Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09:30 on Wednesday 25 June 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month (June 2025)** *Purpose: To **note** the Employee of the Month presentations for June 2025*	Film	Chair *(10 mins)*
09.40	2.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	4.	**TB25/047 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 28 May 2025*	Report	
	5.	**TB25/048 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
09.50	6.	**TB25/049 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	L Barnes L Neary M Szpakowska G Lawrence *(30 mins)*
Committee Assurance Report				
10.20	7.	**TB25/050 Committee Assurance Reports** 7.1. Executive Committee	Report	R Cooper

		7.2. Audit Committee *(including approval of annual accounts)* 7.3. Charitable Funds Committee 7.4. Quality Committee 7.5. Strategic People Committee 7.6. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*		C Spencer obo S Connor H Scott G Brown L Knight C Spencer *(40 mins)*
Other Board Reports				
11.00	8.	**TB25/051 Fit and Proper Person Chair's Annual Declaration** *Purpose: To **note** the Fit and Proper Person Chair's Annual Declaration*	Report	Chair *(10 mins)*
11.10	9.	**TB25/052 2024/25 Safeguarding Annual Report (Adults and Children)** *Purpose: To **note** the 2024/25 Safeguarding Annual Report (Adults and Children)*	Report	L Barnes *(20 mins)*
Concluding Business				
11.30	10.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
11.35	11.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 30 July at 09:30		**11.45 close**
15 minutes 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.

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 28 May 2025
(Approved at Trust Board on Wednesday 25 June 2025)

Name	Initials	Title
Steve Rumbelow	SR	Chair
Gill Brown	GB	Non-Executive Director and Deputy Chair
Rob Cooper	RC	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Lynne Barnes	LB	Acting Director of Nursing, Midwifery and 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	Chief Finance Officer
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	Non-Executive Director
Carole Spencer	CS	Non-Executive Director
Rani Thind	RT	Associate Non-Executive Director
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Viki Hunt	VH	Head of Therapies (Observer) (via MS Teams)
Yvonne Mahambrey	YM	Quality Matron, Patient Experience (Agenda Item 2) (via MS Teams)
Nadine McStein	NMc	Head of Nursing and Quality, Urgent Care Patient Experience (Agenda Item 2) (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Malise Szpakowska	MS	Chief People Officer

Agenda Item	Description
	The Chair made the following statement on behalf of the Trust Board: On behalf of everyone at the Trust, I would like to offer my sincere condolences to all of those affected by the terrible incident in Liverpool on Monday. The Board is horrified and saddened by the events that happened at the end of what was a terrific day of celebration. Our thoughts are with those injured, their families and all the people who witnessed the incident. A communication had been circulated to staff recognising the response of the emergency services to the major incident and reminding staff of the support available if they were affected by these events.
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for May 2025 was Richard Staples, Operations Manager, IT and the Board watched the film of MG reading the citation and presenting the award to Richard. **RESOLVED:** The Board **noted** the Employee of the Month for May 2025 and congratulated the winner
2.	**Patient Story**
	2.1. SR welcomed YM and NMc to the meeting. 2.2. YM introduced the Patient Story video in which Joseph shared his experience of the End-of-Life care that was given to his grandmother in the Accident and Emergency (A&E) Department at Southport Hospital. Joseph described how his grandmother had received care from the Northwest Ambulance Service (NWAS) before being transferred to the A&E following a cardiac arrest. Joseph explained how he and his family were given immediate access to the relative's room on their arrival and how, despite the department being busy, staff had made sure that they were comfortable, and their privacy maintained. Joseph reflected on the compassionate explanation regarding his grandmother's condition which had been very comforting to the family. The nursing staff had requested spiritual care and chaplaincy support who arranged an urgent visit from the Roman Catholic priest and Patricia had died peacefully with her family around her. 2.3. Joseph had made several recommendations to improve the care received and these included:

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

2.4. YM commented that the story had demonstrated that despite a positive experience there were still lessons to be learnt. The Trust had acted on Joseph's recommendations and these included:
2.4.1. Changing the lights in the relatives room to a dimmer switch and placing two small desk lamps and a sideboard with additional items in the room.
2.4.2. A meeting had been arranged to discuss the options available to the Trust for patients and relatives to charge their phones and colleagues from Estates and Facilities and Procurement would be attending.

2.5. NMc commented that the A&E Department at Southport Hospital was currently undergoing some reconfiguration work and, whilst, the location of the relatives room has never before been raised as an issue, this has been discussed with the Deputy Divisional Director of Nursing, Medicine and Urgent Care. The relatives room was currently located near the mental health room and, if the room could not be relocated, it would be important to ensure that mitigations were put in place to protect and safeguard bereaved families.

2.6. CE thanked YM and NMc for sharing the story and commented that she had been impressed by the speed with which the recommendations were addressed.

2.7. LB applauded Joseph for sharing the story at such a difficult time for his family and commented on the compassion that had been displayed by the staff. LB asked if the name of the consultant who looked after Joseph's grandmother was known as it was important to provide feedback to the consultant and the team who cared for the patient. RT commented that it was also important to provide feedback to the junior doctor who interacted with the family first. YM agreed to ensure that this was done.

2.8. LB noted that in other circumstances there were advantages to co-locating these two rooms and NB commented that the Head of Facilities Management, Southport Hospital, was reviewing the proposed design of the A&E to see if there were any options available within national guidance. There were several constraints within the department and these rooms were often multifunctional spaces. SR agreed that the important issue was to respond to the needs of families and loved ones in different situations.

2.9. GB reflected on the spiritual care provided to the patient and family and suggested that the positive feedback be shared with this team as well.

	RESOLVED: The Board **noted** the Patient Story *(YM and NMc left the meeting)*
3.	**Chair's Welcome and Note of Apologies**
	3.1. SR welcomed all to the meeting and in particular VH who was attending the meeting as an observer. SR noted that the Trust had been notified that AB had now stepped down from her role as the Stakeholder representative from Halton Council and thanked her for her contribution to the Board over the preceding two years. 3.2. SR acknowledged the following awards and recognition for Trust staff and services: 3.2.1. The Catering Team in the Spice of Life restaurant at Whiston Hospital achieved the highest possible food rating of 5 stars, showcasing their dedication to maintaining food safety standards 3.2.2. Rebecca Crooke, Digital Midwife, Ormskirk Hospital, represented TEAM MWL at the 60th Florence Nightingale Commemoration Service, which took place at Westminster Abbey in London. Rebeca recently completed an intensive 18-month Digital Leadership Scholarship with the Florence Nightingale Foundation 3.2.3. Louise Moylan, Smokefree Pregnancy Practitioner at Ormskirk Hospital, had been awarded a prestigious Cavell Star Award for her passion and work ethic in the Smoking Cessation service in maternity 3.2.4. MWL Procurement Team has been shortlisted in the Healthcare Supply Association (HCSA) North Regional Awards, recognising best practice and supply chain excellence for Procurement/Supply Team of the Year. The results would be announced on 05 June 2025 Apologies for absence were **noted** as detailed above
4.	**Declaration of Interests**
	4.1. There were no new declarations of interests in relation to the agenda items.
5.	**TB25/037 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 30 April 2025 and approved them as a correct and accurate record of proceedings subject to the following amendments: *5.1.1.* 6.2.1.8 to be amended to read '*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'* **RESOLVED:**

	The Board **approved** the minutes from the meeting held on 30 April 2025 subject to the amendment detailed above
6.	**TB25/035 Matters Arising and Action Logs**
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following action was closed: 6.2.1. Action Log number 9 (TB25/035 Patient Experience) – LB confirmed that Lancashire and South Cumbria Integrated Care Board (ICB) had been invited to comment on the draft Patient Experience and Inclusion Strategy but no feedback had been received. Action closed. **RESOLVED:** The Board **approved** the action log
Performance Reports	
7.	**TB25/039 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for April 2025 was presented.
7.1.	**Quality Indicators**
	7.1.1. LB and PW presented the Quality Indicators. 7.1.2. LB highlighted the following: 7.1.2.1. The inpatient Family and Friends Test (FFT) recommendation rate in April 2025 was 93.6% (target 90%). The Trust compared slightly below peers, and numerous interventions based on the feedback from national surveys were in place. Additionally, several local surveys of patients who had experienced urgent care and maternity services had been undertaken and work was ongoing with the Patient Experience Group. 7.1.2.2. Complaints response performance was 46.5% (target 80%) compared to 64.4% in March 2025. The reason for this was that there had been a focus on resolving the complaints that had already breached the time limits. An extraordinary effort was being made to clear this backlog of overdue complaints. 7.1.2.3. The nurse staffing fill rate was 98.1% (target 90%). The Trust was taking part in the Enhanced Therapeutic Observation of Care (ETOC) project, (sometimes also referred to as supplementary care), and work had been undertaken to understand the workforce requirements, policy and standards including the management of risks. The project had identified best practise which was being reviewed with NHS England (NHSE) and the regional finance team. 7.1.2.4. The pressure ulcers rate was 0.08 per 1,000 bed days in January 2025, which was below the year to date (YTD) position. Work was ongoing to ensure that the validation of pressure ulcers was up to date. An external

