the national uniform followed extensive consultation with staff across the country over several years, and the final designs were inclusive and gender neutral. The standard uniforms could be transferred between trusts and the combined purchasing power across the NHS would reduce unit cost per item. • It was felt that standardisation of uniform across MWL would assist in creating a single identity, but to replace all uniforms would be a considerable initial investment.	Approval

	• The working group was asked to report back on the options to introduce the NHS National Uniform across MWL from 2026.	
Urgent and Emergency Care (UEC) Care Quality Commission (CQC) action plan	• The Acting Director of Nursing, Midwifery and Governance introduced the draft action plan following the publication of the CQC report of UEC care at Whiston Hospital. • The report had identified concerns in relation to regulations 12, 17 and 18 (new terminology for "must" and "should do" actions) and the proposed actions to address each of these. • Committee reviewed the draft and agreed some amendments to clarify what had been achieved since the CQC visit and the next steps.	Assurance
Quarterly Procedural Documents Review	• The Acting Director of Nursing, Midwifery and Governance introduced the report. • The total number of Trust policies and procedural documents had increased to 856 and 20% of these were overdue for review. • 499 required harmonisation across MWL (where appropriate) which had decreased from 609 the previous quarter. • Each Council continued to monitor the policies and procedural documents that were aligned to it, and the action plans to complete the harmonisation process and ensure policies remained in date.	Assurance
Maternity Service Specification	• The Acting Director of Nursing, Midwifery and Governance presented the 2025 Maternity Specification from commissioners. • There were no significant changes in the specification and the services continued to deliver the requirements. • The Committee approved the acceptance of the updated specification.	Approval
Nursing Safer Staffing Report – February 2025	• The Acting Director of Nursing, Midwifery and Governance presented the report • Staffing levels overall remained over 94% for registered nurses (RN) and Health Care Assistants (HCA) fill rates, there were some wards where the establishment was being reviewed. • HCA recruitment continued to be monitored as the uplift in numbers was critical to eliminating HCA agency and reducing reliance on bank staff for supplementary care.	Assurance
Draft Internal Audit Plan 2025/26	• The Director of Finance and Information presented the draft internal audit plan 2025/26 for	Assurance

	comment before this was taken to the Audit Committee for approval.	
2024/25 Workforce Plan – month 11	• The Director of HR presented the month 11 position against the agreed workforce plan. • In February the total Full Time Equivalent (FTE) was 42 (0.4%) above plan, including agency, temporary and bank staff. • Agency usage had decreased steadily from month 7.	Assurance
Proposed 2025/25 Workforce Plan	• The Director of HR presented the draft workforce plan for 2025/26 to meet the targets in the national planning guidance. • The Committee discussed the challenges in delivering the expected reductions. • It was acknowledged that the workforce plan was likely to change to align with the final approved financial plans, as the Cheshire and Merseyside (C&M) system financial position remained under discussion with NHSE.	Assurance
10 April 2025		
Neonatal Cot Configuration	• The Acting Director of Nursing, Midwifery and Governance introduced the report which detailed the differences in demand between the two neonatal units and the opportunity to rebalance internally to reduce neonatal unit closures at Whiston Hospital and better support the Northwest Neonatal Operational Delivery Network. • Based on activity levels over several years the Committee agreed with the proposal to relocate two cots to the Whiston Unit and leaving 23 at the Ormskirk Unit	Approval
Patient Inclusion and Engagement Strategy	• The Acting Director of Nursing, Midwifery and Governance presented the updated draft strategy for final review by the Committee, ahead of recommending to the Board for approval.	Assurance
65+ week waiters – year end position	• The Chief Operating Officer presented the final position against the target to eliminate 65+ week waiters by the end of March 2025. • The Trust had 86 65+ week breaches remaining at the end of the financial year. 45 were due to complexity, 32 were patient choice, eight were waiting for corneal grafts and one was due to Trust capacity. • The focus for 2025/26 was to reduce 52+ week waiters.	Assurance

Predicting the risk of falls	• The Director of Informatics presented an overview of the AI tools being adopted by trusts to predict the risk of patient falls and proposed a working group to develop options for MWL, including of the wider population as part of admission avoidance.	Assurance
Patient Tracking Systems	• The Director of Informatics presented a report detailing the benefits of patient tracking and opportunities to expand the Trust's capability in this area. • Committee agreed the initial priority was to optimise the capabilities with the existing Electronic Patient Record (EPR) systems with the supplier.	Assurance
Partnership Update	• The Director of Integration presented the quarterly partnership update, noting key new appointments in St Helens and at C&M Integrated Care Board (ICB), and initial proposals to move to two Places – Merseyside and Cheshire as part of the drive to achieve the 50% reduction in staff costs required by NHSE.	Assurance
Financial Plan 2025/26	• The Director of Finance and Information reported that the C&M ICB system financial plan had not been accepted by NHSE, and there would be a further round of negotiations to reduce the deficit.	Assurance
17 April 2025		
PricewaterhouseCoopers International Limited (PWC) Financial Grip and Control Action Plan	• The Committee reviewed the latest position against the PWC report recommendations from September 2024, which had led to the establishment of the Finance Improvement Groups • Progress was noted against many of the actions and Committee discussed the challenges and barriers to those that remained outstanding. • 60% of consultant job plans had been finalised and the remaining ones were in progress • The focus of the theatre productivity group needed to remain on driving performance against the key efficiency metrics. • Committee agreed how additional support would be given to the Divisions to move these actions forward by agreed target dates.	Assurance
Corporate Benchmarking 2024/25	• The Committee reviewed the national guidance and timetable for the 2024/25 corporate benchmarking returns. • The Committee also noted the work being undertaken across C&M to try and standardise the local approach to the exercise acknowledging the	Assurance

	national planning requirement to reduce these costs by 50% of the growth since 2018/19.	
Integrated Performance Report (IPR) - March	• The Committee reviewed the draft IPR ahead of publication of the Committee Performance Reports. • Additions to the narrative in relation to the 65+ week position and the appraisal performance were agreed.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services introduced the draft BAF for review before presentation at the April Trust Board for approval.	Assurance
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services reported that the usual RMC assurance report was not available as the Divisions and Teams were still transferring risks to the new InPhase System. The deadline for this to be completed had been agreed as 30 April 2025. • The RMC meeting had gone ahead without the usual reports to allow the InPhase implementation team to provide an update on the development of the system and answer queries from risk leads from Divisions and Departments. • New risks were now being reported directly to InPhase and escalated in accordance with the Trust risk assurance process.	Assurance
Sickness Deep Dive	• The Director of HR introduced a deep dive into sickness absence at the Trust. This was also to be presented to the April Strategic People Committee.	Assurance
24 April 2025		
Carbapenemase Producing Enterobacterales (CPE) Testing Business Case Addendum	• The Acting Director of Nursing, Midwifery and Governance introduced the updated business case, which addressed the queries from the Committee when it was first presented in January 2025, including the expected additional cleaning costs for increased deep cleans, how the proposals could be implemented particularly where there was a shortage of single rooms, and clarification on the guidance in relation to testing of patients re-admitted to hospital within 12 months, if not already known to be CPE positive. • Following discussion, the Committee approved the move to Polymerase Chain Reaction (PCR) testing for CPE, for a test period on the existing test criteria, to assess the impact this had operationally. Accepting the risk of CPE the	Approval

	Committee agreed existing resources would need to be re-aligned to meet the challenge. • The impact would be reviewed in six months to assess if the testing criteria should be broadened.	
CQC Well Led Presentation	• Senior Managers, Non-Executive Directors and members of the quality and risk team joined the Executive Committee to hear a presentation from the CQC about the new format of Well Led inspections.	Assurance
Palantir Theatre List Planning System	• The Director of Informatics presented an overview of the NHSE recommended systems to support waiting list reduction. • The Committee debated the merits of different available systems and agreed more clarity was required as to whether introduction of a particular system was mandatory.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during April 2025 were:</u> • To introduce PCR testing for CPE		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	28 May 2025
Agenda Item	**TB25/040 (8.2)**		
Committee being reported	Quality Committee		
Date of Meeting	20 May 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. • Safe staffing fill rates were 97% across inpatient wards and midwifery; a comprehensive review of inpatient areas has been undertaken and there will be a focus on Emergency Department (ED), Theatres and Critical Care staffing requirements in the coming months. • MWL are participating in an NHSE led Enhanced Therapeutic Observation and Care (ETOC) project reviewing best practice for one-to-one care (supplementary care). • A clinical specialist from the national Falls Team has been invited to do a review of MWL falls data; this will include patient falls assessments in ED. • National Early Warning Score (NEWS) compliance has been challenging within ED, however, there has been some improvement. A weekly meeting/ward round has been established to review triage and ambulance turnaround times. • IT colleagues are supporting migrating MUST assessments to WizBoards to improve recording of patient nutrition assessments.	Assurance

	• Infection, Prevention and Control (IPC): There had been one case of Methicillin-Resistant Staphylococcus Aureus (MRSA) reported in month. Although unavoidable there was some shared learning. • Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) case review deep dive has been undertaken with recommendations and actions. • There had been several norovirus outbreaks at Southport hospital. Visiting has been restricted. There has been increased focus on check and challenge, including peer review. • There has been a reduction in complaints compliance; this is due to a focus on breached cases. • Maternity: There were no Maternity and Newborn Safety Investigation (MNSI) or Strategic Executive Incident System (StEIS) reportable cases and no incidents of baby cooling in month. One to one care during labour was reported at 100% and compliance with supernumerary shift co-ordinator. • VTE risk assessments were reported at 77.4% trust-wide (Whiston 72.9%, Southport 89.1%) against a target of 95%. There has been a significant positive step change, particularly at Whiston following a change in process that had been trialled across several wards. This will now be rolled out further, however, some areas will be initially excluded due to system issues relating to emergency medication prescribing but IT colleagues are assisting with this project. • Mortality was reported at 87.2% in month; there had been a small number of patients with Hospital Standardised Mortality Ratio (HSMR) alerts and an even smaller number of deaths, however, there were no areas of concern. 12 months ending in September 2024 figures were MWL 90.8, Southport and Ormskirk Hospitals	

	90.5, Whiston and St Helens Hospitals 91.7. Year to date (YTD) 92.5 • Summary Hospital-level Mortality Indicator (SHMI) was reported at 1.02 and remains within tolerated margins. • The sepsis data in the report related to December 2024. Although there had been improvement, compliance had been below the 90% target, based on a sample of patients. • A review of the process identified that the clock-start is from the point of arrival, not the point of diagnosis. A triage Task & Finish group has been established to improve triage and consider pre-made antibiotics.	
Infection Prevention & Control (IPC) Q4 Report	• Reported cases of gram negative bacteraemia were below the threshold at year end, however, Clostridioides difficile (C.Diff) reported one case above threshold. • There were six MRSA cases in year against a threshold of zero. Three cases were identified as unavoidable. There had been one case as a result of cannula care, compared to four the previous year. • There are no threshold levels for MSSA however, there had been an increase in reported cases in year; this is in line with regional and national reporting. • Aseptic Non Touch Technique (ANTT) Level 1 and Level 2 training requirements have been harmonised across the Trust. The ANTT training needs analysis (TNA) implementation plan was approved by Executive Committee. • MRSA screening compliance is reported at 93.4% against a target of 95%, unchanged from the previous quarter, however, there had been some improvement at Southport and Ormskirk sites.	Assurance

	• There had been 114 C.Diff cases, unchanged from the previous year. This is one case above the objective however, there had been a reduction of ten cases at Whiston compared with 2023/24 figures. • Escherichia coli (E.Coli), Klebsiella and Pseudomonas were all reported below target at year end. • There had been 33 outbreaks in Q4. There were 17 at Whiston and St Helens sites predominantly Covid-19 and Flu, there has also been two outbreaks of norovirus and one outbreak of Vancomycin Resistant Enterococci (VRE). At Southport there had been 16 outbreaks, the majority of which had been norovirus, however, there have been recent outbreak of scabies which required ed extensive contact tracing and treatment. • There is ongoing work to develop an IPC WizBoard. This will support the Divisional IPC meetings. • IPC mandatory training compliance is currently above 85%, however, level 2 training remains below target. • Harmonisation of IPC policies continue. • Committee requested further information regarding MSSA action plan.	
Mandatory Training Compliance Q4 Report	• Compliance remains above 85% for Core and Compulsory training. • There has been progressive improvement in relation to core mandatory training, however, compliance amongst Medical and Dental staff remains a concern. • Further improvement is required in relation to Fire Response Training, ANTT Level 2 and Moving & Handling and Life Support training compliance. New approaches and local bespoke training are being considered.	Assurance

	• Committee requested determined effort by divisions to further improve compliance in those areas where compliance is below target.	
Quality Account 2024/25	• The draft Quality Account (QA) 2024/25 was presented for comment and feedback. The QA will be presented to Cheshire and Merseyside (C&M) Integrated Care Board (ICB) and local HealthWatch groups for comment before being presented for approval at Trust Board on 28 May. The Quality Account will be published on 30 June.	Assurance
Quality Committee Effectiveness Review	• The annual effectiveness review was presented. • There had been some changes to the Terms of Reference (ToR) and the Workplan. • The Quality Committee Effectiveness Review was approved for presenting to Trust Board.	Assurance
Clinical Effectiveness Council Assurance Reports (April and May 2025)	• Clinical Effectiveness Council Assurance Reports (April and May 2025) were presented. • There had been a number of policies presented for approval; the majority are now MWL policies, with the exception of some that are site-specific. • There had been a presentation from the Resus Team demonstrating collaboration across the Trust is progressing well. Resuscitation Services have moved to the Medical Education Team from 01 April. 2025. An audit of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) showed 100% appropriate reasons for the decisions made. A reduction in cardiac arrests at Southport and Whiston was noted during the period October to December 2024. • There had been follow up and feedback on a new device being used in Urology. This will now be moved to a business case for permanent implementation.	

	• There had been a report on National Institute for Health and Care Excellence (NICE) guidelines compliance which showed 43% full compliance, 43% partial compliance and 17% overdue; there had been a reduction in overdue compliance from the previous quarter. • Advancing Quality Alliance (AQuA) membership will continue for a further 12 months, during which time, a local method of collating data will be developed. • Difficulties covering Lung Clinical Nurse Specialist service requirements at Whiston and St Helens were reported with one fixed term post funding only agreed till June 2025. • Acute Kidney Injury (AKI) rates remain above expected level. Work ongoing across the Trust to improve hydration to reduce AKI post-operatively.	
Patient Safety Report March 2025	• During March 14 incidents had been identified that required Patient Safety Incident Review (PSIR). Of these, three Learning Reviews/ELRs have been requested, nine are awaiting discussion to identify the review that is required, two were actioned as nil further and three Patient Safety Incident Investigations (PSII) were commissioned.	
Maternity & Neonatal Q4 2024/25 Report	• Confirmation of compliance with ten safety actions for Maternity Incentive Scheme (MIS) Year 6 has been received. • MIS Year 7 was received in April 2025 and compliance work has commenced. • Compliance for referral to stop smoking services was reported as 100%; work to promote continued smoke free is ongoing. • Breast feeding initiation was reported at 61%; enhanced infant feeding team and staff training are having a positive impact.	

	• Continued focus on reducing third and fourth degree tears and improving pelvic health. • In Q4 2024/25 there had been six reportable deaths. All cases have undergone review. • There had been one Never Event in February at Ormskirk. A PSII review of consent / Local Safety Standards for Invasive Procedures (LocSSIP) / National Safety Standards for Invasive Procedures (NatSSIP) across the Trust is planned. • During Q4 here had been nine neonatal medication errors, eight of which were categorised as no harm. Over the past four quarters these have reduced. One had been categorised as low harm and related to baby receiving gentamycin eight hours early. Immediate action was taken and no long-term effects are anticipated. Further improvements and action plans regarding neonatal medication management was detailed. • Saving Babies Lives elements were detailed. Two elements require further improvements. • Ormskirk Neonatal Unit were warmly congratulated for achieving stage 2 UNICEF Baby Friendly Initiative accreditation. • Care Quality Commission (CQC) Action plans (Must and Should Do actions) were detailed. • Workforce for maternity and the neonatal units was reported. A Birthrate plus review is being considered during 2024/25. Both units compliant for one to one care in established labour and supernumerary co-ordinator role. • Complaints and claims were detailed. Two complaints during Q4 2024/25. Learning and actions from complaints were also detailed. • Safety Champion and Perinatal Quality Surveillance Model (PQSM) Tool were detailed.	

	• No suspension of maternity services in Q4. Neonatal units closed to external admissions on 12 occasions due to increased activity and acuity. Nine at Ormskirk and three at Whiston. Transitional care at both units was detailed. • Maternity Red Flags were noted – most relating to triage delay linked to number of simultaneous arrivals at the units and acuity, however compliance is monitored and is 99.2%. The teams are striving to achieve 100%. • The Trust's actions regarding the NHS 3-year delivery plan for Maternity and Neonatal Services were detailed. Currently one red action and two amber actions regarding Continuity of Carer and one amber action regarding implementation of Badgernet (Maternity Electronic Patient Records (EPR)).	
Nursing Establishment Review May 2025	• The report provided outcomes and recommendations following the bi-annual establishment review. <u>Medicine & Urgent Care Division</u> • Following approval of an additional 41.8 WTE Health Care Assistant (HCA) investment on the Whiston site a reduction in the overall requirement for additional staff has been noted, however there is a residual requirement for additional investment across medicine and urgent care inpatient areas. Improvement includes standardisation of a bay nursing model and completion of harmonisation work. <u>Surgery Division</u> • ICU and theatres have been excluded from this establishment review but will be completed in the coming months. • The Division have identified that realignment of funded posts will reduce the requirement for temporary workforce to maintain patient safety and care delivery. <u>Community Services Division</u> • Work continues across Community services division. There is a Workforce, Support	

	Services and Procurement Task & Finish group in place looking at opportunities for expansion and as part of the service review and potential redesign. <u>Women's & Children's Division</u> • Assurances are in place via reporting to Quality Committee and Executive Committee regarding staffing ratios. The next Birthrate Plus review is proposed for 2025. • There is currently a Neonatal Cot Reconfiguration review of cot capacity and a transformation programme within Cheshire & Merseyside. • The paediatric ward on the Whiston site has remained consistently over budget due to the increased number of children with eating disorders, Children and Adolescent Mental Health Services (CAMHS) and mental health issues on the ward with long periods of stay. There has also been external support form agencies such as Prometheus and Calgary to provide safe support to these children.	

Alerts:
• None
Decisions and Recommendation(s):
The Board is recommended to note the report.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	28 May 2025
Agenda Item	**TB25/040 (8.3)**		
Committee being reported	Strategic People Committee		
Date of Meeting	21 May 2025		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Workforce Dashboard	The Committee noted the following performance: • Mandatory Training - the Trust continues to exceed its mandatory target at 89.2% (target 85%). • Appraisals - the Trust is no longer meeting its appraisal target of 85%. Current appraisal compliance is below target at 77% owing to the opening of the 2025/26 appraisal window and staff appraisals are now coming due. • Sickness - in-month sickness is above target, at 6.06% (target 5%), however, there has been a month-on-month reduction in sickness. The top three reasons for sickness in April were stress, anxiety and depression, coughs, colds and flu and musculoskeletal (MSK). The committee were assured by the steady reduction in sickness absence for Healthcare Support Workers (April 8.8%). • Vacancies - the Trust continues to be below target for vacancies at 6% (target 8%). • Time to hire - time to hire has declined in April from 50.7 days to 60.8 days. • Turnover - in-month turnover 0.6% (target 1.1%).12-month rolling turnover is 11% (target 13.2%).	Assurance
Looking After Our People Operational Delivery Plan (Trust)	The Committee received the 2025/26 delivery plan for the "Looking After Our People" pillar of the 2025-2028 People Plan and commented about the importance of this pillar and supported the focus of the actions. The actions support the delivery of the six commitments in this pillar of the strategy; to support a culture that fosters holistic wellbeing and allows individuals to thrive both personally and professionally within a supportive work environment. The actions included:	Assurance

	• 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.	
Culture / Engagement Update	The Committee received the Culture / Engagement Update which supports the Trust People Plan 2025-28. The paper outlined the Trust's commitment to recognising and celebrating our people and developing a culture of wellbeing where individuals can thrive. The year 1 priorities were noted as outlining the key celebration and engagement events that will be recognised over the next 12 months. The 2025/26 programme of events cover staff celebrations and recognition events, wellbeing awareness, cultural and religious celebrations and equality, diversity, and inclusion (EDI) awareness. There are a significant number of events nationally, regionally and locally that the Trust supports each year. Based on feedback from staff, analysis of our workforce the objectives, the calendar is populated with key events and celebrations in each month. The Trust will continue to build on its reputation for staff engagement initiatives, which reflect the commitment to valuing our people and creating environment that celebrates everyone contributions to 5 staff patient care. Events include: • Annual Staff Awards, recognising outstanding achievements and everyday excellence across clinical and non-clinical roles. • Delivered staff celebration events, including milestone recognitions, thank-you days, and wellbeing focused activities. • Key religious and cultural events, including Eid,	Assurance

	Christmas, and Black History.	
Equality, Diversity & Inclusion High Impact Actions	The Committee noted the six 'High Impact Actions' (HIAs) outlined to combat prejudice and discrimination within the NHS Workforce and received paper and presentation providing context about regional commitments and the Trust's actions, progress to date and the measures of success that will be used to monitor the impact of the actions. The six HIA for 2025/26 are as follows: • Measurable EDI objectives for all staff from Board to Ward. • Development and delivery of inclusive attraction, recruitment and development practices across MWL to support colleagues to progress and develop. • Work to reduce, then eliminate, total pay gaps in respect to race, disability and gender. • To understand the health inequalities and indices of multiple deprivation affecting our workforce and provide support and signposting to enable colleagues to thrive at work. • To develop and deliver a comprehensive induction and onboarding programme for staff that incorporates the needs of all staff including culture, values and EDI support and services. • Create a safe, inclusive and caring culture where staff are able to speak up to address or report bullying, harassment and physical harassment.	Assurance
Lead Employer People Plan 2025-28	As the largest Lead Employer within England, the Trust provides a range of HR services to support to over 13,000 colleagues in training who will be the senior medical and dental workforce of the future. This is the first People Plan to be developed for the Lead Employer workforce, as a result extensive engagement had taken place with a diverse range of stakeholders across NHS organisations, General Practitioner (GP) practices, local authorities, hospices, NHS England, the ethnic minorities and Lead employer staff representatives to inform the strategy. The Lead Employers people plan aims to support the needs of the workforce and those stakeholders who provide educational opportunities to them.	Approval

	The People Plan 2025-28 is structured around four strategic pillars, reflecting the strategic direction of the national NHS People Plan. Each pillar is designed to support the effective delivery of our services in accordance with NHS England's contractual requirements for the Lead Employer arrangements. The pillars also play a critical role in fostering the national growth and retention of the future Consultant GP, Public Health and Dental workforce. The Strategic People Committee (SPC) approved the Lead Employer People Plan 2025-28 and noted that it would be monitored by the HR Commercial Services Council and reported to the SPC through assurance reports and updates.	
Lead Employer Stakeholder Survey Action Plan	The Committee received a paper, survey report and action plan on the Lead Employer Colleague in Training annual survey for 2024 and noted that the Lead Employer carry out their own local annual staff survey as colleagues in training are not included in the national NHS Staff Survey. The Committee noted that the Lead Employer are carrying out comprehensive stakeholder engagement to understand areas for improvement, and to inform the priorities for the Lead Employer and that feedback had been built into the commitments and deliverables for the People Plan 2025-28. The paper included a 13-point action plan for 2025/26 that addresses the key themes arising from the 2024 survey and that this has been aligned to the four pillars of the NHS People Plan.	Assurance
Assurance Reports from Subgroup(s)	The Committee noted the Assurance Report from the People Performance Council.	Assurance
Annual Effectiveness Review	The Committee noted the Annual Effectiveness Review and recommended the revised Strategic People Committee Terms of Reference (ToR) to the Trust Board for approval.	Assurance
Alerts:		
None.		
Decisions and Recommendation(s):		
• The Committee approved the Lead Employer People Plan 2025-28		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	28 May 2025
Agenda Item	**TB25/040 (8.4)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	22 May 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Annual Meeting Effectiveness Review Report	• The outcome of the annual effectiveness review was shared and the recommendations noted.	Assurance
Chief Finance Officer (CFO) Update	• The Cheshire and Merseyside (C&M) system now have an agreed financial plan enabling access to deficit support funding. Level of risk in system plans noted and the respective values for MWL. • Deficit support cash is being reallocated across the system and will result in an improved Income and Expenditure (I&E) plan in M2. Further guidance is to be issued to systems on mechanisms for accessing this. • C&M has been put into formal turnaround by NHSE and a diagnostic will be undertaken by PricewaterhouseCoopers International Limited (PWC) supplemented by a Cost Improvement Programme (CIP) review and the current Chief Financial Delivery Officer workstreams. • Reports by the Public Accounts Committee and Health Foundation were noted alongside the consultation on the draft NHS Performance Assessment Framework. • Additional national capital funding has been secured to improve sustainability and critical infrastructure over three years.	Assurance
Integrated Performance Report Month 1 2025/26	• Bed occupancy averaged 105.9% in April equating to 71 patients. This resulted in a General and Acute (G&A) bed occupancy of 98.3%, significantly higher than the target of 92%. • Average length of stay for emergency admissions remains high at 8.2, 10.0 at S&O	Assurance

	sites and 7.5 at St Helens, Whiston and Newton sites, the impact of Non-Criteria to Reside (NCTR) patients remains high in April, being 21.7% at Organisation level (21.9% St Helens, Whiston and Newton and 21.3% the S&O sites). • 4-Hour performance was 74.8% in April, National performance 74.8% and C&M 72.7%. Mapped performance was 79.5%. This was 25th best trust across the country. Average ambulance handover time reduced to 50 minutes but remained above target. • 18 Week performance in April for MWL. National Performance (latest month March) 59.8% and C&M performance 58.0% • The Trust had 2,012 x 52-week waiters at the end of April, 119 x 65 week waiters and 4x 78 week waiters. • Diagnostic performance for April for MWL had reduced to 87.3% which remained ahead of national performance 81.6% but below target (95%). Non Obstetric ultrasounds account for the majority of this decrease following a 15% increase in demand and some capacity issues. A recovery plan has been put in place to increase capacity. • Cancer performance for MWL in March deteriorated to 74% for the 28-day standard and increased to 85.6% for the 62 day standard.	
Finance Report Month 1 2025/26	• The approved MWL financial plan for 2025/26 is a deficit of £22.2m, this is a £41m deficit excluding the deficit support funding. • The plan includes £35m of system led strategic opportunities/cost reductions to be realised or reallocated by C&M during 2025/26. • The Trust is reporting a M1 deficit of £6.7m which is in line with plan. • Income assumes variable activity and the Southport Community Diagnostic Centre (CDC) being funded by Commissioners, contracts are not yet finalised, and negotiations continue. • The Trust's combined 2025/26 CIP target is £48.2m. In M1, the target has been achieved with £3.7m delivered.	Assurance

	• M1 agency costs equate to £1.1m, a 12% reduction from March and a 40% reduction from M1 2024/25. • The Trust had a closing cash balance of £3.2m and anticipates a closing cash balance of £2.3m at the end of the year including the deficit support funding. • Aged debt has reduced by £2.5m and work is ongoing to reduce this further. • The capital plan for the year totals £64.6m which includes Public Finance Initiative (PFI) Lifecycle and IFRS16 Lease Remeasurement.	
Month 1 2025/26 CIP Programme Update Women & Children Division CIP update	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, this equates to 5% for all departments. • At M1 27 schemes have been delivered with a further 37 schemes at finalisation stage. Current delivered/low risk schemes have a value of £13m in year equating to 27% of the target. • Schemes identified in 2024/25 but not delivered in year have been rolled forward as part of the CIP programme to support delivery of 2025/26 plans. • The update provided including overview of divisional CIP governance process.	Assurance
Cash Update	• Committee received a detailed update on the cash position for the Trust. • 2025/26 Public Dividend Capital (PDC) national revenue cash support guidance and application process is currently on hold. • Recommendations on managing cash have been shared by NHSE. • Risks and mitigations were discussed.	Assurance
Finance Report Month 12 2024/25	• The draft accounts sent to the auditors comprise of an adjusted financial position of £14.7m deficit, the technical adjustments required by NHSE include a notional charge of £5.4m. • This M12 position is an adverse variance of £3.9m to plan. The notional charge does not result in a cash outflow and does not affect the unadjusted financial position. • The accounts are draft and subject to external audit.	Assurance
Benefits Realisation	• Total number of benefits identified and being mapped was 380. 352 are on track with 28	Assurance

	requiring mitigating actions or not yet reporting delivery. • Examples of current benefits review were included in the report.	
Service Line Reporting (SLR) / Patient Level Costing Information (PLICs)	• Trust approach to the national cost collection was outlined and approved. The committee was assured that plans were in place to produce the Trust cost collection for 2024/25.	Approval
Elective Care Recovery Review	• Update received on Elective Care Recovery, currently exceeding Referral to Treatment (RTT) improvement trajectory but not yet meeting the 52 week waits percentage reduction. • The Trust is part of Further Faster 20 programme, key measurable benefit is an overall reduction in waiting list. Reduction of 15.5% since programme started. • The improvement actions and expected dates of impact were discussed.	Assurance
Assurance Reports from Subgroups:	• Procurement Council - updated Terms of Reference (ToR) approved • CIP Council • Estates & Facilities Management Council • IM&T Council update	Assurance
Alerts		
Cash update – the Committee noted the risks around cash due to the revenue cash support guidance and application process being on hold.		
Decisions and Recommendation(s):		
The Committee approved the Trust costing process to support the 2024/25 National Cost Collection submission.		

Title of Meeting	**Trust Board**		**Date**	28 May 2025
Agenda Item	**TB25/041**			
Report Title	National Quality Board Establishment Reviews			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To inform the Trust Board of the outcomes and recommendations following of the completion of bi-annual establishment reviews and professional recommendations.

Executive Summary

This paper aims to provide assurance that Merseyside and West Lancashire NHS Teaching Hospitals (MWL) has arrangements in place to review the nursing and midwifery establishments in line with regulatory requirements.

The paper details the outcome of the bi-annual establishment reviews for January 2025 for acute inpatient wards based on the configuration and clinical pathways currently in place.

This paper provides the assessment of current staffing levels, using a nationally recognised nurse to patient ratio methodology, and is based on the established bed capacity only.

There is a continued organisational focus on filling all registered and unregistered nursing vacancies, with an emphasis on the development and retention of the nursing and midwifery workforce.

The staffing for the additional unestablished beds continues to be managed through temporary staffing if required, however a key objective is to reduce reliance on bank and agency staff to optimise the quality and safety of patient care.

Going forward, work is now required to review the total ward configuration and clinical pathways to ensure that there is bed model for the period ahead which is clinically, operationally, and financially sustainable.

The report provides professional recommendations for changes in staffing requirements against current funded staffing establishments:

- Support the skill mix review in the Surgical Division – overall cost reduction of £70k
- Catering assistant support on the Spinal Injuries Unit (SIU) - £50k
- Band 4 nurse on night shifts on Newton Ward to support staffing ratios - £129k

Financial Implications

Recommendations supported at the Executive Committee:

- Skill mix review in Surgery – overall cost reduction of £70k
- Substantive funding of catering assistant resource on SIU - £50k
- Band 4 night nurse on Newton Ward to support staffing ratios - £129k

Quality and/or Equality Impact

Not applicable	
Recommendations	
The Board is asked to note National Quality Board Establishment Reviews.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

The purpose of this paper is to provide the latest findings of the nursing staffing inpatient ward establishment review which was undertaken in January 2025 (data collection commenced in December 2024) for all 54 inpatient wards across MWL.

It is a requirement that NHS providers continue to have the right people, with the right skills, in the right place at the right time to achieve safer nursing and midwifery staffing in line with the requirements of the National Quality Board (NQB, 2016). The NQB that states providers

- Must deploy sufficient suitable qualified, competent, skilled, and experienced staff to meet treatment needs of patients safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required and keep them safe at all times.
- Must use an approach that the reflects current legislation.

Incorrect staffing levels compromises care both directly and indirectly. Recurrent short staffing results in increased staff stress and reduced staff wellbeing, leading to higher sickness absence (needing more bank and agency cover), and more staff leaving. All of this impacts on the cost and quality of care provision.

The information in the report will provide the Executive Committee, Quality Committee and Trust Board with assurance that the Trust has a clear validated process for monitoring and ensuring safe staffing levels. The Trust's compliance will be assessed in the annual governance statement by confirming staffing governance processes are safe and sustainable.

This will be reviewed as part of any Care Quality Commission (CQC) inspections to demonstrate compliance with fundamental standards. This compliance will be measured with a 'triangulated approach' including evidence-based tools and professional judgement and outcomes; this will ensure we have the right staff with the right skills are in the right place at the right time.

It is a requirement that every Board receives an annual establishment report with further reporting on a biannual basis (National Quality Board, 2016).

The review will be presented to the Trust Board in May 2025 to provide assurance that the Trust has a nursing workforce with appropriately planned safe staffing and skill mix resources to meet the patient care requirements. This paper will make recommendations to current staffing establishments accordingly for consideration.

2. Background

The aim of the establishment review is to align nurse staffing and skill mix across MWL by:

- Reviewing services across all sites to ensure parity and equity of care delivery through harmonisation of staffing establishment based on service specialty to maintain safe and effective care delivery.

Standardising our approach to nurse staffing establishments to ensure nationally mandated reviews, latest staffing guidance for clinical wards from the National Institute for Health and Care Excellence (NICE) guidance, NHSi guidance (Developing Workforce Safeguards 2018) and the Royal College of Nursing (RCN) nursing workforce standards (2021) are incorporate in the reviews.

- Recognising that the establishments alignment post transaction, is ongoing and to make recommendations for consideration of any required changes to the wards funded establishments.
- Recognise the National ongoing work that has been undertaken by the Trust to review the requirement for specific skillset across the Healthcare Assistant (HCA) workforce and align services to reflect the ratios required for band 2 and band 3 workers.
- Provide assurance to the Executive Committee and Trust Board that MWL has a nursing workforce which has an appropriately planned safe staffing resource to meet the patient care requirements.

3. Methodology.

The Safer Nursing Care Tool (SNCT:2023) data collection was undertaken throughout the month of December 2024. The SNCT is a NICE-endorsed evidence-based tool currently used in the NHS to identify safe staffing levels for:

- adult inpatient wards in acute hospitals
- adult acute assessment units
- children and young people's inpatient wards in acute hospitals

The national safe staffing tool has not been fully developed for community nursing, and as an organisation this will be implemented when released, providing an opportunity to assess community service workloads through evidence-based tools.

The SNCT calculates clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses in their safe staffing decisions. The tools:

- Provide organisational level metrics to monitor impact on the quality of patient care and outcomes
- Give a defined measure of patient acuity and dependency
- Are able to support benchmarking activity in organisations when used across trusts
- Embrace all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE/I 'Safe, sustainable and productive staffing' resources
- Include staffing multipliers to support professional judgement
- Provide accurate data collection methodology

The data collection tool was reviewed in 2023 by the Shelford Group and updated to reflect the care needs for patients who needed additional support to maintain their safety and this was captured as levels 1c and 1d. SNCT care level 1c reflects patients requiring continuous observation as per local policy to maintain patient safety, with 1d highlighting the need for continuous monitoring of patients who pose a significant risk to themselves or others if left unsupported, and this safe care can only be safely delivered by two members of staff.

This was locally adopted by the organisation in 2024; however it was not reflected in June 2024 review that was presented to Board as full understanding and knowledge of the tool had not been embedded into practice. In October 2024, there were education sessions to ensure staff using the data collection tool were able to accurately capture the care requirements on each inpatient area and accurately reflect the additional care levels 1c and 1d.

Across the organisation, we continue to see an increase in the complexity of patients being admitted who require additional care to maintain their safety, particularly in relation to cognitive impairment. We continue to experience extensive delays with patients who require ongoing community or social care provision for patients with ongoing mental health needs, including dementia, and patients who require complex discharge planning to support patients who require permanent or long-term health care placements in a social setting. This cohort of patients has been captured within the data collection as patients who are 1c care dependency needs. During the data collection, there was, on average, per day, 82 across MWL.

Once the data had been collated, the information and findings were validated by the specialty matrons, to give assurance that the information captured was accurate.

The Divisional Nurse/Midwife/Allied Health Professionals (AHP) Directors reviewed the information gathered, and using professional judgement, signed off divisional submissions for required additional requirements across their respective services for inclusion in the full staffing establishment paper.

The minimum skill mix recommended by the RCN:2011 is a ratio of 65/35 registered nurses (RN)/healthcare assistants, however across different specialty areas we identify that there may be a variation based on patient dependency and care needs with some areas increasing to an 80/20 split in children services and 50/50 split in older persons care services.

The establishment review currently does not take into consideration the use of escalation beds. However, it is recognised that additional temporary staffing has been utilised regularly to safely manage the opening of additional beds in times of extremis.

These areas include 4E medical escalation area and cardiac catheter lab at the Whiston site, and Ward 1 and Salus Centre on Southport site. For January alone, there were 624 escalation bed days reported on Whiston site and 343 at the Southport site.

4. Care Hours Per Patient per Day (CHpPD)

CHPPD produces a single comparable figure that represents both staffing levels and patient requirements, unlike actual hours or patient requirements.

CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is reported as a total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix.

$$\textbf{Care Hours per Patient Day} = \frac{\text{Total hours of nurses and midwives plus total hours of care support workers}}{\text{Total number of inpatients}}$$

CHpPD was reported as 7.5 for Whiston and St Helens sites, 9.2 for Southport and Ormskirk sites in January 2025. The national benchmark is 7.0.

Variations in CHpPD have been identified as due to different working arrangements. This breakdown identifies the following variances that still require harmonisation:

- Differences in baseline staffing levels in some areas
- Inconsistencies in skill mix requiring alignment across sites, including band 6 provision.
- Differences in break allowance during 12-hour shifts.
- Variations in the provision of hostess and housekeeper roles.
- Differences in ward layouts across sites.
- HCA Band 2-3 ratio

5. Bank/agency.

There are two separate providers for requests temporary staffing, NHSP and staffing solutions. Human Resources and Finance are undertaking an optional appraisal in relation to temporary workforce provider.

Utilisation and spend is monitored and reported to Executive Committee monthly by the Acting Chief Nursing Officer.

MWL has noted a reduction in agency use and HCA agency will cease from April 2025.

6. Establishment review outcome summary by Division

Below summarises the proposed changes to the nursing establishments following each of the divisional review meetings held in January 25.

Division of Medicine and Urgent Care

The Division successfully secured additional funding for the Emergency Department (ED) Southport last year following a thorough review of the staffing establishment following a full review of activity and acuity. Following the CQC reports, a further review for both ED services is underway and due for completion May 2025, to be presented to Trust Executives by the Division in June 2025**.**

This will give the Division the opportunity to reflect the recent formal feedback received from the CQC inspection that took place in March 2024. The paper for ED staffing will be presented to Executive colleagues.

The Division have undertaken a staffing review and identified that there are areas that require additional investment to increase staffing establishments across both sites. The Division fully acknowledged the challenges faced having the largest number of inpatient areas across both sites with 17 wards on Whiston site and ten wards on Southport site.

The recent approval of the substantive HCA investment on the Whiston site for the top five user wards of 1A, 3C, 5A, 5B and Bevan Court 2 for supplementary care, is starting to demonstrate a reduction in the overall requirement for temporary staff across these wards. This additional investment has supported the Divisional response to cease HCA agency use across clinical services.

There is a residual requirement for additional investment across medicine and urgent care inpatient areas, however there is improvement work to be delivered, with standardisation of promoting a bay nursing model consistently in all areas, and completion of the harmonisation work.

Once the Divisional nursing team are confident that this approach has been embedded in all areas, the Division will complete their light touch staffing review in June 2025 to measure the impact through Shelford data analysis, and any areas that continue to report additional requirement will be captured within the biannual staffing establishment report due later in the year.

The Division has identified that whilst they intend to complete the bay nursing approach, there remains areas of high patient dependency and high additional HCA demand each day and the Division wish to reflect this in the staffing review as the areas require further monitoring to ensure that the teams on wards 7B, 9A and 10A on Southport site are able to maintain the delivery of high-quality care through the approval to increase staffing levels to as identified through clinical professional judgement and Shelford data analysis and SafeCare reporting.

The Division has further identified that the current temporary spends across 7B, 9A and 10A needs further analysis and triangulation in the coming months.

As part of the staffing reviews, it is indicative that the respiratory ward (14B) on Southport site needs to be fully reviewed alongside the Whiston model to deliver a consistent, acute non-invasive ventilation (NIV) service. A comprehensive review is in progress.

Division of Surgery

ICU and theatres across MWL have been excluded from this establishment review but will be completed in the summer months.

There is currently a programme of work underway, supported by Productive Partners, to review the delivery of elective and emergency inpatient and day case activity across MWL. Outcomes from this work will then form a robust establishment review for the required staffing model to support service delivery.

The Division have undertaken their establishment review for inpatient wards and identified that there are areas that required skill mix change to ensure safe delivery of patient care. Following review of the establishments across the whole of surgical Division realignment between cost centres of funded posts means no additional investment is required.

The Division are requesting support to realign existing funding between the wards which in total is a reduction of 1.15 RN and an increase in HCA 1.32 WTE for the division.

If supported, this will release a net budgeted saving of £70k for the Division. This has been achieved in the following ways:

- Converting some remaining early and late shifts to long days
- Reclassification of Band 4 Nurse associates from HCA to RN in specialised areas.
- Review across Ormskirk site of the 4 main wards E, F, G & H.

There has also been a review on the utilisation of the escalation beds in Post Operative Care Ward (G) at Ormskirk, which reflected an increase in capacity from 2023/24 (88.9%) to 2024/25 (99.9%) with an additional 161 HCA night shifts being booked via NHSP to support this in 2024/2025.

The current proposal supports being able to substantively staff two escalation beds through realignment of existing funds. This will provide the additional capacity on a substantive basis removing the need for bank, overtime and NHSP spend.

Supporting the E, F, G, H wards realignment one of the focuses from work with Productive Partners is on utilisation and productivity in theatres, an impact of this will be increased requirement for the utilisation of Elective Orthopaedic Ward (H) bed capacity. The review has reflected this and to fully utilise the inpatient beds has increased the staffing requirement by one HCA on a night shift, all within existing budget.

There is an additional demand for supplementary care support for 4D at Whiston from one to two HCAs on the late and night shift for complex patients. This has been supported by bank shifts on 296 occasions in 2024/2025 and this request will fund this substantively removing the need for bank shifts.

The use of temporary workforce was discussed as part of the establishment review process. The Division have identified that the current proposal and realignment of funded posts will reduce the requirement for temporary workforce to maintain patient safety and care delivery and are requesting support to proceed with the proposed realignment £226k reduction in RN realigned to £156k increase in HCA with an overall reduction in funded establishment £70k.

Division of Clinical Support and Community

Spinal Injuries Unit: As a result of this establishment review it has been highlighted that a comprehensive review of the service is required. A spinal review paper has been completed by the Divisional Triumvirate and is to be scheduled for presenting at Executive Committee in Q2. Following the establishment review, several further actions have been identified for the Divisional team to implement, taking into consideration professional judgement and the Shelford safer care nursing tool:

- E-roster and finance templates to be aligned.
- Benchmarking exercise to be undertaken with other Regional Spinal Units.
- Discuss with Specialist Commissioners regarding the workforce model.
- Explore national standards for Spinal workforce modelling.
- Meet with the Adult Critical Care Network lead to peer review the workforce model for ventilated / tracheostomy patients.
- Develop a business case to increase staffing to achieve recommended safer staffing levels.
- A deep dive into sickness and fill rate is underway.

The unit also has a catering assistant role in place, seven days per week currently at a partial cost pressure. One WTE is funded with an additional 1.33WTE worked at cost pressure. This would require investment of £50k.

Newton inpatient ward: In the previous light touch review in June 2024, the senior nursing team proposed the addition of an extra band 4 registered nursing associate for night duty on Newton ward to achieve a nurse-to-patient ratio of 1:11 and bolster CHpPD. The current staffing levels for Newton are two RNs at night, which gives a nurse: patient ratio of 1:15. Newton is an isolated ward in a community hospital, with no emergency team or other services on site to support in emergencies. There is a lack of resilience across the night staffing levels, and the Division have seen an increase in sickness levels, and the main contributing factor for absence from work relates to work related stress and the level of sickness is currently above the Trust target of 4.5% and is reported at 9.91% (March 2025).

The request for investment for the additional staffing for Newton ward is £129k and this will give an additional registered nurse (band 4) to support staffing levels at night.

Risks that have been raised in relation to staffing levels at Newton are risk numbers 3935 and 4143.

Women and Children's Division

Maternity: Assurances are in place via the Maternity and Neonatal reporting to Quality Committee and Board for midwifery staffing as part of the Maternity Incentive Scheme safety standards. One to one care in labour is reported monthly and consistently at 100% for both maternity units. Midwife to Birth ratios range from 1:22-1:29 across the first three months of 2025. It is noted that their last Birthrate plus review took place in 2022, and it is advised that this process will need repeating in 2025.

Neonates: There is currently a Neonatal Cot Reconfiguration review of cot capacity and a transformation programme within Cheshire & Merseyside. The Women and Children's Division presented a paper to the Executive Committee in April 2025, providing an overview of the current cot status, proposed cot reconfiguration and associated workforce requirements based on activity data from the Neonatal Operational Delivery Network (ODN) intelligence.

Paediatrics: The paediatric ward on the Whiston site has remained consistently over budget in relation to non-registered staff. The increased staffing has been required due to the increased number of children with eating disorders, Children and Adolescent Mental Health

Services (CAMHS) and mental health issues on the ward and who have remained for significant long periods of time. There has been a requirement for external support from agencies such as Prometheus and Calgary to provide safe support to these children.

7. Risks

There are risks associated with the staffing establishments across the organisation and this is reflected Quality Board Assurance Framework:

The risk articulates:
If the Trust is unable to recruit staff with the knowledge, skills and experience required there is a risk that the Trust will not be able to provide safe levels of staffing – currently scored at 16.

There are also additional risks that relate to:

- Variation in working pattern / hours for staff relation to addressing variance in break times across sites.
- Impact on staff morale and resilience.
- Absence for work attributed to work related stress.
- The current time to recruit into posts.
- Attrition rate for HCA workforce.
- The Organisations ability to deliver on the cost improvement plan for 2025-26.

8. Recommendations

The Board is asked to:

1. Note that the annual establishment review process for nurse staffing has been undertaken in line with agreed methodology, with NICE recommended, evidence-based tools.

2. Note the outcome from the Executive Committee of the recent establishment review:

- Support the skill mix review in the Surgical Division – overall cost reduction of £70k
- Catering assistant support on the Spinal Injuries Unit (SIU) - £50k
- Band 4 nurse on night shifts on Newton Ward to support staffing ratios - £129k
- Further analysis on HCA bank utilisation on Ward 7B, 9A and 10A.
- Comprehensive review of SIU and NIV service.

9. Next steps

Alongside the bi-annual establishment review process for inpatient ward areas, the senior nursing and midwifery team also recognised that areas outside of this such as operating theatres, ITU, ED and outpatients also require reviews of their workforce establishments.

Continue the harmonisation work across all areas prioritising the role of the catering assistant across MWL.

An Establishment Review process standing operating procedure (SOP) is in draft to provide clear guidance on this process. The senior nursing team are currently determining future establishment review cycle dates, allowing for seasonal variations and alignment with Board and planning requirements.

The senior nursing and midwifery team continue to identify potential future efficiencies.

Review of bi-annual establishment review cycle and timeframes.

Title of Meeting	**Trust Board**		**Date**	28 May 2025
Agenda Item	**TB25/042**			
Report Title	Aggregated Incidents, Complaints and Claims Report (Q4)			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

The aim of this paper is to provide the Board with a closure report on the management of incidents, complaints, concerns and claims during Quarter 4 2024/25.

Executive Summary

The InPhase system was introduced Trust wide in March 2025 to replace the legacy Datix systems.

Incidents

- 5,210 incidents reported in Q4 at Whiston and St Helens Hospitals (including Newton Hospital and Community Services).
- 2,691 incidents reported in Q4 at Southport and Ormskirk Hospitals.
- 3,999 patient safety incidents reported in Q4 at Whiston and St Helens Hospitals.
- 2,051 patient safety incidents reported in Q4 at Southport and Ormskirk Hospitals.
- 62 patient safety incidents graded as moderate harm or above during Q4 at MWL

- At Whiston and St Helens Hospitals, highest number of incidents reported relate to:
  - Pressure ulcers remain one of the highest reported categories in Q4 with 970 incidents. (this includes non-trust acquired skin damage)
  - Accidents including slips, trips, and falls is the second highest reported category for Whiston and St Helens Hospitals in Q4 (828).

- At Southport and Ormskirk Hospitals, highest number of incidents reported relate to:
  - Bed management, 288 incidents during Q4.
  - Accidents including slips, trips, and falls is the second highest with 246 incidents during Q4.

Complaints

- The Trust received 142 first stage complaints in Q4 and responded to 108.
- Clinical treatment was the main reason for complaints, in line with previous quarters.
- Emergency Department remained the main areas to receive complaints.

Patient Advise and Liaison Service (PALS)

- The Trust received 1,160 PALS enquiries in Q4.

Claims

- In Q4 NHS Resolution were notified of 34 “new” claims.
- The Trust received 87 records requests in relation to potential claims.

Inquests

- The Trust was notified of 27 new inquests and closed 25.

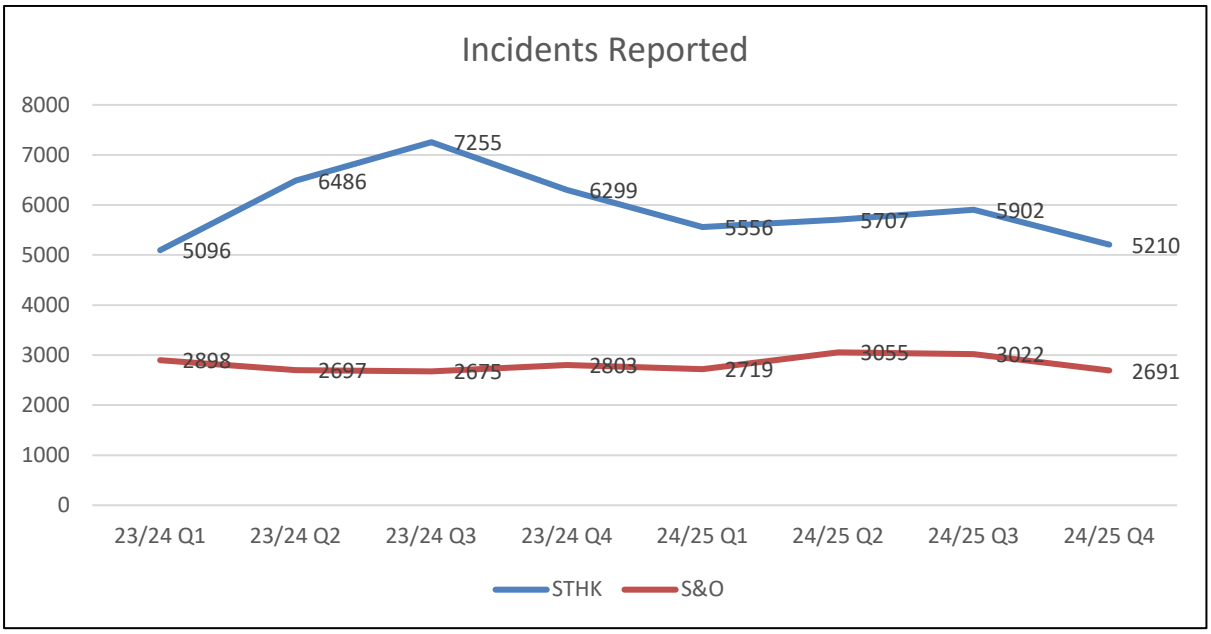
No Prevention of Future Deaths (PFDs) were issued, and coroners did not require any further assurance during Q4.	
Financial Implications	
None as a direct consequence of this paper	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Aggregated Incidents, Complaints and Claims Report (Q4).	
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
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Aggregated Incidents, Complaints and Claims Report (Q4)

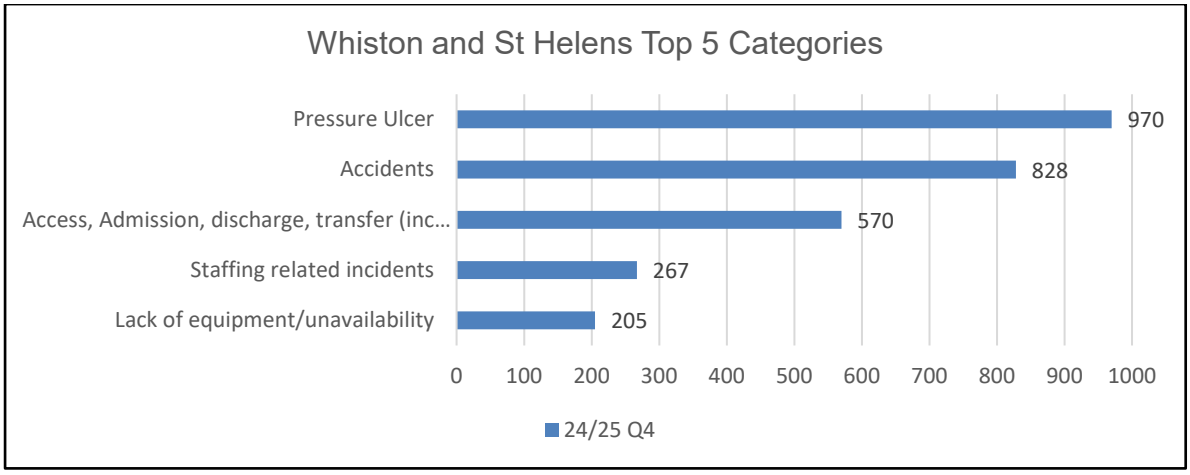
1. Introduction

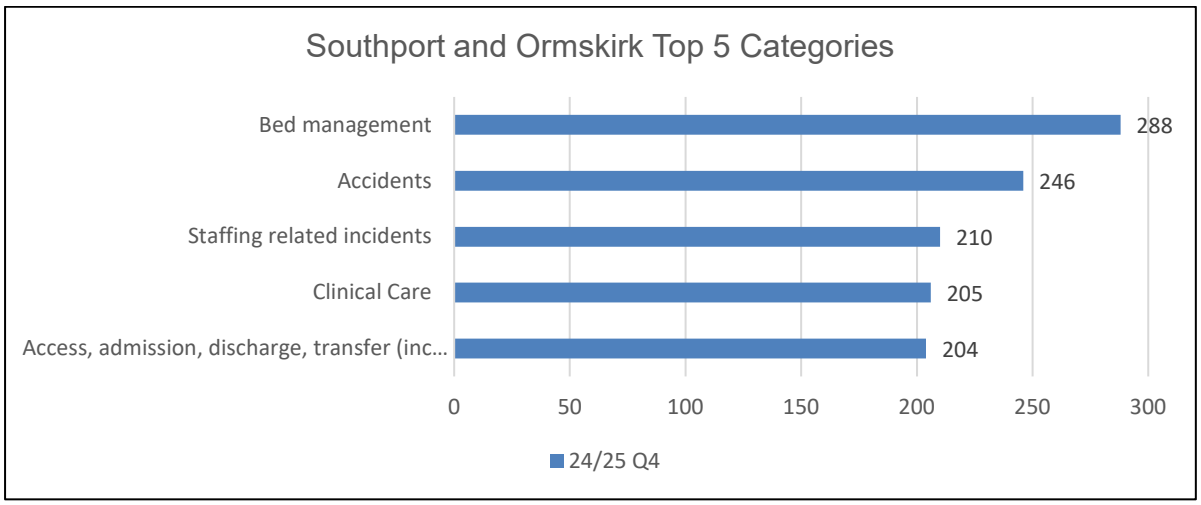
This paper includes reported incidents, complaints, PALS contacts, claims, and inquests during Quarter 4 2024/25, highlighting any trends, areas of concern and the learning that has taken place. In March of Quarter 4 the Trust moved to a new Incident Reporting System, InPhase, which brought all sites onto one reporting platform to record incidents, complaints, PALS, and claims.

2. Incidents



Whiston & St Helens Q4	Southport & Ormskirk Q4	
3999	**2051**	**Incidents affecting patients**
393	**270**	**Incidents affecting staff**
796	**359**	**Incidents affecting the Trust or other organisation**
22	**11**	**Incidents affecting visitors, contractors or members of the public**





- New single incident reporting system - InPhase, was introduced in March 2025, replacing Datix across all sites. Future reports will provide aggregated data as MWL.
- There was a slight drop in incidents reported across both Whiston and St Helens and Southport and Ormskirk sites in Q4 (7,901) compared to Q3 (8,924)
- Pressure ulcers remain the highest reported for Whiston and St Helens Hospitals sites at 970 in Q4.
- Slips, trips and falls (under Accidents on the new system) also remained highest categories for Whiston and St Helens Hospitals sites with 828 reported.
- Bed management incidents remain the highest reported for Southport and Ormskirk Hospitals in Q4 with 288.
- The second highest for Southport and Ormskirk Hospitals has changed from Access, Admission, Discharge, Transfer in Q3 to Accidents (246) in Q4.

2.1. Incidents by harm category

The table below illustrates incidents by harm for Quarter 4.

At Whiston and St Helens Hospitals, for Q4, there were two deaths recorded which is a decrease from Q3. This indicates that there have been seven deaths reported in Whiston and St Helens Hospitals for 2024/25 compared to 23 recorded deaths in 2023/2024.

The two reported deaths in Q4 2024/25 relate to an incident resulting in pulmonary embolism and a cardiac arrest. All incidents are subject to Trust investigation to identify learning and improvement.

Whiston & St Helens	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	24/25Q 2	24/2 5 Q3	24/2 5 Q4
Moderate	25	20	32	18	19	13	20	32
Severe	5	10	8	8	8	8	7	3
Death	3	8	6	6	0	1	4	2
Total	33	38	46	32	27	22	31	37
Southport & Ormskirk	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Moderate	11	11	21	17	18	22	13	22
Severe	2	8	1	2	7	1	2	3
Death	1	0	0	0	0	1	0	0
Total	14	19	22	19	25	24	15	25

2.2. PSIRF activity and PSII incident

The management of patient safety includes not only identification, reporting, and investigation of each incident, but also the implementation of any recommendations following investigation, dissemination of learning to prevent recurrence, and implementation of changes in practice when required. Please see table below.

Q4 2024/25	Total
Learning Reviews	19
Expanded Learning Reviews	8
MDT / AAR (After Action Review)	3

Number of PSII commissioned	5

2.3. Duty of Candour

Verbal Duty of Candour (DoC) was completed for the majority of the incidents resulting in moderate or severe harm in the above table 2.1 with follow up formal DoC being completed within the required timeframe. There are two cases where an update on DoC status has been requested, one case where verbal DoC was completed but all subsequent attempts to contact the patient have been unsuccessful, and a further case that was identified retrospectively and all possible avenues to contact the next of kin have been attempted without success.

3. Complaints

	2023/24	2024/24 Q1	2024/25 Q2	2024/25 Q3	2024/24 Q4	Total 2024/25
MWL First stage complaint	420	109	122	144	142	517
Response Compliance Trust Target 80%	63.16%	74.76%	57.44%	62.9%	64.6%	64.22%

3.1. Outcome codes

Closed complaint by quarter with recorded outcome code

Closed Complaints	23/24 Q3	23/24 Q4	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Not Upheld	37	20	35	44	14	7
Partially Upheld	57	64	80	94	82	84
Upheld	22	15	24	18	18	17
Total	116	99	139	156	117	108

3.2. Themes

Theme (Top 5)	23/24 Q3	23/24 Q4	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Clinical Treatment	54	69	84	68	70	62
Patient Care (Nursing)	11	17	10	11	13	18
Values & Behaviours	7	13	12	12	16	5
Communication	12	15	1	19	23	12
Admission & Discharge	9	5	6	8	3	8

3.3. Complaints – Location

The table below highlights the areas that received the most complaints in Q4

Location	Figure
ED Adults Southport	17
ED Adults Whiston	12
Outpatients Southport (across all specialities)	5
AMU Southport	3
ED Paediatrics Ormskirk	3
Ward 1C	3

The numbers of complaints being made is increasing across all Trust sites. The varying complexity of some of these complaints has also increased. Staff are continuing to make every effort to improve the Trust's performance against the 60-day timescale within this current financial year.

Work has begun, led by the Head of Complaints, around defining responsibilities and expectations with Corporate and Directorate Leads within the new and developing divisions around improving response times and quality of statements.

4. PALS

PALS contacts received by quarter for all sites.

PALS	23/24 Q3	23/24 Q4	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Number received	1099	1077	1167	1117	1156	1160

Five top themes of PALS contacts in priority order.

24/25 Q4 Whiston Site PALS Themes	Communications Clinical Treatment Waiting Times Admissions & Discharge Patient Care Appointment
24/25 Q4 Southport Site PALS Themes	Request for Advice/Information Clinical Treatment Appointments Communication Staff attitude/ behaviour

5. New Clinical Negligence Claims

Implementation of InPhase during Q4 has meant that some of the data available in terms of new claims could not be fully scrutinised/validated. On that basis the Trust has relied on the data available via NHS Resolution in this report. NHS Resolution are the Trust's insurers in relation to clinical negligence matters, and all qualifying claims are notified to them by the Trust at the appropriate time. In addition, there may be some matters which had been closed previously and have been re-opened following direct contact between the claimant's representatives and NHS Resolution (or the Trust's solicitors). This is likely to explain why the figures for new matters are higher that the usual quarterly figure for new claims.

In Quarter 4 the NHS Resolution recorded 34 new matters for the Trust.

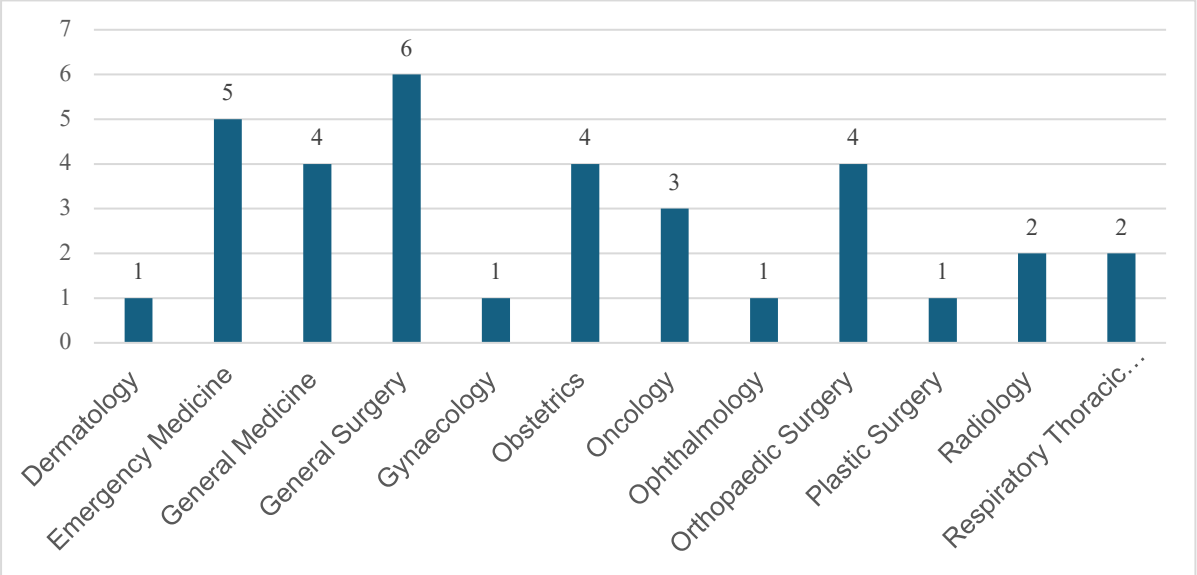
Of these 34 matters, three related to incidents – we will sometimes proactively notify NHS Resolution of matters where the Trust has investigated, and admissions may be

merited. One related to a birth that required notification to MNSI/NHS Resolution under the Early Notification Scheme.

Two matters have been discontinued/withdrawn despite only being notified within this quarter.

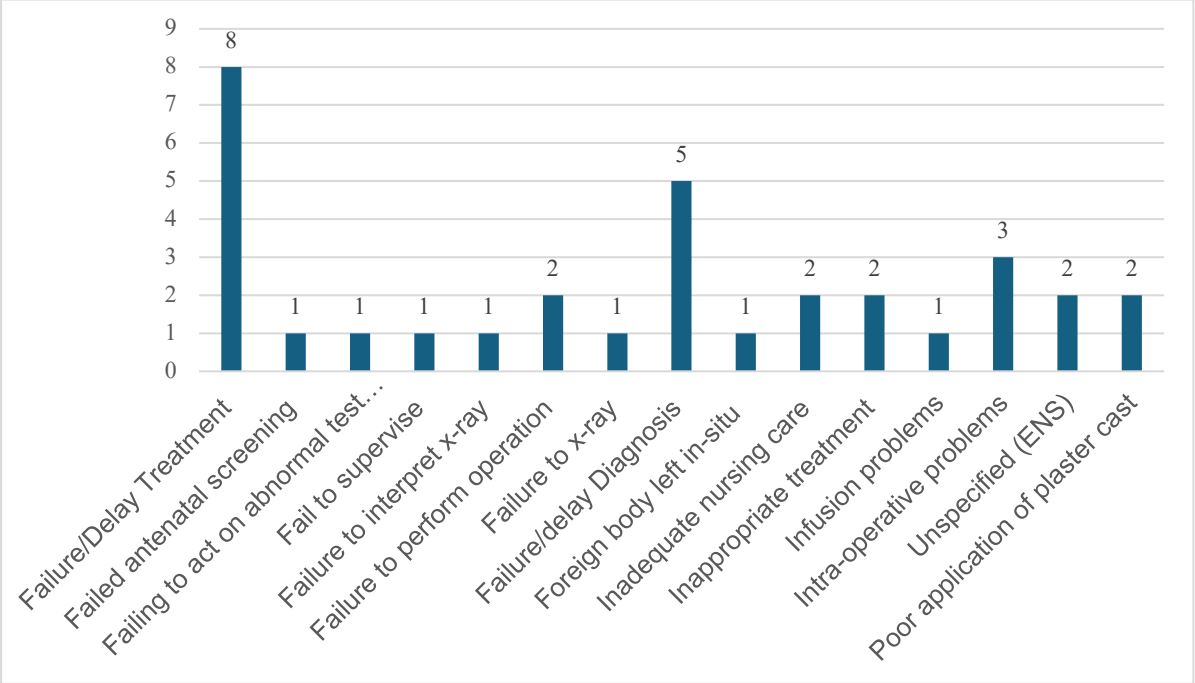
The Trust received 87 requests for records during this period – 41 for Whiston and St Helens Hospitals, and 46 for Southport and Ormskirk Hospitals. This is above the three previous quarters (59 in Q1, 53 in Q2, and 50 in Q3) but broadly in line with Q4 in 2023/24 (78). We will continue to monitor this.

5.1. New claims by speciality



In the previous quarter radiology and obstetrics had the highest number of claims. These figures will be reviewed against the Q1 data from InPhase to see if there are any sustained areas of concern, particularly with regards to General Surgery, which did not generate any claims in Q3.

5.2. New claims by main reason



Failure or delay in diagnosis is usually the most common cause of claims, but in this quarter, there were more matters concerning Failure/Delay in treatment. It is of note that there were two claims relating to poor application of a plaster cast (which is a usual source of claims) although both are, at this stage, being defended.

5.3. Lessons Learned from Claims

No new specific learning has been identified from any of the claims closed in Q4. In practice this means that, where failings in care have been highlighted as part of the claim, the Trust was previously aware of them and has acted to address them. As every claim is reviewed as part of the claims governance process, which includes consideration of an investigation if one has not already taken place, the hope is that new claim specific learning should be rare.

More detail on the extent to which we were aware of the issues that relate the claim will be available for Q1 2025/26.

6. Inquests

6.1. New Inquests

27 new inquests were received in Q4. This is broadly consistent with the previous three quarters of 2024/25 (28, 33 and 31) and the preceding Q4 (29**).**

6.2. Closed inquests

The Trust closed 25 inquests in Q4. A number of these were concluded without a formal hearing.

The Trust has not received any Prevention of Future Death (PFD) notices following the transaction.

None of the coroners who presided over the inquests heard in Q4 required additional assurance around lessons learning for the Trust.

We anticipate that the local coroner (in particular) will continue to focus on falls and pressure ulcers.

6.3. Other news

The Senior Coroner for Sefton, St. Helens and Knowsley Julie Goulding has announced that she will be retiring in June. The Trust has enjoyed a very positive relationship with Ms Goulding and her office and will be sad to see her leave.

7. Recommendations

It is recommended that the Board note the report and the actions taken as a result of inquests and claims.

Title of Meeting	**Trust Board**		**Date**	28 May 2025
Agenda Item	**TB25/043**			
Report Title	Maternity and Neonatal Services Assurance Report Quarter 4			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To update and inform the Trust Board regarding the priorities and progress of the Maternity and Neonatal services across Mersey and West Lancashire Teaching Hospitals (MWL).

Executive Summary

A summary of the progress within Maternity and Neonatal services at MWL that includes:

- Maternity Incentive Scheme (MIS) update
- Perinatal Mortality
- Serious Incidents including one Never Event and Maternity and Newborn Safety Investigation (MNSI) update
- Neonatal Medication incidents
- Saving Babies Lives (SBLv3) - continuous improvement and working towards full compliance supported and monitored by the Local Maternity and Neonatal System (LMNS)
- Complaints, claims and patient experience
- Maternity red flags
- Maternity and Neonatal suspension of services
- Workforce
- Update on the progress of the Three-Year Delivery Plan

Financial Implications

Awareness of potential future investment into the Maternity Services.

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to note the Maternity and Neonatal Services Assurance Report Quarter 4 report.

Strategic Objectives

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

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

Maternity and Neonatal Services Assurance Report Quarter 4

This standardised report template has been developed by the Cheshire and Mersey Local Maternity and Neonatal System (LMNS) and includes the key issues identified within Maternity and Neonatal Services.

1. Maternity Incentive Scheme (MIS)

Evidence for MIS year six was provided for all ten safety actions to Quality Committee and Trust Board in January 2025 demonstrating that MWL had met the required safety actions and sub requirements.

The Board declaration was signed by the Chief Executive Officer (CEO) of the Trust and the accountable officer for the Integrated Care System (ICB) and submitted before the deadline of 12 noon on the 03 March 2025.

A letter was received from NHS Resolution (NHSR) on 31 March 2025 stating that following confirmation through an external verification process and discussion with the Collaborative Advisory Group (CAG), MWL had achieved all ten safety actions for year six of MIS.

MIS Year 7 has been released in April 2025. Work continues to review the new guidance and collate evidence for this submission.

2. Quality and Safety

2.1 Clinical Outcomes/ Dashboard

Maternity and Neonatal Dashboards

Performance is monitored via our local and regional dashboards. Regional and local clinical dashboards are monitored via local governance and presented via the Integrated Performance Report (IPR) at Quality Committee.

Current areas of focus:

- Smoking - a continued focus on referral of women who smoke at booking to stop smoking services aimed at supporting a smoke free pregnancy and reducing the percentage of smokers at the time of delivery. Focussed work to improve compliance continues and 100% compliance was continued throughout Q4 2024/25.
- Breastfeeding – 61% of women initiating breastfeeding at MWL at the end March 2025 with a 61.9% initiation year-to-date rate. An improving trajectory continues with quality improvement projects implemented alongside enhanced staff training within the division.
- Perineal Trauma – there is a continued focus on improving the rates of women sustaining severe perineal trauma (third/fourth degree tears). The last financial year has seen the service launch a Pelvic Health Specialist Team with lead consultants, specialist midwives and pelvic health physiotherapist. The service works to support staff with correct recognition and repair of perineal trauma, with standardised follow up for the women that do. Since Q3 the team have begun to focus on antenatal education of women to improve outcomes around birth. The number of women sustaining severe trauma has remained under the target of 3.5% throughout Q4.

2.2 Perinatal Mortality

Perinatal mortality data forms part of MIS Safety Action 1.

Perinatal mortality includes any fetal loss from 22-week gestation, stillbirths, and neonatal deaths in the first 28 days of life. MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is notified of all eligible perinatal deaths and these deaths are reviewed using the national Perinatal Mortality Review Tool (PMRT).

All perinatal mortality incidents have an initial multidisciplinary review to determine the degree of harm caused, to identify if there is any immediate learning or if the incident is required to be Strategic Executive Incident System (STEIS) reportable.

For the Q4 reporting period (2024/25) there were six reportable deaths.

Q4 2024/25	Total
January 2025	1 neonatal death
February 2025	2 stillbirths 1 termination
March 2025	2 neonatal death

All cases have undergone a multidisciplinary review with the commencement of the PMRT process for those applicable. Care was reviewed and assessed for all cases using the MBRRACE categorisation.

2.3 Serious Incidents

Never Events

There has been one never event for this reporting period in February on the Ormskirk site which involved the retention of a tampon swab. Immediate actions were undertaken, and the incident is part of a Trust wide aggregated review of safety procedures.

Serious Reportable Incidents

Serious incidents (SIs) are reported as they occur and are evidenced on the regional dashboard which is updated monthly. Serious incidents are additionally detailed within the patient safety report presented at Quality Committee.

Maternity Q4 2024/25		
	Whiston	**Ormskirk**
January 2025	1 x MNSI reportable	No Incidents
February 2025	No Incidents	1 never event
March 2025	No Incidents	No Incidents

There was one case reported to MNSI as a suspected hypoxic-ischaemic encephalopathy (HIE) in January, however following an MRI scan HIE was excluded. The case had initial reviews and there were no immediate issues identified that would have made a difference to the outcome.

2.4 Maternity and Neonatal Safety Investigations

MNSI undertake independent investigations into incidents within Maternity Services which fall under a defined criteria that includes maternal deaths, stillbirths and babies that require cooling.

MNSI triage reported cases following a Trust referral based on the following criteria:

- Baby's MRI result.
- Family concerns regarding the care given.
- Trust concerns regarding the care given.

All investigations accepted by MNSI are reported on STEIS as a serious incident. Cases returned to the Trust are investigated with a full multidisciplinary team (MDT) review including an external representative from the Cheshire and Merseyside system.

The Trust is provided with a monthly update of cases reported to MNSI to support effective communication and to advise on the progression of investigations. MNSI case reviews are shared with the Trust for accuracy prior to being finalised and additionally shared with the woman and her family.

Cases to Date April 2019 to December 2024	Ormskirk	Whiston	Total
Total Referrals	16	55	71
Referrals / Cases Returned to the Trust / Rejected	6	21	27
Total Investigations to Date	10	31	41
Total Investigations Accepted	10	31	41
Total HSIB Investigations Completed	10	31	41
Current Active Cases	0	3	3

The one new case is the incident identified in the serious incident section above. The referral has been accepted during Q4. The 2 cases which occurred towards the end of Q3 have also been accepted for investigation by MNSI and are ongoing.

2.5: Neonatal Medication Incidents

MWL Neonatal Medication Errors (as identified via DATIX and InPhase) Q4 2024/25

During Q4 report period there has been nine medication incidents within the Neonatal Units (NNU) of MWL. Medicine incidents during this quarter were categorised as either medication prescribing, administration or storing errors. All incidents were categorised as no harm caused except one which was categorised as low harm caused. This incident was prior to the new prescription booklet being initiated which should see a reduction in medication errors. Other actions are in place to avoid further incidents.

Number of Medication Incidents	Q1	Q2	Q3	Q4
Ormskirk	10	1	6	5
Whiston	4	10	5	3
Total	**14**	**11**	**11**	**8**

Category	Q1	Q2	Q3	Q4
Medication - storing	7.1%	18.2%	0%	12.5%
Medication - prescribing	14.2%	18.2%	45.45%	12.5%
Medication - administration	50%	63.6%	45.45%	75%
Medication - delivery	14.2%	0%	9.1%	0%
Medication - preparing	14.2%	0%	0%	0%

2.6 Saving Babies Lives (SBL) Care Bundle

The requirement to be on track with compliance with all elements of the Saving Babies' Lives Care Bundle Version 3 continues to be a requirement for Safety Action 6 for MIS year 7.

The Q4 quarterly LMNS improvement discussion meeting held in March 2025 has identified an improvement in overall compliance to 97% for the Whiston site and 97% for the Ormskirk site.