	independent review of the Trust's process was being planned for later in the year. 7.1.2.5. Patient falls resulting in harm across all Trust sites was 0.12 per 1,000 bed days in February 2025. The next steps for the external review included analysis of falls data, review of falls policies and Standard Operating Procedures (SOPS) and discussions with the falls practitioners. Feedback was expected before the end of June. 7.1.2.6. The Trust had exceeded the NHSE threshold of no more than 113 Clostridioides difficile (C.Diff) cases for 2024/25 with 114 cases reported to the end of March. The Trust had ended the year below the NHSE threshold of no more than 158 Escherichia coli (E-coli) cases for 2024/25 with 157 cases reported. 7.1.2.7. There had been outbreaks of Norovirus and Carbapenemase-producing Enterobacteriaceae (CPE) at Southport Hospital and work was ongoing to manage these and ensure IPC best practice. 7.1.2.8. A deep dive into the Methicillin-sensitive Staphylococcus Aureus bacteraemia (MMSA) had been undertaken as there had been an increase in the number of reported cases at MWL and at neighbouring trusts. The Infection, Prevention and Control (IPC) team had reviewed all the cases reported in 2024/25 and several interventions and lessons learnt had been highlighted and action plan produced. 7.1.3. PW highlighted the following: 7.1.3.1. No never events, intrapartum or neonatal deaths had been reported in April 2025. 7.1.3.2. The latest reported Hospital Standardised Mortality Ratio (HSMR) included data up to September 2024 and the in-month figure in September was 87.2. The YTD HSMR remained below 100 at 92.5 (93.3 for Whiston and St Helens Hospitals and 90.1 for Southport and Ormskirk Hospitals). 7.1.3.3. The Standard Hospital Mortality Indicator (SHMI) had decreased to 1.02 in December.
7.2.	**Operational Indicators**
	7.2.1. LN presented the operational indicators and noted that both Urgent and Emergency Care (UEC) and elective car recovery plans had been presented at the Finance and Performance Committee. 7.2.2. LN highlighted the following: 7.2.2.1. The 4hour mapped performance for MWL in April 2025 was 79.5% against the temporary national target of 78%. 7.2.2.2. Ambulance handover times within 30 minutes had improved to 56.1% of handovers being achieved within the target time in April (target 95%). In December 2024, 1,284 patients had waited over 60 minutes for ambulance handover at Whiston Hospital, which had decreased to 381 patients in April 2025. Handover times within 45 minutes were achieved for 74% of patients in April (compared to 57.5% in December). The national target for ambulance handovers is 15 minutes and was linked to a national rescue and release scheme for ambulance handovers within 45 minutes that

would be implemented in Cheshire and Merseyside (C&M) from 01 July. Work was ongoing to update the action cards and escalation to proactively review patient flow within the ED.

7.2.2.3. Following the May bank holiday weekend both Whiston and Southport EDs had been full to capacity and Opel 4 had been declared.

7.2.2.4. Non-Criteria to Reside (NCTR) patient numbers had reduced to 21.7% against a target of 15%. This was 20% on the Whiston site but remained higher at Southport due to the IPC issues on a number of wards, which were closed to new admissions and had visiting restrictions in place to control the outbreaks.

7.2.2.5. There had been an improvement in the number of discharges by midday, to 22% at Whiston Hospital, which had improved patient flow and reduced the number of patients on the bed list. It was 21% at Southport Hospital, despite the IPC measures which limited the use of the Discharge Lounge.

7.2.2.6. One of the areas of focus for the Urgency and Emergency Care (UEC) Recovery Plan, led by the C&M Chief System Improvement Delivery Officer, was a focus on a single point of access which would be provided by North West Ambulance Service NHS Trust (NWAS) who would direct patients to the most appropriate treatment option, thereby avoiding unnecessary ED attendances. Another proposal was to create an integrated discharge team, to help reduce the number of NCTR patients. Each Place/Local Authority was being set a target for arranging discharges of NCTR patients from hospital.

7.2.3. There were four in-hospital workstreams to the UEC Improvement Programme which had contributed to the improved performance in ambulatory care. The increased use of Same Day Emergency Care (SDEC) and the avoidance of admissions to hospital had contributed to the reduced length of stay in the ED. Work continued with the Emergency Care Improvement Support Team (ECIST) to reduce inpatient length of stay on the acute wards, including more effective board rounds and reducing the time to receive Take Home Medications (TTOs).

7.2.4. The key metrics for the UEC Recovery Plan were a 50% reduction in patients that had to be cared for on the ED corridor care, achieving the ambulance handover within 45 minutes and achieving the 4hour waiting time target for 78% of patients.

7.2.5. AMS reflected on the reduction in the number of new complaints received and asked whether this attributable to the improved performance in the ED. LB agreed to analyse the recent complaints data to see if there was a correlation with ED performance and patient flow improvements.

Action:
LB to review the latest complaints data to see if there was a reduction in complaints about ED waiting times.

	7.2.6. SR commented that NWAS served three different ICBs in the Northwest and asked if data was available to compare the performance across these different geographical areas. LN responded that there was published ambulance performance data for each ICB. East Lancashire Trust currently had the best ambulance handover time performance and the team were planning a visit to understand the East Lancashire handover process. LN advised that she had been invited to be part of the Regional Ambulance Improvement Group. The first meeting with NHSE had taken place recently and the challenges around the rescue and release model were discussed. Not all trusts had shown the same recent improvements in ambulance handover times as MWL. LN noted that in C&M NWAS did not operate a divert policy, but this was operated in Lancashire and South Cumbria and Greater Manchester and MWL sometimes received diverts from Wigan or Preston to Southport Hospital. 7.2.7. SR asked whether there was a single SDEC model across all hospitals. LN responded that at MWL the SDEC at Whiston Hospital was more established, while this service model was still developing at Southport, but SDEC activity was now increasing and contributing to the improvement in 4hour performance. There were challenges to ensure SDECs were not used as escalation beds, but the ED were working on a standardised MWL approach, as much as possible. 7.2.8. LN then highlighted the key points in relation to Elective Care performance for targets 2025/26: 7.2.8.1. A 5% improvement in patients completing their referral to treatment pathway (RTT) within 18 weeks by March 2026 compared to March 2025. In April RTT performance had been 64.3%, against the March 2026 target of 63.7%. The national performance target remained 92% but the improvement target for 2025/26 was 5% compared to the previous year. 7.2.8.2. The target was for less than 1% of an organisation's total waiting list to waiting over 52 weeks. In April performance was 2.7% (C&M was 2.6%) and work was ongoing to reduce this by improving theatre utilisation, and further work to validate the waiting list. 7.2.9. The Further Faster 20 Programme, which targeted patients who were off sick and not receiving a wage whilst waiting for surgery, had resulted in a 15.5% reduction for this cohort of patients. 7.2.10. Performance against the 62-day cancer standard was 85.7% (target of 85%) with national performance at 71.4% and C&M performance at 76.4%. Tumour site specific action plans continued to be delivered to improve performance. 7.2.11. Performance against the 28-day cancer standard had decreased from 77.8% in February 2025 to 74% in March 2025 (target 77%) and this driven by two tumour sites (skin and lower Gastrointestinal at Southport Hospital).

	Improvement plans were being developed and ways of transforming the services investigated. 7.2.12. RT reflected on the improvements in ED waiting time performance and ambulance handover times and asked whether this had resulted in improved patient flow. LN felt the biggest factors had been the reduction in NCTR patients and the focus on in-hospital processes, which had decongested the EDs.
7.3.	**Workforce Indicators**
	7.3.1. AMS, on behalf of MS, presented the Workforce Indicators and highlighted the following: 7.3.1.1. The compliance rate for mandatory training was 89.2% (target 85%) and the Executive Committee continued to review performance monthly to monitor compliance by staff group and division/service. The Quality Committee also received quarterly assurance reports. 7.3.1.2. The compliance rate for appraisals was 77% (target 85%) as the 20252/26 annual appraisal window for Agenda for Change staff had opened on 01 May 2025 and would close in September. 7.3.1.3. Sickness absence was above target at 6% in April, however, this was a 0.5% reduction from March 2025. The three top reasons for sickness remained stress, anxiety and depression, cough, cold and flu, and musculoskeletal health. A deep dive into sickness absence had been presented at the April Strategic People Committee and the Trust had performed well when benchmarked against other organisations. 7.3.1.4. Staff turnover had reduced from 0.9% in March to 0.6% in April (target 1.1%). 7.3.2. SC commented that he had attended a Teams Talk recently and there had been a lot of positive feedback and suggestions about the appraisal process, particularly on the completion of the form. The feedback from the Team Talk was being collated by the Organisational Development (OD) team. AMS thanked SC for this feedback and commented that several of the questions included on the forms were mandatory questions, for example flexible working and health and wellbeing. The feedback from the Staff Survey had highlighted that whilst a high number of appraisals were being completed, staff felt the quality of the discussions needed to be improved and the team was looking at ways to do this. SC suggested that having seen the appraisal form, his suggestion would be that the wording be reviewed to make the language more positive. AMS undertook to feed this back to the HR team.
7.4.	**Financial Indicators**
	7.4.1. GL presented the financial indicators and reminded the Board that in April 2025 a deficit plan of £22.2m had been agreed for 2025/26. The assumptions underpinning this plan were: 7.4.1.1. Non-recurrent deficit support of £18.8m. 7.4.1.2. Delivery of £48.2m recurrent Cost Improvement Programme (CIP)