The tables below provide the compliance progress from Q2 2023/24 to end of Q4 2024/25:

Ormskirk site

	Baseline assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6
Review Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Assurance review	16/11/23	08/12/23	22/03/24	27/06/24	17/09/24	10/12/24	05/03/25
Element 1	60%	100%	100%	100%	100%	100%	100%
Element 2	60%	75%	95%	100%	100%	100%	100%
Element 3	0%	50%	100%	100%	100%	100%	100%
Element 4	80%	100%	60%	80%	100%	80%	100%
Element 5	26%	85%	96%	96%	100%	81%	93%
Element 6	67%	83%	100%	100%	100%	100%	100%
Total	47%	84%	94%	97%	100%	91%	97%

Whiston site

	Baseline assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6
Review Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Assurance review	17/11/23	07/12/23	07/03/24	06/06/24	17/09/24	06/12/24	05/03/25
Element 1	10%	50%	60%	90%	100%	80%	80%
Element 2	70%	75%	80%	85%	85%	90%	100%
Element 3	50%	50%	100%	100%	100%	100%	100%
Element 4	60%	100%	80%	60%	100%	100%	100%
Element 5	37%	74%	93%	93%	93%	81%	100%
Element 6	33%	67%	83%	100%	100%	100%	100%
Total	40%	71%	83%	88%	93%	87%	97%

The LMNS are still happy with the continued progress of MWL in implementing the care bundle with monitored action plans predominantly in relation to audits and documentation as identified below.

Element 1: Reducing Smoking in Pregnancy
Ormskirk site is fully complaint with Element 1 at 100% and will continue to evidence audits to demonstrate continued compliance.

Whiston site has maintained compliance with Element 1 at 80% in Q4. A detailed action plan has been implemented to improve trajectory of compliance to audits as this has continued from the previous quarter. Themes of non-compliance with documentation of smoking status and carbon monoxide (CO) measurements has continued to be a theme at all visits, particularly for women receiving obstetric antenatal care. This learning has been shared with the wider MDT via multiple platforms including newsletter, safety huddles, staff learning pages, quality bus, global emails, MDT study days, individual emails to staff and at the governance, directorate and consultant meetings highlighting the groups who are persistently non-compliant.

Improvements have been noted in both services in terms of the increased referrals to in house smoking cessation team resulting in 100% compliance throughout Q4. Ongoing audits continue. Harmonisation of policies and implementation of guidance continues to ensure sustained improvement.

Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
Ormskirk demonstrate sustained compliance at 100% and Whiston had improved compliance to 100% from 90%. All recommendations have been implemented; however, work continues to maintain 100% compliance in relation to audits.

Element 3: Raising Awareness of Reduced Fetal Movements
Both maternity sites are 100% compliant including ongoing audits. Harmonisation of policies and implementation of the guidance continues to ensure sustained improvement.

Element 4: Effective Fetal Monitoring in Labour
Whiston demonstrates sustained compliance at 100% and Ormskirk increased compliance from 80% to 100% in Q4 following implementation of a Quality Improvement programme.

Element 5: Reducing Preterm Birth
There has been an improvement in compliance for Whiston from 81% to 100%, and from 81% to 93% at Ormskirk. There are eight process indicators and four outcome indicators within this element of SBL with data submitted as part of the Maternity and Neonatal collaborative. The maternity and neonatal service are working together to ensure improved compliance with data quality and documentation which contributed to not currently achieving 100% on the Ormskirk site.

On both sites a significant improvement has occurred improving provision of early breastmilk. This has included patient focused posters to promote expressed breast milk on the Neonatal unit, staff education to support women and ensuring documentation of discussions which has been facilitated by preterm birth leads and infant feeding team. Ormskirk have recently achieved Stage 2 of UNICEF Baby Friendly Initiative with positive feedback from assessors around staff knowledge and passion for the service.

Element 6: Management of pre-existing diabetes
Both services remain 100% compliant including ongoing audits.

2.7 Care Quality Commission CQC Review

The maternity service CQC inspection on 07 and 08 December 2023 rated the services as:

- Whiston: Good overall and good for being safe and well-led
- Ormskirk: Good overall and for being well-led. It was rated requires improvement for being safe.

Action plans are in place for all must and should do recommendations from previous inspections.

The CQC are refining their assessment and will use a single assessment framework. The five domains of safe, effective, caring, responsive and well led will remain. However, the key lines of enquiry will be replaced by a series of quality statements and will use six evidence categories to help them understand the quality of care being delivered for each quality statement which includes:

- People's experience of health and care services
- Feedback from staff and leaders
- Feedback from partners – people representing organisations that interact with the service or organisation that is being assessed.
- Observation by CQC inspectors, specialist professional advisors and Healthwatch
- Processes (including incidents, waiting times, audits, policies and procedures)
- Outcomes focusing on the impact of care processes on individuals, with data taken from patient level data sets and national clinical audits.

Preparedness for CQC inspections continues across the service with each service completing a self-assessment in relation to the quality standards and collating supporting evidence. Regular updates are in progress with monitoring at the Divisional Governance meeting.

2.8 Safety Champions

Safety Champions are within MIS Safety Action 9.

The aim of Safety Champions is to ensure seamless communication from 'floor to Board' with a focus on Maternity and Neonatal issues and improving safety and outcomes with monthly scheduled meetings.

Schedules for Safety Champion Walkarounds for both sites for 2025 are in place in order to meet frontline clinical and non-clinical staff alongside women and their families to enable to an additional opportunity for any safety concerns to be raised which are feedback at the Maternity safety champions meetings. The feedback proforma has been modified to identify if any safety actions are identified where they are escalated too.

The NED and Executive Safety Champions additionally undertake walkarounds with feedback also presented at the Maternity Safety Champions meetings.

The PQSM tool is presented monthly to the Safety Champions and the Quality Committee. This is also included in the Patient Safety report to Trust Board.

2.9 Complaints and Claims.

Maternity:
There were two formal complaints received in Q4 for the Ormskirk Site. The January complaint related to care on the ward and attitude of staff and the February complaint related to missing test results/referral to hepatology following a maternal medicine MDT meeting.

There were three ongoing complaints from Q3 for the Whiston site in Q4, one of which was delayed due to the unavailability of a staff member named in the complaint who was required to provide a response. The complainant was informed of the delay and the complaint has now been closed. The two other responses were closed as resolved within the 60-day time frame.

One formal complaint was received at the end of February where the mother had concerns about decision making and information provision in relation to her urgent induction of labour during her pregnancy in 2023. After contacting Patient Advise and Liaison Service (PALS) requesting a debrief, she was incorrectly told that this could not happen as her birth was more than 12 months earlier, therefore she submitted a complaint in attempt to have her questions answered. On receiving the letter of complaint, the mother was contacted and a face to face debrief arranged with a consultant obstetrician and midwife. Once facilitated the mother contacted the department and withdrew the complaint thanking the professionals who she saw for answering questions.

Maternity	Jan 2025		Feb 2025		Mar 2025		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of Complaints	1	0	1	1*	0	0	2	1*

*Complaint subsequently withdrawn

Learning and Actions from Closed Complaints
All complaints from Q3 have all been responded to and closed. Actions from these complaints were:

- Ensure that verbal consent is always documented by clinicians performing procedure following a full explanation of care.
- Communication with Catering Services to ensure that if Mother and Baby transfer during meal service a warm meal will still be offered by hostess.
- Bespoke training day organised for MSW/HCA's focusing on expectations of the role including good communication and conflict resolution.
- Shared learning distributed reminding staff of the correct process for following up test results.
- Parent Education offer regarding the information provided around caesarean section to be reviewed.
- Consent update training provided by Hill Dickinson for obstetricians.

Neonatal:

Neonatal	Jan 2025		Feb 2025		Mar 2025		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of Complaints	0	1	1	0	0	0	1	1

There was one complaint on the Ormskirk site relating to an Advanced Neonatal Nurse Practitioner (ANNP) using a biro pen to monitor an area of redness around an open wound.

There was one complaint on the Whiston site relating to a mother perceiving that her child requiring paediatric follow up following birth for alternative therapies.

There was one complaint for the Whiston site which related to care and treatment in 2016 was received in Q3 and closed in Q4.

Learning and Actions from Closed Complaints

- Ensure explanations are provided to parents for the rationale of asking questions in relation to birth in the neonatal period to avoid any confusion or uncertainty or misinterpretation of why the questions needed to be asked.
- Continue to promote good communication with families to ensure they are updated with ongoing investigations and care as clinical situation changes.
- Shared learning disseminated throughout Neonatal/Paediatric teams that only skin marker pens must be used to mark patients' skin.

Claims

There were three total claims for MWL maternity and neonatal service in Q4 2024/25. There were zero claims for the Neonatal services in Q4.

- Ormskirk: Allegations of a failure to remove placental tissue during a caesarean section in 2023 which led to a secondary postpartum haemorrhage and further surgery to remove the retained products causing avoidable pain, suffering and emotional harm.
- Ormskirk: Allegations of skin staining following being given a Ferinject infusion (Iron) during pregnancy in 2024.
- Whiston: One claim related to the baby detailed in the serious incident section of the report where the baby had a perinatal stroke following birth in January 2025.

The claims scorecard is only produced annually in September, and it now contains the data for all MWL sites for the years 2014/15 until the end of 2023/24.

The details for the combined scorecard are:

The Top 5 injuries by volume for obstetrics:

1. Psychiatric/psychological damage
2. Stillborn
3. Fatality
4. Unnecessary Pain
5. Additional/unnecessary Operation(s)

The Top 5 Causes by volume within the scorecard were:

1. Failure or delay in treatment
2. Failure/delay diagnosis
3. Fail to monitor first stage of labour.
4. Fail to monitor second stage of labour.
5. Failure to make a response to abnormal fetal heart rate.

The multidisciplinary review of the case resulting in the new claim at Whiston did not highlight any issues relating to the causes within the claims scorecard. The MNSI investigation is on-going at present. One of the claims on the Ormskirk site relates to the to the injuries by volume in relation to unnecessary operation, pain and psychological damage.

2.10 Maternity Red Flags

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.

A Midwifery Red Flag event is considered as a potential early indicator warning sign. These incidents must be reported to the Maternity Shift Leader to identify and address and identify any immediate actions.

The following are the recommended red flags which require documenting via the Datix Incident Reporting System.

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 15 minutes or more between presentation and triage.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

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Theme	Total for Q4 2024/25							
	Jan 2025		Feb 2025		March 2025		Total	
	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk
Delayed or cancelled time critical activity	0	0	0	0	0	0	**0**	**0**
Missed or delayed care	0	0	0	0	0	0	**0**	**0**
Missed medication	0	1	0	1	0	0	**0**	**2**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**	**0**

Theme	Total for Q4 2024/25							
	Jan 2025		Feb 2025		March 2025		Total	
	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk
Delay of 15 minutes or more between presentation and triage	8	0	9	0	2	2	**19**	**2**
Delay of 30 minutes or more between presentation and triage	0	0	3	0	0	0	**3**	**0**
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**	**0**
Delay of 2 hours or more between admission for induction	0	1	2	2	0	2	**2**	**5**
Delay in transfer to delivery suite for ARM	0	2	0	2	0	2	**0**	**6**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**	**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0	**0**	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**	**0**
TOTAL	**8**	**4**	**14**	**5**	**2**	**6**	**24**	**15**

There were 24 midwifery red flags on the Whiston site reported in Q4, 22 of these were related to delays in triaging women on their attendance at Maternity Triage. This included 19 with a delay of >15mins & 3 with a delay of >30 mins. Continued work to review for any themes continues by the Matron and Clinical lead. During the investigation it emerged that there was increased call volume or length which took place around the times triage breaches occurred.

On the Ormskirk site, there were five delays in over two hours in commencing the induction process and six delays in transfer to Delivery suite for artificial rupture of membranes (ARM) which were all attributed to acuity on the unit at that time.

Proactive escalation to the Maternity bleepholder is now occurring and this enables consideration of redeployment of staffing to prevent or mitigate breaches. Responsive reporting within triage of any breaches continues and hasn't been affected by the change in the move to InPhase.

The Whiston telephone system ensures all calls can be answered, with a fail safe for periods of high acuity or if calls were not answered. There were 4,401 calls answered Q4, and the department had 2,127 attenances maintaining a performance of attendance to triage for 99.2% attendances.

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area, and they are present 24/7 which is a recommendation within the Ockenden Report. The Delivery

Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. No red flags have been reported in this reporting period due to compliance. A monthly audit is also undertaken which has confirmed 100% compliance to the shift coordinator being supernumerary and is presented at the Maternity Governance meeting. The maternity bleep holder documentation has a section to confirm at the minimum four hourly walkabouts that the shift leader is supernummary and if this was not achieved a narrative and rationale as to the reason for non-compliance.

Midwifery red flags are all incident reported, and any learning is disseminated via ward meetings, safety huddles and the Maternity Governance & Quality meetings.

3. Workforce

Maternity workforce is a requirement of MIS Safety Action 5 and the Neonatal staffing relates to MIS Safety Action 4.

The Women's and Children's division was formally established in April 2024 with a dedicated divisional structure of a triumvirate consisting of a Divisional Director of Operations, Divisional Director of Midwifery and a Divisional Medical Director. The Division consists of Maternity, Gynaecology services, Paediatric and Neonatal services on two sites.

Across the two legacy sites there is a difference in the percentage uplift used to determine the required staffing levels. The Division will be undertaking a staffing review to identify the required uplift incorporating sickness, annual leave, training, and maternity leave. Once completed this review findings will be presented to the Executive Team to enable standardisation across the maternity service and detailed within the maternity update paper to quality committee.

Ormskirk Maternity Service:
The number of births recorded at MWL (Ormskirk site) between January to March 2025 was 460, which is a decrease of (8.35%) 42 births compared to the previous three months (Q3 2024/25) and a decrease of 87 births compared to the same reporting period in 2023/24.

There were 569 bookings in quarter 4 which is a decrease of 64 bookings (10.1%) compared with quarter 3 2024/25. Comparing the quarter 4 bookings with quarter 4 in 2023/24 there has been a 9.5% decrease (58 bookings).

The January 2022 BR+ report identified that the Delivery Suite (DS) case mix for 2021 indicated that 58.2% of women were in the two higher categories IV and V which was in keeping with the average for England of 58%. This was an increase of 7% compared with the 2018 report of 51%, which reflected the increase of induction rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The recommendation for the funded establishment for the provision of direct midwifery care in BR+ included a 25% uplift for annual leave, sickness, and study leave was 117.40 whole time equivalent (WTE). Following the recommendations in the Ockendon report the clinical midwife uplift was amended to 30%.

The overall funded establishment is 128 WTE and includes 5.28 WTE Band 3 midwifery support workers (MSWs) who are based on the maternity ward and providing clinical care in line with the recommendations of the Birthrate plus report.

The midwifery establishment is divided into direct clinical care and non-direct clinical care.

The reporting timeframe of January to March 2025 identifies that BR+ recommended 107.89 WTE for the provision of direct maternity care. The funded establishment is above this figure at 110.79 WTE which includes 5.28 WTE maternity support workers.

The recommendation is for there to be 9.51 WTE staff for non-direct clinical roles which was based on 9% of the total clinical time. The current funded establishment is 17.22 WSTE and is above the recommended staffing. The additional staff include the provision of cover for elective caesarean section lists, increased training because of Ockenden and 3.37 WTE externally funded posts which include 0.4 WTE bereavement midwife, 1 WTE preceptorship/ workforce midwife, 0.11 WTE perinatal trauma midwife, 0.4 WTE pre-term birth/ multiple pregnancy midwife and 0.6wte for MSW retention. There is also 1 WTE band 7 digital midwife secondment in place to support the implementation of the new electronic maternity system. This is funded via the digital transformation monies.

There was a vacancy for one WTE community/ outpatient. Following the creation of the Women and Children's division, a decision was made to revise this post and its portfolio. An Antenatal Outpatient and Screening Matron was developed to cover antenatal services and antenatal screening services across MWL. This post was successfully recruited to and the postholder will commence on 28 July. The current community Matron on the Whiston site took over the whole community footprint service across MWL.

The Antenatal and Newborn Screening team are now fully established with a named specialist screening midwife, a deputy and failsafe officer in post.

The Midwife to birth ratio for this reporting period has been recorded as

Month	Midwife to Birth ratio
January 25	1:22
February 25	1:22
March 25	1:22

There has been 100% compliance noted for the provision of one to one care in labour and the availability of a supernumerary Delivery suite shift coordinator for this three month reporting period.

Whiston Maternity Service:
The number of births at MWL (Whiston site) between January and March was 876 which was an increase of 3 (0.03%) compared to the previous quarter, and a 9.8% decrease compared to the same reporting period in 2024.

Bookings remained static at 1009 in Q4, which is a 5.7% decrease from same period in 2024. The annual bookings were 126 fewer than 23/24 which represented a 3% decrease and followed the national trend

The last BR+ report which was received by the Trust in October 2022 identified that the generic case mix, 55.6% of women were in the 2 highest categories of care required which is slightly below the average for England of 58% with the DS case mix indicating that 60.9%

of women are in the highest two categories for care within the DS environment which is an increase of 9% from the previous BR+ assessment in 2016. This reflects the increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and identified that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 14.39 WTE and aligns to the recommendations and therefore no variance is noted. In addition, the non-direct care band seven posts include three fixed term externally funded posts (2.2 WTE) which are included in the contracted figures but not in the funded establishment and a business case will be required as the expectation is that these posts will be substantive once the external funding ceases.

The BR+ report identified that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 168.22 WTE. Agreement to substantively over establish by six WTE to cover maternity leave is maintained and the service is therefore in line with the recommendations of the BR+.

At the end of Q4 the service had 0.32 WTE actual midwifery vacancy due to a reduction in hours DUE partial retirement, and Nil MSW vacancy following the commencement of 2.25 WTE MSW on Ward 2E. A recruitment open evening is planned for May 2025 to showcase opportunities working in Maternity and Neonatal Services at MWL, with interviews planned for June to recruit to the existing and projected gaps due to reduction in hours, retirements, and leavers currently working notice period. Our ongoing rolling recruitment programme continues to ensure any deficits are advertised as early as possible and that a proactive approach is adopted to fulfil vacancies that arise.

Midwife to birth ratio for this reporting period has been recorded as:

Month	Midwife to Birth ratio
January 25	1:25
February 25	1:24
March 25	1:29

The LMNS have been asked to support in looking at a review across C&M to ensure that the calculation of the midwife to birth ratio is standardised and consistent for all providers, specifically relating to non-direct care giving staff, DS shift coordinators and ward managers and if they are included or excluded in the calculation. MWL currently use the formula and methodology suggested by BirthRate Plus to produce the calculation.

There has been 100% compliance noted for the provision of one to one care in labour and the availability of a supernumerary Delivery suite shift coordinator for this three-month reporting period.

The Maternity Service will be required to consider a further BR+ workforce review in 2025/26 as in 2025 it is three years since the previous review. MIS Year 6 requirements were that a systematic, evidence-based process to calculate midwifery staffing establishment must have been completed within the last three years for which the service was compliant but there is a requirement to undertake or commence discussions with BR+ to begin an assessment for MIS Year 7.

Consultant Obstetric Workforce

Ormskirk site is fully recruited to the funded Consultant establishment, however a Consultant on the team is going to Manchester Foundation Trust for an eight-month secondment in Urogynae and will need to be back filled for this period.

Cross site working for specialist clinics including fetal medicine services and service alignment ongoing with close working of the Consultant delivery suite leads.

There has been expansion of the Consultant body on the Whiston site in 2024 as four new Consultants were appointed with a 0.5 WTE gap due to the staff not working full time with continued working towards 24/7 consultant presence on delivery suite.

The current challenges relate to middle grade rota gaps due to staff also not working full time

Neonatal Workforce
Neonatal staffing relates to Safety Action 4 of MIS.

There is currently a transformation programme in existence in Cheshire & Merseyside with a renewed focus and pace to implement changes to the current commissioned capacity within 2025, however timescales remain unclear from the Neonatal Operational Delivery Network (ODN). The paper will summarise the current and potential cot reconfiguration based on data from the ODN intelligence and the Division will outline the associated workforce required.

Both Neonatal units currently meet the BAPM Neonatal Nursing Standards utilising the Neonatal workforce calculators for each site which was undertaken in 2024 and shared with the ODN based on the current cot configuration.

Ormskirk Neonatal Service:
Ormskirk neonatal service is currently funded in accordance with British Association of Perinatal Medicine (BAPM) requirements with the provision of transitional care provided on the maternity ward from the current funded establishment.

Currently there is 1.0 WTE Band 6 on Maternity Leave alongside a 0.96 WTE Band 5 and 0.96 WTE Band 4. Recruitment took place and currently 0.8 WTE of these posts were covered with a deficit of 2.12 as appointed staff withdrew from the post. Ongoing recruitment in place.

Whiston Neonatal service:
A review of the staffing has recently been undertaken and identified the following vacancies:

- 1.00 WTE Band 6 vacancy. 0.92 WTE Band 5 has recently been promoted to a Band 6 to fill this post. Awaiting recruitment checks to be completed.
- 4.06 WTE Band 5 vacancy (2.14 Maternity Leave, 1.00 Leaver, 0.92 B5 promotion to B6)
- 0.84 WTE Band 4 vacancy
- 0.56 WTE Band 2 vacancy

The service has recruited two trainee Advanced Neonatal Nurse Practitioners who are now in post and have commenced the MSc programme in January 2025 alongside a 0.4 WTE Band 7 Digital Neonatal Nurse who has been recruited.

The Neonatal medical staffing at MWL is compliant to BAPM standards for Tier 1, 2 and 3 although recruitment has been challenging to ensure consistent cover on the Ormskirk site. This required a consultation with the medical staff in 2024 to amend working patterns to support coverage to fill gaps whilst further recruitment is underway. The new rotas were developed and agreed in November 2024 within the MIS reporting period and have commenced.

Qualified in Speciality (QIS) trained staff across MWL.
There is a mandatory requirement to ensure 70% of the neonatal workforce are Qualified in Specialty (QIS). There is a programme in place to support staff to achieve this qualification. The pathway to achieve QIS requires initial completion of the Foundation in Neonates (FIN) course followed by a QIS course both of which require a period of secondment to a Level 3 unit for four to six weeks for each course (longer for part time staff). In view of this requirement the release of staff is on an individual basis to ensure the provision of a safe service.

There is a national shortage of QIS nurses and therefore we are required to develop our own staff, it is essential our workforce is optimum in order to support the nurses whilst undertaking the programme.

There is a plan already in place to achieve 70% compliance of QIS nurses within the Whiston site. Current compliance is 58.6% with three staff currently undertaking the course and two staff commencing in September. This will increase QIS compliance to 66.7% by September and approximately 75% by March 2026.

The current QIS compliance on the Ormskirk site is 68%, with an ongoing plan in place for all staff in post.

FiCare Accreditation:
Ormskirk currently stage 1 Green. Reassessment for Stage 1 passed in July 2024. Stage 2 Assessment due in 2025.

Achieved at Whiston December 2023. FiCare sustainability visit completed January 2025 and reassurance was provided that FiCare remains embedded on the unit. Working towards FiCare 2 accreditation with an updated action plan recently submitted to ODN.

UNICEF Accreditation:
The Ormskirk Neonatal Unit achieved Stage 2 Baby Friendly Initiative (BFI) accreditation in February 2025.

Whiston Neonatal service do not as yet have a date for accreditation but are working towards the required standards.

Transitional Care:
Progress towards implementation of a full transitional care service in line with the BAPM Transitional care framework continues in accordance with the action plan on the Whiston site. All staff who were recruited to support are now in post however long-term sickness on the NNU at Whiston site is creating an additional pressure which has further delayed the

commencement of the service. There has also been a recent leaver and three staff members who have declared that they will be commencing maternity leave later this year. Recruitment into to these posts will commence imminently.

Several recruitments for the Maternity Support Workers (MSW) have been undertaken with all now commenced in post. Training is ongoing for MSW staff in post supported by a Band 6 Midwife on secondment to support developing and enhancing MSW skills.

3.1 Sickness Including Covid-19

Sickness	January 25	February 25	March 25
Ormskirk Maternity	4.85%	7.07%	5.23%
Whiston Maternity	9.99%	10.19%	11.18%
Ormskirk Neonatal	8.73%	5.42%	6.87%
Whiston Neonatal	15.88%	14.47%	16.01%

Sickness is being managed according to the MWL policy, with monthly oversight and support from Human Resources.

3.2 Maternity Continuity of Carer (MCoC)

The current MCoC position and expansion at both legacy sites is currently on hold which has previously been agreed at Executive level. A revised plan for the delivery of a Maternity Continuity of Carer model in line with delivering 'Maternity Continuity of Carer Model at Full-Scale' guidance which identified that a whole new model of care is required utilising a mixed risk model providing enhanced midwifery care to women and babies of Black, Asian and mixed ethnicity and those living in the 10% decile of deprivation. Further review of this model is required alongside a review of required staffing to support this revised model of care once the current funded establishment is achieved and with appropriate skill mix to enable to model to be achieved. This will be undertaken as an MWL Maternity service.

The Maternity service now has a plan in place to formally align services across both legacy sites in readiness for a whole scale re-review of the plans for MCoC. This will commence with the mapping and aligning of services across the Community Midwifery footprint with the aim of becoming one service and removing current geographical boundaries.

During the alignment and wholescale review of the MCoC plan as an MWL maternity service the current MCoC teams in place will remain operational.

Ormskirk maternity currently has one team (Sapphire Team) providing continuity to women that live out of area on a shift-based model. Whiston currently have a homebirth team that provides full continuity of care to women once a decision has been made to birth at home which can be undertaken at any stage of a woman's antenatal pathway. Whiston Amethyst team continues to provide continuity to the most vulnerable women although they are currently unable to provide the intrapartum element of the model currently with the intrapartum support coming from the Delivery Suite.

3.3 Maternity Suspension of Services.

For the reporting period of January 2025 to March 2025 there were no suspensions of Maternity Services on the Whiston or Ormskirk sites.

3.4 Neonatal Suspension of external services

Ormskirk site			Whiston site	
Q4 24/25	**No of closures**		**Q4 24/25**	**No of closures**
January 25	1		January 25	1
February 25	0		February 25	0
March 25	8		March 25	2
Total closures	**9**		**Total closures**	**3**

There were 12 neonatal suspensions of services in Q4. Throughout these periods of closures which were to external admissions/ repatriation of babies from the tertiary referral unit, both units remained open to emergency admissions with plans to stabilise and transfer any babies that required admission. During this period no external transfers of babies were required following birth.

There were nine closures of the Neonatal Unit on the Ormskirk site which were reported to the NW ODN during the reporting period which were all due to being full or at capacity.

During the periods of suspension of services there was no impact on the maternity women. No woman was required to be transferred to another unit or had delayed care.

There were three closures of the Neonatal Unit on the Whiston site which were reported to the NW ODN during Q4. This is a significant decrease from 22 closures in Q3.

The closures impacted on one mother who was an antenatal inpatient on the maternity ward at Whiston and required delivery by a Category 3 Caesarean Section at 33+6weeks gestation. An interfacility transfer to our Ormskirk site was arranged and the baby was delivered safely that day and cared for on the Ormskirk neonatal unit until discharged home.

3.5 One to One Care in Labour

Maternity Services aim to achieve 100% of one-to-one care to women in established labour and this is monitored and reported within the safe staffing report and the monthly dashboard. For the Q4 period there have not been any occasions when one to one care in labour was not provided.

4. Patient Experience.

The National 2024 NHS Maternity Survey was undertaken and of the 57 questions asked, MWL scored about the same as other trusts in 48 questions, five questions somewhat worse and four questions worse than expected. The results have been triangulated with other sources of patient feedback including feedback from MNVP and Trust Safety Champions walkaround where the feedback was positive and not reflecting themes from the national survey. PALS, Complaints and Friends and Family Test (FFT) feedback form part of the triangulation with key themes identified around ante-natal waiting times, communication (with women and family at various points in a way that they understand) and increasing partners staying overnight to offer support following birth.

A robust action plan has been developed to address the findings of the national survey which have been disseminated and shared with Maternity Staff. The action plan is formally monitored monthly at the Women and Children's Divisional Meeting to provide oversight and to drive continuous improvement. Of the 35 actions, 15 are completed, 17 on track and three are currently amber which are directly linked to the implementation of a new Maternity EPR. Maternity Matrons with the support of Patient Experience team have developed local surveys based on the areas of concern to assess the impact of the changes and completed actions and identify other areas of focus ahead of the next Maternity survey being undertaken.

5. NHSE: Three-Year Delivery Plan for Maternity and Neonatal Services

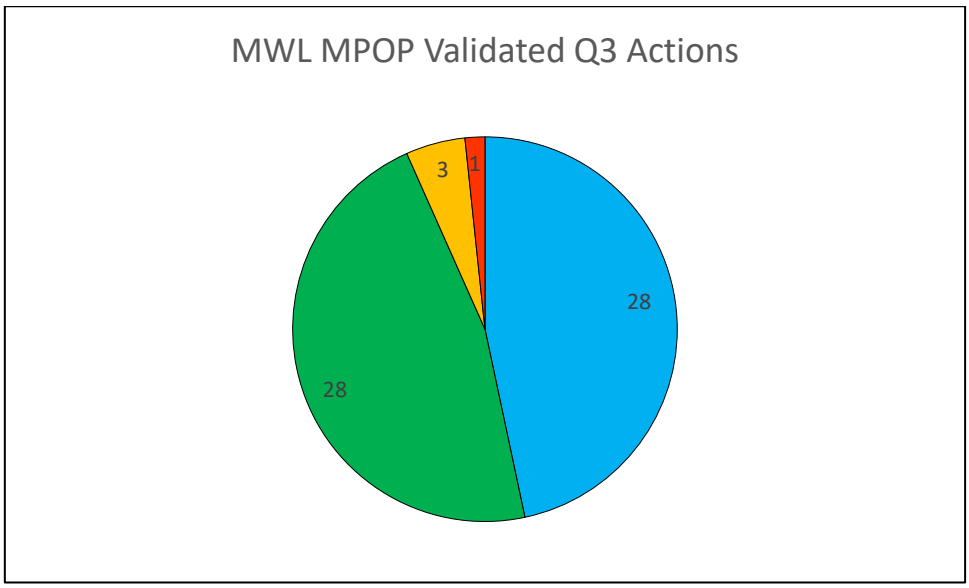
While most women have a positive experience of NHS maternity and neonatal services in England, independent reports show that some families have experienced unacceptable care, trauma, and loss. The publication of NHSE: Three-Year Delivery Plan for Maternity and Neonatal Services in March 2023, brought together learning and actions from national reports including the Ockenden final report into one document, ensuring accountability at every level of the system encouraging the effective spread of best practice in maternity and neonatal care, and support the implementation of a cross-system approach to improving care for services users.

NHS England Regional Maternity Team have developed a process via a Maternity Provider Oversight Panel (MPOP) to review ongoing actions and progress towards the deliverables set out in the NHSE Three-Year Delivery Plan for Maternity and Neonatal Services, with assurance of implementation and ongoing monitoring and evaluation sought from quarterly provider submissions of evidence via the LMNS, with an additional annual provider visit scheduled for each site. Quarterly LMNS assurance meetings commenced in 2024 to review evidence and monitor progress.

Currently in Q4 Year 2 of Maternity and Neonatal Services Three Year Delivery Plan. The LMNS have validated the evidence for the Q3 submission, and this was shared with the Trust in this reporting period and continues to highlight the progress of MWL actions. There is one red and two amber actions relate to MCoC and continued roll out. Following discussion with LMNS funding has been secured to support enhancing MCoC teams to deliver a targeted offer for most vulnerable women to reduce health inequalities, and they are appraised of the current MWL Community Midwifery service alignment.

One amber action relates to the implementation of a Maternity EPR - BadgerNet which will have a formal implementation launch in Q1 and with expected timescales of completion by March 2026.

The current BRAG status of all actions is highlighted in the chart below following the LMNS validation of Q3 submission.



Q4 MPOP submission will be made to the LMNS in May 2025. The MPOP update is presented to the Quality Committee.

The NHSE NW Regional Team, including the Regional Chief Midwife, Deputy Chief Midwife, Regional Lead Obstetrician and Quality Leads completed their annual provider visit to MWL on 07 May 2025 visiting both Ormskirk and Whiston Sites. The feedback was very positive on the day.

6. Recommendations

The Trust Board are asked to note the report.

Title of Meeting	**Trust Board**			**Date**	28 May 2025
Agenda Item	**TB25/044**				
Report Title	Quality Account 2024/25				
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

The purpose of this report is for the Trust Board to review and approve the Quality Account 2024/25 prior to publication 30 June 2025.

Executive Summary

Quality Accounts are annual reports to the public from providers of NHS Healthcare Services about the quality and standard of services they provide. They are required by the Government to help NHS trusts, including providers of hospital acute services, community health services and mental health services, maintain focus and improve the quality of care for patients.

By producing a Quality Account, trusts can demonstrate their commitment to continuous evidence-based quality improvement and to explain their progress to patients and their families, the public and those who have an interest in the services that the Trust provides.

There is a standard format Quality Accounts should follow as set out by NHS England in the 2020 document titled *Detailed requirements for Quality Reports 2019/2020.*

The account should have three parts:

- Part 1 - Statement on quality from the Chief Executive.
- Part 2 - Priorities for improvement looking forward. Statements relating to quality of NHS services provided.
- Part 3 - Other information. Review of quality performance.

The report also includes:

- Annex 1 – Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees
- Annex 2 – Statement of Directors' responsibilities for Quality Account.

It should be noted that the figures in this report are subject to change and will remain **draft** until the final report is published.

Please note that the Quality Account is no longer subject to review by external auditors, and it has been agreed with the Commissioners we are not required to include a section on seven days services this year.

Executive colleagues reviewed and provided feedback on the draft account on the 08 May.

Quality Committee members reviewed and provided feedback on 20 May.

On the 21 May the draft account was presented to the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) including local Healthwatch with no immediate amendments requested pending formal written feedback.

On the 27 May the draft account was presented to the Sefton Oversight and Scrutiny Committee.

Any final comments from the Trust Board members will also be incorporate before publication of the Quality Account.

Following Trust Board, the Quality Account will go through a final proofread before publication by 30 June.

Financial Implications

No direct costs arising from this report.

Quality and/or Equality Impact

The Quality Account provides a review of the Trust's quality objectives and provides an overview of how quality is maintained across the Trust.

Recommendations

The Board is asked to approve the Quality Account prior to publication 30 June 2025.

Strategic Objectives

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

Draft Quality Account 2024-25

Contents

Part 1
1.1 Statement on quality from the Chief Executive of the Trust

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) is pleased to present the Trust's second annual Quality Account as a new Trust, which demonstrates our ongoing commitment to ensuring we provide the highest quality of care to our patients and the communities we serve.

This is my first introduction to the annual Quality Account since my appointment as Chief Executive of MWL, on 1st December 2024. MWL is a fantastic organisation, with a longstanding history of outstanding care, and a trusted reputation in our local communities and I am truly honoured to be Chief Executive here. I've been part of MWL for nine years now and over that time, I have had the absolute pleasure of working alongside so many amazingly talented staff.

I would like to take this opportunity to thank my predecessor, Ann Marr OBE, for her tireless commitment to our patients and staff over her 22 years at the Trust. Ann transformed Whiston and St Helens hospitals into the world-class facilities they are today, as well as overseeing the culmination of 18 months' work to bring St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O) joined together to form a new Trust, MWL, which has enabled us to provide sustainable and high quality services for the populations of Merseyside, West Lancashire and beyond.

2024-25 continued to present many challenges for staff with ongoing demands on an already stretched workforce. Every part of the NHS is under significant pressure at the moment and the areas of Merseyside and West Lancashire are no exception. My focus has, and will be, on making sure that we continue to look after our patients and our staff to provide the highest standards against this challenging backdrop.

There have not been any Care Quality Commission (CQC) Inspections undertaken between 1st April 2024 to 31st March 2025 and MWL continues to retain the outstanding CQC rating. We have maintained contact with our CQC relationship manager throughout the year including regular onsite relationship meetings with CQC colleagues. The Trust has continued to monitor key quality indicators via the monthly comprehensive Corporate Performance Report, which is reviewed by the Board and its Committees.

I was, however, extremely disappointed that during the year there were five never events, relating to a retained guide wire, wrong site steroid injection, wrong site surgery, wrong site nerve block and retained foreign object. Actions have been taken following these as part of the Trust's commitment to learning from incidents and these are outlined in more detail in the report.

Our vision to provide 5 Star patient care remains the Trust's primary objective so that patients and their carers receive services that are safe, person-centred and responsive, aiming for positive outcomes every time. The mission and vision have remained consistent and embedded in the everyday working practices of staff

throughout the Trust, where delivering 5 Star patient care is recognised as everyone's responsibility. The vision is underpinned by the Trust's values, behaviours and five key action areas – care, safety, pathways, communication and systems.

The Trust has delivered a comprehensive programme of quality improvement clinical audits throughout the year, with several actions taken as a result of the audit findings. Delivery of the quality improvement and clinical audit programme is reported to the Quality Committee via the Clinical Effectiveness Council.

In addition, the Trust reviewed and updated the ward accreditation programme, to ensure it is fit for purpose for the new organisation. The 5 Star Accreditation was launched in June 2024 and by 31st March 2025 all 46 inpatient wards and clinical areas across all of our sites have been assessed which is an amazing achievement. The aim is to continue to roll this programme out to all other areas including theatres and community in 2025-26. In January 2025, the 5 Star Accreditation was externally reviewed by Mersey Internal Audit Agency (MIAA) and was awarded a high level of assurance. A number of quality ward rounds with members of the Trust Board took place throughout the year across all sites to see and hear first-hand how staff are striving to provide the best possible care for patients that is safe, effective, caring, responsive and well-led.

We continue to work with our local Healthwatch partners to improve our services. Healthwatch representatives are key members of the Patient Experience Council, who report to the Trust Board's Quality Committee, and the Equality and Diversity Steering Group which reports to the People Performance Council. This ensures effective external representation in the oversight and governance structure of the Trust. Meetings have continued to be held virtually to maximise attendance.

The Trust has a Patient Participation Group, which met quarterly throughout the year and patients have continued to share their experiences of their care via patient stories for the Board and the Patient Experience Council.

We are extremely grateful to our volunteers who make a unique and valuable contribution to patients and carers, relatives, visitors, and staff. The skills and support they provide has a positive impact for people who use our services, including our staff, and the community. An incredible 205 volunteers were recruited across our 5 hospital sites during 2024-25.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the challenges faced during the year. It outlines our quality improvement priorities for 2025-26.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2024-25 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and patient-centred services we have continued to deliver during the ongoing challenges in 2025-26.

I remain extremely proud of all our staff who continue to give the best of themselves to care for the people who need us. I would like to thank all our staff for everything they continue to deliver during the most challenging times we face.

Rob Cooper
Chief Executive
Mersey and West Lancashire Teaching Hospitals NHS Trust

1.2 Celebrating Success in 2024-2025

Our staff make our organisation and to celebrate the outstanding work they undertake we held our first joint MWL staff awards in May 2024. The winners are acknowledged below with the detail of the nominations.

Special Recognition Award	**Sylvia Sinclair, Deputy General Manager** Sylvia began her career as a laundry assistant at Whiston Hospital 49 years ago. Today, she oversees domestic, portering, catering and linen services across Whiston and St Helens hospitals. Always putting the patient at the heart of everything she does, Sylvia's standards are second to none and her commitment to the Trust, her team, and colleagues across all areas of our hospitals is unwavering. Under Sylvia's leadership, Whiston and St Helens hospitals have achieved a remarkable 100% in their cleaning audit scores for the past 8 consecutive years, securing our position as the best patient environment in the NHS. We know it takes a team effort, but every team needs a Sylvia, and we are honoured to recognise her career-long dedication to our hospitals and patients.
Special Recognition Award	**Critical Care Unit, Southport Hospital** Winning the Critical and Emergency Care Nursing Times Awards in 2023, Southport Hospital's Critical Care Unit has been recognised for the compassionate and respectful way they support families and each other following the sad loss of a patient. Through a ground-breaking initiative, called The Pause Campaign, which embraces 60 seconds of silent reflection, the team has made a lasting difference to many. Coming together to recognise the contribution they make to patients at the end of life, staff are able to help families start the grieving process and support

	each other through some of the most difficult of times. The Critical Care Team is hailed as one of the best in the country, always demonstrating exemplary practice, with a sensitive and human approach. They embody our vision of 5 Star patient care.
Excellence in Clinical Care	**Ward 10B, General Surgery, Southport Hospital** This team of dedicated professionals make patient-centred care a priority. One of the busiest surgical wards at the Trust, this well-led team works extremely hard to deliver the highest standards to an increasing number of complex patients. Feedback from patients is overwhelmingly positive, and colleagues across the hospitals praise the team for their consistent professionalism and efficiency.
Excellence in Quality Improvement	**Frailty Urgent Community Response Team** This team have demonstrated remarkable commitment and innovation in addressing the complex healthcare needs of an increasing number of frail elderly people in our community. Ensuring patients receive the highest levels of care and best possible experience, in the right place, first time, their valuable work supports the prevention of avoidable admissions to our very busy hospitals.
Excellence Patient Safety	**Haematology Department** This dedicated multi-disciplinary team provide specialised care for patients being treated for blood disorders and cancers. One of the first to work cohesively across MWL, this service was recently hailed as an exemplar in its field by NHS England. Delivering 5 Star patient care across all the communities we serve, they undoubtedly improve outcomes and save lives.

Excellence in Support Services	**Payroll Services** Delivering services to over half of the NHS workforce in Cheshire and Merseyside, this vital team ensures that over 85,000 healthcare staff receive efficient payroll and pension services. In the past 12 months, they have been recognised as one of the best in the country, passing their national audit with flying colours and winning a prestigious payroll innovation award.
Patient Experience Award	**Burney Breast Unit, St Helens Hospital** Outstanding in every way, this team is renowned for the extremely high standards of care they provide to patients with breast conditions and cancer. Led by a nationally acclaimed team of highly skilled specialists, the Burney Breast Unit delivers amazing clinical outcomes and a patient experience that is second to none.
People's Choice Award Sponsored by the St Helens Star	**Sanderson Suite, St Helens Hospital** This exceptional team are dedicated to always delivering the highest standards of care, and this is reflected in the overwhelming amount of positive feedback received from patients having day-case surgery. Reassuring and supportive, nothing is too much trouble for this team who make a world of difference to so many patients each and every day.
People's Choice Award Sponsored by Stand up for Southport	**Jo Unsworth, Bereavement Midwife, Ormskirk Hospital** Caring for those following the loss of their baby takes a unique combination of compassion, understanding, and the ability to listen to what parents and the family's needs truly are – Joanne embodies all of these values and more. Instrumental in the creation of the Rainbow Team, families say she is a true angel that helps them to grieve, rebuild and prepare for the future.

Employee of the Year	**Sarah McKenna, Advanced Nurse Practitioner, Emergency Department, Whiston Hospital** Described as the best of the best by colleagues, Sarah has helped to drive change in the Emergency Department with her knowledge, experience, and sheer determination to provide the highest standards of care for her patients. She has been pivotal to the newly developed, award-winning, primary care streaming service, that has helped to greatly reduce attendances at Whiston ED.
Team of the Year	**Plastic Surgery Department, St Helens & Whiston hospitals** When life gets turned upside down through either illness or injury, this team of highly knowledgeable experts use their exceptional skills to rebuild and transform the lives of their patients. They work tirelessly to deliver innovative surgical solutions and provide outstanding clinical and therapeutic care. Recognised across the NHS as exemplary, this is a team we are incredibly proud of.

Part 2 – Priorities for improvement and statements of assurance from the board.

2.1 Quality objectives for improvement during 2025-26

The Trust's quality objectives for 2025-26 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an online survey that was circulated to staff and stakeholders, as well as being placed on the Trust's website for public participation.

The consultation was undertaken using an electronic survey with 52 responses received. There was a high level of agreement with the proposed objectives, all receiving over 90% positive responses, with the exception of infection control at 87%. The highest being 96% support for timely and effective assessment of patients in the Emergency Department.

Further suggested objectives for coming years included:

-Digitisation of documentation
-Back to basic (Kindness and Compassion)
-Focus on care of people with additional needs
-Meal provision and nutrition

It is to be noted that some of the suggestions are already a focus for quality improvement with the Trust having in place a long-term strategy for the digitisation of documentation, back to basics being the focus of our 5 Star Accreditation and the focus on care of people with additional needs being addressed by the patient experience team. We have also recently reinvigorated our focus on nutrition and hydration with the establishment of a Trust wide group.

No	Objective	Lead Director	Measurement
1. 5 STAR PATIENT CARE – Care We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families			
1.1	Improve measurable success in areas where our patients told us we didn't get it right first time including inpatient areas, ED, maternity with a focus on antenatal.	Chief Nurse	• Improvement against previous year's national survey results in relation to: o Management of pain o Kindness and compassion whilst in hospital o Experience of waiting time information

			• As a minimum, conduct quarterly local surveys based on national survey indicators Maintain and embed the patient experience score from 5 Star Ward Accreditation Programme
1.2	Ensure improvement and sustainability of nutritional standards for patients.	Chief Nurse	• Achieve 95% of adult inpatients screened for malnutrition on admission using the MUST tool • Achieve 95% of patients with a score of 2 or more who receive an appropriate care plan • Improve the processes to ensure 95% of high-risk patients are referred to a dietician Achieve and maintain 90% for nutrition score consistently across all wards for the 5 Star Ward Accreditation Programme
1.3	Improve measurable success for people that birth have told us we didn't get it right first time who access antenatal services	Chief Nurse	• Improvement against previous year's national survey results via quarterly surveys
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**			
2.1	Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.	Chief Nurse	• Achieve 95% of appropriate patients triaged in the emergency departments in line with the national standard of triage within 15 mins • NEWS – 80% of observations completed on time or within tolerance • All patients with a working diagnosis of sepsis receive antibiotics in line with the NICE guidance
2.2	Improve the Trust's compliance with IPC standards.	Chief Nurse	• Eliminate methicillin-resistant Staphylococcus Aureus (MRSA)

			bacteraemia infections as a result of lapses of care • Implement action to reduce avoidable hospital onset MSSA bacteraemia • Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for Level 2 across MWL (practical) • 90% compliance with visual infusion phlebitis (VIP) monitoring • Achieve 90% for the IPC and indwelling devices standard for the 5 Star Ward Accreditation programme
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**			
3.1	Continue to improve the effectiveness of the discharge process for patients and carers.	Chief operating officer	• Achievement of 20% target for patients discharged before noon by March 2026 • 10% improvement in discharges by 6pm and 8pm during the week against 2024/25 position • 10% reduction in the number of patient bed moves after 9pm (core wards) against 2024/25 position • 10% improved utilisation of the discharge/transfer lounges against the 2024/25 position. • Improve average discharge prescription dispensing turnaround time by 10 mins (from 92 to 82 mins) by March 2026 to below the national average

			• Reduce average take home prescription arrival time to pharmacy by 60 minutes

Part 2.2 Statements of assurance from the Board

The following statements are required by the regulations and enable comparisons to be made between organisations, as well as providing assurance that the Trust Board has considered a broad range of drivers for quality improvement.

2.2.1 Review of services

During 2024-25, the Trust provided and/or sub-contracted £935m NHS services.

MWL has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2024-25 represents 94% of the total income generated from the provision of NHS services by MWL for 2024-25.

2.2.2 Participation in Clinical audit

Annually NHS England publishes a list of national clinical audits and clinical outcome review programmes that it advises Trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing and new items.

During 2024/25, 64 national clinical audits and seven national confidential enquiries covered NHS health services that Mersey and West Lancashire Hospitals NHS Trust provides.

During that period, Mersey and West Lancashire Hospital NHS Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits that Mersey and West Lancashire Teaching Hospital NHS Trust participated in during 2024-25 are listed in appendix 1.

The national confidential enquiries that MWL was eligible to participate in during 2024-25 are as follows:

Name of Study	Status during 2024-25	MWL Position
Blood Sodium	Data Collection	Awaiting final report
Emergency procedures in children and young people	Data Collection	Awaiting final report

Acute Limb Ischaemia	Data Collection	Still Active
Acute illness in people with a Learning Disability	Data Collection	Still Active
Juvenile Idiopathic Arthritis	Report Published	Gap Analysis Stage
End of Life Care	Report Published	Gap Analysis Stage
Endometriosis	Report Published	Gap Analysis Stage

The reports of 216 local clinical audits were reviewed by the provider in 2024-25 and MWL has taken and intends to take the following actions to improve the quality of healthcare provided.

Re-Audit of Delirium Guidelines

The project is a reaudit against the NICE guideline NICE CG103 – delirium: prevention, diagnosis and management (2023).

The **4 'A's Test** (**4AT**) is a bedside medical scale used to help determine if a person has positive signs for delirium. The 4AT also includes cognitive test items, making it suitable also for use as a rapid test for cognitive impairment.[3]
Our aim was to improve the use of the 4AT – in 2019 when the first audit was undertaken 0% of patients had a 4AT completed.

Improvement:
2019 = 0%
2020 = 38%
2022 = 72%
2023 = 100%
2024 = 96%

The improvement has been achieved due to the work of the dementia and delirium team. Over the last 4 years the team have delivered education to nursing and medical staff of any grade regarding the identification, prevention, treatment and causes of delirium, as well as strategies for staff and families to help to resolve acute confusion, and the need for reassessment and follow up when home
Working with the bed management team we have implemented the “Keep Me Here” initiative for patients with complex symptoms of dementia and slow to resolve delirium to prevent worsening symptoms by reducing their number of bed moves while in hospital.

Introducing an Ambulatory Pleural Effusion Pathway at Whiston Hospital

A 3-month audit of all inpatient pleural referrals found only 27% of patients meeting criteria for appropriate ambulatory care were discharged to ambulatory pleural clinic. Patients that were not ambulated had an average 3.5-day inpatient stay compared to less than 1 day for those ambulated.

SMART Aim: By July 2024, 100% of eligible pleural effusion patients are discharged home and ambulated to outpatient pleural clinic via newly implemented pleural referral pathway.

Changes made

-Creation of a new Trust Ambulatory Pleural Pathway which provides guidance to the referrer to optimise the referral process

-Education around ambulation of appropriate pleural effusion patients meaning the patients are discharged home quicker and brought back to pleural clinic as an outpatient for specialist respiratory review and appropriate investigations.

Improvement following intervention

-Improved identification of patients who are eligible for referral to pleural clinic

-100% appropriate ambulation rate with all patients correctly referred via the new pleural pathway

-No complications or unexpected readmissions resulted from patients being ambulated

Improving Neonatal Optimisation in Ormskirk Hospital

In July 2023 NHS England published Saving Babies Lives version 3 (SBL3) which is a care bundle for reducing perinatal mortality. There are 6 elements of care which are monitored quarterly by the Local Maternity and Neonatal System (LMNS).

This quality improvement initiative focused on Element 5 and the optimisation of perinatal care:

Element 5 - reducing preterm birth recommends three intervention areas to reduce adverse fetal and neonatal outcomes: improving the prediction and prevention of preterm birth and optimising perinatal care when preterm birth cannot be prevented.

Improvement we have made during 2024-25

	SBL3 Target	Our Improvement
1. Percentage of women who deliver preterm where the neonatal team have a discussion with the parents regarding care options	70%	Achieving 100%
2. Perinatal optimisation pathway compliance	70%	Achieving 86%
3. Magnesium sulphate to be offered to women between 22+0 and 29+6 weeks of pregnancy who are in established labour or are having a planned preterm birth within 24 hours	85%	Achieving 100%
4. All women in preterm labour at less than 37 weeks of gestation should receive intravenous intrapartum antibiotic prophylaxis	25%	Achieving 100%

5. Babies born less than 37 weeks have their umbilical cord clamped at or after one minute after birth	70%	Achieving 100%
6. Babies born less than 37 weeks gestation should have a first temperature which is both between 36.5 and 37.5 within one hour of birth	70%	Achieving 100%
7. Babies born less that 37 weeks gestation should receive their own mother's milk, ideally within 6 hours but aiming within 24 hours of birth	30%	Achieving 80%

Our Improvement Journey - Smoking Screening of Inpatients within MWL

We are very proud the impact the tobacco dependency team has had on improving the provision of smoking cessation services within MWL.

-Improved screening was achieved by education and training ward staff including nurses, doctors, pharmacist, therapists in screening inpatients admitted into hospital who are current smokers. This training was delivered in a number of different ways and methods to accommodate everyone's different style of learning. This included face to face session, use of the quality bus, 1:1 on the spot training on the wards, meetings over teams with different hospital departments and lunch and learn sessions with the doctors and preceptorship.
-Improved Nicotine Replacement Therapy (NRT) was achieved by updating the NRT Standard Operating Procedure to ensure it was in line with NICE current guidelines and changing the strength of patch available for prescription from only 24 hour to also having 16 hour patch available on the wards. This is an immediate benefit to patients as the 24 hour patch works well only for patients who will get up and smoke during the night and can lead to nightmares for people who do not smoke during the night.
-Education on nicotine replacement therapy for example - dispelling the myth that patients had to remove their NRT patch when going for an MRI or X-ray because it contained metal.
-Improved referral to Smoking Cessation Services was helped by the fact the new lead for the Tobacco Services with MWL had previously working in the community setting and had built up important working relationships with the necessary services. The team also developed a spreadsheet that would prompt the tobacco dependency advisor (the member of the team who visits the wards) to make the referral to community services appropriately once the patients had been discharged. This was beneficial to the nursing staff as it reduced workload for them but also ensured more referrals were completed accurately and thus accepted by community services.

Improvements
-Smoking Assessment rates have improved from 32% (October 2023) to 66% (February 2024)
-Nicotine Replacement Therapy being offered has increased month on month since April 2024 and we are now second in Cheshire and Mersey Region for providing NRT
-Referral to Community Smoking Cessation Services has increase month on month

- April 2024 = 67 patients
- January 2025 =116 Patients

-Rated A for the 10 data quality points required by NHS England for monthly smoking cessation data upload.

2.2.3 Participation and Recruitment in Clinical Research

Participation in clinical research demonstrates MWL's commitment to improving the quality of care we offer and to making our contribution to the wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The aim of Clinical Research is to offer patients access to new and emerging treatments. MWL is committed to delivering safe and effective high quality patient centred services, based on the latest evidence and clinical research. Our focus is on improving care, developing better treatments and increasing our understanding of disease by providing an environment that is conducive to the undertaking of quality research and development activities.

The number of patients receiving relevant health services provided or sub-contracted by MWL in 2024-25 that were recruited during that period to participate in research approved by a research ethics committee/Health Research Authority was 2046 participants.

All sites met their annual recruitment target, recruiting 2046 participants against a target of 1400.

This is the result of a huge effort from all the staff within the Research, Development and Innovation (RDI) Department; and demonstrates our commitment to offering patients and public the opportunity to take part in research.

The number of research studies open to recruitment at the Whiston, St Helens and Newton sites during 2024-25 was 77 compared to 76 in 2023-24. The number of studies that were issued with Confirmation of Capacity & Capability (MWL NHS Permission) in 2024-25 was 26 compared to 27 in 2023-24. For the Southport and Ormskirk sites there was an increase in the number of studies that were issued with Confirmation of Capacity & Capability, 52 in 2024-25 compared to 49 in the previous year.

During 2024-25 the Whiston site had 15 active commercial studies on their portfolio, this included studies where patients were being followed up after their treatment. The Southport and Ormskirk sites were working an important commercial study, the RADIANT study, supporting the treatment of type 1 diabetes in children and adults. This is an increase in our commercial activity since 2023-24 and shows our commitment to focusing on commercial research, it also allows our patients the benefit from earlier access to new treatments and technologies.

Commercial Research Delivery Centre

In 2024, The Department of Health and Social Care (DHSC) announced plans to establish 20 Commercial Research Delivery Centres (CRDCs), giving patients access to pioneering clinical trials and treatments in record time. The new centres will enhance the speed and efficiency of commercial clinical research delivery, contributing to the health and wealth of the nation. They will work with industry and other research delivery infrastructure to support the UK's status as one of the best places in the world for innovative companies to bring their portfolio of research.

The host for the new NIHR Commercial Research Delivery Centre (CRDC) is NHS University Hospitals of Liverpool Group (UHLG), formerly known as Liverpool University Hospitals. In 2024, MWL were notified that they had been successful in a bid to become one of its 10 spoke organisations. The new, purpose-built research facilities will enable 'efficient delivery of research studies and a smooth, pleasant and safe experience for study participants'.

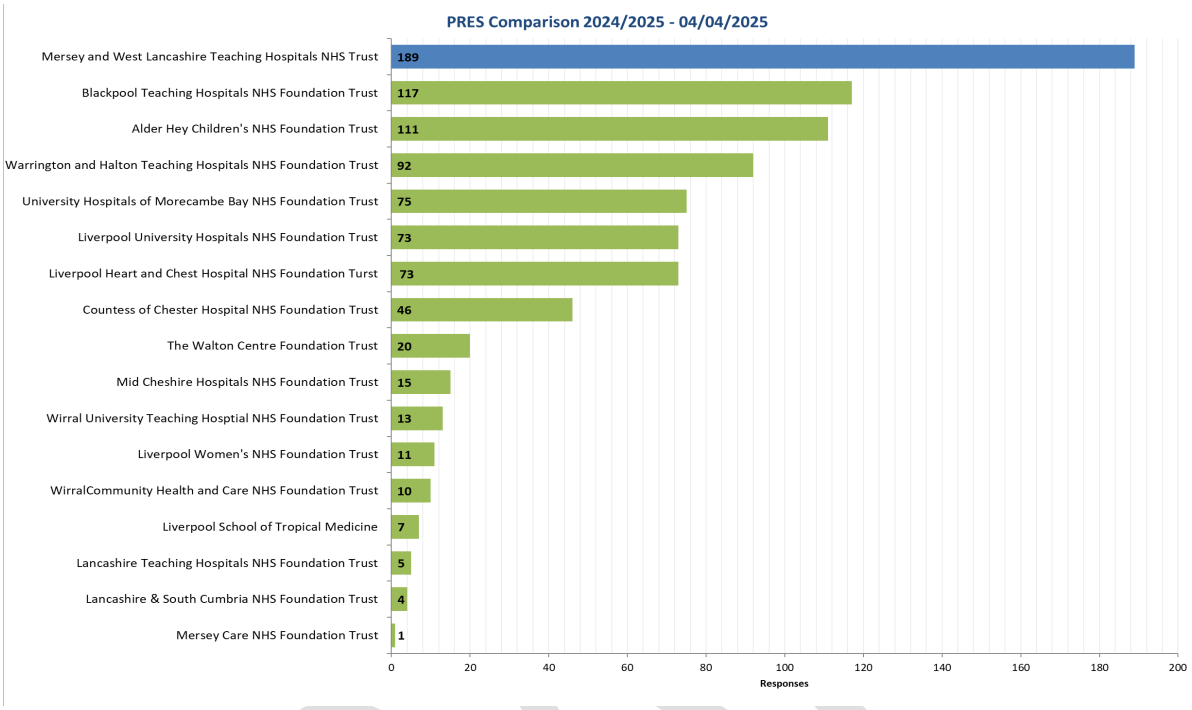
The CDRC will give patients access to pioneering clinical trials and treatments in record time and will support the rapid set-up of commercial studies, meaning patients can begin accessing treatments as part of clinical trials as early as possible. Studies show that research-active hospitals and organisations achieve better health outcomes for patients, due to better understanding of the effects of treatments, ongoing care and monitoring as part of a research study.

Research Hubs

In 2024, MWL opened two new Research Hubs at Ormskirk Hospital and Marshalls Cross GP Surgery in St Helens. They have also expanded the existing Research Hub based at Whiston Hospital. This was using the National Institute for Health & Social Care Infrastructure funding that we secured at the end of 2023. These facilities offer patients a safe, comfortable and friendly environment to take part in essential research and will be vital to the delivery of research at the Trust.
The Participant in Research Experience Survey (PRES) is conducted annually by the National institute For Health Research (NIHR) Clinical Research Network (CRN).

The PRES is a priority for MWL as participant experience is at the heart of research

delivery by providing an opportunity for as many research participants as possible to share their experience of taking part in research. We are pleased that for 4 out of the past 5 years MWL have received the most responses to the PRES, and in 2024-25 we were top of the PRES dashboard by some distance:



2.2.4 Clinical goals agreed with commissioners

In 2024-25, the nationally mandated CQUIN scheme was paused whilst a wider review of incentives for quality is undertaken.

2.2.5 Statements from the Care Quality Commission (CQC)

The CQC is the independent regulator for health and adult social care services in England. The CQC monitors the quality of services the NHS provides and takes action where these fall short of the fundamental standards required. The CQC uses a wide range of regularly updated sources of external information and assesses services against five key questions to determine the quality of care a Trust provides, asking if services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

If the CQC has cause for concern, it may undertake special reviews/investigations and impose certain conditions. There have not been any CQC inspections undertaken between 1st April 2024 to 31st March 2025 and MWL continues to retain the outstanding CQC rating.

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Good	Outstanding	Good	Outstanding	Outstanding

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against MWL during 2024-25.

In the last financial year (2023-24), both Urgent and Emergency Care (UEC) services at Southport and Whiston hospitals received unannounced inspections. Final reports were published in January and April 2025, the results of these inspections did not impact the Trust's overall rating. Plans are in place following the published reports to make identified improvements in triage, ambulance turnaround times and waiting times to see specialities. Staff and leaders were commended in the report.

2.2.6 Information Governance Toolkit

Information Governance (IG) is the way in which the Trust manages its information and ensures that all information, particularly personal and confidential data, is handled legally, securely, efficiently and effectively. It provides both a framework and a consistent way for employees to deal with the many different information handling requirements in line with Data Protection legislation.

The Trust uses the Data Security and Protection Toolkit (DSPT) to benchmark its IG and IT security controls, also known as the IG Assessment Report. The DSPT is an annual online self-assessment tool that allows health and social care organisations to measure their performance against the National Data Guardian's 10 Data Security Standards (covering topics such as staff responsibilities, training and continuity planning) and reflects legal rules relevant to IG. The Trust must address all mandatory requirements within the DSPT in order to publish a successful assessment.

The 2023-24 DSPT was submitted in June 2024. This was the first DSPT as MWL. Prior to this the two separate organisations, St Helens and Knowsley Teaching

Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust had demonstrated their IG and IT security controls via the DSPT independently, both submitting in the required timeframe and achieving substantial assurance via an independent audit.

This 2023-24 DSPT was also audited by Mersey Internal Audit Agency, who check the quality and veracity of the evidence that has been provided. MWL's first DSPT achieved 'substantial assurance.' All key Information Governance policies were created and approved for MWL during 2023-24. A key policy being the Data Breach Management Policy and Procedure which is adhered to when a personal data breach/incident occurs. All incidents during 2023-24 were risk assessed and scored; it is a requirement that any incidents scoring highly are reported to the Information Commissioner's Office (ICO). MWL had one incident that when scored met the criteria to report to the ICO, this was in April 2024. At the time the ICO were informed of the lessons learned and action plan the Trust had put in place. To date no further actions have been received from the ICO.

The Trust has assigned specific roles to ensure the IG framework is adhered to and is fully embedded:

- Director of Informatics – Senior Information Risk Owner (SIRO)
- Assistant Medical Director - Caldicott Guardian
- Head of Risk Assurance and Data Protection Officer

All three staff are appropriately trained.

2.2.7 Clinical coding

Clinical coding is the translation of medical terminology that describes a patient's complaint, problem, diagnosis, treatment, or other reason for seeking medical attention into codes that can then be used to record morbidity data for operational, clinical, financial and research purposes. It is carried out using International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) for diagnosis capture and Office of Population, Census and Statistics Classification of Interventions and Procedures Version 4.10 (OPCS 4.10) for procedural capture.

MWL was not subject to the Payment by Results clinical coding audit during 2024-25 by the Audit Commission.

The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security and Protection Toolkit (DSPT) 2024-25.

It is widely known throughout the NHS that there is a national and local shortage of qualified and experienced Clinical Coders, which unfortunately does create recruitment challenges for all Clinical Coding departments across the country. Despite vacancy challenges faced by the team, the Trust and wider community should be reassured that the data reported at MWL is accurate and reflects the activity that is

taking place, and in order to demonstrate this, the 2024-25 DSPT clinical coding audit submission achieved a high standard of accuracy.

These results demonstrate that the department continues to maintain the excellent quality of clinical coding.

Mersey and West Lancashire Teaching Hospitals NHS Trust			
	%	Audited	Errors
Primary Diagnosis	93.00	200	14
Secondary Diagnosis	96.17	758	29
Primary Procedure	96.30	189	7
Secondary Procedure	94.01	334	20

MWL will be taking the following actions to improve data:
-Continuing to promote clinical engagement to ensure that clinical coding accurately reflects the patient journey
-Ensuring staff are working towards achieving the national clinical coding qualification (NCCQ)
-Ensuring staff attend regular refresher workshops to ensure coding skills are kept up to date
-Continuing to provide a robust audit service to highlight areas for improvement

2.2.8 NHS number and General Medical Practice Code Validity

MWL submitted records during 2024-25 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid registered GP practice code contributes to the overall Data Quality Maturity Index (DQMI) scores. The DQMI score for the most recent 12 months is shown in the table below. (will go up

DQMI	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Trust Score	92.7	92.8	92.9	93.2	93.6	93.4	93.1	93.6	93.5	93.5	93.6	92.7	93.6
National Average	81.8	81.2	81.4	81.4	80.3	79.3	80.7	78.5	73.8	71.8	72.4	72.1	74.1

(Source: DQMI)

The Trust performed better than the national average, demonstrating the importance the Trust places on data quality.

The Trust takes the following actions to improve data quality:
- Data Quality team monitors the nationally mandated submissions via the NHS digital toolkit and a formal report is presented at the Information Steering Group meeting. Any elements requiring action are agreed at this meeting

- Data Quality Team will continue to monitor data quality throughout the Trust via a suite of reports
- Provision of data quality awareness sessions regarding the importance of good quality patient data and the impact of inaccurate data recording
- Data Quality Forum has been established to provide oversight to ensure the timely completion of data quality checks across departments in the Trust

2.2.9 Data quality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering care to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

Data quality is fully embedded across the organisation, with robust governance arrangements in place to ensure the effective management of this process. Audit outcomes are monitored to ensure that the Trust continues to maintain performance in line with national standards. The data quality work plan is reviewed on an annual basis ensuring any new requirements are reflected in the plan.

There are a number of standard national data quality items, which are routinely monitored, including:

- Blank/invalid NHS numbers
- Unknown or dummy practice codes
- Blank or invalid registered GP practices
- Patient postcodes

The Trust implemented a new Patient Administration System (PAS), Careflow, in 2018 which has the functionality to allow for National Spine integration, giving users the ability to update patient details from national records using the NHS number as a unique identifier.

The Careflow configuration restricts the options available to users. Validation of this work is on-going and forms part of the annual data quality work plan.

2.2.10 Learning from deaths

MWL has well-established processes across all sites to review deaths occurring in hospital and identifying areas of learning where practice can be improved. The delivery of the Learning from deaths (LFD) processes were different in the organisations which came together to form MWL in July 2023 but both follow the guidance for NHS providers as set out by the National Quality Board (NQB) on how organisations should learn from the deaths of people in their care.

Hospital Site	Process

Southport and Ormskirk	All deaths in hospital reviewed by Medical Examiner (ME) Team and feed into the LFD process. Any concerns around lapses in care referred for Structures Judgement Review (SJR) and logged via Incident Reporting System. Mortality Outcomes Group reviews learning from ME reviews and SJRs
Whiston and St Helens	Separate ME and LFD process Deaths in hospital within scope referred for SJR and review at Mortality Surveillance Group. Any concerns around lapses in care logged via Incident Reporting System.

Cases are rated as Amber when areas which are identified as possibly contributing to patient harm. Cases are rated as Red when the death was identified as being more likely than not due to problems in healthcare (i.e. avoidable) All cases rated as Amber or Red are reviewed within their respective Mortality Groups by the LFD and a final rating given. Any learning is fed back to the Divisional team and shared throughout the organisation. to ensure that all staff are given the opportunity to determine how this could impact on their practice in order to make things better for other patients.

The process to merge the two review groups (Mortality Outcomes Group and Mortality Surveillance Group) has begun in order to have a single Trust-wide group for review of in-hospital deaths. Both groups work closely with Specialist Palliative Care Teams to identify actions which can be taken to improve End of Life Care.

During Quarters1-4 2024-25 2667 of MWL's patients died (in hospital). This comprised the following number of deaths which occurred in each quarter of that reporting period:
657 in the first quarter
649 in the second quarter
657 in the third quarter
704 in the fourth quarter

By the end of Quarter 4, 246 case record reviews and 4 investigations (reds and ambers) have been carried out in relation to the 2,667 deaths included in item 2.4.6.1.

In 4 cases (reds and ambers), a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
2 in the first quarter
1 in the second quarter
1 in the third quarter
0 in the fourth quarter

0 representing 0.00% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient (red rated).
In relation to each quarter, this consisted of:
0 representing 0% for the first quarter
0 representing 0% for the second quarter
0 representing 0% for the third quarter
0 representing 0% for the fourth quarter

To date the LFD results have been presented for Quarter 1 and Quarter 2 of 2024-25 to the Trust Board:

For Quarter 1 (April-June) at Whiston and St Helens Hospitals:

Total cases with Structured Judgement Review (SJR) Quarter 1	63
Total outstanding a review Quarter 1	4
Total Red SJRs Quarter 1	0
Total Amber SJRs Quarter 1	2

For Quarter 1 (April-June) at Southport and Ormskirk Hospitals:

Total cases with ME Case Record Review Quarter (CRR) 1	177
Total cases with Structured Judgement Review (SJR) Quarter 1	6
Total Red CRR/SJR Quarter 1	0
Total Amber CRR/SJR Quarter 1	3

For Quarter 2 (July-September) at Whiston and St Helens Hospitals:

Total cases with Structured Judgement Review (SJR) Quarter 2	45
Total outstanding a review Quarter 2	25
Total Red SJRs Quarter 2	0
Total Amber SJRs Quarter 2	0

For Quarter 2 (July-September) at Southport and Ormskirk Hospitals

Total Number of CRR Quarter 2	192
Total Red CRR Quarter 2	0
Total Amber CRR Quarter 2	4

Summary of learning from deaths

- Availability of translation services to support care of patients unable to speak English
    - Work for patients attending for elective care has been completed
    - 24 hours telephone / videoconference facilities are available. Next stage is to raise awareness of these.

- Intravenous access
    - Obtaining and maintaining appropriate intravenous access in patients is a multi-factorial challenge and is placing increase pressure on other services.
    - An Intravenous therapy group has been established to review and improve these pathways.

- End of life planning
    - Issues with planning when recovery is uncertain, conversations with patients and loved ones in difficult and emotive situations and processes to promote earlier planning toward the end of life.
    - Trust wide group set up and training available to all senior clinical staff in escalation planning in clinical uncertainty, delivered by a collaboration between acute specialties and palliative care.

- Nutrition and hydration
    - Delays in appropriate provision of this due to delayed decision making and appropriate use of the Speech and Language Therapy (SALT) service.
    - Nutrition group formed to understand the frailties in the process and what options are available to staff to promote appropriate nutritional delivery.

- Escalation
    - Case reviews indicate a frailty in the process of escalation when the next most senior clinician in the team is unavailable. There is a tendency for the escalation process to be delayed or referred back 'down' to a junior colleague.

- 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, it may be that families and carers do not take in what is happening to their loved one and may not be able to comprehend a poor diagnosis, this is even more challenging over the phone. Staff must remain aware of verbal and physical cues from families / carers suggesting key messaged haven’t been fully appreciated, so the communication can be reinforced accordingly.

- 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 Lorezepam in the elderly
    - Guidance is given in the Delerium assessment and management pro-forma under the elderly & frail medication, ED section of the intranet.

- DNACPR communications on Transfer
    - On a transfer form there is a specific box to indicate a DNACPR is in place, this must be ticked and they must ensure the Lilac form is prominent at the front of the case.

- GKI (Glucose / Potassium / Insulin regime)
    - This is only to be used with patients who have a definite diagnosis of diabetes. If used on patients that are non-diabetic, this can lead to a detrimental outcome.

- Palliative Care (SPCT)
    - Methadone should not be stopped, this can be given via syringe driver, contact SPCT for advice
    - Blood glucose monitoring may still be required on a dying patient who is T1DM to prevent further detrimental impact of a hypoglycaemic episode during their vulnerable stage of dying
    - Parkinsons medication can be converted to a patch (conversion charts available via the intranet)
    - Anti-convulsion medication should not be stopped, can be given via a syringe driver, contact SPCT for advice
    - Fentanyl patches must not be removed, they are to be continue to be replaced as patients are dying
    - Consider environmental factors before using benzodiazepines i.e. have the patient has passed urine, do they some, have we prescribed a nicotine patch, when did they last have their bowels open.
    - Do not give midazolam to patients who have a nonterminal dementia and dementia symptoms, this is only to be used for these patients when they have terminal agitation.

Following the creation of MWL, work is underway to align the two learning from deaths processes into one process. Once created and approved this will be reflected in a new MWL Learning from Deaths Policy. It is hoped that this will be complete by Quarter 3 2025-26.

Lessons identified from the structured judgement reviews have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, intranet home page, global email, local governance and directorate meetings.

2.2.11 Freedom to speak up

The Trust has an established system to encourage and support staff to have the freedom to raise concerns. Staff are encouraged not only to speak up about anything that gets in the way of delivering great care and treatment but also about areas of good practice that could be replicated elsewhere.

The Trust has four Freedom to Speak Up (FTSU) Guardians, two of whom undertake a dedicated role to both support staff and the development of a speak up, listen up and follow up culture, within the organisation. The team is supported by a FTSU Specialist Administrator and a developing network of FTSU champions, who come from different professional groups and are working at various levels and roles within the Trust. Whilst champions primarily support the culture within the teams in which they are embedded, they may also offer support and signposting to any staff member within the Trust. Guardians and champions come together once a month to share information and develop ideas for further developing the culture.

Staff are encouraged to speak up and raise any concerns, within their own teams, however they can also access support via the FTSU guardians and champions. They can raise concerns via the web based, Speak in Confidence system, by email to a dedicated inbox, via a hotline to the Medical Director, who is also a FTSU Guardian.

FTSU guardians participate in corporate staff inductions and offer an array of sessions to individual departments or as part of a training programme. The FTSU guardians meet on a regular basis to discuss any emerging trends, whilst maintaining confidentiality regarding individual cases.

The Trust Board completed a self-assessment of the FTSU arrangements within the Trust in using the National Guardian's Office and NHS England's, Reflection and Planning Tool. This has been reviewed in March 2025.The outcome of the assessment and subsequent review has been used to develop an action plan for continuous improvement in line with the draft updated merged FTSU Strategy.

Each year, October is freedom to speak up month and the theme for 2024 was listening up, with several activities undertaken to raise awareness of speaking up including:

- Away Day for Champions for learning and to set priorities for the year ahead
- FTSU Executive Lead walkabouts across sites
- FTSU guardian and champions walk arounds on each site
- Information stands on each site and encouragement to staff to make a FTSU pledge
- Distribution of quizzes and word search relating to speaking up
- Wear green Wednesdays
- Team take-over at Trust Brief Live in the first week of October
- Ongoing recruitment of FTSU champions across all Trust sites
- Contract extended for the anonymous Speak in Confidence system across all sites

The FTSU system is complementary to the just and learning culture adopted by the organisation.

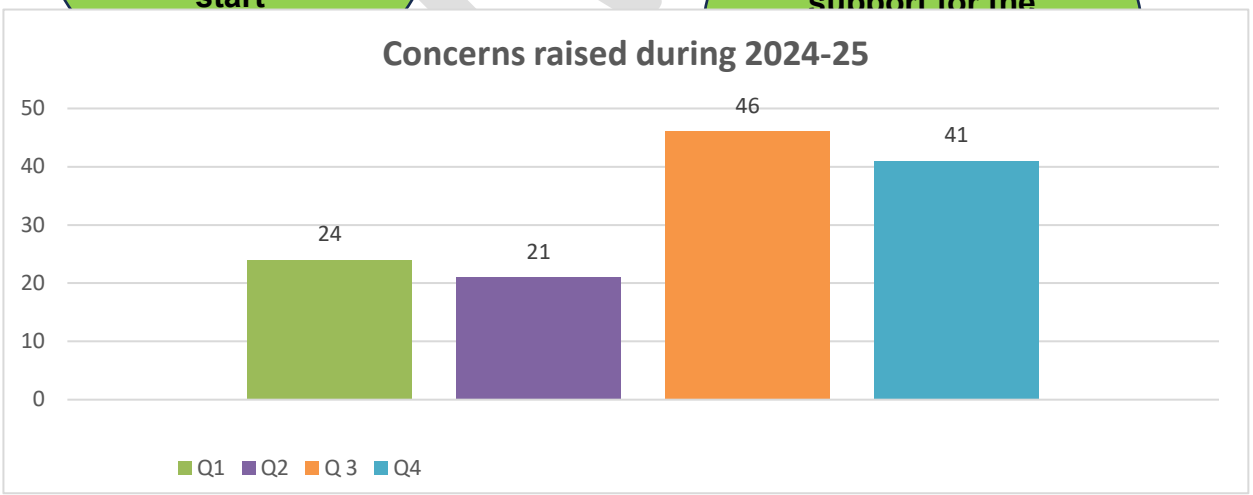
Following analysis of FTSU cases the Trust themes are in keeping with the national picture, where inappropriate behaviour and staff wellbeing are the most significant themes. To support in addressing this the Freedom to Speak Up Guardian's now present on the Leadership Development course and the Foundation Leadership course.