	7.4.1.3. Realisation or reallocation of strategic opportunities of £8m 7.4.1.4. Realisation or reallocation of system led cost reductions of £27m 7.4.2. GL noted that the System risks/ strategic issues equated to a further 3% of CIP. Currently plans were in place for £3.7m 7.4.3. GL also noted that the deficit support funding had now been increased and this would be reflected in the M2 position. 7.4.4. At M1 a deficit of £6.7m had been reported which was in line with the plan or a £7.8m deficit without the deficit support funding. GL highlighted that it was important for the Board to understand the true Trust position without the deficit support funding, as this was not recurrent. 7.4.5. GL highlighted the following: 7.4.5.1. Agency spend had reduced to 2% of the pay bill which was an improvement of 40% compared to the same period in 2024/25 and a 12% reduction from March. 7.4.5.2. At M1 £3.7m of CIP had been delivered which was in line with the plan. 7.4.5.3. Cash balances at M1 were £3.2m and it was anticipated that cash would be an issue throughout the year. 7.4.5.4. There had been an improvement in aged debt, including the Lead Employer (LE) debt. This was a % of total turnover i.e. £2b, including Lead Employer 7.4.6. GL noted that there were several risks within the financial position including the 3% of additional CIP that was being held within the plan; Community Diagnostic Centre (CDC) income with discussions regarding the CDC Southport Hospital ongoing as part of the contract negotiations; the cost of the recently announced pay awards which were in excess of the 2.8% pay inflation assumed in the planning guidance. Further guidance on this from NHSE was awaited. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB25/040 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. RC presented the Executive Committee Assurance report from the meetings held in April 2025 and noted that any bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. Additionally, the meeting had received assurance reports from the weekly vacancy control panel. 8.1.2. RC highlighted the following items from the report:

	8.1.2.1. The Committee had reviewed the NHS National Uniform proposal for the Nurses and Allied Health Professionals (AHP). It would be a significant investment to replace all existing uniforms immediately; however, savings would be achieved in the long term. A Task and Finish Working Group would be established to draw up different options for the implementation of the new national uniform. A standardised uniform across MWL would be helpful to enable patients to identify different types of staff. 8.1.2.2. The Committee had reviewed the Urgent and Emergency Care (UEC) Care Quality Commission (CQC) action plan following the inspection of the ED at Whiston Hospital. It had been agreed that an overall UEC Improvement plan would be developed rather that individual plans that related to individual inspections or specific aspects of UEC and the Committee had reviewed this draft action plan and had suggested several amendments. RC confirmed the response had been submitted to the CQC to provide assurance that the specific actions following the inspection were being addressed. 8.1.2.3. The Committee had approved the Maternity Service specification. 8.1.2.4. The Committee had reviewed the Nursing Safer Staffing Report and noted that the staffing levels overall remained over 94% for registered nurses (RN) and Health Care Assistants (HCA). 8.1.2.5. The Committee had received the proposed 2025/26 Workforce Plan and discussed the challenges in delivering the expected full time equivalent (FTE) reductions and it was agreed that this would need to be done in a safe way and where there was no impact on patient care. 8.1.2.6. The Committee had received the latest position against the PricewaterhouseCoopers International Limited (PWC) Financial Grip and Control Action Plan. 8.1.2.7. The Committee had reviewed the national guidance and timetable for the Corporate Benchmarking returns for 2024/25. 8.1.3. RC advised that the following investment had been approved in April 2025: 8.1.3.1. Carbapenemase Producing Enterobacterales (CPE) Testing Business Case Addendum to introduce Polymerase Chain Reaction (PCR) testing for CPE. This would be used for quicker decisions so that patients were not isolated for lengthy periods in side rooms. This would improve patient flow and improve quality and safety. 8.1.4. NF agreed that it was important to implement the national uniform but felt that there would be a considerable cost. RC responded that there were costs associated with providing the current uniforms which were more expensive than the new uniforms and commented that there were benefits to being aligned, especially for patients. NB commented that the Trust held a stock of uniforms which had a value attached and that there were other staff, for example HCA's or Domestics, who also wore uniforms and this would need to be taken into account to avoid any confusion. RC noted that this had been considered by the working group. SR asked if there had been discussions with staff around the new uniform. RC responded that an extensive national consultation had taken place, and the new uniforms took account of

	inclusivity and diversity needs. The working group would also include a communications work stream. LB confirmed that roadshows were being planned for each site and engagement with senior staff had already taken place. Staff were being given the opportunity to see and try on the new uniforms. The University Hospitals of Derby and Burton NHS Foundation Trust (UHBB) had already implemented the new national uniform and a site visit was planned. 8.1.5. GB noted the item about the neonatal cot reconfiguration and asked that the proposed changes be presented to Quality Committee to assess the impact. **ACTION** LB to present an update on the neonatal cot reconfiguration at the Quality Committee. 8.1.6. RT asked about a recent communication regarding the gaps in the neonatal service and RC clarified that this had related to transitional care for babies with retinopathy and prematurity and noted that work was ongoing to improve this service. LB advised that there was a 'live' dashboard in place to monitor demand. 8.1.7. CS asked if MWL worked with the North West United Network in relation to early supported discharge for families who were a long way from home. LB was not aware that the Trust was involved by agreed to look into this. The remainder of the report was **noted.**
8.2.	**Quality Committee**
	8.2.1. GB presented the Quality Committee Assurance Report for the meeting held on 20 May 2025 and noted that several items would be discussed in reports later on the Board agenda. 8.2.2. Other items to highlight were: <u>Corporate Performance Report (CPR)</u> 8.2.2.1. One case of Methicillin-Resistant Staphylococcus Aureus (MRSA) had been reported in month which had been unavoidable, however, there had been some shared learning. 8.2.2.2. Venous Thromboembolism (VTE) risk assessments were reported at 77.9% (target 95%) and there had been a positive step change, particularly at Whiston Hospital, following a change in process that had been trialled across several wards. 8.2.2.3. Sepsis data was for December 2024 and the Committee had noted the lag was due to the external reporting and this was the same for all organisations. A Task and Finish Group had been established to identify ways to improve sepsis performance. <u>Infection, Prevention and Control (IPC) Quarter 4 Report</u> 8.2.2.4. The Trust had reported one case above the NHSE threshold of no more than 113 cases for 2024/25 of C.Diff

	8.2.2.5. Six MRSA cases had been reported in 2024/45 of which one had related to cannula care. This was an improvement compared to 2023/24 when there had been five cases relating to cannula care. 8.2.2.6. There were no NHSE thresholds in place for Methicillin-sensitive Staphylococcus Aureus bacteraemia, however there had been an increase in the number of cases reported and this was in line with regional and national position. The Committee had requested an action plan in response to this increase. 8.2.2.7. Training for level 1 and 2 Aseptic Non Touch Technique had been harmonised across the Trust and the training needs analysis (TNA) implementation plan had been approved by the Executive Committee. 8.2.2.8. Escherichia coli (E.Coli), Klebsiella and Pseudomonas were all reported below target at year end and this was an improvement on 2023/24. 8.2.2.9. There had been 33 outbreaks during Q4, particularly at Southport Hospital and this was reflected in the operational performance and impacts on patient flow. There was work being undertaken to reduce the risk of further outbreaks. <u>Mandatory Training Compliance Q4 Report</u> 8.2.2.10. There had been continuing improvement in core mandatory training during 2024/25. 8.2.2.11. The Committee had noted the additional monitoring of areas where compliance was below target. <u>Quality Committee Annual Effectiveness Review</u> 8.2.2.12. The Committee had received the report and approved the 2025/26 workplan. It was noted that there had been improvements compared to 2023/24 following implementation of the agreed action plan. <u>Clinical Effectiveness Council Assurance Reports (April and May 2025)</u> 8.2.2.13. An audit of Do Not attempt Cardiopulmonary Resuscitation (DNACPR) had shown 100% appropriate reasons for the decisions made. 8.2.2.14. Concerns about Lung Specialist Nurse clinic cover had been raised as the fixed term funding for a post was due to expire in June 2025. 8.2.2.15. Acute Kidney Injury (AKI) rates remained above expected level and work was ongoing across the Trust to improve hydration to reduce AKI post-operatively. 8.2.3. GB reflected on the comprehensive Maternity and Neonatal Q4 Report and thanked the Director of Midwifery for drafting the report and noted that LB would be nominating her for a Chief Midwife Award. 8.2.4. GB commented on the work undertaken on the Nursing Establishment Review and thanked LB and the team for their hard work. The remainder of the report was **noted**.
8.3.	**Strategic People Committee**

	8.3.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 21 May 2025 and highlighted the following: 8.3.1.1. The Committee had received the Looking after Our People Operational Delivery Plan for 2025/26. 8.3.1.2. The Committee had received the Culture and Engagement Update which included the programme of events for 2025/26. The programme of events would be shared with Board members. 8.3.1.3. The Committee had received the six Equality, Diversity & Inclusion High Impact Actions (HIAs) plans. 8.3.1.4. The Committee received the Lead Employer (LE) People Plan 2025-28. The LE Stakeholder Survey Action Plan Report, in which the actions were aligned to each of the four pillars, was also reviewed. The remainder of the report was **noted**.
8.4.	**Finance and Performance Committee**
	8.4.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 22 May 2025 and noted GL's apologies for the meeting. 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. 8.4.2. Other points to highlight from the report were: 8.4.2.1. The Annual Committee Effectiveness Review report was received and the recommendations had been noted. 8.4.2.2. C&M has been put into formal turnaround by NHSE and a diagnostic exercise was being undertaken by PricewaterhouseCoopers International Limited (PWC) supplemented by a Cost Improvement Programme (CIP) review, in addition to supporting the work of the Chief System Improvement Delivery Office work. The resource impact of supporting these reviews was noted by the Committee. 8.4.2.3. The Committee had noted the strong performance in the M1 finance report including agency cost reductions. 8.4.2.4. The Committee had received the Women and Children Division CIP update and it was noted that there was a good pipeline in place. 8.4.2.5. The Committee had received a detailed update on the cash position for the Trust and expectations for managing cash from NHSE. 8.4.2.6. The Committee had received the Elective Care Recovery Review and a further update, which included the aggregated impact of the various schemes, was requested for October, using a tracking methodology similar to that used to track CIPs. 8.4.3. SR reflected on all the different 'grip and control' meetings that were taking place and reflected that this felt like duplication of effort and that there could be a risk of double counting the benefits. 8.4.4. The Committee had received council assurance reports from the Procurement Council which included the approve of the Terms of Reference,