When a FTSU guardian has supported a member of staff to raise concerns, feedback is requested before a case is closed. There is consistent positive feedback from staff in relation to the support offered by guardians, with examples below:

"I felt listened to and my questions and anxieties were taken seriously."

"Very easy to talk to, felt like my concerns were being listened to. FTSU Guardian kept in touch during the process and was kind and understanding."

"Grateful for the professionalism, but also the compassion which was shown."



Staff are also asked if they feel they have suffered detriment because of speaking up. There has been one case of detriment reported during 2024-25 where a member of staff chose to leave the organisation after raising concerns.

The Trust continues to work in partnership with the National Guardian's Office and Northwest Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns.

The range of other routes to raise concerns and receive support are listed below:

Health, work and wellbeing hotline

Staff members have access to a dedicated helpline, to provide advice and support regarding health and wellbeing aspects relating to work or impacting on the individual. Bespoke support can be offered depending on the needs and circumstances. Concerns about the workplace can be raised through the hotline.

Hate crime reporting

A hate crime is when someone commits a crime against a person because of their disability, gender identity, race, sexual orientation, religion, or any other perceived difference. The Trust, in partnership with Merseyside Police, continues to support staff members with the first ever Hate Crime Reporting Scheme based at an NHS Trust. This is a confidential online reporting service that enables anyone from across our organisation and local communities to report, in complete confidence, any incidents or concerns around hate crime to Merseyside Police.

Policies and procedures

There are a number of Trust policies and procedures that facilitate the raising of staff concerns, including the Freedom to Speak Up policy, Grievance Policy and Procedure, Respect and Dignity at Work Policy and Being Open Policy. Staff are also encouraged to informally raise any concerns to their manager, nominated HR lead or their staff-side representative, as well as considering the routes listed above.

All concerns are taken seriously, and changes made where appropriate, including making changes to the working environment, providing individual support and information available to staff and reviewing staffing levels in key areas. The Trust has made available nationally recommended FTSU training to all staff members on its e-learning platform.

2.2.12 NHS Doctors in Training

This section is intended to illustrate the number of exception reports raised against the vacancy rate by the grade of doctor. Fill rates for ad hoc shifts are provided to illustrate how successfully vacant shifts are filled. This section also illustrates the actions taken to mitigate the risk of having unfilled shifts and any adverse impact on the training experience of Doctors in Training whilst on rotation to the Trust.

High level data

- Number of doctors and dentists in training (total): 266 hosted trainees and 165 locally employed foundation trainees.
- The medical vacancy rate is 1.8%

Exception Reports								
Period	**Medicine**	**Surgery**	**Emergency Medicine**	**Orthopaedics**	**Paediatrics**	**Urology**	**Obst & Gynae**	**TOTAL**
April - June 24	17	16	1	6	1	3	1	45
July 24 - Sept 24	49	36	0	7	1	2	0	95
Oct 24 - Dec 24	32	7	3	1	1	0	0	44
Jan 25 - Mar 25	27	11	1	1	1	0	1	42
TOTAL	125	70	5	15	4	5	2	226

The numbers represent a count of unique exception reports recorded by trainees. Grades range from Foundation Year (FY) 1, 2 through to Specialist Trainee (ST) 1,2,3,4,5,6,7 and 8.

Issues arising

The last few years have proved challenging for the junior doctor workforce, working through the Trust merger. The merger has brought about an integration of clinical services, which resulted in further periods of disruption due to increased training needs and transfer time.

2.2.13 Reporting against core indicators

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, where the NHS is aiming to improve. All trusts are required to report against these indicators using a standard format. NHS Digital makes the following data available to NHS trusts. The Trust has more up-to-date information for some measures; however, in the main only data with specified national benchmarks from the central data sources is reported, therefore, some information included in this report is from the previous year or earlier and the timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Please note the information below is based on the latest nationally or locally reported data with specified benchmarks from the central data sources.

Summary Hospital-level Mortality Indicator (SHMI)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
SHMI	NHS Digital	Dec-23 to Nov-24	1.025	1.000	0.702	1.285
SHMI	NHS Digital	Nov-23 to Oct-24	1.028	1.000	0.697	1.299
SHMI	NHS Digital	Oct-23 to Sep-24	1.026	1.000	0.697	1.309
SHMI	NHS Digital	Sep-23 to Aug-24	1.046	1.000	0.697	1.324
SHMI	NHS Digital	Aug-23 to Jul-24	1.067	1.000	0.704	1.323
SHMI	NHS Digital	Jul-23 to Jun-24	1.059	1.000	0.695	1.312
SHMI Banding	NHS Digital	Dec-23 to Nov-24	2	2	3	1
SHMI Banding	NHS Digital	Nov-23 to Oct-24	2	2	3	1
SHMI Banding	NHS Digital	Oct-23 to Sep-24	2	2	3	1
SHMI Banding	NHS Digital	Sep-23 to Aug-24	2	2	3	1
SHMI Banding	NHS Digital	Aug-23 to Jul-24	2	2	3	1
SHMI Banding	NHS Digital	Jul-23 to Jun-24	2	2	3	1
% of patient deaths having palliative care coded	NHS Digital	Dec-23 to Nov-24	50.2%	44.1%	16.9%	66.1%
% of patient deaths having palliative care coded	NHS Digital	Nov-23 to Oct-24	50.7%	44.0%	16.5%	65.6%
% of patient deaths having palliative care coded	NHS Digital	Oct-23 to Sep-24	51.0%	43.8%	16.7%	67.3%
% of patient deaths having palliative care coded	NHS Digital	Sep-23 to Aug-24	50.8%	43.7%	16.9%	66.7%
% of patient deaths having palliative care coded	NHS Digital	Aug-23 to Jul-24	50.7%	43.6%	17.4%	67.0%
% of patient deaths having palliative care coded	NHS Digital	Jul-23 to Jun-24	51.3%	43.6%	17.7%	68.8%

MWL considers that this data is as described for the following reasons:
-Information relating to mortality is monitored monthly and used to drive improvements.
-The mortality data is provided by an external source (NHS Digital).
-MWL has taken the following actions to improve the indicator and percentage, and so the quality of its services by:

-Monthly monitoring of available measures of mortality. Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned.

Patient Reported Outcome Measures (PROMS)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-23 to Mar-24 (final)	0.456	0.458	0.352	0.581
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-23 to Mar-24 (final)	0.288	0.323	0.231	0.405

Indicator	Source	Reporting Period	SOHT	STHK	National Performance		
					Average	Lowest Trust	Highest Trust
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-21 to Mar-22 (final)	*	0.396	0.462	0.393	0.534
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-21 to Mar-22 (final)	*	0.256	0.324	0.181	0.417

MWL considers that this data is as described for the following reasons:
-The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation (IQVIA).
-MWL has taken the following actions to improve these outcome scores, and so the quality of its services, by:
-Reviewing the process for PROMs collection Trust wide and agreeing a Trust wide forum where results will be discussed.

FRIENDS & FAMILY TEST (FFT)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Jan-25	86.1%	79.8%	55.6%	97.4%
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Dec-24	83.4%	75.8%	12.5%	95.2%
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Nov-24	82.7%	76.8%	36.4%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Oct-24	83.1%	77.9%	60.0%	96.4%
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Sep-24	85.8%	79.2%	53.1%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Aug-24	90.5%	82.6%	66.6%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Jul-24	84.5%	79.8%	61.4%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - A&E	NHS England	Jun-24	87.0%	78.6%	59.6%	95.7%
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Jan-25	92.4%	94.7%	71.8%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Dec-24	92.5%	94.4%	71.8%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Nov-24	94.7%	94.9%	74.6%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Oct-24	93.8%	94.5%	81.5%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Sep-24	94.7%	94.4%	53.7%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Aug-24	94.7%	94.9%	82.7%	100.0%

Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Jul-24	95.4%	94.9%	81.0%	100.0%
Friends and Family Test - % That Rate the service as Very Good or Good - Inpatients	NHS England	Jun-24	94.6%	94.2%	55.9%	100.0%

MWL considers that this data is as described for the following reasons:

-The Trust actively promotes the FFT across all areas.
-The data was submitted monthly to NHS England.
-MWL has taken the following actions to improve these percentages, and so the quality of its services by:

- Continuing to promote FFT using a variety of methods, including face-to-face and technology, supported by volunteers in key areas.
- Actively working with ward staff to improve levels of engagement with the system, to ensure the latest results are shared at local level and actions are delivered to respond to the feedback.

VTE

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 4 2024-25	81.1%			
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2024-25	83.2%	90.4%	13.7%	100.0%
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2024-25	66.4%	89.0%	14.3%	100.0%
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2024-25	67.1%	88.6%	14.9%	100.0%

MWL considers that this data is as described for the following reasons:

-Reviews are carried out for all patients who develop a hospital acquired thrombosis (HAT). A HAT venous thromboembolism (VTE) covers all VTEs that occur in hospital and within 90 days after a hospital admission. Treatment in relation to VTE prevention.
-Patient Safety Investigations undertaken on VTEs are recorded on Datix to ensure best practice is followed.
-MWL is taking the following actions to improve this percentage, and so the quality of its services, by:
-Utilising IT systems and pathways to facilitate VTE risk assessment and prescribing

of thromboprophylaxis.
-Undertaking audits on the administration of appropriate medications to prevent blood clots.
-Completing investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed.
-Sharing any learning from these reviews and providing ongoing training for clinical staff.

C. DIFFICILE

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-23 to Mar-24	51.0	29.5	0	131.2
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-22 to Mar-23	46.6	27.3	0	133.6
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-21 to Mar-22	46.5	25.2	0	138.4
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-20 to Mar-21	41.6	22.2	0	140.5

MWL considers that this data is as described for the following reasons:

-All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate mandatory external reporting.
-The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea.
-Cases are thoroughly investigated, which is reported back to a multidisciplinary panel to ensure appropriate care was provided and lessons learned are disseminated across the Trust. The Trust have implemented improvement plans in place for E.Coli , indwelling devices and C. difficle. This has resulted in the trust being below the threshold set for rates of E coli and C. difficle
-MWL has taken the following actions to improve this rate, and so the quality of its services, by:

- Focussing on ensuring staff compliance with mandatory training for infection prevention.
- Ensuring compliance with IPC practice including isolation of patients with suspected / confirmed symptoms
- Actively promoting the use of hand washing and hand gels to those visiting the hospital.

- Providing a proactive and responsive infection prevention service to increase levels of compliance.
- Ensuring comprehensive guidance is in place on antibiotic prescribing.

Infection prevention remains an ongoing priority for the Trust.

INCIDENTS

Incidents per 1,000 bed days	Internal	Apr-23 to Mar-24	S&O 48.73	STHK 62.13
Incidents per 1,000 bed days	Internal	Apr-24 to Mar-25	MWL 53.263	
Number of incidents	Internal	Apr-23 to Mar-24	S&O 8372	STHK 17469
Number of incidents	Internal	Apr-24 to Mar-25	MWL 23705	
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-23 to Mar-24	S&O 0.08	STHK 0.137
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-24 to Mar-25	MWL 0.124	
Number of incidents resulting in severe harm or death	Internal	Apr-23 to Mar-24	S&O 13	STHK 39
Number of incidents resulting in severe harm or death	Internal	Apr-24 to Mar-25	MWL 55	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-23 to Mar-24	S&O 0.16%	STHK 0.22%
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-24 to Mar-25	MWL 0.23%	

MWL has taken the following actions to improve this number and rate, and so the quality of its services by:
-Undertaking comprehensive investigations of incidents resulting in moderate or severe harm.
-Delivering simulation training to enhance team working in clinical areas.
-Providing staff training in incident reporting and risk management.
-Monitoring key performance indicators at the Patient Safety Council, Quality Committee and the Trust Board.
-Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.

2.2.14 Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2024-25 is shown in the table below:

Performance Indicator	2023-24 Performance	2024-2025 Performance
Cancelled operations (% of patients treated within 28 days following cancellation)	92.40%	88.0% *(Apr-Feb)*
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	60.80%	64.6%
Cancer: 31-day wait from diagnosis to first treatment	91.70%	90.0% *(Apr-Feb)*
Cancer: 62-day wait for first treatment from urgent GP referral	78.1%	79.2% *(Apr-Feb)*
Cancer: 28 day wait from GP referral to Diagnosis informed	69.50%	74.0% *(Apr-Feb)*
Emergency Department waiting times within 4 hours – all types (mapped performance)	74.90%	78.1%
Percentage of patients who spent at least 90% of their stay on the stroke unit.	85.30%	*Awaiting update*
Clostridium Difficile	103	114
MRSA bacteraemia	6	6
Maximum 6-week wait for diagnostic procedures: % of diagnostic waits waited <6 weeks	87.80%	93.1%

Part 3 – Other Information

This section of the Quality Report provides information on our quality performance during 2024-25. Performance against the priorities identified in our previous quality report and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

3.1. Summary of how we did against our 2024-25 Quality Account objectives

Every year, the Trust identifies its priorities for delivering high quality of care to patients, which are set out in the Quality Account. The section below provides a review of how well the Trust did in achieving the targets set last year.

No	Objective	Lead Director	Measurement	2024-25 Year End Position
1.	Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.	Chief Operating Officer	All patients requiring triage are either triaged within 15 mins or have a baseline set of observations within 15 minutes based on monthly audits	Triage working groups have been established to develop actions plans to drive improvements in the achievement of this national standard. This remains an objective in 2025-26.
			First clinical assessment median time of <2 hours over each 24-hour period	Consistently demonstrated compliance with this measure.
			Compliance with the Trusts Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits.	Consistently achieved 85% compliance with this target.
			Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring.	Administration of antibiotics within 1 hour of diagnosis has not been achieved consistently and there are improvement actions that will be implemented in 2025/26, including - • Microbiology to provide a list of all positive blood cultures each week • Clinical Audit Team to develop an in-house Sepsis audit tool Safety huddles - need for blood cultures within an hour for high risk and within 3 hours for moderate risk patients
2.	Reduce the incidence of methicillin-resistant Staphylococcus	Director of Nursing (DoN)/ Med Director (MD)	Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for	• Level 1 achieved. • Level 2 is not recorded on ESR for

	aureus (MRSA) healthcare associated bacteraemia infections to meet the zero-tolerance threshold and a 15% reduction of avoidable hospital onset MSSA bacteraemia		Level 1 (theory) and Level 2 (practical).	the legacy S&O sites but this has been addressed for 2025-26 following implementation of the harmonised ANTT project. The IPC Team engaging with divisional teams and practice educators to promote completion of the practical competency training.
			Achievement of 95% compliance with MRSA screening	MWL MRSA screening compliance was 93.4% during Q3, which is below the Trust target of minimum 95% admission screening for all inpatients. Going forward this will be a metric of focus within divisional governance meetings.
			90% compliance with visual infusion phlebitis monitoring	A monthly PIVC spot check audit is part of the IPC audit plan for 2025-26 to improve cannula care. A target of minimum 90% compliance with VIP monitoring has been set. The IPC Team is supporting divisional leads to strengthen IPC governance and drive improvements in cannula care.
3	Ensure patients in hospital remain hydrated to improve recovery times and reduce the risk of deterioration, kidney injury, delirium and falls.	DoN	Monthly audits on every ward to ensure all patients identified as requiring assistance with hydration have red jugs in place.	Red jugs compliance has continued to improve since Quarter 1 and is over 90% target.
			Monthly audits on every ward to ensure fluid balance charts are up-	Southport and Ormskirk Hospital sites are now digital for fluid balance charts on adult inpatient

			to-date and completed accurately.	wards in line with the Whiston, St Helens and Newton hospital sites. A new patient information leaflet has been introduced on the adult inpatient wards for patients able to utilise it.
			High compliance with Advancing Quality (AQ) AKI (Acute Kidney Injury (audit results	MWL is one of the top three C&M Trusts for performance against the Advancing Quality (AQ) targets for acute kidney injury (AKI) – January 2025 data. AKI pathways continue to be standardised and training on completion of fluid balance charts delivered by the critical care outreach at Southport Hospital and AKI team at Whiston Hospital.
4.	Continue to improve the effectiveness of the discharge process for patients and carers.	Chief Operating Officer (COO)	Improved Inpatient Survey satisfaction rates for receiving discharge information.	The latest inpatient survey (2023) showed a decline of scores relating to discharge. This was the first MWL survey and therefore, the results are not directly comparable to previous surveys, however, there was an improvement in 6/11 measures compared to the previous Southport and Ormskirk NHST survey.
			Achievement of 20% target for patients discharged before noon during the week.	Ongoing improvement throughout the year. Planned ECIST development for board rounds will support early plans for discharge and ensure engagement improves with discharge lounges in both sites. Golden patients will continue to be identified by the flow teams bed management teams and to ensure wards are supported with booking of transport, blood results and completion of To Take Out (TTOs).

			Proportion of patients who have received the discharge from hospital booklets (audits)	Consistently achieving target.
			Review of discharge data to confirm reason for delay is not due to waits for take home medication (threshold 5%)	This area remains an objective for 2025/26. A key In Hospital Workstream in the MWL System UEC Improvement Plan for 2025-26 is Improving Discharges. This includes implementing the ECIST recommendation on board and ward round processes and focussed work on reducing the length of time for it takes for TTOs and ensuring TTOs requests are at the pharmacy earlier.
5	Continue to improve the overall experience for women using the Trust's Maternity Services	DoN	Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys and feedback from women receiving maternity care and delivery of the agreed action plan.	For the 2024 NHS Maternity Survey results MWL scored about the same as other Trusts in 48 questions, somewhat worse for 5 and worse than expected for 4. The results were triangulated with other sources of patient feedback including feedback from Maternity Neonatal Voices Partnership (MNVP) and Trust Safety Champions walkarounds which reflecting positive feedback and did not pick up the same themes as the national survey. Patient Advice and Liaison Service (PALS), complaints and FFT feedback was also triangulated with key themes identified around ante-natal waiting times, communication (with women and families at various points in the patient journey) and increasing the partner facilities to stay overnight to offer support following birth,

				which has been implemented in 2024-25. An action plan has been developed to address the findings of the national survey and shared with Maternity Staff. The action plan is monitored monthly at the Women and Children Divisional Meeting. Of the 35 actions, 15 are completed, 17 are on track for delivery by the agreed deadline on track and 3 are currently amber- as linked to the implementation of a new Maternity Information System (Badgernet), which is not due to be implemented until March 2026. The Maternity and Patient Experience teams have developed local surveys to assess the impact of the completed actions and identify other areas of focus ahead of the next national Maternity Survey.
			Create a MWL Maternity Strategy to support delivery of the national three-year maternity plan.	Consultation with staff, service users and stakeholders is underway on the new MWL Maternity Strategy.

3.2 Patient experience and Inclusion

The Trust acknowledges that patient experience is fundamental to the quality of healthcare and that a positive experience leads to better outcomes for patients, as well as improved morale for staff. Patient experience is at the heart of the Trust's vision to provide 5- star patient care.

The first MWL patient experience strategy 2025-28 has been developed. The strategy builds upon all the achievements of the previous respective strategies describing the Trusts 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 merging to MWL. The strategy was developed in partnership with our patients, key stakeholders, local communities. It sets 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, by building on our current engagement activities and ensuring people from all our local communities are included.

There are three commitments, and 14 associated objectives laid out in the strategy that will support a continuous cycle of engagement throughout every step of the patient journey and embodies the Trust values:

- We are kind
- We are open
- We are inclusive

The strategy is re-enforced with a detailed implementation plan which is monitored by the Trust Patient Experience Council.

At MWL, 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. We do not want to just meet expectations; we want to exceed them. This means we are committed to working in partnership with our patients to improve the quality of care that we provide, and we commit to actively seek, listen and act on feedback received from our patients.

Patient stories have continued to be shared in multiple formats such as written, digital and filmed. Stories have been collected from a wide variety of areas and featured maternity care, the smoking cessation service and the acute oncology service. They are shared at the Patient Experience Council and bi-monthly at Trust Board. Stories have been presented that have demonstrated both positive experiences and those where learning and improvements are required. For example, the introduction of a Parkinson's specialist nurse at Southport Hospital.

3.2.1 Patient Inclusion

Commitment 3 of our Patient Experience Strategy states that we are inclusive and that the Trust will:

- 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

By including the inclusivity value as an MWL commitment ensures that we actively listen to the voices of all our patients and use the feedback they give us to create and support an environment where everyone's cultural, social and personal needs are valued, and our differences are not only noticed but celebrated.

As part of our inclusive commitment, we have set out the following objectives that we aim to achieve:

- Objective 1 – Expand out 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 EDS22
- Objective 5 – Maintain/improve on relevant accreditations

All our objectives aim to improve accessibility and inclusion in all our services for all of our local communities, regardless of a person's background or protected characteristic.

3.2.2 Engagement and Consultation

- The Patient Participation Group is held each quarter, with a face-to-face meeting and virtual access for those who cannot travel

- In summer 2024 we started to engage with local stakeholders from inclusion heath groups in collaboration with our Healthwatch partners to understand when patients are accessing our services 'What matters to me' from the first point of contact from the Trust right through to being an inpatient or outpatient in one of our hospitals. To date we have engaged with drug and alcohol users, homeless mothers and veterans.
- Regular updates are given regarding changes to the estate in the Trust, new services and service development. The group helped to develop our Trust values and priorities for the next year and were actively involved in our EDS22 assessment
- We continue to engage regularly with our community stakeholders to understand any barriers that they may face when trying to access our services and also to show them what changes we have made, some of which will be based on their feedback
- Carers groups to explain our carers passport and the benefits for carers detailed in the passport
- Access audits and PLACE inspections restarted following the pandemic and patient representatives from our local communities and local Healthwatch groups participated alongside Trust staff
- Engaged and consulted on policies and standard operating procedures (SOPs) from specialist groups e.g. trans polices with Lesbian and Gay Foundation (Rainbow Badge) and our Proud staff network

3.2.3 Patient equality objectives 2023-27

The following objectives will be the focus for the coming years looking at all areas of the Trust, and not only how accessible the estate is, but also how accessible and inclusive are our services which will include:

- Patient app has now been launched and feedback is telling us it is being well received
- To address all the issues around accessibility, communication methods, call signal etc the Patient Experience and Inclusion (PEI) Team will start their whole Trust accessibility review
- Optimise the way interpreting services are delivered in the Trust

3.2.4 Equality Delivery System (EDS)

The patient element in the new EDS22 is Domain 1, which involves a deep dive into three services per year to see how inclusive and accessible they are and to identify any gaps and as such is tool for improvement.

For Domain 1 – 'commissioned and provided services' – each Trust must select three services to do a deep dive into and assess how accessible and inclusive the service is, and following a self-assessment of the evidence provided a presentation is given to panel made up of senior staff, relevant stakeholders and the Governance Lead from Cheshire and Merseyside Integrated Care Board who also score the evidence presented and agree a final domain score for the Trust.

The 2024-2025 EDS assessment was held on 25th February 2025, and our agreed scores for each service and the overall Domain 1 score are shown below.

During 2024-25 the services studied were:

- Breast reconstruction = scored excelling
- Maternity services = scored excelling
- MSK service = scored achieving

Domain 1: Commissioned and provided services Approved scores 2024-25	
1A: patients (service users) have required levels of access to the service	**EXCELLING**
1B: Individual patients (service user's) health needs are met	**EXCELLING**
1C: When patients (service users) use the service, they are free from harm	**EXCELLING**
1D: Patients (service users) report positive experiences of the service	**EXCELLING**

Veterans Aware

In March 2025, MWL was pleased to announce that Veterans Aware Accreditation was awarded. Feedback from the assessors and programme director included:

'Following the Trust's initial accreditation awarded in August 2021 and subsequent accreditation on the merger in Nov 2023 your efforts in continuing to drive the Veteran Aware agenda in your organisation are clearly progressing and making a difference.'

General Lord Richard Dannett,
GCB, CBE, MC, CB, DL
Patron of Veterans Covenant Healthcare Alliance

The eight manifesto requirements we were assessed on, and successfully met were:

Manifesto Requirements Met	

1. The Organisation understands and is compliant with the Armed Forces Covenant	Yes
2. The Organisation has a clearly designated Veterans and armed forces Champions	Yes
3. The Organisation identifies Veterans and armed forces community status patients to ensure they receive appropriate care	Yes
4. Staff at the Organisation are trained and educated in the needs of veterans and the armed forces community	Yes
5. The Organisation has established links to appropriate nearby veteran and armed forces community services	Yes
6. The Organisation will refer veterans and armed forces community to other services as appropriate	Yes
7. The Organisation raises awareness of veterans and armed forces community	Yes
8. The Organisation supports the UK Armed Forces as an employer	Yes

3.3. Friends and Family Test (FFT)

The FFT allows patients to rate their overall experience of care. It is an important feedback tool that supports the fundamental principle that people who use NHS services are able to offer real-time feedback at any point in their care.

Feedback that is gathered is used to identify trends and themes to direct local improvements to patients, families and carers. Positive feedback is often shared with staff to ensure that they feel valued.

The opportunity to give feedback is provided via multiple methods such as postcards, online surveys, automated SMS text messaging and interactive voice messaging.

Wards and departments across the Trust monitor the patient feedback and display 'you said, we did' improvement posters to highlight the actions being taken to continuously improve the care we provide, as well as maintaining staff motivation and influencing change. The table below highlights some examples of feedback and actions taken:

You Said	We Did
Lack of resources for activity and entertainment.	Charitable funds application submitted and approved for resources to support activity

You Said	We Did
(Ward 1 Southport Hospital)	and socialisation. Including table and chairs, DVD player and radio.
Lack of bereavement support following a death out of hours in the theatre department. **(Theatre Department – Southport Hospital)**	Department bereavement box reviewed. Out-of-date information removed and replaced with new booklets. Bereavement property bags now in place along with contact information for the Spiritual care and chaplaincy team.
'Discharged with no explanation of what had previously happened or any plan going forward' **(Ward 7a – Southport Hospital).**	Information of actions taken following feedback are displayed to patients and their families on the ward information noticeboard. Doctors to ensure medical plans are discussed prior to discharge. Discharge summaries to include treatment and ongoing plans.
Incorrect meal order in line with religious and cultural needs. **(Regional Spinal Injuries Unit – Southport Hospital)**	Individual meal ordering processes audited. Outcome shared with family and staff. Patient needs now included in handovers, safety huddles and also highlighted within the care plan.
A need for more antenatal information. **(Maternity and Maternity Neonatal Voices Partnership - Ormskirk DGH)**	Virtual listening event was introduced. 'An evening with your local obstetrician'.
Long wait in reception before procedure and long wait in ward after waiting discharge. Would like to have been told long waits possible, this would have made the waiting easier. **Plastic Surgery Day Unit**	Thank you for your feedback, waiting times have unfortunately increased recently due to extra theatre activity. We will be creating a poster to advise patients of potential long waits during busy periods and will endeavour to keep patients up to date on how long they can be expected to wait in the future.
Appointment was very poor. Clinician I seen did not introduce herself, so I am unsure what role she had/ if she was a consultant etc. She was very rude and dismissive as if I was wasting her time. I was	We are sorry to hear about your recent experience. We understand how stressful attending an appointment. I have shared your experience with our clinicians and radiology team, we will be discussing this

You Said	We Did
sent for an ultrasound and again no introductions were made and the lady performing ultrasound was also very rude and did not close the door to the room when performing ultrasound on my breast. I was made to feel I should not have been given an appointment. I was sent back outside to wait and then waited almost 2 hours for the results of the ultrasound. I appreciate these things take time. **Burney Breast Unit, St Helens Hospital**	matter and review our patient flow and if there are things that can be added to improve our service. I will also share this with the nursing team to make them aware of privacy and dignity is maintained.
Great service by staff but the heat and lack of fresh air as the windows are locked is horrendous. It made me so uncomfortable. **(Ward 3A – Whiston Hospital)**	Unfortunately, the windows were locked by our Estates and Facilities Team for a short period due to a safety issue; this is now rectified and all patient windows are able to be opened.
I thought that the staff are nice, service poor, food very cold all the time. **(Newton Inpatients)**	Checked with catering re food temperature checks. Each meal is checked for correct temperature and only four meals are given out at a time to make sure correct temperature is maintained. Only 3 microwaves currently in use. A new microwave has been ordered to ensure meals are given out in a timely manner.

3.4. Complaints

MWL takes patient and carer complaints and feedback extremely seriously. Staff work hard to ensure that any concerns are acted on as soon as they are identified and that there is a timely response to resolve issues at the earliest opportunity. Concerns, complaints, comments and feedback are raised either at a local level, via the Trust's two PALS Teams, or through the Chief Executive's office AskRob process where anyone can contact Rob Cooper directly via a dedicated email address.

Matrons, Ward and Departmental Managers are available for patients and their carers or representatives to discuss any concerns and to provide timely resolution to ensure patients receive the highest standards of care. In every area across the Trust there is a Patient Experience notice board to highlight how patients and carers can raise a concern.

Regrettably patients and their carers may wish to raise a formal complaint, which is thoroughly investigated and following this, complainants are provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust website. MWL has a current target to respond to formal complaints within 60 working days, where appropriate.

MWL complaint figures for 2023/24 and 2024/25 are detailed in the below table:

	2023/24	2024/24 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	Total 2024/25
MWL – First stage complaint	420	109	122	144	142	517
Response Compliance % Trust Target 80%	63.16%	74.76%	57.44%	62.9%	64.6%	64.22%

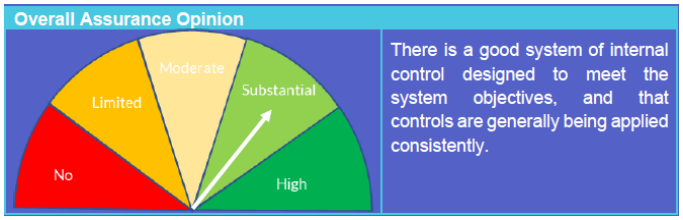
In 2024-25 the Trust received 517 new complaints. This is an increase in comparison to the previous year when the Trust received 420 new complaints.

During 2024-25 the Trust has received 39 complaints back for stage 2 further investigation. This is a decrease of 19% in comparison to the previous year when the Trust received 48 complaints.

MWL has achieved total compliance of 64.22% against the timescale of 60 working days from 2024-25. Significant work has been undertaken by key staff at the Trust who are working hard to reduce the time taken to respond to complaints, including the appointment of a dedicated Head of Complaints, recirculation of the guidance on drafting and quality checking of statements and complaint responses, offer of training on statement writing to new divisions and discussions with divisions about appropriate resources for complaints within their new structures. A particular focus on early resolution meetings has also proved successful.

MIAA – Complaints Management Review Audit

The Trust has received and overall assurance opinion of substantial following the audit conducted by Merseyside Internal Audit Agency (MIAA) in October 2024. There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.



Lessons Learned

The Trust is committed to learning lessons from complaints and ensuring robust actions are put in place and are monitored and accountability identified. This is to offer assurance to the complainant and to prevent a similar issue from occurring again.

Below are some of the key lessons and changes from the last financial year:

- **Improve Communication with patients and their families regarding discharge planning, including on the day discharge communications -** Engagement the medical and nursing teams to ensure staff aware that the discharge booklets are to be given out to patients from admission. Allocation of a champion for the area to promote this. Clear documentation when conversations have taken place through reminder at Safety Huddles across all wards. Documentation to record that updates have been provided to patients and their nominated next of kin regarding progress and discharge planning, promoted through reminders at daily Red to Green (R2G) meetings.

- **Ward Manager to be present on the daily boards rounds and will ensure that mobility/therapy requirements are discussed routinely -** Ward Managers to undertake education at ward level with nursing teams to ensure there is clarity around requirements for referral and the process to ensure all patients are referred appropriately and staff have a good understanding of this.

- **Pre-discharge actions –** Pharmacy will review whether amendments of guidance in patients who have swallowing difficulties would be useful. Pharmacy will provide lessons learnt bulletin for dispensary staff to escalate items which are out of stock to a pharmacist as the earliest opportunity. Pharmacy will review with a view to expand ward-based Pharmacy Technician service to support with discharges.

- **Difficulty contacting named midwife** – The Community Midwives have now activated a voicemail on their mobile telephones reiterating that it is not an emergency number and information given of who to contact in an emergency, with additional information added advising what day they are next on duty and the number to contact in a non-emergency if the caller wishes to speak with someone sooner.

- **Discharge process robust and patients being given clear guidance and safety netting post procedure** – Discussions at departmental meetings and gain an understanding of what staff feel are the expectations of discharge conversations. Explore if this process needs reviewing to establish a better process. Reiterate to staff the importance of documenting what discussions have been held and evidencing this in the health records.

3.5. Our volunteers

Volunteers make a unique and valuable contribution to patients and carers, relatives,

visitors, and staff. MWL are extremely grateful for the time, skills and support the volunteers offer and recognise the positive impact this makes for people who use our services, including our staff, and the community. Volunteering can significantly benefit individuals who choose to give up their time to help others and it is recognised as a means for promoting healthy populations and improving public health. Volunteers are visible and seen as a fundamental part of MWL, complementing our workforce and contributing to a better experience for our people.

A total of 377 volunteers completed 2–4 hours of volunteering each	**Volunteers can choose from 28 different roles covering 5 hospitals.**	**205 volunteers were recruited in 2024 across 5 hospitals.**

Our roles

Butterfly Volunteers
The Butterfly Volunteer Project was launched in June 2024 in partnership with the Anne Robson Trust, with the aim of providing companionship to patients identified as being in the last days and hours of life. Referrals are made by our Specialist Palliative Care Team who can then ensure volunteers have relevant information and support. We currently have 14 volunteers with further applications being received on a regular basis.

Butterfly Volunteers enable patients and those important to them to share their story, offering a listening ear and comfort to reduce anxiety and isolation. Butterfly volunteers will alert staff if patients require support such as mouthcare, pain relief or re-positioning and staff have welcomed the reassurance of knowing that a volunteer is present to support patients who may otherwise die alone.

The Volunteer service was successful in acquiring charitable funds to purchase resources for volunteers to use during visits such as sensory lights and music to create a calming, pleasant environment. This has been well received by patients, visitors and staff. In addition, we offer knitted hearts and butterflies to patients and visitors to create connection and positive memories.

Relatives have commented that our service has been a *"beacon of light in a dark world"* and have also welcomed the opportunity to be offered respite and updated on relevant services within the Trust that may improve their experience.

During the first six months of service, the team has completed 500 visits, providing approximately 350 hours of support to 639 people (163 patients and 476 visitors)
Plans are being explored to extend the service across Southport and Ormskirk hospitals in the near future.

Discharge Support

The discharge support service continues to operate Monday to Friday and supports

patients 48 hours post-discharge via telephone.

Sefton CVS referral feedback

'I just wanted to offer you some feedback following on from your referral for this very lovely couple (Mr & Mrs B). I have now closed the case with our service, after providing welfare visits and calls, supporting with AA forms and Blue Badge applications. I have also carried out a T/A assessment and ordered aids and adaptions for the bathrooms and supported A to review the current level of support and to provide additional care hours each day.

Carers are going in each morning and additional hours built in four afternoons a week to give Mrs B sometime to herself. They expressed their gratitude for the referral to our service and would like to pass this on to your team.'

Dining Companions

We currently have 13 active dining companions across Whiston and Southport hospitals. In 2025 we will be focusing on increasing the number of dining companions as they play a crucial role in the hospital; encouraging and enabling patients to eat and drink and therefore helping to reduce the risk of malnutrition and dehydration. Staff are very appreciative of this service and their feedback is very positive. We have 4 training dates set for 2025 to increase numbers for this service.

Voice of the Volunteer

Volunteers who leave are asked to complete an Exit Questionnaire so that we are able to collect feedback on their experience. The data shows that 100% of leavers would recommend the Trust to other people who are interested in volunteering.

Volunteering provided insights on my career path, gave me self confidence and helped to enhance and develop new valuable skills.

The best thing about volunteering was knowing you were helping the patients and visitors. I met new friends and became more confident. I felt supported and I really enjoyed volunteering.

A fantastic organisation! All staff are friendly, kind and welcoming. I got to use a wide range of skills, I loved how the role felt very rewarding, and staff and patients appreciated me. I had a great time volunteering.

Volunteers into Work

Lauren - Midwife

At 16 I had my first interview to become a volunteer! Volunteering was the start of my midwifery journey; I will always be grateful to have had the opportunity to learn and grow

before applying to university. I developed my confidence, communication and social skills

	making me evolve into a confident young adult who was comfortable conversing with everyone, a skill very necessary in midwifery. I achieved my A levels and started university in 2020. Midwifery is a calling, and I feel very honoured to be able to say from being a volunteer at 16, I am now a midwife at MWL at the age of 22 having delivered 40 babies!
Katy – Sonographer 	After gaining my Masters is in Public Health, it was always my plan to work within healthcare. I managed to secure a couple of interviews, but I lacked hospital experience, so I was not considered. I signed up as a volunteer to gain more experience which led to a role as a healthcare assistant at Ormskirk. I learnt so much about the hospital and the NHS in general, which really helped me with my interview questions. Most importantly, I was able to use so many examples of interactions I had with patients which demonstrated my ability to work under pressure, with difficult scenarios and situations. As a result, I got the job! I know that this would never have been possible without volunteering, and I would not be in such an amazing job without it.”

3.6. Patient safety

MWL continues to embed a culture of safety improvement that reduces harm, improves outcomes and enhances patient experience.

The Trust introduced Patient Safety Incident Response Framework (PSIRF) in Autumn 2023 and has progressed with enhancing how organisation respond to patient safety incidents (PSIs). The framework has been a further improving a safety management system that embeds the key principles of patient safety culture, with a focus on understanding how incidents occur and how we can effectively make sense of and

learn from them. Trust has introduced a variety of tools and techniques to carry out review of incidents and identify learning.

Trust has reviewed and refreshed Patient Safety Incident Response Framework Plan (PSIRP) and revised for 2024-26, which sets out Trust's approach to the way that patient safety incidents are responded to and how patient safety investigations are undertaken.

3.6.1 Falls

The Falls Team continues to develop strategies to minimise the occurrence of inpatient falls and YTD 2024-25 falls per 1000 bed days for MWL is 6.256. This is a newly combined figure for MWL.

The Trust continued to implement its Falls Prevention Strategy 2022-25 with a focus on 5 key areas for improvement:

- Embedding a culture of safety improvement that reduces harm caused by falls
- Improvement in communication of patient risk factors between wards/areas and the Falls Team
- Providing assurance of improvements and learning
- Education and development
- Equipment and environment

The Trust Falls team have continuously provided staff with various methods of support, education and guidance to ensure the action plan associated with our strategy is completed within the specified timeframes.

The Trust has implemented a trial of decaffeinated hot beverages to be offered to patients on six wards across the Trust and there has been a positive response from patients. Decaffeinated drinks were offered as the first line option for patients, to reduce bladder irritability and urgency. The Trust plans to roll out decaffeinated drinks across all of our sites by 2026.

Falls prevention training continues to be provided to newly qualified nursing staff, junior doctors and healthcare assistants, as part of the induction programmes. Updating and training staff on various medical equipment and manual handling devices.

The Trust falls team is an active member of North West regional falls nurse forum. The forum enables opportunity for all members to share practice and news on national and local initiatives in falls prevention roles across the region.

3.6.2 Pressure ulcers

The Trust has continued to focus on reducing the risk of patients developing hospital acquired pressure ulcers due to any lapses in care. There have been no category 3 or 4 cases.

The Trust-wide action plan highlights the main activities implemented in year to improve performance and is showing some improvements in several areas, including, documentation, compliance with policy and engagement in education and training, which the team offer bespoke at ward level. Harmonised pressure ulcer risk assessment tool has been introduced across all sites.

3.6.3 Venous thromboembolism (VTE)

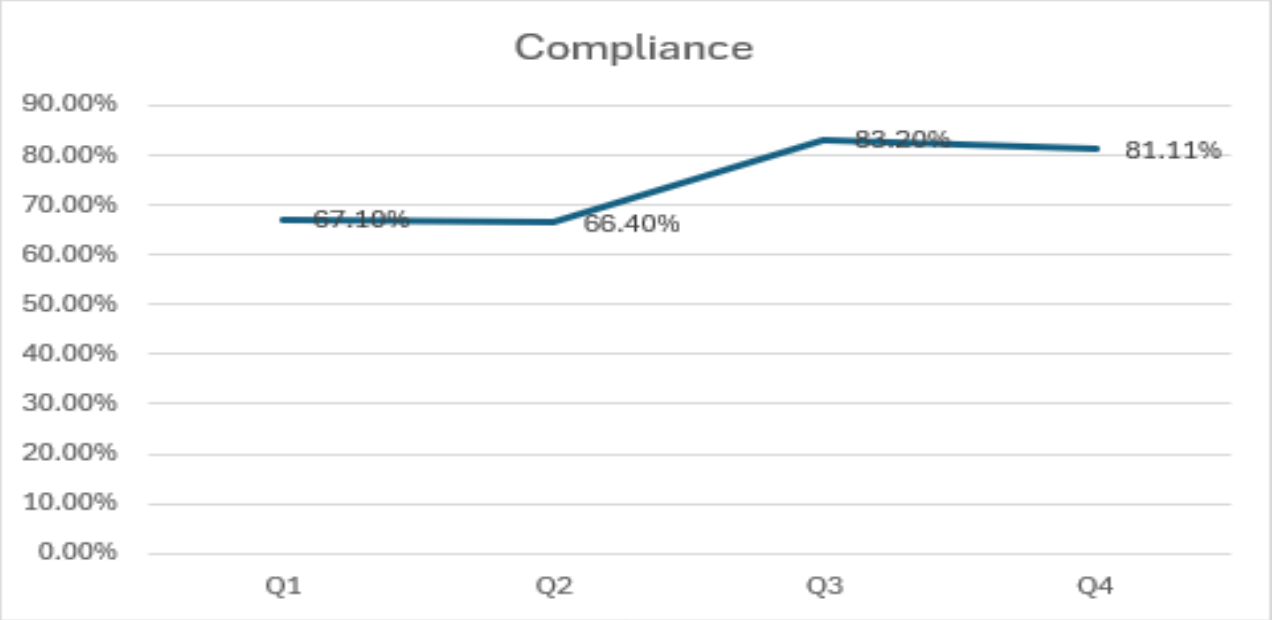
VTE covers both deep vein thrombosis (DVT) and its possible consequence, pulmonary embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. However, if the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE) that could lead to death.

The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action. This might include prescribing and administration of appropriate medication to prevent blood clots and application of specialised stockings.

National reporting for VTE risk assessment compliance was recommenced in 2024/25 after a pause since COVID -19 outbreak.

The Trust continues to support timely completion of VTE risk assessment and VTE prevention intervention by:

- Electronic VTE risk assessments live on Careflow narrative system
- Paper document integrated into acute assessment medical pro forma making a documented VTE risk assessment available for acute admissions
- VTE risk assessment recorded on patient flow boards with distinct purple circle assisting ward staff to identify status at a glance
- Sharing risk assessment compliance through daily dashboards
- Undertaking an investigation of all cases of hospital acquired thrombosis in order to reduce the risk of it happening again
- On-going VTE training including Moodle based online learning for all clinical staff
- Face to face training for new starters to the Trust



3.6.4 Medicine safety

The Pharmacy Department has continued to focus on medicine safety, with a number of actions taken as outlined below.

Electronic Prescribing and Medicines Administration (ePMA)

There has been an ongoing programme of ePMA system development and rollout overseen by the project board. In 2023-24, the Spinal Unit at Southport went live with ePMA, with further roll out to the rest of Southport and Ormskirk sites anticipated to be in the second half of 2025. Discharge processes remain disconnected from the ePMA system resulting in a manual process to produce discharge letters. In addition to the Southport roll out, work has been undertaken to install ePMA in the Intensive Care Unit at Whiston, whilst requests have been put forward to utilise ePMA in maternity and paediatrics at Whiston.

Chemocare

Electronic prescribing system is now a Trust wide system for MWL. This supports effective monitoring of our chemotherapy workload which is dispensed through our Aseptic Units at both Southport and Whiston. This activity continues to increase as medication protocols continue to get ever more sophisticated.

Pharmacy dashboard (at Whiston, St Helens and Newton sites and Spinal Unit S&O - linked to ePMA)

During 2024-25, the pharmacy dashboard continued to be developed. This is an invaluable ‘live’ resource which enables clinical pharmacy staff to review the medicines status of patients on each ward at a glance and prioritise their workload. This takes

feeds from multiple systems including ePMA, laboratory results, alerts, and the dispensary systems.

In addition to the dashboard, the pharmacy service is now able to track our discharge turnaround times more efficiently for both legacy Trusts displaying data in an equivalent manner despite it coming from two different IT systems.

Medicines audits

Standardisation of safe and secure handling medicines and Controlled drug audits across MWL, recorded in Tendable®, reports to Medicines Safety / Controlled Drugs oversight groups and Patient Safety Council.

Audits remain ongoing and continued improvement in performance has been reported from the previous year. Targeted improvement work has been provided to areas identified as requiring support in the audits. Ward based pharmacy technicians now also perform weekly audits on safety and security of medicines on wards. Feedback is given to the ward manager and escalated to the matrons and an action plan put in place if improvement is not made.

Policy Alignment

During the year, notable work has been completed to update MWL Patient Group Directive (PGD) policy, Controlled Drug Policy, Medicines Optimisation Policy, Potassium policy and Cannabis Policy.

Currently reviewing self-administration, discretionary medicines, covert administration, outpatient antibiotic therapy and paediatric antimicrobial policies.

Medicines Safety

The Medicines Safety team continue to provide an exemplary service to the Trust with highlights such as:

- Monthly input into the Trust's safety huddles and Trusts 5 Star Accreditation Process.
- Cross site medicines safety bulletins, with MWL branding to inform on issues such as safe paracetamol dosing, Eezy® CD rulers to enable accurate checks of Controlled Drug liquids, 5R'sand management of shortages of critical medicines (e.g. IV vitamins, potassium liquid).
- Critical medicines guidance cards updated for use across MWL.
- Contribution to safety Summit week (cultural change podcast and demonstration of the drug library)
- Contribution to investigation of serious incidents, pharmacy representation at weekly patient safety panel and the monthly patient safety council
- Ongoing work to review NHS England's (NHSE) enduring standards to benchmark and align processes across MWL.
- Process for pharmacy oversight of MHRA medicines recalls and assurance these are dealt with in a timely manner.

- Compliance with national recommendations for Antidotes in ED's across MWL (Whiston, Southport and Ormskirk)
- Work with risk department regarding timely management of NatPSA alerts.
- An IV access group has been set up to oversee issues related to cannulation, aseptic preparation of IV drugs, critical drug monographs and development of drug library (to make IV drug administration safer)
- Leading on work to standardise single patient information leaflet and written consent for IV iron administration, in all clinical indications following several incidents (including potential litigation)
- Ongoing work nurses' link group (STHK), with plans to extend to S&O.
- Continuing work to standardise Controlled Drug processes for pharmacy and wards across MWL.

Clinical

The Pharmacy Clinical Service operates as two distinct services pending the introduction of a harmonised EPR/EPMA solution for MWL. Wherever possible, we still aim to support clinical services with a "do it once" methodology across the sites with some significant developments over 2024-25 and further harmonisation plans for 2025-26 regarding our divisional support:

- Discharge medicines service to prompt follow up of patients by community pharmacists performing well.
- Falls and AKI reviews of patients by clinical pharmacists.
- Specialist inpatient diabetes and pain reviews (Southport only) are embedded in practice.
- Consultant pharmacist and other pharmacist colleagues providing input to frailty and virtual wards.
- Joint MWL posts active e.g. AKI, HIV pharmacists.
- Antibiotics- EOLAS (a guideline portal for antibiotic guidance) rolled out; hosts MWL anti-microbial policy.
- Active pharmacist Involvement in antimicrobial stewardship programme on both acute sites.
- Review of clinical service to Women's and Children's underway seeking to install professional pharmacy leadership within the division.

Emergency Department (ED) developments

The ED pharmacy teams are now well embedded in the multi-disciplinary team (MDT) but continue to come under increased pressure. The pharmacy staffing model is under review.

The storage of individual patients' medicines in ED has also been reviewed and there is a plan to support the safe storage of medicines. At Southport and Ormskirk hospitals, bedside lockers are in place in ED, Ambulatory Care Unit and Clinical Decision Unit.

Pharmacy

In addition to the above there have been a number of significant improvements specifically to the pharmacy team and pharmacy environments:

- Pharmacy Technician leadership structure has been adjusted to introduce a MWL Chief Pharmacy Technician to our team who will help with the journey of harmonising the MWL Pharmacy team.
- Automatic labelling process started at Whiston sites for inpatient dispensing activity to increase efficiency of the dispensary. Expected outcome of this has been realised with an improvement in discharge turnaround times.
- Merging Medicines Information service to be based primarily at Ormskirk site by Summer 2025.
- New robot installed at Ormskirk site with capital bid and plans for new robot at Southport site.
- Increased pharmacy technician presence on wards at S&O aligning with service at Whiston and St Helens sites
- Merged Pharmacy audit meeting is now operational and tracking the Pharmacy specific audit plans through AMaT clinical assurance software.
- Single EPRR action card developed for MWL pharmacy sites.
- Risk registers rationalised and moved to singular MWL Pharmacy InPhase® Risk Register.
- MWL Pharmacy SOP alignment continues to progress alongside Policy harmonisation.
- Approval for additional trainee pharmacy technician at Southport from NHSE.
- Homecare staffing monies have been awarded from the ICS and NHSE to support the High-Cost Drugs agenda.

3.6.5 Infection prevention

The Health and Social Care Act 2008 requires trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infections (HCAI). The Director of Nursing, Midwifery and Governance was previously DIPC the Trust's Director of Infection Prevention and Control (DIPC), with Board level responsibility for infection control. The position of a designated Director of Infection Prevention and Control (DIPC) was formally appointed to in January 2025.

The Trust's infection prevention priorities are to:

- Reduce the incidence of healthcare associated infections.
- Adopt and promote evidence-based infection prevention and control practice across the Trust
- Identify, monitor and prevent the spread of pathogenic organisms, including multidrug-resistant organisms throughout the Trust
- Reduce the incidence of HCAI by working collaboratively across the whole health economy

The Infection Prevention and Control Team provides expert advice to the organisation regarding all aspects of IPC, including national policy initiatives and the development

and implementation of the HCAI Annual Plan with key stakeholders.

The NHS Standard Contract for 2024-25 outlines the reportable healthcare associated infections and the combined threshold for the Trust as follows.

- C. difficile </=113
- E coli </=171
- Klebsiella </=49
- Pseudomonas </=16
- Zero tolerance to MRSA bloodstream infection

MRSA bacteraemia

A zero-tolerance approach is still in place to support no MRSA bloodstream infection. There was a total of six cases in year, 4 cases at the Whiston site and 1 case each at Southport and Ormskirk sites. Two cases were deemed unavoidable following post infection review panel, one awaits panel review, and the other cases had organisational lessons for improvement identified.

Case	Date	Attribution	Dept	Site	Source	Avoidable
1	22/06/24	HOHA	ED	Whiston	Cannula	Yes
2	27/09/24	COHA	Maternity Ward	Ormskirk	Episiotomy	No
3	05/10/24	HOHA	Spinal Injuries Unit	Southport	Sacral wound	Yes
4	04/11/24	HOHA	Ward 4B	Whiston	Hand wound	Potentially
5	30/12/24	HOHA	Bevan Ct 2	Whiston	Deep source	No
6	25/02/25	COHA	Ward 2A	Whiston	TBC	TBC

Clostridioides difficile (CDI)

The Trust combined NHSE threshold for C.difficile was for no more than 113 cases of hospital associated C. difficile in 2024-25. At year end there have been 114 cases (87 HOHA, 27 COHA), one case above the Trust threshold for 2024-25, but one case below the outturn for 2023-24.

In the most recent comparative UKHSA data available, for Quarter 4, the MWL rate of 28.6 per 100,000 bed days is below the Cheshire & Merseyside (C&M) rate of 31.4. MWL and the legacy Trusts have been below the C&M rate for the last four quarters.

The C.difficile Improvement Plan remains on track, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training. Hydrogen peroxide vapour is now routinely used for terminal cleaning following cases of CDI across the three main sites. Although scoping took place regarding a preventative bay-by-bay deep clean programme the deep clean is being undertaken from a reactive perspective following outbreaks or incidents and

approximately 22 wards across MWL were deep cleaned in year.

The Consultant Nurse IPC is a representing the Trust at the Cheshire and Mersey IPC Provider Collaborative (CMAST). The first improvement project was completed in Quarter 3, with the development of a C difficile Toolkit, which includes standardisation of the approach to diarrhoea management and testing, cleaning and Antimicrobial Stewardship (AMS). The toolkit will be implemented at MWL in Quarter 1.

All cases of hospital-associated C. difficile undergo infection prevention learning review (IPLR). Themes in these cases are largely unchanged, with the most common lessons identified in the timely isolation and stool testing of patients, and antimicrobial stewardship in some cases.

The Infection Prevention Team undertakes a programme of clinical practice and environmental audits, to provide assurance on compliance with key standards and to identify areas where improvements can be made.

E. coli

The E. coli NHSE threshold for MWL was for no more than 171 cases. The Trust is below the NHSE threshold by 12 cases, with 158 cases at year end.

The implementation of an E. coli bloodstream infection (BSI) improvement plan, with a focus on hydration and urinary catheter care resulted in the trust being below the Cheshire and Merseyside rate for the last four quarters. In Quarter 4 the MWL rate of 30.4 per 100,000 bed days is below the Cheshire and Merseyside rate of 33.8. The E. coli Improvement Plan was closed in Quarter 3 as all actions were completed.

Klebsiella

There have been 47 cases against an objective of no more than 49 cases in 2025-26. The Trust is below the NHSE threshold by 2 cases.

Pseudomonas

There have been 14 cases against an objective of no more than 16 cases in 2025-26. The Trust is below the NHSE threshold by 2 cases.

Further achievements for 2024-25 included:

The Infection Prevention Team working collaboratively across the new MWL Trust, with a focus on harmonising policies and guidance, to ensure standardised and reliable IPC practice.

The revised Infection Prevention Learning Review (IPLR) process has been embedded across all sites for hospital-associated CDT cases, and MSSA, E coli, Klebsiella and Pseudomonas HOHA bloodstream infections. This aim is to support the

PSIRF principles and to assist with thematic review across MWL, to identify further areas for improvement regarding healthcare-associated infections.

As part of the MWL Mandatory Training project, ANTT has now been harmonised with alignment of the delivery model, frequency and staff groups who require training. m.
Proactively responded to the endemic and emerging infections e.g. mpox, tuberculosis and measles, ensuring appropriate surveillance and management of the patients presenting to the Trust.

The IPC Team plays a key supportive role in the Trust's clinical accreditation programme.

The IPC Team supports a network of IPC link practitioners and delivers regular education sessions and study days to develop their knowledge and skills.
Improved engagement with ward leaders to optimise the clinical environment for patients, with a programme of estates walkarounds, with estates and the IPC Team Matron.

Support from the IPC Team on the extensive capital estates projects, to improve the built environment for patients and staff across MWL.

The IPC Team continues to work closely with Trust sustainability leads and Procurement to seek further efficiencies, both financially and in terms of driving the sustainability agenda e.g. improving waste streaming and standardising hand hygiene and cleaning products.

3.6.6 Being Open – Duty of Candour (DOC)

The Trust is committed to ensuring that we tell our patients and their families/carers if there has been an error or omission resulting in harm. This duty of candour is a legal duty on trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency. Our statutory duty of candour is delivered under the Trust's Being Open - A Duty of Candour Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts. The Trust operates a learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.

The Trust's incident reporting system has a mandatory section to record duty of candour. Weekly incident review meetings are held, where duty of candour requirements are reviewed on a case-by-case basis allowing timely action and monitoring. This ensures the Trust meets its legal obligations.

The Trust has continued to raise the profile of duty of candour through the lessons learned processes and incident review meetings. In addition, duty of candour training is included as part of mandatory training and investigation training for staff.

3.6.7 Never events

Never events are described by NHS England in its framework published in 2018 as serious incidents that are wholly preventable. Each never event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a never event.

The Trust remains committed to understanding the cause of these incidents through comprehensive investigation. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and to feed back in the knowledge that the issues will be fairly investigated, and any learning and improvement opportunities implemented.

The Trust reported five never event in 2024-25, which met the criteria.

Retained guidewire	Low harm
Wrong site steroid injection	Low harm
Wrong site surgery	Moderate harm
Wrong site nerve block	Low harm
Retained foreign object	Moderate harm

The Trust has also extended its focus to learning from never events by way of a targeted approach to improving theatre processes and other clinical environments where invasive procedures are performed. This has led to the formation of the Invasive Procedures Working Group which endeavours to improve safety by reviewing current best practice whilst taking into account the principles of NatSSIPS2. The group has senior clinical leadership representative and is underpinned by QI methodology. The key drivers for this area of improvement are the recent never events and the learning identified following investigation.

Learning from these incidents was identified using Systems Engineering Initiative in Patient Safety (SEIPS) methodology to minimise chances of a such an incident happening again in the future. This methodology is part of the national PSIRF toolkit and is a well-recognised and endorsed system- based model.

A number of actions were identified and implemented, including review and update of the policy for the Local Safety Standards for Invasive Procedures (LocSSIP) and local safety checklists and enhancing the pause/stop moment for local anaesthetic procedures. Further learning which will require focus is in regard to the distractions in the theatre environment during the safety critical stages of surgery.

3.6.8 Theatre safety

The Trust Operating Theatre Department continues to develop and refine patient safety initiatives in keeping with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs), to reduce the number of patient safety incidents related to invasive procedures.

The department has reported 3 incidents meeting Never Event criteria in 2024-25, with immediate actions taken to reduce the risk of further incidents. This relates to an incident of retained guidewire, an incident of wrong site surgery and an incident of wrong site nerve block. There has not been any identified long-term harm to affected patients as a result of these incidents.

All incidents have been subject to an in-depth Patient Safety Incident Investigation (PSII) in accordance with Patient Safety Incident Response Framework (PSIRF). Careful evaluation of systems and pathways using Systems Engineering Initiative in Patient Safety (SEIPS) have been undertaken. The methodology helps develop insight into a process or problem, to drilling down deeper into individual tasks or processes in more detail. Theatre safety checking process and Surgical safety checklists continue to evolve in response to learning from incidents and other improvement work. The department has focused upon initiating several actions within the patient pathways.

3.6.9 Safeguarding

The Trust is committed to ensuring safeguarding responsibilities are carried out in line with legislation and national and local policy. There are dedicated Safeguarding Teams situated on the locality sites. Within the teams there are Named Nurses and Named Midwifes for both children and adults supported by specialist safeguarding practitioners. There are two Assistant Directors who support the Director of Nursing. Midwifery and Governance to ensure that the Trust is fulfilling its statutory safeguarding responsibilities.

There is a suite of safeguarding policies which have been harmonised following the transaction along with associated robust processes to protect unborn infants, children and young people and adults at risk (including those with a diagnosis of a learning disability and/or autism) from harm or abuse. In addition, there is a specific Safeguarding Training Needs Analysis which identifies the level of training every staff member within the organisation must complete, including safeguarding adult and children training, mental capacity, prevent and learning disability awareness. The Safeguarding Team also ensure there are processes in place to support patients who are unable to consent to care and treatment and require a formal capacity assessment and completion of an urgent deprivation of liberty safeguard (DoLS) authorisation; these are quality assured and processed by the Safeguarding Teams.

The Safeguarding Teams maintain a visible presence across sites and are available to offer advice, support and supervision to all Trust staff. The Trust safeguarding key performance indicators (KPIs) are submitted on a quarterly basis and quality assured

by the Integrated Care Board (ICB) Designated Nursing Team (St Helens and Sefton Places). During 2023-24, a red/amber/green (RAG) rating of green was given in all areas except safeguarding training compliance and completion of Looked After Children (LAC) initial health assessments within the St Helens based Developmental Paediatric Service. There has been a steady increase in training compliance with the 90% required compliance achieved in the majority of all levels.

The expectation in relation to initial health assessments for LAC is that 100% of children will receive their assessment within 20 days of entering the care system; this continues to prove challenging due to both internal and external pressures, including late notifications from the Local Authority, children not being brought to appointments and an increase in the numbers of children requiring assessments. The Developmental Paediatric Team has taken steps to increase appointment capacity and provide weekend appointments to support attendance, as well as working with community partners to review processes and consider any potential barriers.

The ICB continue to confirm assurance in relation to safeguarding activity which has risen consistently across all areas, particularly numbers of referrals and evidence of good multi-agency working. Quarterly safeguarding reports and an annual report are presented to the Quality Committee and a safeguarding report is presented quarterly to each of the Divisions Clinical and Quality meeting

The Trust provides representation at five local safeguarding partnership boards for adults and children and to associated subgroups. When required, there is additional representation and contribution to adult and children multi-agency reviews, domestic abuse related death reviews (previously known as Domestic Homicide Reviews) and theme specific multi-agency audits.

There has been further external scrutiny by way of a Mersey Internal Audit Agency (MIAA) safeguarding audit. This was a positive report with a rating of substantial assurance with elements of high assurance. The medium/low level recommendations will be implemented as per the Safeguarding Action Plan.

3.7. National Staff Survey

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. For the 2024 survey, reported in 2025, the Trust conducted a full census staff survey. There were 3944 completed questionnaires returned giving a 37% response rate.

Eligibility to participate in the NHS Staff Survey continues to include Bank workers in NHS organisations, using a tailored version of an online questionnaire. Eligibility was based on Bank workers who had worked in the six months between 1st March 2024 and 1st September 2024 and who did not have a substantive or fixed term contract. Out of the 1223 people the survey was sent to, 145 people responded providing a response rate of 11.9%.

We are able to make comparisons with the Trust's benchmarking group, which comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. The Trust's benchmarking group comprises 122 organisations under the heading 'Acute and Acute & Community Trusts' although this does include a couple of specialist children's hospitals such as Alder Hey.

The survey questions remain related to the themes and sub-themes of the NHS People Promise with additional themes of staff engagement and morale retained from earlier surveys. The results give a wide picture of satisfaction across the whole organisation.

Results are reported both as individual question responses and as themes, aligned to the NHS People Promise which are:

• We are a team
• We are always learning
• We are compassionate and inclusive
• We are recognised and rewarded
• We are safe and healthy
• We each have a voice that counts
• We work flexibly

Plus the two recurring themes:

• Morale
• Staff engagement

The results for MWL against the best/worst/average for our comparator group are shown in the chart below: *Scores are out of a scale of 10 with 10 being the best.*

	MWL	**Best Result**	**Average**	**Worst result**	
We are compassionate and inclusive	7.37	7.69	7.21.	6.61	Above Average
We are recognised and rewarded	5.95	6.30	5.92	5.24	Above Average
We each have a voice that counts	6.77	7.14	6.67	5.95	Above Average
We are staff and healthy	6.28	6.53	6.09	5.54	Above Average
We are always learning	5.61	6.09	5.64	4.76	Above Average
We work flexibly	5.98	6.86	6.24	5.60	Above Average
We are a team	6.74	7.12	6.74	6.26	Average
Staff Engagement	6.94	7.39	6.84	5.98	Above Average
Morale	6.08	6.38	5.93	5.13	Above Average

Motivation	7.03	7.33	6.98	6.49	Above Average
Involvement	6.79	7.27	6.83	6.20	Below Average
Advocacy	7.03	7.90	6.70	5.24	Above Average

Staff Engagement is calculated as an average from the scores of the following three sub-themes: motivation, involvement and advocacy. MWL preformed above the national average for all but one sub theme within this sector, involvement,

Results from the NHS Staff Survey have been disseminated to service leads, managers, and subject matter experts. Plans are currently being developed to implement improvements based on the feedback received. Additionally, staff survey team talks, led by the CEO, have been scheduled at each site to engage with staff and discuss the implications of the survey results.

3.8. Equality, Diversity and Inclusion (EDI)

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally underserved groups are not disadvantaged when accessing the services that the Trust provides.

The Trust's EDI Steering Group meets regularly to ensure compliance with all external standards, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and members of the Trust staff networks.

The Trust is a member of the following external charter marks, accreditations and commitments, which are used to further our equality strategy:

- Armed Forces Covenant (re-signed 2023)
- Defence Employer Recognition Scheme (Armed Forces, gold accreditation 2020)
- Disability Confident Scheme, Leader (Level 3, reaccredited 2023)
- Dying to Work Charter (member, 2023)
- NHS Rainbow Badge Accreditation (LGBT) (Bronze, accredited 2022)
- NHS Sexual Safety Charter (member, 2023)
- Veterans Aware (Armed Forces, reaccredited 2023)
- North West region Stroke Voices

The Trust is a member of the North West black, Asian and minority ethnic (BAME) Assembly and is working towards applying for the North West Anti-Racism Framework accreditation.

3.9. Summary of national patient surveys reported in 2024-25

The national patient survey programme is run by the Care Quality Commission to gather feedback on patient feedback on patient experiences in healthcare settings. It aims to identify areas for improvement in care and treatment cross the NHS. The surveys cover various aspects of the patient journey including access to services and treatment experiences.

National Inpatient Survey 2024	Awaiting publication of report-Aug 25
National Maternity Survey 2024	Published November 2024
National cancer patient experience survey 2024	Awaiting publication of report-June 25
National general practice GP patient survey 2024	Published July 2024
National Children and Young Peoples Survey 2024	Awaiting publication of report-May 25
National Urgent and Emergency Care Survey 2024	Published November 2024

The full results for all the latest Care Quality Commission's national patient surveys can be found on their website at www.cqc.org.uk

National Urgent and Emergency Care Survey

The 2024 survey asked people who attended A&E during February 2024 for feedback on their visit. Responses were received from 345 people at MWL.

The Trust performed the same as other organisations with 10 being the highest score:

Section	Score	Compared with other Trust's
Arrival	7.1/10	About the same
Waiting	4.8/10	About the same
Privacy	7.2/10	About the same
Doctors and Nurses	7.2/10	About the same
Care and Treatment	6.7/10	About the same
Tests	7.7/10	About the same
Hospital Environments and facilities	6.3/10	About the same
Support recovery at home	7.0/10	About the same
Leaving A&E	7.1/10	About the same
Respect & Dignity	8.0/10	About the same
Experience overall	6.9/10	About the same

The Trust intends to take the following actions to improve results from the National Urgent and Emergency Care Survey.

- Improve waiting times for patients when they attend the emergency department by ensuring waiting times continue to be escalated and discussed at the bed meetings throughout the day.
- Keep patients up to date with current wait times and are updated of any changes

throughout their time in the department by utilisation of screens to display current wait times.

- Signs in the waiting room explaining how patients can alert staff if they are feeling more unwell or in pain to ensure patients feel they can get help from members of staff with their conditions and symptoms whilst they are waiting.
- With the support of the pharmacy team, introduce the process of providing a standardised patient guidance sheet to accompany new medications dispensed in the ED to ensure patients have the opportunity to ask any questions and have contact number if they have further questions.
- Patients will feel they have enough information to manage their condition at home by reinforcing to all staff via daily safety huddles the requirement for them to ensure robust and detailed discharge discussions are being held, thus allowing patients to ask further questions and give staff the opportunity to provide any relevant information leaflets and contact numbers.
- Patients will feel that they have enough privacy when discussing their conditions with the receptionist by creating a poster that is displayed at reception which informs patients there is a private space available should they wish to request this.
- Patients will have the appropriate health and social care support in place if they are discharged from the ED ensuring all staff complete the discharge checklist which will be monitored monthly via nursing care indicator audits.

National maternity survey 2024

The 2024 NHS Maternity Patient Experience Survey was undertaken between April and Aug 23. 463 women aged 16 or over at the time of delivery who had given birth to a live baby between 1st January and 31st March 2024 at either Whiston, Ormskirk or at home, were invited to give their views and feedback on the antenatal care, labour and birth, postnatal care both in hospital and at home that they received.

170 people completed and returned the survey which was a response rate of 37%. This was lower than the national average of 41%.

As this was the first survey undertaken as MWL there is no direct comparison to previous scoring and therefore the results provide a baseline and for future comparison.

Of the 57 questions asked, MWL scored about the same as other Trusts in 48 questions, 5 questions somewhat worse and 4 questions worse than expected.

The results have been triangulated with other sources of patient feedback and a robust action plan has been developed to address the findings.

The table below details the overall section scores:

Section	Theme	Trust Score	Trust Ratings

Antenatal Care	Start of pregnancy	6.8	About the same
	Antenatal check-ups	7.8	Worse than expected
	During pregnancy	8.0	Worse than expected
	Triage assessment	8.7	About the same
Labour and Birth	Your labour and birth	8.0	About the same
	Staff caring for you	8.1	About the same
Postnatal Care	Care in the ward after birth	6.6	About the same
	Feeding your baby	7.8	About the same
	Care at home after birth	7.7	About the same
Complaints	Complaints	6.4	About the same

The questions which scored somewhat worse than expected were:

Question	Trust Score	National Average
B6. During your antenatal check-ups, did your midwives or doctors appear to be aware of your medical history?	6.1	7.0
B8. During your check-ups did your midwives listen to you?	8.6	9.1
B13. Thinking about your antenatal care, were you involved in decisions about your care?	8.4	8.9
B15. Did you have trust and confidence in the staff caring for you during antenatal care?	7.7	8.3
C16. Thinking about your labour and birth, were you involved in decisions about your care?	8.0	8.5

The questions which scored worse than expected were:

Question	Trust Score	National Average
B4. Did you get enough information from either a midwife or a doctor to help you decide where to have your baby?	5.5	6.8
B7. During your antenatal check-ups were you given enough time to ask questions or discuss your pregnancy?	8.1	8.9
B17. If you raised a concern during your antenatal care, did you think it was taken seriously?	7.7	8.8
B18. Thinking about your antenatal care, were you given information about any warning signs to look out for during your pregnancy?	7.7	8.6

The Trust intends to take the following actions to improve results from the National Maternity Survey:

- Procurement of reclining chairs on Whiston site to facilitate comfortable stay to improving feedback on partners or someone else close to the patient involved in their care being able to stay with them as much as the patient wanted.
- Review of birth choices leaflet and Trust website to ensure patients get enough information from either a midwife or doctor to help decide where to deliver.
- Develop communication guidance to support midwives and doctor's conversations to be used at the end of each contact to specifically ask if there are any concerns / issues that remain unaddressed or require more clarity.
- Implement a new clinical system and full digitisation to enable easier and complete digital access to health records by all staff to ensure that during antenatal check-ups patients felt midwives or doctors appear to be aware of their medical history.
- Introduce antenatal education session which promotes use of BRAIN tool regarding shared decision making throughout pregnancy, birth and the postnatal period.

National general practice (GP) patient survey

Marshalls Cross Medical Centre participates in the national GP patient survey each year. In 2024, 126 surveys were returned from a total of 419 resulting in a response rate of 30%.

Question	Marshalls Cross	National Results
-find it easy to get through to this GP practice by phone	35%	50%
-find it easy to contact this GP practice using their website	54%	48%
-find it easy to contact this GP practice using the NHS App	35%	45%
-find the reception and administrative team at this GP practice helpful	70%	83%
-usually get to see or speak to their preferred healthcare professional when they would like to	22%	40%
-were offered a choice of time or day when they last tried to make a general practice appointment	25%	53%
-were offered a choice of location when they last tried to make a general practice appointment	15%	13%
-felt they waited about the right amount of time for their last general practice appointment	53%	66%
-say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment	80%	87%

-say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment	81%	85%

An improvement plan has been developed with GPs to address the identified areas of concern, actions include:

- **Review Appointment Scheduling:** Implement a new scheduling system to improve appointment availability and reduce waiting times. Increase the number of same-day appointments available by additional overflow phone for appointments.
- **Improve Telephone Access:** The practice telephone system FINESSE (call Waiting) and it give comfort message, and que number. The practice has 3 Patient Care Advisers (call handles) to handle multiple queries, and appointment for booking on the day and advance bookings.
- **Staff Training:** Provide additional training for staff on effective communication skills and the importance of clear information sharing. Staff receive monthly training on patient engagement techniques.
- **Patient Information:** Revise and update patient information to ensure they are clear, comprehensive, and easy to understand. Staff will collate information in both digital and physical formats as requested.
- **Patient Involvement:** Multidisciplinary team approach to involve patients in their care decisions. GPs and Mult professional gather patient input and preferences regarding their treatment plans and discuss, their patient centre care.
- **Monitoring and Feedback:** Establish a system for ongoing monitoring of patient satisfaction and the quality of care provided. Regularly reviews of feedback, Friend and Family is shared monthly with the GPs and lesson learned to ensure that issues are addressed promptly.
- **Reporting:** Provide quarterly updates on the progress of the action plan to ensure transparency and accountability. Share these updates with Patients Experience and stakeholders.

3.10. 5 Star Accreditation Programme

NHS England recommend that locally driven ward/unit accreditation approaches bring together key measures into a single overarching framework. These programmes incorporate a set of standards so that areas for improvement can be identified as well as areas of excellence celebrated. From their experience these programmes can drive continuous improvement in outcomes, satisfaction and staff experience.

During this year we have created a new robust MWL accreditation programme. The programme utilises our existing audit tool, Tendable, which allows electronic data/results to be collected as well as photos & comments to be provided by the accreditation team.

Each of the 16 standards would focus on a key theme and would cover key quality elements of care – Documentation, Environmental Observations, Patient Questions/Experience, Staff Questions / Knowledge and Ward Manager Questions / Leadership.

An additional benefit of the programme is to help prepare the wards/clinical areas for a CQC visit. The process sets ambitious but realistic goals thus taking wards/departments on a quality improvement journey. The accreditation framework has the following benefits:

- Targets setting consistent expectations of patient care delivery across the Trust
- Provides strong focus to the leadership team
- Strengthens leadership
- Improves quality
- Reduces avoidable harm
- Improves patient experience
- Provides evidence compliance against regulatory standards thus improving CQC ratings
- Improves clinical efficiency and effectiveness
- Shares good practice
- Team building

The ward/department accreditation framework provides ward to Board assurance of quality and safety standards, highlighting performance across the five CQC key questions and the Trust's 5 star vision, celebrating success and providing a platform for continuous improvement strategies.

Since launching the programme in June 2024, we have seen steady improvements across wards, as each accreditation is repeated (repeat timeframe dependent on final result). From 1st assessments to second assessments, it is clear to see the shift from Aspiring to 3,4 or 5 star awards.

Following assessments clinical areas are provided with action trackers to develop and monitor their own improvement plans, these are monitored within the divisions. We also have created an accreditation dashboard so themes can be identified of good practice and areas requiring improvement across all standards (also aligned to the CQC domains of safe, effective, caring, well led and responsive). This provides assurance to board that results are being monitored and acted upon.

In January 2025 the Mersey Internal Audit Agency (MIAA) audited the MWL Accreditation Programme. From their report we received 'High Assurance' (the highest level possible) which shows:

'*There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed'.*

Appendix 1

National Clinical Audits

NHS England Quality Accounts List 2024-25. The table below lists the National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2024-25.