	CIP Council, Estates & Facilities Management Council, and IM&T Council, with no issues escalated. 8.4.5. The Committee alerted the Board to the risk in relation to cash management during 2025/26 and withdrawal of the usual national support for cash flow fluctuations. SR noted the risk and that there was a detailed briefing on the Closed Board agenda for the Board to explore the implications and mitigation strategies to manage this risk. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**TB25/041 National Quality Board Reports**
	9.1. LB presented the MWL Nurse Staffing Establishment Review which provided assurance that Merseyside and West Lancashire NHS Teaching Hospitals (MWL) has arrangements in place to review the nursing and midwifery staffing establishments in line with regulatory requirements. The reviews are undertaken twice yearly for acute inpatients wards based on the bed configuration and clinical pathways in place. 9.2. LB noted the following: 9.2.1. Going forward changes to the process were proposed to the timetable and prioritisation of areas of concern for a higher level of review. 9.2.2. Staffing levels were reviewed against several different measures, in line with national guidance. 9.2.3. There were differences in Care hours per patient per day (CHPPPD) across the legacy Trust sites due to historic decisions about the roles included in the nurse establishment. 9.2.4. Professional judgement was also important from staff who understood the services and patient acuity. 9.3. LB highlighted the following from the report: 9.3.1. A comprehensive review of the Southport ED staffing had been completed earlier in the year and the staffing levels had been increased. 9.3.2. The work on supplementary care at Whiston Hospital had been undertaken during 2024/25 which had highlighted the spend on bank shifts. A different model of care had been introduced and the use of HCA agency staff was no longer being sanctioned. A similar review was required for the high acuity medical wards at Southport Hospital. 9.3.3. Further staffing reviews were needed to ensure a consistent model of staffing for the acute non-invasive ventilation (NIV) beds at Whiston and Southport Hospitals. 9.3.4. Recommendations made to the Executive Committee as a result of the review included

	9.3.5. Support to realign existing funding between the surgical wards to change skill mix between RN and HCA staff on three wards. 9.3.6. Seven day catering assistant support for the spinal injuries unit. 9.3.7. An additional band 4 RN associate for nights on Newton ward. 9.3.8. These recommendations had been approved. 9.4. LB noted that the last Birthrate plus review of Midwifery staffing had taken place in 2022 and the process would need to be repeated in 2025. 9.5. Also, the increase in the number of children with eating disorders, Children and Adolescent Mental Health Services (CAMHS) and mental health issues being admitted to the Paediatric Ward at Whiston Hospital was causing considerable strain as these patients often had long lengths of stay and were both complex and challenging to care for. If this trend continued the staffing on these wards would need to be reviewed to reflect the acuity and special needs of these patients. 9.6. LB reported that the next review would focus on the ED departments following the feedback in the recent CQC reports, plus operating theatres, critical care and outpatients. 9.7. NF asked for clarity about the role of the catering assistant for the Spinal Injuries Unit. LB responded that at the former St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) Catering Assistants were Facilities Management roles whilst at the former Southport and Ormskirk Hospital NHS Trust (S&O) some of the wards had catering assistants whilst others had an additional allowance of HCAs to undertake this role. Work was ongoing to harmonise staffing models across the sites. In the meantime the Catering Department would now be responsible for the catering assistants supporting the Spinal Injuries Unit and this increase in the establishment would enable seven day cover. 9.8. LK asked how the reviews for specialist services such as NIV would be taken forward. LB responded that there would be an assessment of the differences between the two legacy service and staffing models to see if a single model could be adopted for MWL. **RESOLVED:** The Board **note** the MWL Nurse Staffing Establishment Review
10.	**TB25/042 Aggregated Incidents, Complaints and Claims Report (Q4)**
	10.1. LB presented the Aggregated Incidents, Complaints and Claims Report (Q4) of 2024/25. 10.2. LB highlighted the following: 10.2.1. The new InPhase system had been introduced in March 2025 and the challenges of combining the information from the two legacy trusts' DATIX

systems into a single system had been a challenge. One of the benefits of having a single system in place was to allow for MWL wide reporting, and the 2025/26 Q1 report would look different. The enhanced reporting capabilities of InPhase would also allow the Quality and Risk teams to undertaken more detailed analysis to support continuous improvement.

10.2.2. The Trust benchmarked well in terms of the numbers of Patient Safety Incident Investigations (PSII), learning reviews and extended learning reviews undertaken.

10.2.3. The Duty of Candour (DoC) policy had been updated and had elected for an approach that focused on the harm whether it was known that this could be validated or not, rather than wait until the investigation had been completed. The Trust had chosen to include patients and families at the start of the intervention and this decision had been based on the Trust's values.

10.2.4. Whilst the Trust was compliance with the DoC when cases were reviewed, an update had been requested on two of the cases. The DoC on one of these cases had been completed, but for the other attempts to contact the patient had been unsuccessful.

10.2.5. The Complaints performance target was for 80% to be completed within 60 days. In Q4 there had been several complex cases that had breached. The EDs at Whiston and Southport Hospitals remained the areas receiving the most complaints.

10.2.6. Reviews of the upheld and not upheld outcomes showed that more complaints were being upheld. The reasons for this were being investigated further to establish if it was a trend.

10.2.7. There had been a spike in the number of pre-action claims in Q3 of 2023/24 and whilst these requests had steadily declined during 2024/25, there had 87 requests for records received in Q4 compared to 50 requests in Q3. However, there had not been a corresponding increase in the number of new claims. No new specific learning had been identified from any of the claims closed in Q4. The Trust was aware of any failings in care that had been highlighted as part of a claim and actions were in place to address them.

10.2.8. The Trust had been notified of 27 new inquests during Q4 and 25 inquests had been completed, most without a formal hearing. No Prevention of Future Deaths notices had been issued as a result of any of the inquests.

10.3. LB advised that the Senior Coroner for Sefton, Knowsley and St. Helens (Julie Goulding) would be retiring in June 2025 and formerly thanked her on behalf of the Trust.

10.4. RT asked if the reduction in the number of reported incidents in Q4 was as a result of the introduction of InPhase. LB responded that InPhase was implemented in March so would only have impacted one month of the quarter. The team had closely monitored the incident reporting trends and feedback about accessing and using InPhase to address any barriers to reporting. A temporary dip had been anticipated during the immediate post implementation period, but this had not continued as staff got used to the new system.

	RESOLVED: The Board **noted** the Aggregated Incidents, Complaints and Claims Report (Q4)
11.	**TB25/043 Maternity and Neonatal Services Assurance Report Quarter 4**
	11.1. LB presented the Maternity and Neonatal Services Assurance Report for Quarter 4. It was noted that a more in-depth report had been presented at the Quality Committee, by the Divisional Director of Midwifery. 11.2. This was a standard report that was required by the Local Maternity and Neonatal System (LMNS) as part of the Clinical Negligence Scheme for Trusts (CNST) and the Maternity Incentive Scheme (MIS). 11.3. The Trust had self-declared full compliance for Year 6 MIS against all ten safety actions for Whiston and Ormskirk Maternity units in March 2025 and this had now been confirmed by NHS Resolution. Work was underway on the Year 7 safety actions which had been released in April 2025. 11.4. LB highlighted the following: 11.4.1. There had been six reportable deaths in Q4 and all cases had undergone an MDT review with the commencement of the Perinatal Mortality Review Tool (PMRT) process where applicable. Care was reviewed and assessed for all cases using the Mothers and Babies: Reducing Risk through Audits (MBRRACE) categorisation. 11.4.2. There had been one reportable Maternity and Newborn Safety Investigation (MNSI) reported in Q4. 11.4.3. One never event had been reported in Q4 related to a retained swab. A Trust-wide review of safety checks had been initiated and was being led by PW. 11.4.4. The Saving Babies Lives (SBL) project had shown an improvement in the outcomes for babies, and this included the public health initiatives in relation to smoking cessation, monitoring reduced foetal movement and growth and mothers with diabetes. SBL was included as part of Safety Action 6 for MIS Year 7. LB reported that the LMNS had recognised the improvement in overall compliance to 97% for both Whiston and Ormskirk Maternity Units. 11.4.5. The Whiston and Ormskirk Maternity Units were last inspected by the CQC in December 2023. The action plans based on CQC report recommendation were almost completed. A Divisional Strategy had been drafted but not yet formally approved. 11.4.6. Safety Action 4 (Neonatal staffing) and Safety Action 5 (Maternity Workforce) highlighted that the Trust had a 100% compliance rate with one to one care in labour. 11.4.7. It was a mandatory requirement to ensure that 70% of the neonatal workforce were Qualified in Speciality (QIS) and a programme was in place to support staff to achieve this qualification. There were challenges in recruiting experienced neonatal nurses and releasing staff to obtain the qualification, due to national staff shortages 11.4.8. The Maternity Safety Champions met monthly with the Maternity team and additional safety champions were being recruited from all staff grades. .

	11.4.9. The Perinatal Quality Surveillance Model (PQSM) tool was reported at the Maternity Safety Champions meetings and at the Quality Committee. 11.5. There had been 12 neonatal unit closures reported in Q4 (three at Whiston and nine at Ormskirk Maternity Units) and LB assured the Board that no patients from the units had been transferred out of the organisation and the closures were to manage risk internally. One mother, who needed a Category 3 Caesarean Section, was transferred from Whiston to Ormskirk and the baby was delivered safely and cared for on the Ormskirk neonatal unit until discharged home. 11.6. The maternity red flags had been reviewed in detail at the Quality Committee, and it was noted that 100% of the red flag incidents had been due to triage times. The issue had now been resolved and the next step would be to have a single triage team across the Trust which would ensure resilience. 11.7. Work around the continuity of care and the implementation of a maternity Electronic Patient Records (EPR) system as part of the NHSE Three-Year Delivery Plan for Maternity and Neonatal Services was ongoing. 11.8. LB reported that the NHSE Midwifery Team had visited both units, and the feedback had been positive. 11.9. RT acknowledged the success of the work undertaken to harmonise the culture across the two maternity units and in particular the introduction of the single triage system. 11.10. RT commented that during a recent safety champion walkabout on the Ormskirk Maternity Unit, staff had been aware of the recent never event and the actions that had been put in place following it, which she felt demonstrated a positive learning culture. **RESOLVED:** The Board **noted** the Maternity and Neonatal Services Assurance Report Quarter 4
12.	**TB25/044 Quality Account**
	12.1. LB presented the draft Quality Account for 2024/25 for MWL and noted that the report had been reviewed by the Executive Committee and Quality Committee and was recommended to Board for approval. 12.2. The report had been presented to the C&M ICB and local Healthwatch colleagues and no immediate amendments were requested. The report had also been presented to the Sefton Council's Oversight and Scrutiny meeting and several minor amendments had been suggested, including additional assurances about how the Trust would respond in the event of a cyber-attack, and to develop a 'plan on a page' for the quality improvements. A summary version of the Quality Account would be uploaded to the Trust's website.

	12.3. The Quality Account had to be published by 30 June 2025. 12.4. LB thanked the Deputy Director of Governance, Quality and Patient Experience and the Assistant Director of Quality for compiling the report. 12.5. CE felt the document provided a good overview of the organisation's achievements and challenges during 2024/25, for the Trust and its system partners. 12.6. SR suggested that it any Board member had any further minor comments they should provide these to LB within a week, but if the Board were content overall the document could be approved. **RESOLVED:** The Board **approved** the Quality Account
13.	**TB25/045 2024/25 Board and Committee Effectiveness Review**
	13.1. NB presented the revised Terms of Reference (ToR) for the Board and its Committees which reflected the outcomes of the 2024/25 meeting effectiveness review process. NB noted that the effectiveness reviews of each Committee had been considered at that Committee and a full summary would be presented to the Audit Committee. 13.2. NB thanked the Corporate Governance Manager who had done most of the work on this year's effectiveness reviews. 13.3. There were no significant amendments proposed, with changes mainly reflecting changes to job titles. **RESOLVED:** The Board **approved** the updated Terms of Reference following the Annual Effectiveness Reviews
14.	**TB25/046 Review of Trust Objectives for 2024/25**
	14.1. RC presented the Review of Trust Objectives for 2024/25 and noted that at the mid-year review in November 2024 four of the objectives had been achieved and three were at risk of not being fully delivered by 31 March 2025. At the end of 2024/25 16 of the objectives had been fully achieved, 15 were partially achieved and one had not been delivered. 14.2. The objective not delivered was 2.2 (reduce the incidence of MRSA healthcare associated bacteraemia infections to meet the zero-tolerance threshold and a 15% reduction of avoidable hospital onset MSSA bacteraemia's). As noted in the Quality Committee Assurance report that there had been six MRSA cases

	reported during 2024/25 which was an increase on the five cases reported in 2023/24. The Trust had achieved a compliance rate of 92.8% (target of 85%) for ANTT Level 1 (theory), however, the minimum compliance of 85% for Level 2 (practical) had not been achieved. Additionally, the MRSA screening compliance was below the target of 95% and this metric would remain as an area of focus going forward. **RESOLVED:** The Board **noted** the Review of Trust Objectives for 2024/25
Concluding Business	
15.	**Effectiveness of Meeting**
	15.1. SR invited comments on the effectiveness of the meeting. 15.2. RC felt it had been a well chaired meeting.
16.	**Any Other Business**
	16.1. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.12 The next Board meeting would be held on **Wednesday 25 June 2025 at 09:30**

Meeting Attendance 2025/26												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Steve Rumbelow		✓										
Richard Fraser (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	✓	A										
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 25 June 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
10	28/05/2025	**TB25/039 Integrated Performance Report** 7.2 Operational Indicators	LB to review the latest complaints data to see if there was a reduction in complaints about ED waiting times .	LB	Jul-25		
11	28/05/2025	**TB25/040 Committee Assurance Reports** 8.1 Executive Committee	LB to present an update on the neonatal cot reconfiguration at the Quality Committee as part of the next Maternity and Neonatal Service Assurance Report in November 2025.	LB	Nov-25		Report to be presented at Quality Committee

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	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.	LB	May-25	**28/05/2025** - LB advised that Lancashire and South Cumbria Intergrated Care Board had been asked to comment on the draft strategy but no feedback had been received. **Action closed**	**Closed**

Title of Meeting	**Trust Board**		**Date**	**25 June 2025**
Agenda Item	**TB25/049**			
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 29 key metrics. Quality has 11 metrics, Operations 11 metrics, Workforce 4 metrics and Finance 3 metrics.
Financial Implications
The forecast for 2024/25 financial outturn will have implications for the finances of the Trust.
Quality and/or Equality Impact
The 10 metrics for Quality provide an overview for summary across MWL.
Recommendations
The Trust Board is asked to note performance for assurance.

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

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	Nov-24	84.2	100	90.4	
FFT - Inpatients % Recommended	May-25	94.3%	90.0%	94.0%	Best 50%
Nurse Fill Rates	Apr-25	98.7%	90.0%	98.7%	
C.difficile	May-25	11		17	
E.coli	May-25	16		28	
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-25	0.08	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Apr-25	0.14	0.00	0.14	
Stillbirths (intrapartum)	May-25	0	0	0	
Neonatal Deaths	May-25	0	0	0	
Never Events	May-25	0	0	0	
Complaints Responded In 60 Days	May-25	47.2%	80.0%	46.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Apr-25	68.2%	77.0%	68.2%	Worst 30%
Cancer 62 Days	Apr-25	80.9%	85.0%	80.9%	Best 20%
% Ambulance Handovers within 30 minutes	Apr-25	56.1%	95.0%	56.1%	
A&E Standard (Mapped)	May-25	79.5%	78.0%	79.5%	Best 30%
Average NEL LoS (excl Well Babies)	May-25	4.0	4.0	3.9	Best 30%
% of Patients With No Criteria to Reside	May-25	19.1%	10.0%	20.4%	
Discharges Before Noon	May-25	19.2%	20.0%	20.3%	
G&A Bed Occupancy	May-25	98.1%	92.0%	98.2%	Worst 30%
Patients Whose Operation Was Cancelled	May-25	1.1%	0.8%	1.0%	
RTT % less than 18 weeks	May-25	64.7%	92.0%	64.7%	Best 30%
18 weeks: % 52+ RTT waits	May-25	2.8%	1.0%	2.7%	Worst 40%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	May-25	74.2%	85.0%	74.2%	
Mandatory Training	May-25	89.5%	85.0%	89.5%	
Sickness: All Staff Sickness Rate	May-25	5.9%	5.0%	6.0%	
Staffing: Turnover rate	May-25	0.6%	1.1%	0.6%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	May-25		10,383	1,519	
Cash Balances - Days to Cover Operating Expenses	May-25	1.5	10		
Reported Surplus/Deficit (000's)	May-25		-11,416	-11,403	

Board Summary - Quality

Quality

Clostridium difficile infection - There were 8 HOHA and 3 COHA cases at MWL in May. The CDI Improvement Plan continues into the new financial year, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training.

E coli - There were 16 healthcare-associated cases in May, 10 HOHA and 6 COHA, which is one case below NHSE threshold.

Never Events - There were no never events in May

Complaints: There has been a significant increase in the number of complaints received Trust wide in May. The majority of these have been received on the Whiston site. It is to be recognised that there has been a 50% reduction in complaints being re-opened at the second stage which evidences the improvements in quality of complaint responses across the Trust. There has been an increase in the number of complaints that have been closed within timescales. Due to the focus and associated progress during April and May on clearing those complaints that had breached there has been a drop in compliance however it is anticipated that the next scheduled report will deliver an increase in Trust wide compliance figures.

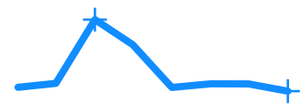
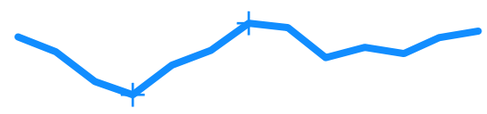
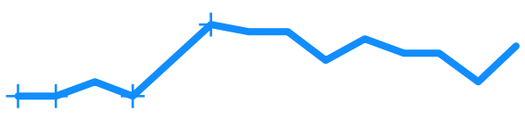
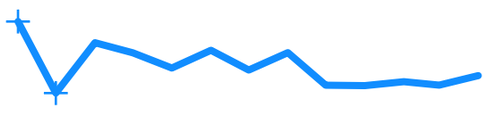
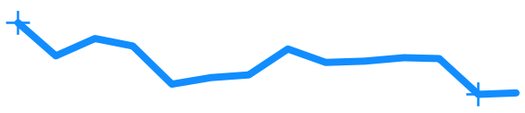
Mortality - Data covers deaths in the Trust until Nov 2024. The latest month (Nov-24) HSMR for MWL was 84.2. All individual diagnosis groups with HSMR alert for this period have had deaths reviewed with none highlighting any areas of concern. The latest 12 months (ending Nov-24) had an overall low HSMR (90.1 for MWL, 91.6 for S&O and 89.6 for STHK). The YTD HSMR remains below 100 (90.4 for MWL, 86.6 S&O and 91.7 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	Nov-24	84.2	100	90.4	Worst 50%	
FFT - Inpatients % Recommended	May-25	94.3%	90.0%	94.0%	Best 50%	
Nurse Fill Rates	Apr-25	98.7%	90.0%	98.7%		
C.difficile	May-25	11		17		
E.coli	May-25	16		28		
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-25	0.08	0.00	0.13		
Falls ≥ moderate harm per 1000 bed days	Apr-25	0.14	0.00	0.14		
Stillbirths (intrapartum)	May-25	0	0	0		
Neonatal Deaths	May-25	0	0	0		
Never Events	May-25	0	0	0		
Complaints Responded In 60 Days	May-25	47.2%	80.0%	46.8%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E: 4-Hour performance decreased in May, achieving 74.4% (all types). Trust performance dropped below National (75.4%), and ahead of C&M (73.7%). The Trusts mapped 4-Hour performance achieved 79.5%.