Number	Project Name	MWL Status
1	BAUS Penile Fracture Audit	Participating
2	BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Participating
3	BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Participating
4	Breast and Cosmetic Implant Registry	Participating
5	British Hernia Society Registry	Delayed national launch, aiming to participate
6	Case Mix Programme (CMP) - Intensive Care National Audit & Research Centre (ICNARC)	Participating
7	Child Health Clinical Outcome Review Programme	Participating
8	Cleft Registry and Audit NEtwork (CRANE) Database	Not applicable
9	RCEM - Adolescent Mental Health	Participating
10	RCEM - Care of Older People	Participating
11	RCEM - Time Critical Medications	Participating
12	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Participating
13	Fracture Liaison Service Database (FLS-DB	No service, not applicable
14	National Audit of Inpatient Falls (NAIF)	Participating
15	National Hip Fracture Database (NHFD)	Participating
16	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Participating
17	Maternal, Newborn and Infant Clinical Outcome Review Programme1	Participating
18	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Participating
19	Mental Health Clinical Outcome Review Programme	Not Applicable
20	National Diabetes Core Audit	Participating
21	Diabetes Prevention Programme (DPP) Audit	Not applicable
22	National Diabetes Footcare Audit (NDFA)	Participating
23	National Diabetes Inpatient Safety Audit (NDISA)	Participating
24	National Pregnancy in Diabetes Audit (NPID)	Participating

25	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Participating
26	Gestational Diabetes Audit	Participating
27	National Audit of Cardiac Rehabilitation	Participating
28	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	Not applicable
29	National Audit of Care at the End of Life (NACEL)	Participating
30	National Audit of Dementia (NAD)	Participating
31	National Bariatric Surgery Registry	Participating
32	National Audit of Metastatic Breast Cancer (NAoMe)	Participating
33	National Audit of Primary Breast Cancer (NAoPri)	Participating
34	National Bowel Cancer Audit (NBOCA)	Participating
35	National Kidney Cancer Audit (NKCA)	Participating
36	National Lung Cancer Audit (NLCA)	Participating
37	National Non-Hodgkin Lymphoma Audit (NNHLA)	Participating
38	National Oesophago-Gastric Cancer Audit (NOGCA)	Participating
39	National Ovarian Cancer Audit (NOCA)1	Participating
40	National Pancreatic Cancer Audit (NPaCA)	Participating
41	National Prostate Cancer Audit (NPCA)	Participating
42	National Cardiac Arrest Audit (NCAA)	Participating
43	National Adult Cardiac Surgery Audit (NACSA)	Not applicable
44	National Congenital Heart Disease Audit (NCHDA)	Not applicable
45	National Heart Failure Audit (NHFA)	Participating S&O sites behind with data collection
46	National Audit of Cardiac Rhythm Management (CRM)	Not applicable
47	Myocardial Ischaemia National Audit Project (MINAP)	Participating S&O sites behind with data collection
48	National Audit of Percutaneous Coronary Intervention (NAPCI)	Not applicable
49	National Audit of Mitral Valve Leaflet Repairs (MVLR)	Not applicable
50	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Not applicable
51	Left Atrial Appendage Occlusion (LAAO) Registry	Not applicable
52	Patent Foramen Ovale Closure (PFOC) Registry	Not applicable
53	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Not applicable
54	National Child Mortality Database (NCMD)	Participating
55	National Clinical Audit of Psychosis (NCAP)	Not applicable
56	National Comparative Audit of NICE Quality Standard QS138	Participating
57	National Comparative Audit of Bedside Transfusion Practice	Participating
58	National Early Inflammatory Arthritis Audit (NEIAA)	Participating

59	National Emergency Laparotomy Audit (NELA)	Participating
60	National Joint Registry	Participating
61	National Major Trauma Registry [Note: Previously TARN. To commence data collection in 2024]	Participating
62	National Maternity and Perinatal Audit (NMPA)	Participating
63	National Neonatal Audit Programme (NNAP)	Participating
64	National Obesity Audit (NOA)	Participating
65	Age-related Macular Degeneration Audit - National Ophthalmology Database (NOD):	Participating
66	Cataract Audit - National Ophthalmology Database (NOD):	Participating
67	National Paediatric Diabetes Audit (NPDA)	Participating
68	National Perinatal Mortality Review Tool	Participating
69	National Pulmonary Hypertension Audit	Not Applicable
70	COPD Secondary Care	Participating
71	Pulmonary Rehabilitation	Participating
72	Adult Asthma Secondary Care	Participating
73	Children and Young People's Asthma Secondary Care	Participating
74	National Vascular Registry (NVR)	Participating
75	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Not applicable
76	Paediatric Intensive Care Audit Network (PICANet)	Not applicable
77	Perioperative Quality Improvement Programme	Not participating
78	Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour (POMH)	Not applicable
79	The use of melatonin (POMH)	Not applicable
80	The use of opioids in mental health services (POMH)	Not applicable
81	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	Not applicable
82	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	Not applicable
83	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	Not applicable
84	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	Participating
85	Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	Participating
86	Sentinel Stroke National Audit Programme (SSNAP)	Participating
87	Serious Hazards of Transfusion (SHOT)	Participating
88	Society for Acute Medicine Benchmarking Audit (SAMBA)	Participating
89	UK Cystic Firbrosis Registry	Participating
90	UK Renal Registry Chronic Kidney Disease Audit	Not applicable
91	UK Renal Registry National Acute Kidney Injury Audit	Not applicable

Annex A
Statement of directors' responsibilities in respect of the Quality Account

Annex B
Written statements by other bodies

Annex C
Amendments made to the Quality Account following feedback and written statements from other bodies

The following amendments were made following feedback from other bodies:

Annex D
Abbreviations

ADR	Adverse drug reaction
AHPs	Allied Health Professionals
AI	Artificial intelligence
AIS	Accessible Information Standard
AKI	Acute kidney injury
AMU	Acute Medical Unit
ANC	Ante-natal Clinic
ANTT	Aseptic non-touch technique
App	Application
AQ	Advancing Quality
AMaT	Audit Management and Tracking (computer package)
ARC NWC	Applied Research Collaboration North West Coast
BAME	Black, Asian and minority ethnic
BAUS	British Association of Urological Surgeons

BJP	Bence Jones Protein
BP	Blood pressure
BRAIN	Benefits, Risks, Alternatives, Intuition and Nothing – tool used during pregnancy to help parents get the information they need to make decisions about their care providers during pregnancy, birth and postpartum.
BSI	Blood stream infection
BSL	British Sign Language
BSPED	British Society for Paediatric Endocrinology and Diabetes
BTS	British Thoracic Society
CCS	Clinical Classifications Service
CD	Controlled drugs
C. difficile	Clostridioides difficile infection
CGM	Continuous glucose monitoring
CHPPD	Care hours per patient per day
CMAST	Cheshire and Merseyside Acute and Specialist Trust provider collaborative
CMP	Case mix programme
COO	Chief Operating Officer
COPD	Chronic obstructive airways disease
CPD	Continuing professional development
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQuIN	Commissioning for quality and innovation
CRAB	Copeland risk adjusted barometer
CRB	Cervical ripening balloon
CRN NWC	Clinical Research Network, North West Coast
CSP	Cervical Screening Programme
CT	Computerised tomography
CTG	Cardiotocography
CYP	Children and young people
Datix	Integrated risk management, incident reporting, complaints management system
DIEP	Deep inferior epigastric perforators
DIPC	Director of Infection Prevention and Control
DLQI	Dermatology Life Quality Index
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation
DoN	Director of Nursing
DQMI	Data quality maturity index
DRC	Deafness Resource Centre
DrEaM	Drink, eat and mobilise
DSPT	Data Security and Protection Toolkit
DVT	Deep vein thrombosis
EASI	Eczema Area and Severity Index
ED	Emergency Department
EDI	Equality, diversity and inclusion

EDS or EDS2	Equality Delivery System
EMIS	Egton Medical Information System
ENT	Ear, nose and throat
ePMA	Electronic prescribing and medicines administration
EPR	Electronic patient record
ESR	Electronic staff record
eVTE	Electronic venous thromboembolism (recording)
FBC	Full blood count
FDA	Food and Drug Administration
FDS	Faster diagnosis standard
FFT	Friends & Family Test
FGR	Fetal Growth Restriction
FRAX	Fracture Risk Assessment Tool
FTSU	Freedom to speak up
GAP	Growth assessment protocol
GAP SCORE	Growth assessment protocol standardised case outcome review and evaluation
GI	Gastrointestinal
GIRFT	Get it right first time
GP	General Practitioner
HASU	Hyper-Acute Stroke Unit
HAT	Hospital-acquired or hospital-associated thrombosis
HbA1c	Haemoglobin A1c - average blood glucose (sugar) levels for the last two to three months
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HCSW	Healthcare Support Worker
HES	Hospital Episode Statistics
HHS	Hyperosmolar Hyperglycaemic State
HPMA	Healthcare People Management Association
HR	Human Resources
HS	Hidradenitis Suppuritiva
HWWB	Health, Work and Well-being
IBD	Inflammatory bowel disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner’s Office
ICB	Integrated Care Board
ICCR	Individual care and communication record
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
ICS	Integrated Care System
IG	Information governance
IMCA	Independent mental capacity advocate
IPC	Infection prevention and control
IT	Information technology
IV	Intravenous
JAK	Janus Kinase

JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
LAC	Looked after children
LeDeR	Learning disability mortality review
LFPSE	Learn from Patient Safety Events
LGA	Large for gestational age
LGBT	Lesbian, gay, bisexual, transgender
LGBTQIA+	Lesbian, gay, bisexual, transgender, questioning, intersex, asexual
LocSSIPs	Local safety standards for invasive procedures
MBRRACE-UK	Mothers and babies - reducing risk through audits and confidential enquiries across the UK
MDT	Multi-disciplinary team
MINAP	Myocardial infarction national audit programme
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant staphylococcus aureus
MRSAb	Methicillin-resistant staphylococcus aureus bacteraemia
MWL	Mersey and West Lancashire Teaching Hospitals NHS Trust
NACAP	National asthma and COPD audit programme
NACEL	National audit of care at the end of life
NAOGC	National audit oesophago-gastric cancer
NatSSIPs	National safety standards for invasive procedures
NBOCA	National bowel cancer audit
NCAA	National cardiac arrest audit
NCAP	National cardiac arrest programme
NCCQ	National clinical coding qualification
NCEPOD	National confidential enquiry into patient outcome and death
NCPES	National cancer patient experience survey
NDA	National diabetes audit
NELA	National emergency laparotomy audit
NEWS	National early warning score
NG	Nasogastric
NHS	National Health Service
NHSE	National Health Service England
NHSP	NHS Professionals
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National joint registry
NLCA	National lung cancer audit
NMPA	National maternity and perinatal audit
NMTR	National Major Trauma Registry (formerly TARN)
NNAP	National neonatal audit programme
NOD	National ophthalmology audit
NPCA	National prostate cancer audit
NPDA	National paediatric diabetes audit
NRLS	National Reporting & Learning System
NVR	National Vascular Registry

OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OH	Occupational Health
OPCS	Office of Population, Census and Statistics Classification of Interventions and Procedures
OSCE	Objective structured clinical examination
OT	Occupational Therapist/Therapy
P2, P3, P4	Priority 2, 3, 4
PALS	Patient Advice and Liaison Service
PACS	Picture archiving and communication system
PAS	Patient administration system
PCC	Prothrombin complex concentrate
PCI	Percutaneous coronary intervention
PE	Pulmonary embolus
PIR	Post infection review
PLACE	Patient-led assessments of the care environment
PMRT	Perinatal mortality review tool
PRES	Participant in research experience survey
PROMs	Patient reported outcome measures
PSII	Patient safety incident investigation
PSIRF	Patient Safety Incident Response Framework
QI	Quality improvement
QICA	Quality Improvement and Clinical Audit
RAG	Red, amber, green
RCEM	Royal College of Emergency Medicine
RDI	Research, development and innovation
RDIG	Research, Development and Innovation Group
RCOG	Royal College of Obstetricians and Gynaecologists
RLC	Rugby League Cares
RN	Registered Nurse
RNDA	Registered Nurse Degree Apprenticeship
RTT	Recruiting to time and target
RSV	Respiratory syncytial virus
SAG	Safeguarding Assurance Group
SAMBA	Society for Acute Medicine (SAM) benchmarking audit
SAU	Surgical Assessment Unit
SBAR	Situation, background, assessment, recommendation
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SFLC	Serum free light chains
SHMI	Summary hospital-level mortality indicator
SHOT	Serious hazards of transfusion
SIRO	Senior Information Risk Owner
SJR	Structured judgement review
S&O	Southport and Ormskirk Hospital NHS Trust
SOP	Standard operating procedure
SSI	Surgical site infection

SSNAP	Sentinel stroke national audit programme
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TAR	Transfusion authorisation record
TAT	Thrombin-Antithrobin Complex
TIA	Transient ischaemic attack
TILIA	Tozorakimab in Patients Hospitalised for Viral Lung Infection Requiring Supplemental Oxygen
TNA	Trainee nursing associate
TTO	To take out
TURBT	Transurethral resection of bladder tumour
TURP	Transurethral resection of prostate
uDNACPR	Unified do not attempt cardiopulmonary resuscitation
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
UK	United Kingdom
VBAC	Vaginal birth after caesarean
VIP	Visual infusion phlebitis
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WHO	World Health Organisation
WRES	Workforce Race Equality Standard

Annex E

Contact details

Additional information about the Trust is available on the website: www.merseywestlancs.nhs.uk

If you have any queries relating to this Quality Account please direct them to the following email: lynne.barnes@merseywestlancs.nhs.uk

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	28 May 2025
Agenda Item	**TB25/045**				
Report Title	Meeting Effectiveness Reviews				
Executive Lead	Nicola Bunce, Director of Corporate Services				
Presenting Officer	Nicola Bunce, Director of Corporate Services				
Action Required	X	**To Approve**		**To Note**	

Purpose

To seek the Board's approval for the revised Board and Committee Terms of Reference (ToR) that reflect the outcomes of the 2024/25 Board and Committee effectiveness review process.

Executive Summary

1. The annual effectiveness review of the Board and its Committees has been undertaken, reflecting the meetings that took place in 2024/25.
2. The detailed review of each Committee has been shared with the Committee Chair and or will be reported at its next scheduled meeting.
3. A summary of the findings of each review will be reported to the Audit Committee.
4. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remain fit for purpose and provides the assurance that the Trust is effectively and appropriately managed. This evidence supports the development of the Annual Governance Statement.
5. The final part of this review is the issuing of revised ToR incorporating any agreed changes from the reviews (in red text).

The changes ensure that as a whole, the Board governance structure remains comprehensive and there are clear lines of accountability.

Financial Implications

None directly because of this report

Quality and/or Equality Impact

Not applicable

Recommendations

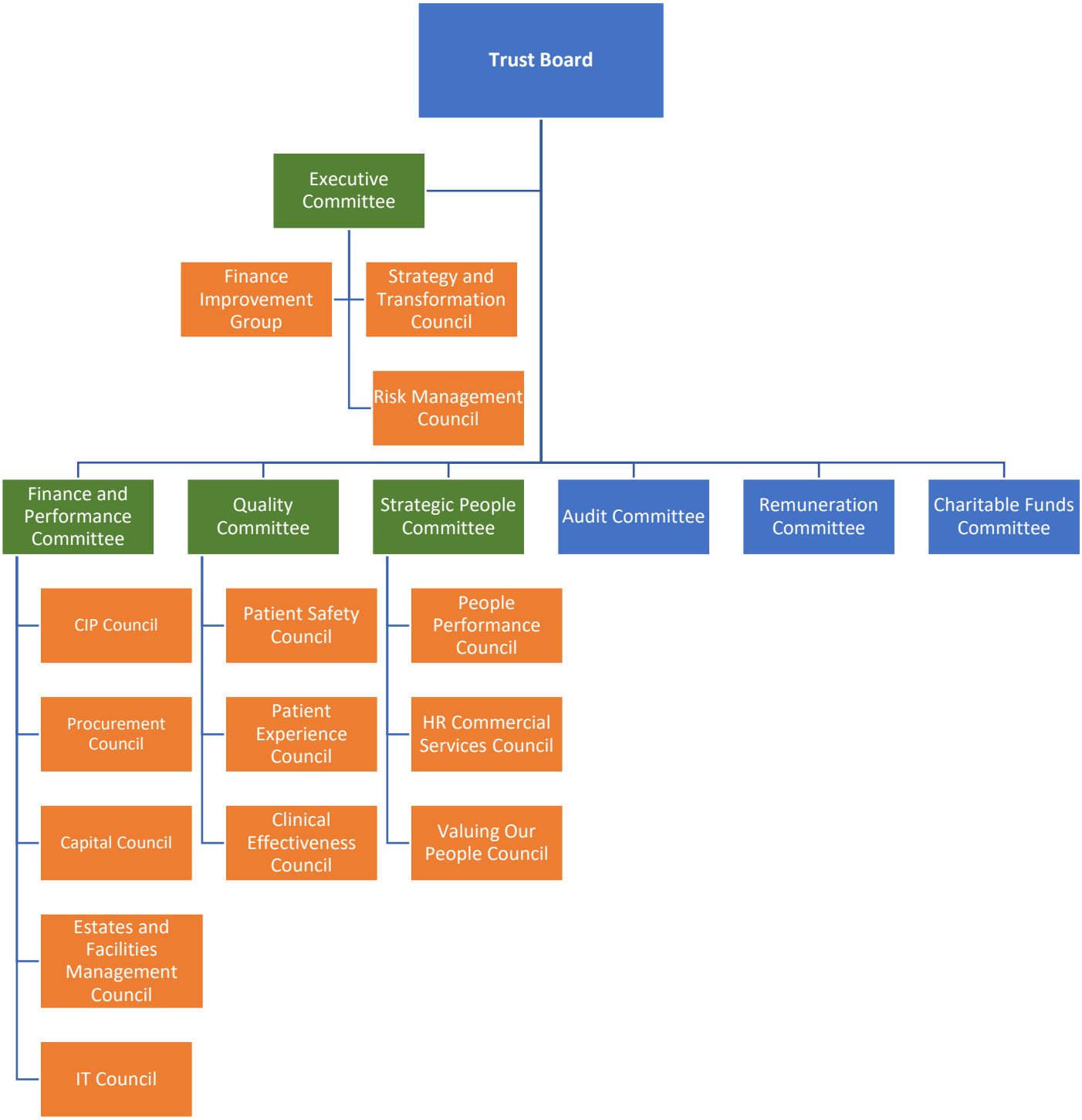
The Board is requested to approve the updated Terms of Reference.

Strategic Objectives

	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance

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

GOVERNANCE STRUCTURE 2025/26



COMMITTEE TERMS OF REFERENCE 2024/25

TRUST BOARD – Terms of Reference (2025/26) – Proposed	
Authority	Mersey and West Lancashire Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 1990/2446) amended by SI 1999/632 and SI 2023/711(the Establishment Order). The principal place of business of the Trust is the address as per the establishment order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Strategic People Committee vi) Charitable Funds Committee vii) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance, and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman a minimum of ten days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should

	include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	Each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Terms of Reference.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) Six Non-Executive Directors (one of which will be appointed Vice Chair) Chief Executive Four Executive Directors (to include ~~Director of Finance, Medical Director, Nursing Director~~ Chief Finance Officer, Chief Medical Officer, Chief Nursing Officer, plus one other, which is the Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility

	for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. <u>In attendance</u> The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

AUDIT COMMITTEE – Terms of Reference (2025/26) – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations clinical and non-clinical activities that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u> 1. In particular the Committee will review the adequacy of: • All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. • The structures, processes and responsibilities for identifying and managing key risks facing the organisation. • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. • The operational effectiveness of policies and procedures via internal audit reviews. • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Agency (NHSCFA) 2. The Committee will: • Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews); • Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity. • Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility. • Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

	• Request assurance of the delivery of the annual trust objectives aligned to the Committee. <u>Internal Audit</u> 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <u>External Audit</u> 6. Make recommendations to the Trust Board about the appointment and independence of the External Auditor. 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community. 9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account in line with DHSC guidance. 11. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-statutory audit work including the pre-approval by the Audit Committee's Auditor Panel for this work. <u>Financial Reporting and Governance</u> 12. Approve the Annual Report and Accounts on behalf of the Trust Board, when the audit timetable does not allow for the Annual Report and Accounts to be approved at a scheduled Trust Board meeting. When approving the Annual Report and Accounts the Audit Committee should focus particularly on: • The Annual Governance Statement; • Changes in, and compliance with, accounting policies and practices; • Unadjusted mis-statements in the Financial Statements; • Letters of representation; • Major judgemental areas, and; • Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board.

	15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.
Membership	Core Members The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members, one of whom will be the committee chair (who will be a qualified accountant or have a finance background). In attendance The Chief Finance Officer ~~Director of Finance~~, the Director of Corporate Services, the Head of Internal Audit, and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to attend the Audit Committee to discuss the Annual Governance Statement and Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: • Ensure that they read papers prior to meetings, • Attend as many meetings as possible, • Contribute fully to discussion and decision-making, • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	A quorum shall be two members.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.
Meeting Frequency	Meetings shall be held not less than three, but usually four to five times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Committee should be in line with the corporate standard.

REMUNERATION COMMITTEE – Terms of Reference (2025/26) - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Remuneration Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised to make recommendations to the Trust Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Directors and Associate Directors with due regard to market rates, NHS guidance, affordability, and equal value.
Duties	The Committee will undertake the following duties: 1. To receive and consider information and advice from the Chief Executive on the levels of remuneration for individual Directors taking into account internal relativities, the particular contribution and value of individual Directors and affordability. 2. To consider the level of remuneration for the Chief Executive taking into account the above factors. 3. To receive and consider external information on the wider pay scene including: - Guidance on Executive remuneration from the Department of Health or NHS England. - The levels of Executive remuneration offered by similar NHS organisations. - Consideration of the environment in which the organisation is operating. 4. To advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate including the approval process for: - Redundancy payments made to Chief Executives and Directors. - Redundancy payments in excess of £50,000 made to all other staff. - Special payments, i.e. any severance payments exceeding contractual obligations (or exceeding 3-months pay in lieu of notice). 5. Ratify the appointment of new Directors and approve the remuneration and terms of service if outside the parameters agreed for previous appointments to the role. 6. Approve novel or potentially contentious changes to the pay or terms and conditions of other staff working for the Trust
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core Members Membership will comprise the Chairman and all Non-Executive Directors. In attendance The Chief Executive (except during discussions about his /her remuneration or terms of service) shall normally attend meetings. ~~The Director of Human Resources shall be Secretary to the Committee and shall attend to take minutes of the meeting.~~

	The Chairman may co-opt other members, such as the Director of Finance, as appropriate, in order to assist the Committee in meeting its objectives.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Remuneration Committee would be considered quorate when the Trust Chair or Deputy Chair plus 3 Non-Executive Directors are in attendance.
Accountability & Reporting	The Remuneration Committee is a Non-Executive function and its decisions must be agreed by a majority of the Non-Executive Directors and reported in accordance with the Trust's publication scheme, via the annual report and accounts.
Meeting Frequency	The Committee will meet at least once a year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The ~~Director of Human Resources~~ Director of Corporate Services (Company Secretary) will be responsible for all administrative arrangements.

QUALITY COMMITTEE – Terms of Reference (2025/26) – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients. In establishing the Committee, the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance. The Committee is authorised by the Board to commission independent professional or legal advice within the delegated authority of the ~~Director of Nursing Midwifery and Governance or the Medical Director~~ Chief Nursing Officer or the Chief Medical Officer.
Role	The Committee shall review all aspects of clinical quality, including patient experience, patient safety and clinical effectiveness and provide assurance to the Trust Board that the Trust is delivering high quality safe care to patients.
Duties	The Committee's role is to: 1. Provide assurance on clinical quality, including triangulating relevant information and ensuring an effective framework in place for learning lessons and acting on feedback from incidents, complaints, claims, patient, and staff feedback. 2. Provide assurance that appropriate quality governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance, national patient surveys) and assessing the Trust's performance against each. 3. Provide assurance to the Board on the delivery of the Trust's Clinical Strategy, based on the Trust's vision for 5-star patient care. 4. Provide assurance to the Board of compliance with regulatory standards and guidelines, including compliance with NICE. 5. Monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances. 6. To recommend measures of success /targets in relation to new quality improvement initiatives so that the Board can monitor outcomes. 7. Identify areas for action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board.

<table>
<tr><td></td><td>8. Request assurance of the delivery of the annual trust objectives aligned to the Committee.
9. Review the final draft Annual Quality Account prior to submission to the Board for approval.
10. Gain assurance that the reporting councils are approving the policies and procedures for which they are responsible, in line with the Trust Procedural Documents development and Management Policy.
11. Approve any policies and procedures that are aligned to the Quality Committee and if necessary, make recommendation to the Board, in line with the Trust Procedural Document Development and Management Policy.
12. Agree the ToR and the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately.
~~13.~~ Receive assurance reports from the Council chairs following each meeting of the Councils and to request in-depth reviews where performance is below the expected levels.
14. Receive assurance that effective safeguarding arrangements are in place.
15. Receive assurance that high quality maternity services are delivered, for example confirmation and approval of the CNST MIS submission to the Board.
16. Receive annual reports on behalf of the Board, e.g., complaints, infection prevention control, safeguarding, medicines management, patient engagement strategy, the clinical audit and clinical research programmes.
17. Receive assurance that the appropriate quality and equality impact assessments of proposed service developments or service changes are being undertaken.
18. Undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils.
19. Escalate any issues or concern or newly identified risks relating to quality to the Board.</td></tr>
<tr><td>Review</td><td>Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.</td></tr>
<tr><td>Membership</td><td>Core Members
<table>
<tr><th>No</th><th>Title</th><th>Named Deputy (if app)</th></tr>
<tr><td>1.</td><td>Non-Executive Director (chair)</td><td>n/a</td></tr>
<tr><td>2.</td><td>Non-Executive Directors x 2</td><td>n/a</td></tr>
<tr><td>3.</td><td>Chief Executive</td><td>n/a</td></tr>
<tr><td>4.</td><td>Deputy Chief Executive</td><td>n/a</td></tr>
<tr><td>5.</td><td>~~Director of HR~~ Chief People Officer</td><td>Deputy Director of HR</td></tr>
<tr><td>6.</td><td>~~Director of Finance~~ Chief Finance Officer</td><td>Deputy Director of Finance</td></tr>
<tr><td>7.</td><td>~~Medical Director~~ Chief Medical Officer</td><td>Deputy Medical Director</td></tr>
</table></td></tr>
</table>

	8.	Chief Nurse ~~Director of Nursing, Midwifery and Governance~~	Deputy Director of Nursing and Quality
	9.	~~Managing Director~~	~~Chief Operating Officer or Divisional Director of Operations~~
	10.	Chief Operating Officer	Divisional Director of Operations
	11.	Director of Corporate Services	Corporate Governance Manager

~~*The CEO can attend any meeting of the committee, but it is recognised that responsibilities in relation to Cheshire and Merseyside ICS/CMAST do not allow regular attendance.~~

Core members should ensure that if they are unable to attend a meeting, a fully briefed deputy is appointed and attends in their place.

Requested attendees.
In addition to core members the committee shall be able to require the attendance of any other member of staff, to present reports, including the Chief Pharmacist, Divisional Directors of Nursing/Midwifery, Head of Safeguarding, Infection Prevention Control lead, Deputy Director of Nursing and member of the Corporate Nursing Team including Council Chairs (where this is not the ~~Director of Nursing or Medical Director~~ Chief Nursing Officer of Chief Medical Officer).

A log of all members and supporting staff names and titles (and where external members, email addresses) are to be recorded on the Group's membership and circulation list. This list is to be reviewed and/or updated every financial year in accordance with the terms of reference review.

Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: • Ensure that they read papers prior to meetings, • Attend as many meetings as possible, • Contribute fully to discussion and decision-making, • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress. A record of attendance will be maintained throughout each financial year
Quorum	A quorum shall be 50% of core members including at least two Non-Executive Members (including the Chair).
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Quality Committee Chair. The Committee should undertake regular effectiveness reviews, including reviews of the terms of reference and annual workplan.

	Meeting effectiveness will be a standing agenda item.
Meeting Frequency	The Committee will meet monthly each year, except August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the ~~Director of Nursing, Midwifery and Governance~~. Chief Nursing Officer. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference (2025/26) - Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance & Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In establishing the Committee, the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives and maintain the Trust as a going concern. To contribute to the overall governance framework and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties: - 1. To review and make recommendations to the Board on the annual financial and business/activity plan and the assumptions which underpin it and review the Trust's longer-term financial and operational strategies to be able to make recommendations to the Board. 2. To monitor the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Committee Performance Report (CPR) including against national and contractual waiting time and access standards. To make recommendations to the Board on key risks, and actions and recovery plans to ensure the Trust performs to the optimum level and operates within the resources available. 3. To oversee the Trust's commercial services activity and the decision-making underpinning service developments and market strategy, including for the Informatics shared services ~~MMDA~~, Payroll, Lead Employer. 4. To monitor the effectiveness and delivery of the Trust Information and digital strategy annual work programme. 5. To review proposed Cost Improvement Programme (CIP) and to monitor implementation and report, to the Board, proposals for corrective actions if required. 6. To monitor the financial and non-financial benefits realisation from approved business cases to provide assurance of a return on investment.

	7. To approve policies and procedures in respect of finance and performance and if necessary, make recommendations to the Board. 8. To receive reports on the impact and efficacy of finance policies and controls to deliver the agreed financial plans and provide assurance to the Board. 9. Based on forecast resources available, to plan the five-year rolling capital programme and in year delivery of the agreed capital programme 10. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability, escalating any concerns to the Board. 11. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 12. To review the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately. 13. To receive assurance reports from the reporting Council chairs following each meeting of the Procurement, CIP, Capital Planning, Estates and Facilities Management and IT councils and to request in-depth internal reviews, commission independent reports where necessary or make recommendations to the audit committee. 14. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils. 15. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external benchmarking reports (including Model Hospital, GIRFT, ERIC, Corporate services benchmarking and report recommendations) and seek assurance on the action being taken where the Trust is an outlier. 16. Monitor delivery of the Trusts annual objectives where the assurance route is via the committee.
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	Core Members Non-Executive Director (chair) Non-Executive Director x 2 Chief Executive Chief Financial Officer ~~Director of Finance & Information~~ Deputy Chief Executive Chief People Officer ~~Director of HR~~ ~~Managing Director~~ Chief Medical Officer ~~Medical Director or Director of Nursing Midwifery and Governance~~

	Chief Operating Officer Director of Corporate Services Director of Informatics ~~The CEO can attend any meeting of the committee, but it is recognised that responsibilities in relation to Cheshire and Merseyside ICS/CMAST do not allow regular attendance.~~ The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. <u>In attendance -</u> In addition to core members the Deputy Director of Finance, Assistant Director(s) of Finance and nominated Divisional Directors of Operations may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result, members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two ~~one~~ Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in accordance with the annual work plan and reporting schedule of the Committee. Meeting administration, minute production and distribution are ~~is~~ via the office of the Chief Finance Officer ~~Director of Finance and Information~~. Documents submitted to the Committee should be in line with the corporate standard.

STRATEGIC PEOPLE COMMITTEE – Terms of Reference 2025/26 – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as Strategic People Committee which will formally be constituted as a Committee of the Trust Board. The Committee shall provide assurance to the Trust Board on all matters pertaining to the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, education and training, employee health and wellbeing, learning and development, employee engagement, organisational development, leadership, workforce development, workforce planning and culture, diversity, and inclusion. In establishing the Committee, the Trust Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Trust Board level significance it is to be reported to the Trust Board for approval before action. The Trust Board may request the Committee to review specific aspects of workforce performance where the Board requires additional scrutiny and assurance.
Role	The Committee will provide assurance to the Trust Board of the achievement of the Trust's strategic and operational objectives and specifically the Trust's People Strategy. To enable the Board to obtain assurance that high standards of workforce and people practices and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on all workforce issues. 2. Identify, prioritise, and monitor risk arising from workforce and people policies and practice. 3. Ensure the effective and efficient use of resources through benchmarking and evidence-based practice. 4. Protect the health and safety and wellbeing of Trust employees. 5. Ensure compliance with legal, regulatory, and other obligations. The Committee has established a Valuing our People Council, People Performance Council and the HR Commercial Services Council and may recommend additional Councils aligned to key areas of its activity as it deems appropriate. Triangulation with other committees of the Board to ensure themes are identified and actions are progressed to support the development of the people agenda and delivery of high-quality services.

Duties	The Committee will undertake the following duties: - 1. Consider and recommend to the Board, the Trust's overarching People Strategy and associated action/implementation plans. 2. Obtain assurance of the delivery of the People Strategy through the associated action/implementation plans. 3. Consider and recommend to the Board the key people and workforce performance metrics and improvement targets for the Trust. 4. Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. 5. Review the people and workforce risks on the corporate risk register and the risks relating to HR/Workforce as detailed on the Board Assurance Framework (BAF). 6. Receive reports in relation to internal and external quality and performance targets relating to people and workforce and associated activity/implementation plans. 7. Conduct reviews and analysis of strategic people and workforce issues and to recommend the Board level response. 8. Review and make recommendations to the Board in respect of regulatory and statutory workforce publications and returns, such as: • Annual Gender/BAME/Disability Pay Gap • Freedom to Speak Out declarations • The annual staff survey • WDES/WRES//MWRES/Bank WRES/PSED • Workforce planning
Review	The Committee will undertake an annual meeting effectiveness review. Part of this process will include a review of the Committee Terms of Reference.
Membership	**Core Members** • Non-Executive Director (chair) • Non-Executive Directors x 2 • Chief Executive • Deputy CEO • ~~Director of Human Resources~~ Chief People Officer • ~~Director of Nursing, Midwifery and Governance~~ Chief Nursing Officer • ~~Managing Director~~ • Chief Operating Officer • ~~Director of Finance & Information~~ Chief Finance Officer • Director of Corporate Services **Other Members**

	Deputy Director of HR x 2 (by invitation as per agenda) The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. **In Attendance** In addition to core members, other officers of the Trust may be co-opted or requested to attend as considered appropriate may be asked to attend all or part of the meetings to present on specific issues. Members are selected for their specific role or because they are representative of a function of service. As a result, members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet 10 times per annum
Agenda Setting and papers	Agendas agreed by the Chair and ~~Director of HR~~ Chief People Officer~~/Deputy CEO~~, will be in accordance with the annual reporting schedule of the Committee. Administration, minute production and distribution are via the PA to the Deputy Director of HR & Governance. Items for the agenda must be sent to the Chair a minimum of 5 working days prior to the meeting. Urgent items may be raised under any other business. The agenda will be sent out to the Committee members at least 3 working days prior to the meeting date together with the updated action list and other associated papers. Formal minutes shall be taken of all Committee meetings. Once approved by the Committee the Chair will produce an assurance report for the following Trust Board.

	Assurance reports from the People Councils reporting to the Strategic people Committee (and associated groups) will be received by the Committee along with the reports as agreed.

CHARITABLE FUNDS COMMITTEE – Terms of Reference 2025/26 - Proposed	
Delegated authority	The Trust shall establish a Committee to be known as the Charitable Funds Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee has no executive powers other than those specifically delegated in these Terms of Reference (ToR).
Purposes	The Charitable Funds Committee ('the Committee') is established to ensure that the Trust's duties as Corporate Trustee of its subsidiary charity ('the Charity') have been discharged. The formal purposes of the Charitable Funds Committee can be summarised as follows: • To agree the purpose, strategy, policies, and controls of the Charity. • To oversee the Charity's financial and treasury management processes. • To control expenditure from the funds. • To control and support fundraising and income initiatives. • To recommend an Annual Report and Accounts to the Corporate Trustee, outlining the Charity's key achievements. The Board of Directors of the Corporate Trustee maintains overall responsibility and legal obligations for these areas. However, the Charitable Funds Committee has delegated authority/responsibility, from the Corporate Trustee, within the limits set out in this ToR.
Authority	The Committee will oversee the administration of the Charity in line with statute and with Charity Commission (and other regulatory) requirements. The Committee has duties and delegated authority from the Board as follows. i) Approve the purpose, strategy, policies, and controls of the Charity, having due regard for propriety, compliance, risk, effectiveness, and efficiency. ii) Approve any significant changes in the Charity's governing document and registration with the Charity Commission, for recommendation to the Board of Directors of the Corporate Trustee. iii) Review those aspects of Standing Orders and Standing Financial Instructions that relate to the Charity and its operation, advising the Audit Committee on any such matters which need further attention. iv) Control all charitable expenditure in accordance with the Charity's Objects, Charities Act 2011/2016, *patient benefit criteria*, and best practice, through review and approval of the Charity's *Expenditure Policy.* v) Control income generation / handling mechanisms, including official fundraising, in accordance Charities Act 2016 and best practice, through review and approval of the Charity's *Fundraising*

	and Incomes Policy. vi) Approve detailed proposals for: appeals, the accumulation of funds for major purchases, delegated fundholder-ship and financial limits, fund structure, closing funds, and/or the establishment of new funds. vii) Oversee the use of investments in line with the Trustee Act 2000 and best practice, restricted to the explicit conditions or purpose of each donation, bequest, or grant, through review and approval of *the Charity's Treasury Management Policy* and the *Reserves Policy.* viii) Oversee the appointment of investment advisors when required and monitor the performance of any resultant portfolio. ix) Receive and consider reports addressing the Charity's risks and risk management arrangements. x) Receive regular reports on the performance of the Charity, and steer activity with a view to maintaining acceptable levels of risk and maximising compliance and effectiveness. xi) Appoint the external auditor for the Charity and approve any change from audit to independent examination if the Charity qualifies as below-threshold. xii) Receive the Annual Report and Accounts, consistent with *Charities SoRP* and relevant legislation and accounting standards, for review and recommendation for final approval to the Board of Directors of the Corporate Trustee. The Charitable Funds Committee's duties may be discharged by any sub-committees or working groups that it seeks to establish. It would approve the Terms of Reference, workplans and duration of any such groups. The Committee must respond to any action plans referred to it by the Audit Committee. The Committee is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources. **All decisions on behalf of the Charity must be distinct from Trust decisions, must be in the best interests of the Charity, and must be in accordance with the *duty of prudence*.**
Associated documents	This ToR is to be read in conjunction with the following. • ***The essential trustee: what you need to know, what you need to do*** – *Charity Commission* (to be interpreted for an NHS Charity context, and a Corporate Trustee context). • **The Trust's Standing Financial Instructions -** Additionally, the following governance documents – taken as a set - describe the separate Charity entity**.**

	• **The Charity's 5-year Vision and Income Strategy**, as approved by this Committee.
	
	• **The Charity's Annual Report and Accounts,** which outlines the Charity's history, constitution, governance, and management arrangements, as recommended to the Trust Board for approval.
	
	• **The Charity's policies**, as approved by this Committee, including the following.
	  ○ Treasury Management Policy;
	  ○ Reserves Policy;
	  ○ Fundraising and Incomes Policy; and
	  ○ Expenditure Policy, including Mission Statement.
	
	The above documents make direct reference to the following legislation.
	• Charities Acts 2011 and 2016
	• Trustee Act 2000
	• General Data Protection Regulation (GDPR) 2018

Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. This process includes review of this ToR, and the setting of the Committee's annual workplan.
Membership	**Core membership** • Nominated Non-Executive Director (Chair) • Two additional Non-Executive Directors • ~~Director of Finance & Information~~ Chief Finance Officer • ~~Managing Director~~ Chief Operating Officer • ~~Director of Nursing, Midwifery and Governance~~ Chief Nursing Officer In attendance • Head of ~~Hospital~~ Charity • Charitable Funds Financial Accountant • Charitable Funds Officer • Assistant Director of Communications • Fundraising Team representatives • Assistant Director of Finance, Financial Services • Corporate Governance Manager All members should aim to attend all scheduled meetings. Other officers of the Trust may be invited to attend on an ad-hoc basis to present papers or to advise the Committee. Professional advisors and/or auditors may be invited to attend, when deemed necessary. Other members of the Board of the Corporate Trustee may attend meetings of the Committee if they wish.