Patient Flow: Bed occupancy across MWL averaged 104.4% in May equating to 74.8 patients - similar to the 105.9% reported in April. There was a peak of 116 patients (52 at S&O, 82 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 5% higher than last May, driven by a 8% increase in 0 LOS activity, and a 3% increase in 1+ day LOS activity. Southport had a 79.2% increase in 0 LOS from May 24 to May 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 9.8 at S&O and 7.6 at StHK, with an overall average of 8.2 days, the impact of non CTR patients being 19.1% at Organisation level, 2.6% lower than April and 2.9% lower than May 2024 (18.9% StHK and 19.6% S&O).

Elective Activity: The Trust had 2090 52-week waiters at the end of May, (407 S&O and 1683 StHK), 221 65-week waiters and 6 78-week waiters.
The 52-week position is an increase of 78 from April and the 65-week waiters have increaesd by 86% from April to May.
18-Week performance in May for MWL was 64.7%, S&O 66.3% and StHK 63.9%. This was ahead of national performance (latest month April) of 59.7% and C&M regional performance of 58%.

Cancer: Cancer performance for MWL in April deteriorated slightly, at 68.2% for the 28 day standard (target 77%), with Southport achieving 47.9% and St Helens performance being 79.5%. Latest published data (April) shows national performance of 76.7% and C&M regional performance of 75.4%. Performance for 62-day decreased, achieving 81% (target 85%), with Southport achieving 67.7% and St Helens 86.5%. C&M performance was 76.1% and National 69.9%. 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 2025/26.

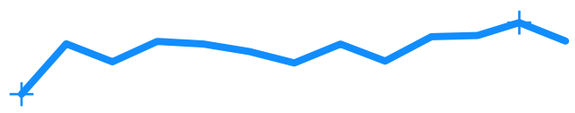
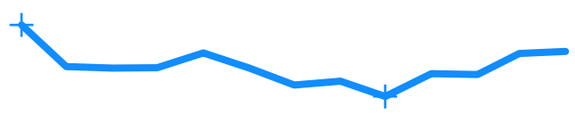
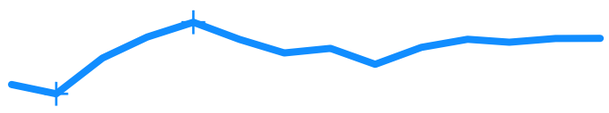
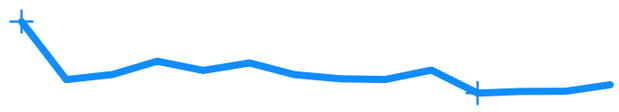
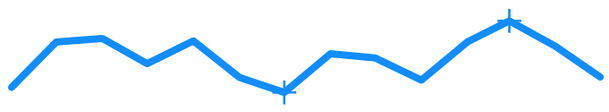
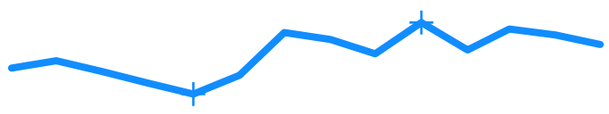
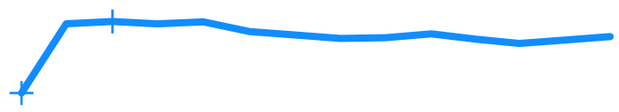
Diagnostics: Diagnostic performance in May was 85.3% for MWL, failing to achieve the 95% target, with S&O achieving 94.2% and StHK 80.6%. MWL performance is ahead of national performance (latest month April) of 78.8% and C&M regional performance of 89.9%.

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	Apr-25	68.2%	77.0%	68.2%	Worst 30%	
Cancer 62 Days	Apr-25	80.9%	85.0%	80.9%	Best 20%	
% Ambulance Handovers within 30 minutes	Apr-25	56.1%	95.0%	56.1%		
A&E Standard (Mapped)	May-25	79.5%	78.0%	79.5%	Best 30%	
Average NEL LoS (excl Well Babies)	May-25	4.0	4.0	3.9	Best 30%	
% of Patients With No Criteria to Reside	May-25	19.1%	10.0%	20.4%		
Discharges Before Noon	May-25	19.2%	20.0%	20.3%		
G&A Bed Occupancy	May-25	98.1%	92.0%	98.2%	Worst 30%	
Patients Whose Operation Was Cancelled	May-25	1.1%	0.8%	1.0%		
RTT % less than 18 weeks	May-25	64.7%	92.0%	64.7%	Best 30%	
18 weeks: % 52+ RTT waits	May-25	2.8%	1.0%	2.7%	Worst 40%	

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 89.5% 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 has reduced in May 2025 to 74.2%. 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 with high quality appraisals.

Sickness - In-month sickness continues to be above target, at 5.9% against the 5% target. This is a slight reduction of 0.1% compared to April. In May there was an improvement of 0.5% in sickness absence at Southport and Ormskirk sites however and St Helens and Whiston sites sickness increased by 0.6%

The top 3 reasons for sickness in April continue to be 1) Stress, Anxiety & Depression, 2) Gastrointestinal and 3) MSK. A sickness absence improvement plan has been developed and progress is being 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.

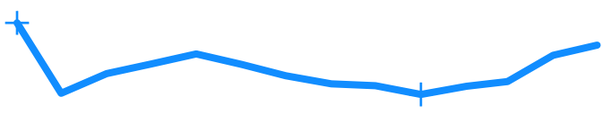
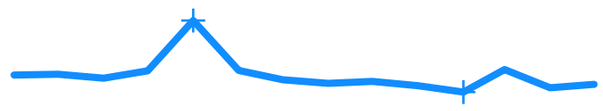
Turnover- In month turnover continues to be below our targe of 1.1% at 0.6%.

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	May-25	74.2%	85.0%	74.2%		
Mandatory Training	May-25	89.5%	85.0%	89.5%		
Sickness: All Staff Sickness Rate	May-25	5.9%	5.0%	6.0%		
Staffing: Turnover rate	May-25	0.6%	1.1%	0.6%		

Board Summary - Finance

Finance

The approved MWL financial plan for 2025/26 submitted in May 2025 gives a deficit of £10.7m, assuming:
-Non-recurrent deficit support of £30.2m.
-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 2, the Trust is reporting an adjusted deficit position of £11.4m 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 2, the Trust has successfully transacted CIP of £7.4m year to date, in line with plan. The recurrent full year effect of delivered schemes is £7.9m (16% of the £48.2m recurrent target).

Cash - At the end of M2, the Trust's cash balance was £3.7m. The Trust has reported to NHSE as part of its 2025/26 annual plan, that it 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.

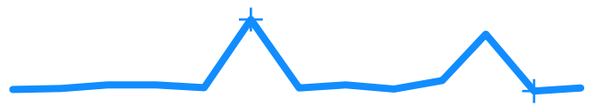
Capital - The capital plan for the year is £64.6m (including PFI lifecycle and lease remeasurements). Capital expenditure for the year to date [including PFI lifecycle maintenance and lease remeasurements] totals £1.5m, which is £11.2m below plan. At M2, the plan assumes expenditure of £2.8m for several 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	May-25		10,383	1,519		
Cash Balances - Days to Cover Operating Expenses	May-25	1.5	10			
Reported Surplus/Deficit (000's)	May-25		-11,4...	-11,4...		