	The Committee may establish appropriate time-limited working groups to consider specific issues on a project basis. Representation from such groups may be required at Committee meetings.
Attendance	Core Members are expected to attend a minimum of 60% (2 of the 3 meetings) of meetings per year. Members are expected to engage as follows. • Ensure that papers are read prior to meetings. • Attend as many meetings as possible. • Contribute fully to discussion and decision-making. • If not in attendance, seek a briefing from another member who was present, to ensure that they are informed about progress. Core members, and officers who engage in Charity business, are also expected, from time to time and with appropriate notice, to contribute to Charity events and promotional activities, as requested by the Head of Charity. If a decision is needed between meetings, it can be made via an ad hoc virtual meeting, or a shared email trail, with quoracy as below. It must be ratified at the next full meeting of the Committee.
Quorum	The Committee would be considered quorate with 50% attendance, to include both of the following. • At least one Non-Executive Director. • At least one Executive Director.
Accountability & reporting	The Committee will report to the Board of Directors following each meeting via a Chair's report, covering key decisions, developments and risks, and the basis of any recommendations made to the Board.
Frequency	The Committee will meet at least three times per year. Meetings may also be convened with the agreement of all core members at any time.
Administration	The office of the ~~Director of Finance & Information~~ Chief Finance Officer will be responsible for all administrative arrangements, including the following. • Timely notice of meetings. • Agendas based on the Committee's annual workplan. • Distribution of electronic papers at least 4 working days prior to the Committee, unless there are exceptional circumstances agreed with the Chair. • Minutes and Action Log updates for each meeting.

EXECUTIVE COMMITTEE – Terms of Reference (2025/26) – Proposed	
Delegated Authority	The Trust shall establish a committee to be known as the Executive Committee which will formally be constituted as a committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within the year. 3. To monitor the delivery and benefits realisation of approved business cases and service developments 4. To review and approve significant tender/bid documents submitted by the Trust for new services 5. The management of issues with reputational and relationship management significance 6. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 7. Receiving and considering the Chair's report from the Risk Management Council, the Premium Payment Scrutiny Council, the Transition and Transformation Council and other appropriate supporting governance or project groups 8. Governance matters including preparation and arrangements for regulatory review 9. Brief the Trust's senior managers on the business and decisions made at the Executive Committee
Review	Each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee Terms of Reference.

Membership	Core membership of the meeting will comprise: • Chief Executive (chair) • Deputy CEO (vice chair) • ~~Director of Human Resources~~ Chief People Officer • ~~Medical Director~~ Chief Medical Officer • ~~Director of Nursing, Midwifery and Governance~~ Chief Nursing Officer • ~~Director of Finance and Information~~ Chief Financial Officer • ~~Managing Director~~ • Director of Corporate Services • Chief Operating Officer • Director of Informatics • Director of Integration • Director of Strategy The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is allowable for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the EA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

Title of Meeting	**Trust Board**		**Date**	28 May 2025
Agenda Item	**TB25/046**			
Report Title	Trust Objectives 2024/25 – Year End Review			
Executive Lead	Rob Cooper, Chief Executive			
Presenting Officer	Rob Cooper, Chief Executive			
Action Required		**To Approve**	X	**To Note**

Purpose

To note the assessment of delivery of the 2024/25 Trust Objectives.

Executive Summary

In March 2024 the Board approved Trust objectives for 2024/25.

The Trust objectives (Appendix 1) are aligned to the Trust vision to deliver Five Star Patient Care: five representing the Five Star Patient Care criteria of care, safety, pathways, communication, and systems. A further four categories covering; organisational culture and support for the workforce; operational performance; financial performance, efficiency, and productivity; and strategic planning are also included.

Progress in delivering these objectives was reviewed at the mid-year point and a report presented to the November Board meeting.

Fully achieved by 31/10/24	4
On track to be delivered by 31/3/25	25
At risk of not being fully delivered by 31/3/25	3

The Executive Leads for each objective have now reviewed the position at the end of quarter 4, and rated them on the following scale –

Fully achieved	16
Partially achieved	15
Not achieved in 2024/25	1

As previously agreed by the Board, several of the objectives not fully delivered in 2024/25 have been rolled forward to 2025/26.

Financial Implications

None as a direct result of this paper

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the end of year assessment of delivery of the 2024/25 Trust Objectives.

Strategic Objectives

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

Appendix 1

Mersey and West Lancashire Teaching Hospitals NHS Trust

2024/25 Trust Objectives – Year-End Review

	Objective fully delivered		Objective partially delivered		Objective not delivered in 2024/25

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**					
1.1	Continue to improve the overall experience for women using the Trust's Maternity Services	DoN	• Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys and feedback from women receiving maternity care and delivery of the agreed action plan. • Create a MWL Maternity Strategy to support delivery of the national three-year maternity plan.	Quality Committee	For the 2024 NHS Maternity Survey results MWL scored about the same as other Trusts in 48 questions, somewhat worse for 5 and worse than expected for 4. The results were triangulated with other sources of patient feedback including feedback from MNVP and Trust Safety Champions walkarounds which reflecting positive feedback and did not pick up the same themes as the national survey. PALS, complaints and FFT feedback was also triangulated with key themes identified around ante-natal waiting times, communication (with women and families at various points in the patient journey) and increasing the partner facilities to stay overnight to offer support following birth, which has been implemented in 2024/25. An action plan has been developed to address the findings of the national survey and shared with Maternity Staff. The action plan is monitored monthly at the Women and Children Divisional Meeting. Of the 35 actions, 15 are completed, 17 are on track for delivery by the agreed deadline on track and 3 are currently amber- as linked to the implementation of a new Maternity Information System (Badgernet), which is not due to be implemented until March 2026. The Maternity and Patient Experience teams have developed local surveys to assess the

<table>
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<tr><td></td><td></td><td></td><td></td><td></td><td>impact of the completed actions and identify other areas of focus ahead of the next national Maternity Survey.

Consultation with staff, service users and stakeholders is underway on the new MWL Maternity Strategy.</td></tr>
<tr><td>1.2</td><td>Ensure patients in hospital remain hydrated to improve recovery times and reduce the risk of deterioration, kidney injury, delirium, and falls.</td><td>DoN</td><td>• Monthly audits on every ward to ensure all patients identified as requiring assistance with hydration have red jugs in place.

• Monthly audits on every ward to ensure fluid balance charts are up-to-date and completed accurately.

• High compliance with Advancing Quality (AQ) audit results</td><td>Quality Committee</td><td><table><tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr><tr><td>Red Jugs audits</td><td>82%</td><td>92%</td><td>95%</td><td>95%</td></tr></table>
Red jugs compliance has continued to improve since Q1 and is over 90% target.

<table><tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr><tr><td>Fluid Balance audits</td><td>82%</td><td>87%</td><td>87%</td><td>85%</td></tr></table>
Southport and Ormskirk Hospital sites are now digital for fluid balance charts on adult inpatient wards in line with the Whiston, St Helens and Newton hospital sites. A new patient information leaflet has been introduced on the adult inpatient wards for patients able to utilise it.

MWL is one of the top three C&M Trusts for performance against the Advancing Quality (AQ) targets for acute kidney injury (AKI) – January 2025 data. AKI pathways continue to be standardised and training on completion of fluid balance charts delivered by the critical care outreach at Southport Hospital and AKI team at Whiston Hospital.</td></tr>
<tr><td>1.3</td><td>Launch and deliver the Trust wide Nursing Pride quality programme to support and deliver consistently high-quality compassionate care.</td><td>DoN</td><td>• Re-launch back to basics best practice programme by September 2024

• Measure improvement in nursing quality indicators in the IPR (Quality Committee CPR)</td><td>Quality Committee</td><td>• Weekly quality walkabouts continue at all sites with the focus on safety documentation (fluid balance, MUST, falls, pressure ulcers, supplementary care, pain) compliance with uniform policy, smoking and support for carers. The results are sent out following the audits to divisions, along with 7 minutes of learning posters.
• Nursing Care Indicators (NCI) completed monthly for all inpatient wards. Results posters are displayed, and an action tracker is in place to monitor improvements. A</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year-end progress review and RAG rating</th></tr>
<tr><td></td><td></td><td></td><td>• Evaluate the impact of the programme via the new MWL ward accreditation scheme.

• Achieve substantial assurance in the internal audit quality ward spot checks.</td><td></td><td>quality bus has a theme of the month to share learning across different specialities.
• The 5 Star Accreditation Programme commenced in June 2024. 47 areas have had their first assessments and 26 a second. The programme had resulted in improvements across all sites, with 3 areas achieving the 5 star award. The accreditation programme focuses on IPC (ANTT, PPE, hand hygiene, environment) visual infusion phlebitis (VIP) scores, education and training, safe cannula care and documentation, falls, safeguarding, Tissue Viability, and the environment. The accreditation is supported by quarterly audits of practice, the environment, quality and safety walk abouts and bite size practical training.
• MIAA audited 10 clinical areas in 2024/25 compared to 4 in 2023/24. The audit had been given Moderate Assurance. This included a re-audit of the 4 wards checked in 2023/24 and all showed improvement.</td></tr>
<tr><td colspan="6">2. 5 STAR PATIENT CARE – Safety
We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care</td></tr>
<tr><td>2.1</td><td>Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.</td><td>COO</td><td>• All patients requiring triage are either triaged within 15 mins or have a baseline set of observations within 15 minutes based on monthly audits.

• First clinical assessment median time of <2 hours over each 24-hour period

• Compliance with the Trusts Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits.</td><td>Quality Committee</td><td>
<table>
<tr><th colspan="5">All patients requiring triage are either triaged within 15 mins or have a baseline set of observations within 15 minutes</th></tr>
<tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>15 Mins</td><td>56.4%</td><td>49.8%</td><td>40.0%</td><td>53.3%</td></tr>
<tr><td colspan="3">90% Target</td><td colspan="2"></td></tr>
</table>
Triage working groups have been established to develop actions plans to drive improvements in the achievement of this national standard. This remains an objective in 2025/26.
<table>
<tr><th colspan="4">First clinical assessment median time of <2 hours over each 24-hour period</th></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>113</td><td>95.5</td><td>117.8</td><td>100</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year-end progress review and RAG rating</th></tr>
<tr><td></td><td></td><td></td><td>• Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring.</td><td></td><td>Compliant with 120-minute target
<table>
<tr><th colspan="4">Warning Score (NEWS), with appropriate escalation of patients who trigger</th></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>94%</td><td>92.8%</td><td>86.3%</td><td>86.9%</td></tr>
</table>
Compliant with 85% target for patients within ED.

Sepsis – NEWS score within 1 hour of arrival was 88% in Q4 (Q3 92.9%)

Sepsis – administration of antibiotics within 1 hour of diagnosis has not been achieved consistently and there are improvement actions that will be implemented in 2025/26, including -
• Microbiology to provide a list of all positive blood cultures each week
• Clinical Audit Team to develop an in-house Sepsis audit tool
Safety huddles - need for blood cultures within an hour for high risk and within 3 hours for moderate risk patients</td></tr>
<tr><td>2.2</td><td>Reduce the incidence of methicillin-resistant Staphylococcus aureus (MRSA) healthcare associated bacteraemia infections to meet the zero-tolerance threshold and a 15% reduction of avoidable hospital onset MSSA bacteraemia’s.</td><td>DoN/ Med D</td><td>• Achieve minimum aseptic non-touch technique compliance of 85% for Level 1 (theory) and Level 2 (practical).

• Achievement of 95% compliance

• 90% compliance with visual infusion phlebitis monitoring</td><td>Quality Committee</td><td>There were 6 reported cases in 2024/25. Two of these were shown to have no lapses in care.
<table>
<tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>ANTT Level 1</td><td>82.5%</td><td>87.6%</td><td>91.9%</td><td>92.8%</td></tr>
<tr><td>ANTT Level 2 (Whiston, St Helens & Newton)</td><td>69.2%</td><td>71%</td><td>69.2%</td><td>68.8%</td></tr>
</table>
Level 2 is not recorded on ESR for the legacy S&O sites but this has been addressed for 2025/26 following implementation of the harmonised ANTT project. The IPC Team engaging with</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year-end progress review and RAG rating</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>divisional teams and practice educators to promote completion of the practical competency training.

<table><tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr><tr><td>MRSA</td><td>96.3%</td><td>94%</td><td>93.4%</td><td>94.7%</td></tr></table>
MWL MRSA screening compliance was 93.4% during Q3, which is below the Trust target of minimum 95% admission screening for all inpatients. Going forward this will be a metric of focus within divisional governance meetings.

<table><tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr><tr><td>PIVC</td><td>86.9%</td><td>90%</td><td>82.3%</td><td>82%</td></tr></table>A monthly PIVC spot check audit is part of the IPC audit plan for 2025/26 to improve cannula care.

A target of 90% compliance with VIP monitoring has been set.</td></tr>
<tr><td>2.3</td><td>Reduce avoidable harm by preventing falls</td><td>DoN</td><td>• Reduction in the incidence of falls per 1000 bed days compared to 2023/24.

• ~~Benchmark in the top 25% of acute Trusts.~~ (removed as a national benchmark)

• 95% of patients to have a documented falls risk assessment within 6 hours of admission and repeat assessments at every change of the patient’s condition (evidenced via monthly audits)

• Develop and implement training for HCAs to improve patient</td><td>Quality Committee</td><td>• Daily walkarounds to identify areas for improvement e.g. documentation compliance and education needs
• Part of ward accreditation programme
• Daily snapshot audits of falls risk assessment compliance on 10 patients across two wards
• Intervention by the falls team to wards where harms have occurred or increased rates of falls noted to provide additional support
• Patient story-focused training incorporating lessons learned from falls investigations
• Decaffeinated drinks trialed at Newton Hospital for 2 months and showed a 30% reduction in falls from the previous quarter.
• Falls and Pharmacy review medicines for patients at risk of falls, who have fallen to prevent falls and following falls with harm.</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year-end progress review and RAG rating</th></tr>
<tr><td></td><td></td><td></td><td>enrichment and engagement activities</td><td></td><td>
<table>
<tr><th colspan="4">Falls rate per 1000 bed days</th></tr>
<tr><td></td><td>StH, Wh & Newton Sites</td><td>S&O Sites</td><td>MWL</td></tr>
<tr><td>2023/24</td><td>7.11</td><td>4.2</td><td>6.0</td></tr>
<tr><td>2024/25</td><td>7.01</td><td>4.7</td><td>6.25</td></tr>
</table>

In Q4 falls risk assessment completed within 6 hrs of admission for 96.5% of adult in patients
Healthcare Academy program includes falls training to new HCAs
The Dementia and Delirium team deliver Tier 1 and 2 Dementia training

</td></tr>
<tr><td colspan="6">3. 5 STAR PATIENT CARE – Pathways
As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient</td></tr>
<tr><td>3.1</td><td>Continue to improve the effectiveness of the discharge process for patients and carers.</td><td>COO</td><td>

Improved Inpatient Survey satisfaction rates for receiving discharge information.
Achievement of 20% target for patients discharged before noon during the week.
Review of discharge data to confirm reason for delay is not due to waits for take home medication

</td><td>Quality Committee</td><td>
The latest inpatient survey (2023) showed a decline of scores relating to discharge. This was the first MWL survey and therefore, the results are not directly comparable to previous surveys, however, there was an improvement in 6/11 measures compared to the previous Southport and Ormskirk NHST survey.
<table>
<tr><th colspan="4">Achievement of 20% target for patients discharged before noon during the week</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>18%</td><td>18%</td><td>20%</td><td>19%</td></tr>
<tr><th colspan="4">Proportion of patients who have received the discharge from hospital booklets (Target 75%)</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>69.2%</td><td>94.0%</td><td>94.4%</td><td>99.64%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year-end progress review and RAG rating</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><th colspan="4">Review of discharge data to confirm reason for delay is not due to waits for take home medication (Target < 5%)</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>2.13%</td><td>9.1%</td><td>7.5%</td><td>3.08%</td></tr>
</table>

This area remains an objective for 2025/26. A key In Hospital Workstream in the MWL System UEC Improvement Plan for 2025/26 is Improving Discharges. This includes implementing the ECIST recommendation on board and ward round processes and focussed work on reducing the length of time for it takes for To Take Out (TTOs) and ensuring TTO's requests are at the pharmacy earlier.
</td></tr>
<tr><td>3.2</td><td>Reduce Cancer waiting times.</td><td>COO/ Med D</td><td>• Achieve the NHS Faster Diagnosis Standard (FDS) for Cancer to ensure that 77% of patients referred with a suspicion of cancer have a this diagnosed or ruled out within 21 days of referral by March 2025.

• Ensure that local pathways support the delivery of the FDS through the FDS Prioritisation Group.

• Achieve the 62-day Cancer Treatment Standard of to a 85% by March 2025.</td><td>Finance and Performance Committee</td><td>The 28 day FDS performance in March 2025 was 74% , but the standard was achieved in December 2024 (78.2%) and February 2025 (77.8%).

The programme has been expanded by the Cheshire & Mersey Cancer Alliance (CMCA) from a Faster and Early Diagnosis Programme to a complete Pathway Improvement Programme for 2025/26. This area remains an objective for 2025/26 with an 80% target for March 2026.

The 62 day cancer treatment standard was 85.7% in March 2025.

This area remains an objective for 2025/26 with a national target of 82% to be achieved by March 2026.</td></tr>
<tr><td>3.3</td><td>Implement unified clinical pathways across MWL, aligned to best practice guidance for SDEC, Fractured neck of femur and Day Case Surgery</td><td>Med D</td><td>• Patients follow the same pathway for common conditions irrespective of where they present across MWL</td><td>Quality Committee</td><td>• Deputy Divisional Medical Director appointment in progress, to be followed by Trust-wide Clinical Directors to enable integration of clinical specialities
•
• Clinical Teams working together in Orthopaedics and SDEC to share best practice and develop unified clinical pathways for SDEC and Fractured NOF
•</td></tr>
</table>

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
					• Surgical Division implemented unified principles for theatre planning following work with GIRFT and Productive Pathways • • Plastic Surgery Day Unit at Southport using best practice for Day Case Surgery based on principles used in PSDU at Whiston
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1	1 Implement a new speech recognition system to improve the turnaround times for clinic letters.	DoI/MD	• Implement the new system and train staff in its use. • Achieve a 48-hour (working week) turnaround for urgent letters and 7 days for routine letters.	Finance and Performance Committee	A replacement Digital Dictation solution, (Dictate IT) has been implemented, but not yet a speech recognition system. The target for turnaround times for letters to GPs within 48 hours was achieved in 2024/25, the target for letters within 7 days was not achieved at 83% in March 2025, which had improved but remains below the 90% target.
4.2	Continue to align the internal and external communications systems across MWL to ensure they are effective.	Deputy CEO	• Encourage and support staff to be part of the new MWL culture programme and to share stories, ideas, successes, and suggestions for improvement. • Develop innovative and creative digital communications channels to ensure staff and patients can access clear information conveniently and with ease. • Enhance the use of digital and social channels and continue to grow engagement with staff, stakeholders, patients and people across all our communities	Executive Committee	• Continue to produce and share original content re. awareness days, religious festivals and events happening at the Trust and in our local communities across all channels, internal and external • The Trust has 51,588 followers across all social channels – increasing around 1000 followers on average each quarter • 2,118 staff are now members of the MWL staff Facebook group MWL People • The MWL LinkedIn audience is developing at pace. Increasing 578 followers in Q4 as the Trust focuses on growing the reach and engagement of this channel. • Delivered NEW staff intranet for staff at Southport and Ormskirk hospital sites which means all MWL staff have access to the same platform, content and layout. • CEO Blog launched January 25 issued to all staff Trust wide.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
4.3	To complete the implementation of technology to support and improve patient engagement, and experience with the trust	DoI	• To complete the implementation of phase 1 of the patient engagement portal (PEP), enabling patients to view their outpatient letters on the NHS app.	Finance and Performance Committee	The rollout of PEP has progressed successfully at the Southport and Ormskirk Hospital sites, with 18 specialties now live for outpatient appointments, digital letters and reminders. 87,000 appointments have been communicated through the portal, with circa 60% of patients accessing information digitally. All information is integrated and available in the NHS App. Over 3,000 patients have been discharged from waiting lists following digital wait list validation through the PEP. A 'Waiting Well' service was launched in Feb 2025 which informs patients on referral via the PEP, providing reassurance and reducing calls into the booking teams. To ability to fully implement PEP across all MWL sites is linked to the Outpatient Transformation programme which is focused on the Whiston and St Helens hospital sites, however the Waiting Well service is being launched for these sites in May 2025.
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**					
5.1	To progress the convergence and unification of clinical digital systems to ensure collaborative working across MWL.	DoI	• To complete the procurement of a new EPR, so that the FBC is approved, and the contract signed. • To review clinical digital systems across the trust and understand the clinical prioritisation for system convergence and develop a programme that complements the EPR implementation programme.	Finance and Performance Committee	The procurement process has now re-started working with a neighbouring Trust. The revised procurement programme is estimated to take 18 months. A digital programme plan is being developed that will complement the revised EPR programme Plans have been agreed with the two existing EPR providers to improve the performance and enhance the functionality of the current systems, in the interim. Deployment of EPMA across all MWL sites and Badgernet as the maternity MIS will be completed in 2025/26.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
			• To support the ongoing development of the St Helens Care Record, including the onboarding of additional places – Knowsley, Southport, Sefton, Halton, and the migration to the C&M cloud		The St Helens Care Record has migrated into the Cheshire & Mersey Connected Care Record (C&MCCR) and all MWL sites and partner Places now have single sign on which has increased usage. The MWL digital team continue to support the ICB with this initiative.
5.2	Improve access to patient information via the implementation of Narrative Digital Clinical Documentation	DoI	• Clinicians can access the patient information they need. • Patient information entered electronically only entered once.	Finance and Performance Committee	• Implemented at Whiston, St Helens and Newton sites and usage and demand for new proformas continues to grow. • The go live at the Southport and Ormskirk Hospital sites has been delayed to July 2025 due to technical issues that need to be resolved.
5.3	Achieve the same level of technology across all Trust sites which is safe, secure, and available, this will allow staff to work from any sits and access the systems they need to carry out their roles, from any device	DoI	• To have a fully reviewed and updated information asset register with highlighted consolidation opportunities. • Complete the email migration work to ensure all staff have a single-branded email address for MWL. • To consolidate the server and storage infrastructure across the data centres allowing for the removal of one or two of the data centres. • Setup infrastructure to facilitate shared working with a single set of network drives across the whole organisation. • Move the networking over to a single outbound network link	Finance and Performance Committee	• Asset register has been input onto Sostenuto, has been fully reviewed and updated, and has regular reviews. • Email migration completed for all MWL staff. • New server and storage infrastructure has been installed and 99% of systems have been migrated. • Network drives and print services now available cross site for all staff regardless of site they go to or device they use. • Network services such as VPN and Internet traffic have moved over to use the same network link/technologies. The final part of the project to move over the Health and Social Care network traffic will be completed in May 2025 • All new applications being procured are being added to single sign on ensuring staff do not need to remember multiple usernames/passwords.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
			which will reduce the need for further investment in firewalls and other associated networking equipment. • Agree opportunities to expand Single Sign On, resulting in easier/ quicker log ins.		
6. DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.					
Looking after our people					
6.1	Continue to support the standardisation of our staff support services and polices ensuring that all staff have access to the same levels of support wherever they work	DoHR	• Continue to harmonise workforce policies across MWL • Review the wellbeing support offer so it continues to be accessible, proactive and meets the needs of staff and managers.	Strategic People Committee	Significant progress has been made on workforce policies, with 12 policies remaining that require harmonisation. Work plans in place in partnership with Trade union colleagues for completion by July 2025 Wellbeing support policies developed and in place including Menopause and Stress Awareness. Wellbeing Network in place, and manager support sessions focusing on utilising HWWB services. A range of Health and Wellbeing support services, guidance, and tools available to managers and staff to support staff to be well in work. Successfully launched and completed the Healthcare Worker vaccination campaign 2024/25 from 03/10/2024 ended 30/012025 for Covid and 31/03/2025 for Flu. No national CQUIN target stands for 2024/25 • MWL COVID: 17.13%: Flu: 36.60% • NW COVID: 16% Flu: 38% • C&M COVID: 20% Flu: 40% The Wellbeing Hub continues to provide a comprehensive health promotion and calendar of events to support staff with a holistic health and wellbeing approach. Average attendance for sessions is 13.25 per session. 90% of attendees responded that they would recommend.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
					Wellbeing conversations embedded into appraisal process. Health and Wellbeing Operational Plan 2022 to 2025 concluded, and summary presented to SPC in March 2025. 2025-2028 Trust People Plan has been developed. Annual delivery plans to support People Plan are in development and progress and assurance will be reported through SPC
Belonging to the NHS					

6.2	Create a culture of compassionate leadership and one that celebrates inclusivity and embraces flexibility through the embedding of the new values and behaviours of the organisation.	DoHR	• Agree the priority actions from the 2023 staff survey to improve staff experience, confidence in speaking up and engagement for delivery during 2024/25.
			
			• Launch the new Trust values and promote and explain them to all staff.
			
			• Increase access to immediate line manager training programmes such as Making the Transition
			
			• Improve access to flexibly working opportunities for all staff groups across MWL.
			
			• Deliver the Equality Diversity and Inclusion operational action plan.
			
			• Implementation of the 10 principles relating to the Sexual Safety Charter by June 2024.
				Strategic People Committee	• Staff survey action plan 2023 has concluded following the receipt of 2024 results. 2024 actions developed following survey results and a series of focused Team Talk events across the Trust. Progress on actions to be monitored through PPC and SPC
					• Successfully developed and co-created with staff the new values for MWL that encompass the Trusts vision of 5-star patient care and commitment of kindness, opens and inclusivity.
					
					• Internal leadership development programmes have been expanded to provide access to line managers or aspiring leaders
					
					• Work ongoing to harmonise and develop training offer for everyone in a managerial role, including bitesize learning to help build confidence and capability.
					
					• Operational manager training programme developed and due to launch May 2025.
					
					• Delivered EDI Operational plan objectives;
					
					  • The EDS 2024 self-assessment with an overall score of Achieving. Published the Trusts Public Sector Equality Duty (PSED) Report for 2024
					  • Launched the EDI Training programme in Q4 2024-25 which covers LGBT, Trans and Race Awareness.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
					• Renewed MWL Gold Award for the Defence Employee Charter • The Trust had 6 colleagues (including 2 senior leaders) engaged on Liverpool City Regions BME shadowing programme. • EDI for Clinical Leaders training embedded in the new clinical leader development programme. Significant progress made on the delivery of the 10 principles of the NHS Sexual Safety Charter. National policy launched in 2024.
6.3	Achieve 85% appraisal and mandatory training compliance target, so that staff across the Trust are equipped with clear objectives and the knowledge to help them undertake their role successfully and fulfil their ambitions for career development and progression within our organisation.	DoHR	• Improve the access to learning opportunities through a range of offers including the new career development platform. • Embed the new appraisal process across the whole of MWL during the 2024 appraisal window. • Continue to develop career pathways for a wider range of roles across the Trust. • Undertake a review of mandatory training requirements and delivery models. • Provide reports and analysis to support managers target activities to improve compliance levels in particular departments, staff groups or subjects	Strategic People Committee	• Trust compliance for core mandatory training subjects is consistently above the 85% target. Work continues to introduce a standardised model for mandatory training across MWL for all core and compulsory subjects • Improvement plans in place and monitored through Executive Committee to support areas of low compliance • Appraisal compliance over 85% • Appraisal window in place across all sites for AfC staff • Career Development Portal launched in April 2024 • Training and development programmes developed for nursing roles including Registered Nurse Apprentice programme

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
New ways of working					
6.4	Maximising workforce systems and technology to aid efficiency of the workforce to deliver safe care.	DoHR	• Harmonisation of workforce systems e.g., Occupational Health • Maximise the use of technology and digital solutions across the HR directorate to deliver the best possible people services.	Strategic People Committee	New Occupational Health Management System implemented E-roster harmonised across all MWL sites including roster publication dates Workforce data developed including weekly bank and agency and overtime reports Work ongoing in partnership with Business Information (BI) team to develop workforce dashboards as part of Trust performance management framework.
Growing for the future					
6.5	Ensure the Trust has effective workforce plans in place to support new models of care. Create a sustainable workforce supply which meets the needs of our patients.	DoHR	• In partnership with the Medical Director and Director of Nursing, Midwifery & Governance continue to create a strong pipeline of new clinical roles including Trainee Nurse Associates and Advanced Clinical Practitioners (ACP) • Continue to create diverse and innovative offerings to aid recruitment and retention in staff groups with a traditionally high turnover. • Maximise the use of the apprenticeship levy to support more staff to undertake further training in Advanced Clinical Practice and Leadership Development	Executive Committee	Delivered the 2024/2025 workforce plan and developed 2025/2026 plan in line with national, regional and local priorities 19 Trainee ACPs commenced training in 2024/25. Apprenticeships continue to be promoted as the predominant route for staff undertaking higher level management and leadership qualifications including the Elizabeth Garrett Anderson, Edward Jenner and Mary Seacole programmes through NHS Leadership Academy. The Trust now has two Apprenticeship and Work Experience Coordinators. MWL celebrated National Apprenticeship week in February 2025 with stalls across 5 sites to promote apprenticeship opportunities, which generated interest. Levy transfers completed to support local health and social care. Adoption of an apprenticeship first approach for clinical training posts such as Trainee ACPs has supported the organisation in utilising its apprenticeship levy.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
			• Develop workforce plans to support the Trust with the delivery of its Clinical Strategy		All vacancies subject to consideration of an apprenticeship pathway as part of vacancy control panel process
6.6.	Create the right conditions for continuous improvement so staff feel empowered to suggest or seek new ways to improve care and outcomes for patients	MD/MedD	• Develop an MWL approach to continuous improvement. • Promote and create awareness of the MWL continuous improvement culture and methodology. • Develop a MWL Research, Development and Innovation Strategy and increase the Trust involvement in both clinical research and research targeted at identifying and reducing health inequalities. • Increase the number of patients recruited to commercial contract research studies in line with NIHR objectives.	Executive Committee	• Continuous improvement strategy in place. • Initial continuous improvement learning and development programme delivered for senior leaders including divisional triumvirates. • Post senior leadership development programme, further cascade planned. • MWL Research and Innovation Strategy presented to Board and increased recruitment of patients to research studies delivered.
7. OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**					
7.1	Deliver the 2024/25 elective recovery targets	COO	• Eliminate waits of over 65 weeks for elective care by September 2024 (except where the patient chooses to wait longer) • Deliver the C&M ICS system specific activity targets assigned to the Trust.	Finance and Performance Committee	There were 86 x 65+ week waiters at the end of March 2025, with 32 due to patient choice, 45 complex, 8 corneal graft and 1 due to capacity challenges. The Trust performed significantly better than local acute Trust peers apart from LUFT. (Warrington 149, Countess of Chester 128, Mid Cheshire 238). The focus in 2025/26 is to drive improvement back to 2019/2020 levels with a target of no more than 1% of waiting list waiting over 52 weeks. As at March 2025, this was 2.5% for MWL. The NHS has been set a 5% improvement target for 18 week referral to treatment in 2025/26.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
			• Maximise the capacity and efficiency of the Trusts resources to reduce long waiting times. • Provide mutual aid in specific specialities to support the delivery of system recovery targets. • Improve theatre productivity and efficiency to maximise capacity		In March 2025 MWL delivered 127% of the 2019/20 baseline activity against the ICB target of 109% however was behind the internal plan. Theatre Productivity – capped utilisation has improved from 70% to 77% in March 2025 against the target of 85%. The Trust engaged Productive Partners to review and support theatre improvements which has resulted in improvements in utilisation, and reductions in fallow lists, late starts and early finishes. This remains a focus for 2025/26. MWL have provided mutual aid for diagnostic tests, so support system recovery targets.
7.2	Deliver the diagnostic recovery targets	COO	• Eliminate waits of over 26 weeks by June 2024 and 13 weeks by March 2025 for diagnostic tests (except where the patient chooses to wait longer) • Deliver 95% diagnostic tests in < 6 weeks. • Deliver the system specific Community Diagnostic Centre (CDC) activity targets	Finance and Performance Committee	In March 2025 there were 49 x 13 week waiters. These breaches were predominantly in echocardiology. In March 2025 6 weeks diagnostic performance = 93.1% with 7 out of 12 months in 2024/25 the Trust achieving over 95%. Both the CDCs (St Helens and Ormskirk) are delivering above target activity levels. This remains an objective for 2025/26.
7.3	Deliver the NHS urgent and emergency care performance targets	COO	• Improve A&E waiting times so that no less than 77% of patient are seen within 4 hours by March 2025 • Reduce the average length of stay in the Emergency Departments	Finance and Performance Committee	• A&E 4 hour mapped performance in March 2025 was 79.1%. • The average length of stay historically increases in the 2nd half of the year, reflecting winter pressures. In 2024/25 the average LOS increased by 99 minutes in Q3&Q4. In 2023/24 this increase was 207 minutes. • Average ambulance handover time for MWL in November 2024 was 75 minutes, as by March 2025 this was 36

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
			• Consistently achieve ambulance handover times of less than 30 minutes • Increase the number of direct access pathways for assessment/speciality review. • Urgent Community Response – respond to 70% calls within 2 hours. • Increase the number of patients accessing SDEC services.		minutes. There has been a with a 23% improvement in the % of patients handed over within 45 minutes. • Urgent community response – 2 hours target achieved for 80% of calls. • There has been a 5% increase in SDEC attendances across MWL. • The MWL System Urgent Care Improvement Plan for 2025/26 is currently being finalised which will set out the key actions across the system, associated metrics and trajectories for improvement. This remains an objective in 2025/26.
8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**					
8.1	Deliver the agreed financial plan including outturn, cash balances and capital resourcing limits.	DoF	• Achieve the approved financial plan for 2024/25 • Delivery of the agreed Cost Improvement Programme and transaction business case benefits • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income. • Deliver the approved capital programme, to progress the strategic estates delivery plans, equipment replacement and IT investments.	Finance and Performance Committee	The Trust: • Delivered the adjusted/agreed financial outturn. • Delivered the CIP target for 24/25. • Delivered the approved capital programme adjusted for the change in EPR purchase. • Delivered the minimum cash balance. The new notional charge for Public Dividend Capital (PDC) resulted in the financial plan not being fully achieved. The final deficit position was 14.7m deficit, which was 3.8m adverse to plan. Without the notional PDC charge the Trust would have delivered a 9.3m deficit that would have been better than plan

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
8.2	Deliver the agreed capital schemes to deliver the capacity needed to meet service demand and a safe, high-quality environment for patients and staff.	DoCS	• Deliver the planned capital developments for 2024/25 including the CDC/TiF schemes. • Deliver year two of the backlog maintenance reduction programme at Southport and Ormskirk Hospitals • Deliver the agreed capital programme to optimise capacity/space utilisation and improve patient experience.	Finance and Performance Committee	Capital Programme delivered, including year 2 backlog maintenance
8.3	Work with partner organisations across the ICS to develop and deliver opportunities for collaboration at scale and increased efficiency	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system. • Drive forward other opportunities for collaboration with system partners.	Executive Committee	The Trust has continued to support the collaboration at scale and efficiency programmes and has progressed developments within: • Payroll – Plan in place to on Board 5 further C&M Trusts within the next 6 months. • Pathology collaboration with WHH • Opportunities for a system wide HWWB and procurement services continue to be developed
9. STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**					
9.1	Ensure the Trust continues to influence and fully participate in the Integrated Care System to achieve a clinically and financially sustainable acute provider services.	CEO	• Develop areas for collaboration that bring benefits for patients and partner organisations. • Continue the development of effective Provider Collaboratives that enhance collaboration and integration of services that support the objectives of the ICS.	Trust Board	MWL continues at the forefront of shared services and collaboration. CEO has led CMAST workstreams – Pathology/diagnostics Trust continues to host CMAST core team on behalf of the ICB The changes to NHSE announced at the end 2024/25 have resulted in the creation of a single Provider Collaborative for C&M.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
9.2	Complete the post transaction effectiveness reviews with NHS England and the ICBs	DoCS	• All transaction risk rating recommendations completed. • 12 month post transaction review with NHSE is positive	Trust Board	Completed. 12-month post transaction review took place in October. NHSE Transformation team are scheduled to undertake an informal lessons learned review in Q1 of 2025/26
9.3	Continue to deliver the post transaction transition and transformation programme to fully integrate services and systems across MWL.	MD	• Fewer fragile services • Delivery of the planned integration and transaction benefits	Trust Board	Of the original 18 fragile services identified pre-transaction, 6 have been stabilised with a further 6 having transformation plans underway. 3 require a system level solution working with partner organisations and the final 3 are being addressed as part of the divisional business as usual plans. Transaction benefits - Patients • Improved access to services • Improved cancer waiting times and RTT for S&O pop • Better/safer environment • New equipment and re-opening services to referrals • Shaping care together to resolve service configuration. • Single EPR/Integrated IT systems • East Pathology Hub being taken forward • Levelling up standards Staff • Access to training/development • staff support and the resources. • More career opportunities • Improved/safer environment. • Better equipment and IT connectivity • Improved recruitment e.g. Southport ED As the Trust moves to focus on transformation and integration of services, the transition element of this action is complete.
9.4.	Deliver the key milestones of the Shaping Care Together Programme for 2024/25 in	MD	• Achieve the 2024/25 milestones for the Shaping Care Together Programme –	Trust Board	Case for Change approved at the Cheshire and Merseyside (C&M), and Lancashire and South Cumbria (L&SC) Integrated Care Boards (ICB) in July 2024 and subsequently published.

No	Objective	Lead Director	Measurement	Governance Route	Year-end progress review and RAG rating
	collaboration with Place and ICB partners.		including approval of the Pre-Consultation Business Case		A ten-week period of pre-consultation engagement undertaken, to October 2024. Public roadshow events, public townhall meetings and staff engagement events have taken place across Southport, Formby, and West Lancashire. C&M and L&SC ICB boards approved the creation of a joint committee in November 2024 and has met. The Pre-Consultation Business Case (PCBC) has been developed and been reviewed by the Joint Committee, Clinical Senate and passed the NHSE assurance process. Public consultation was delayed due to the national and local authority elections and is now due to commence in July 2025.
9.5	Work with each of the Place Based Partnerships where the Trust provides services to improve the health of the local population and reduce health inequalities	DoInt	• Position the Trust as a key partner in each Place Based Partnership • Maximise the potential of the Trust as an anchor institution in our communities to improve health, education, and employment. • Work with Places to turn data into action through targeted programmes with a focus on health inequalities	Executive Committee	• MWL remains an active partner in all current places; taking the leading role in St Helens, Supporting the SEND Strategic Improvement Board and leading a cancer improvement group in Halton. Presenting Trust progress in other Health and Wellbeing Boards. • MWL is the Lead Partner developing a Health and Social Care Academy in St Helens. A Business Case has been approved by the St Helens Town Deal Board for the establishment of a £1.3m venue. • MWL has developed a Health Inequalities Dashboard which is being adopted across Cheshire and Merseyside and has approved a Health Inequalities strategy. • Worked positively with Places to reduce delays in discharge pathways. Discharge processes have been improved with the introduction of EDIS, ward staff will 'describe' and social workers will 'prescribe' the pathway avoiding over prescribing and ensuring the most appropriate destination for the patients