Board Summary

Legacy S&O

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Nov-24	83.2	100	86.6	
FFT - Inpatients % Recommended	May-25	96.5%	90.0%	95.7%	
Nurse Fill Rates	Apr-25	100.3%	90.0%	100.3%	
C.difficile	May-25	4		6	
E.coli	May-25	6		8	
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-25	0.16	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Apr-25	0.32	0.00	0.32	
Stillbirths (intrapartum)	May-25	0	0	0	
Neonatal Deaths	May-25	0	0	0	
Never Events	May-25	0	0	0	
Complaints Responded In 60 Days	May-25	62.5%	80.0%	47.2%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Apr-25	47.9%	77.0%	47.9%	
Cancer 62 Days	Apr-25	67.7%	85.0%	67.7%	
% Ambulance Handovers within 30 minutes	Apr-25	62.2%	95.0%	62.2%	
A&E Standard (Mapped)	May-25				
Average NEL LoS (excl Well Babies)	May-25	4.2	4.0	4.1	
% of Patients With No Criteria to Reside	May-25	19.6%	10.0%	20.4%	
Discharges Before Noon	May-25	19.4%	20.0%	20.2%	
G&A Bed Occupancy	May-25	97.3%	92.0%	97.7%	
Patients Whose Operation Was Cancelled	May-25	0.7%	0.8%	0.8%	
RTT % less than 18 weeks	May-25	66.3%	92.0%	66.3%	
18 weeks: % 52+ RTT waits	May-25	1.8%	1.0%	1.6%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	May-25	66.8%	85.0%	66.8%	
Mandatory Training	May-25	90.1%	85.0%	90.1%	
Sickness: All Staff Sickness Rate	May-25	5.6%	5.0%	5.5%	
Staffing: Turnover rate	May-25	0.5%	1.1%	0.5%	

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy STHK

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Nov-24	84.6	100	91.7	
FFT - Inpatients % Recommended	May-25	93.5%	94.0%	93.3%	
Nurse Fill Rates	Apr-25	97.1%	90.0%	97.1%	
C.difficile	May-25	7		11	
E.coli	May-25	10		20	
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-25	0.04	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Apr-25	0.04	0.00	0.04	
Stillbirths (intrapartum)	May-25	0	0	0	
Neonatal Deaths	May-25	0	0	0	
Never Events	May-25	0	0	0	
Complaints Responded In 60 Days	May-25	35.0%	80.0%	46.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Apr-25	79.5%	77.0%	79.5%	
Cancer 62 Days	Apr-25	86.3%	85.0%	86.3%	
% Ambulance Handovers within 30 minutes	Apr-25	52.5%	95.0%	52.5%	
A&E Standard (Mapped)	May-25				
Average NEL LoS (excl Well Babies)	May-25	3.9	4.0	3.8	
% of Patients With No Criteria to Reside	May-25	18.9%	10.0%	20.4%	
Discharges Before Noon	May-25	19.0%	20.0%	20.5%	
G&A Bed Occupancy	May-25	98.5%	92.0%	98.4%	
Patients Whose Operation Was Cancelled	May-25	1.2%	0.8%	1.1%	
RTT % less than 18 weeks	May-25	63.9%	92.0%	63.9%	
18 weeks: % 52+ RTT waits	May-25	3.2%	1.0%	3.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	May-25	77.6%	85.0%	77.6%	
Mandatory Training	May-25	89.3%	85.0%	89.3%	
Sickness: All Staff Sickness Rate	May-25	6.0%	5.0%	6.2%	
Staffing: Turnover rate	May-25	0.7%	1.1%	0.6%	

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 June 2025
Agenda Item	**TB25/050 (7.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the five Executive Committee meetings held in May 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were five Executive Committee meetings held during May 2025. At every meeting bank or agency staff requests that breached the NHS England (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 May.		
01 May 2025		
Digital and Technology 2023/24 Corporate Benchmarking	• The Director of Informatics presented further analysis of the 2023/24 corporate benchmarking data. • The 2023/24 returns had included exceptional and interim costs to address the IT system and infrastructure risks at the legacy Southport and Ormskirk hospital sites. Since this time, contracts had also been consolidated, which improved efficiency. • There were areas of integration still to be realised, such as digitising medical records and the implementation of a single Electronic Patient Record (EPR) system for MWL. • There were some critical vacancies that would have a detrimental impact on benefits realisation and delivery of the IT strategy, therefore impacting patient care and these were to be risk assessment before consideration by the Vacancy Panel.	Assurance
Performance Management Framework	• The Chief Operating Officer presented the proposed Performance Management Framework for the Trust, supported by Divisional Performance Reports (DPRs). • Each Division would have a performance review meeting with the Executive Team once a month,	Approval

	from June 2025. Corporate Functions were also included. The Committee approved the proposal. • The Committee also reviewed the proposed performance metrics for 2025/26 and agreed to close or remove metrics that no longer aligned to the NHSE Performance Framework and were no longer reported nationally, unless they were contractual.	
St Helens Urgent Treatment Centre (UTC) – Opening Hours	• The Chief Operating Officer introduced the report detailing the impact of reducing the UTC opening hours to 8.00am to 8.00pm, reduced from 7am to 10pm. • It was noted that this aligned to the recent Integrated Care Board (ICB) directive to standardise all UTC opening hours to 12 per day. • St Helens commissioners had given support for the proposal as on average only three patients attended after 8.00pm each day, which would have a minimal impact on the Emergency Department (ED). • The Committee therefore approved the proposal to reduce the opening hours of St Helens UTC to 8.00am – 8.00pm, and the associated communication plan.	Approval
Vacancy Control and Workforce Principles	• The Chief People Officer presented an updated remit for the Vacancy Control Panel and a set of Workforce Principles to help guide the Trust in reaching decisions to achieve the 2025/26 planning guidance for headcount reductions. • Additional controls on overtime were included in the Workforce Principles, which incorporated a risk assessment so there was assurance that patient safety, quality and productivity would not be adversely impacted if vacancies were not filled. • The Committee noted the latest ICB instruction to not fill non-clinical vacancies but noted this had not been accompanied by a definition of non-clinical posts, therefore it was agreed that MWL would need to agree a Trust definition to ensure patient services were not jeopardised. • A review of fixed term contracts and secondment arrangements was being undertaken with service leads. • The Workforce Principles were approved.	Approval
May 2025 Trust Board Agenda	• The Director of Corporate Services presented the draft Trust Board agendas based on the annual workplan.	Approval

	• The Committee selected an Employee of the Month for May based on the nominations received during April.	
Freedom of Information (FOI) Performance Report 2024/25	• The Director of Informatics presented the report. • During 2024/25, 842 FOI requests had been received containing 5,665 individual requests for information. • The Trust is not consistently achieving the 20-day response target, often because they require input from multiple departments. • There had been one contact with the Information Commissioners Office in the year, where the requestor had disagreed with the Trust applying one of the legal exemptions to this FOI. • At the end of April there were 64 live FOIs being processed.	Assurance
08 May 2025		
Quality Account 2024/25	• The Acting Director of Nursing, Midwifery and Governance presented the draft Quality Account for review. • The deadline for publication is 30 June 2025 and prior to this the Quality Account would be presented to Quality Committee, Trust Board and to commissioners and partners for feedback.	Assurance
Laboratory Information Management System (LIMS) – Updated Business Case	• The Director of Informatics presented the updated business case reflecting the additional £2.85m capital allocation to support this implementation programme across Cheshire and Merseyside (C&M). MWL is hosting the LIMS on behalf of the ICB. • The additional funding was to be used for the development of business continuity solutions, data management and interfaces with Trust EPRs and removal of manual reporting. • The business case had been approved by the ICB LIMS governance.	Assurance
Inter-speciality Referrals	• The Director of Informatics presented the update on implementing a system for inter-speciality referrals from the ED, which had been a recommendation in the Care Quality Commission (CQC) inspection report. • The current EPR provider was unable to upgrade the system in the timescales required, so an in-house solution had been developed and was currently undergoing testing by the lead clinician, which would then support implementation training.	Assurance

	• Committee had discussed the timescales to implementation and the need for a Standard Operating Procedure to be agreed.	
Nurse Safe Staffing Report – March 2025	• The Acting Director of Nursing, Midwifery and Governance presented the report. • Overall fill rates in March had been 94.61% for Registered Nurses (RN) and 107.07% for Health Care Assistants (HCA). • The report triangulated staffing levels with areas where patient harm incidents had been reported and concluded staffing levels had been at safe levels at these times. • Variations across wards were noted, which were primarily driven by requirements for supplementary care and areas of low occupancy. • HCA agency bookings had stopped from 01 April. • RN and HCA sickness absence levels had fallen in March.	Assurance
Infection Prevention Control	• The Acting Director of Nursing, Midwifery and Governance reported on an outbreak of norovirus at Southport Hospital which had closed several wards to new admissions. • It was agreed that visiting should be restricted to help manage the outbreak.	Assurance
15 May 2025		

Nurse Staffing Establishment Review	• The Acting Director of Nursing, Midwifery and Governance presented the Establishment Review report, covering the inpatient ward areas.
	• The Committee approved the recommendations to maintain safe levels of care based on the acuity of patients:
	  ○ Continue monitoring the demand for supplementary care and bank usage on the acute medical wards at Southport Hospital
	  ○ To adjust the skill-mix on some surgical wards (within existing budget)
	  ○ To create an additional catering assistant position to provide 7-day cover for the Spinal Injuries Unit
	  ○ To increase night staffing at the Newton Hospital Intermediate Care ward
	• The Committee noted that the paper was to be presented to Quality Committee and Board to provide assurance that the establishments had been reviewed, in line with National Safety Board guidance.
		Assurance

Lead Employer People Plan 2025-2028	• The Chief People Officer presented the proposed Lead Employer Committee People Plan. • The plan was a first for the Lead Employer and had been developed with external stakeholders. • The Plan was due to be presented to the next Strategic People Committee meeting. • The Committee approved the Lead Employer People Plan.	Approval
Aseptic Non-Touch Technique (ANTT) Training Implementation Plan	• The Acting Director of Nursing, Midwifery and Governance presented the proposals to standardise ANTT training requirements across MWL, following completion of the new Training Needs Analysis (TNA). • The new TNA required circa 2,000 additional staff to complete the ANTT level 2 practical training and to record this in their Electronic Staff Record (ESR). It was estimated that there was capacity to complete over the next six months • Committee approved the plans, and noted the compliance under the new TNA would be monitored and reported officially from September 2025.	Approval
Methicillin Sensitive Staph Aureus Bacteraemia (MSSA) Case Note Review	• The Committee noted the findings of the case note review of 90 patients with confirmed MSSA during 2024/25. • The review identified several themes including the timeliness of taking blood cultures, and sepsis screening. There had also been some improvements identified in relation to antimicrobial prescribing practice. • Of the 90 patients reviewed, 23 had MSSA as the cause of death. • The Trust was not an outlier, when benchmarked to other acute hospitals for the rate per 100k bed days. • An action plan had been developed to address the areas for improvement including confirmation as to whether the infections were community onset or hospital acquired.	Assurance
Infection Prevention Control (IPC) Board Assurance Framework (BAF)	• The IPC team had reviewed and updated the IPC BAF for MWL. • The team had assessed the Trust was compliant for most fields and partially compliant in a few areas, which formed the basis of the IPC workplan for 2025/26.	Assurance
MWL Bed Strategy	• The Director of Strategy introduced the report which outlined the actions being taken and initial	Assurance

	options for the best utilisation of the available beds across the MWL sites and commissioned in the community to meet the needs of patients and ensure acute beds were available for acutely ill patients. • Opportunities to change the bed configuration and create a decant ward were available following the refurbishment of ward A at Ormskirk Hospital. • In the longer term it was recognised that there was a need for more surgical beds at Southport Hospital. • Options to create a step-down facility at Ormskirk Hospital were also discussed, including the clinical pathways and staffing requirements. • Committee asked for a more detailed options appraisal	
MWL Culture and Engagement Plan	• The Chief People Officer introduced the proposal to create a live events planner on the staff intranet, to increase awareness and inclusion. • No new funding was requested. • The plans were approved.	Approval
2025/26 Cash Flow	• The Chief Finance Officer advised the Committee of the challenges expected in managing the cash flow during 2025/26 and the mitigation plans that the Board may need to consider. • The Committee agreed that the Finance and Performance Committee and Board would need to be briefed on this risk.	Assurance
2024/25 Trust Objectives – End of Year Review	• The Director of Corporate Services presented the summary assessment of progress against each of the 2024/25 objectives. • Committee reviewed the assessment and agreed some minor changes, ahead of the report being presented to the Trust Board.	Assurance
Executive Committee Annual Effectiveness Review	• The Director of Corporate Services presented the 2024/25 annual effectiveness review of the Executive Committee • This included recommendations for improvement, acknowledging the Committee also served as an operational management forum for the Executive team, and at times needed to respond to urgent issues. • Overall, the Committee was judged to be effective	Assurance
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the assurance report from the RMC meeting on 13 May.	Assurance

	• Good progress had been made in transferring risks from the legacy Datix systems to the single MWL risk register in InPhase, but there remained some further housekeeping to be completed before reporting from the new system would be meaningful. All new risks were being reported using InPhase. • The RMC had received assurance reports from the Claims Governance Council and the Emergency Preparedness, Resilience and Response (EPRR) Working Group • The RMC had approved four EPRR policies	
22 May 2025		
Electronic Patient Record (EPR) Update	• The Director of Informatics presented the update in respect of the new procurement programme, following the discussions with NHSE. • It was noted that a new Outline Business Case (OBC) was required, and this would need to be presented to the Board for approval in June.	Assurance
Finance Improvement Group	• The Committee approved the establishment of the Finance Improvement Group (FIG) as a formal sub-group of the Executive Committee. • The draft terms of reference were reviewed and approved. • The FIG would subsume the functions of the Premium Payments Scrutiny Council which was abolished. • The Committee noted that the Quality Impact Assessment process was being revised and would be applied to both Cost Improvement Programmes (CIP) and other improvement programmes being overseen by the FIG.	Approval
Procedural Documents Update	• The Acting Director of Nursing, Midwifery and Governance presented the report. • MWL has 856 live policies and procedural documents. This number continued to decrease as policies and procedural documents were harmonised. • 79.2% of these were in date and 179 were currently overdue and progressing through the review process. • Each Council received regular updates on the status of the policies it was responsible for approving.	Assurance
29 May 2025		

Managed Equipment Service (MES) contracts for diagnostic equipment	• The Chief Finance Officer introduced a paper setting out options for the future of the two MES contracts currently in place; one for the Whiston and St Helens hospital sites which forms part of the Public Finance Initiative (PFI) agreement and one for Southport and Ormskirk hospitals sites. • Both contracts are due to expire. • To facilitate a full options appraisal and complete the approvals processes via NHSE/DHSC and the cabinet office, a short extension was agreed to align the termination dates of the contracts.	Approval
Outpatient Transformation Project Update	• The Chief Operating Officer introduced the report which detailed the progress made against each of the three work streams: Administrative Services, Further Faster, Clinic Reconfiguration and Utilisation. • Committee discussed the timescales for delivery, the need for effective communications and staff engagement and the links to the Digital strategy, such as ambient artificial intelligence (AI). • The Committee will continue to receive regular progress reports	Assurance
Board Development	• The Director of Corporate Services presented the draft programme for the Board development timeout in June. • Committee agreed some changes to the programme and the leads for each of the planned sessions.	Assurance
Partnership Update	• The Director of Integration presented the regular partnership update, which included the national ICB blueprint, developing ideas about neighbourhood health, changes proposed by C&M to the model of community services and Urgent Treatment Centres to support the Urgent and Emergency Care agenda. • Committee was concerned that Neighbourhood Health could result in the Trust having even more complex relationships, than the current place model • It was noted that the ICB was moving forward with its re-structuring with consultation on the new structure due to commence in June.	Assurance
Trust Board - June	• The Director of Corporate services presented the draft agendas for the public and strategy board meetings in June, from the agreed workplan.	Assurance

	• The Committee agreed the employee of the month for June, from the nominations received during May.	
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during May 2025 were:</u> • None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 June 2025
Agenda Item	**TB25/050 (7.2)**		
Committee being reported	Audit Committee		
Date of Meeting	18 June 2025		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
External Audit Reports	Grant Thornton (GT) provided an overview of the external audit findings to date and shared the draft Audit Findings report (ISA 260) and draft Annual Auditors Report. The ISA 260 contains one new issue and potential risk concerning the Trust's achievement of its statutory breakeven duty, one unadjusted non-material misstatement and two recommendations along with associated management responses. Although work is ongoing, GT expect to issue an unmodified opinion at the end of June 2025. The Annual Auditors report contained four improvement recommendations along with associated management responses. Although work is ongoing, GT have not identified any significant weaknesses in any of the Trust's arrangements for 2024/25. The Audit team expect to complete their audit and for the Trust to submit its audited Annual Report and Accounts by the 30 June 2025 deadline.	Assurance
Adoption of MWL Accounts	Committee reviewed and approved the annual accounts and letter of representation (LoR) for the Trust for 2024/25.	Approval
Head of Internal Audit Opinion (HoIAO)	No changes to the HoIAO previously presented in April 2025. Overall substantial assurance opinion provided by MIAA for 2024/25	Assurance

Draft Annual Report and Draft Annual Governance Statement	Committee reviewed and approved the Trust's draft annual report and draft annual governance statement for 2024/25.	Approval
Annual Meeting Effectiveness Review Assurance Report	Committee received a summary of the findings from all annual effectiveness reviews undertaken in March and April 2025 for all Trust committees.	Assurance
Annual Review of Register of Interests	Committee received and reviewed a summary of the Trust's register of interests as of June 2025.	Assurance

Alerts:

None

Decisions and Recommendation(s):

MWL Accounts adoption
Head of Internal Audit Opinion (HoIAO)
MWL Annual Report and Annual Governance Statement

The final 2023/24 accounts, annual report and annual governance statement were approved by the Committee subject to satisfactory conclusion to the external audit. Approval of the final accounts will be concluded outside of the meeting following the release of final external audit reports.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	25 June 2025
Agenda Item	**TB25/050 (7.3)**		
Committee being reported	Charitable Funds Committee		
Date of Meeting	05 June 2025		
Committee Chair	Hazel Scott, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Head of Charity Report	Updates were provided on the Charity teams activity between April and June 2025 key points included • Staff engagement activities • Whiston Abseil September 2025 • Spinal Unit appeal progress	Assurance
Finance Report	An update of MWL NHS Charity's financial performance and financial position (fund balances) as at as at April 2025 MWL NHS Charity balance was £1,455,300 at 31 March 25 with plans to spend down high balance funds and NHS Charities Together grants.	Assurance
Review of Charity Risk Register	No change to the risk register has been made since the previous meeting in March 2025.	Assurance
Charitable Funds Committee Annual Effectiveness Review	Charitable Committee Annual Effectiveness Review was presented • Committee documentation was of a high standard. • The Charitable Funds Committee met three times during 2024/25. • The conclusion of the 2024/25 review was that the purpose and the remit of the Charitable Funds Committee remain appropriate, and meetings were judged as effective.	Assurance
Summary of Applications received since February 2025	A list of all applications MWL NHS Charity has received since April 2025. A total of 12 projects have been granted with a total value of £68,500	Assurance
Fundraising Manager role review	Charitable Funds Committee were asked to approve the Band 5 fundraising manager role (a change from band 4).	Decision

Alerts:
None
Decisions and Recommendation(s):
Charitable Funds Committee were asked to approve the Band 5 fundraising manager role (a change from band 4).

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 June 2025
Agenda Item	**TB25/050 (7.4)**		
Committee being reported	Quality Committee		
Date of Meeting	17 June 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. • CPR: Safeguarding training information and Infection, Prevention and Control (IPC) information omitted. Review of CPR planned against contracts/quality schedules. • MWL are participating in cohort 2 of NHSE led Enhanced Therapeutic Observation and Care (ETOC) pilot reviewing best practice for one-to-one care (supplementary care). • Falls: Review of new National Institute for Health and Care Excellence (NICE) guidelines. Work commenced with nationally recognised Falls clinical specialist. Systematic review published assures MWL reports an accepted rate of falls (5.8) within the metrics of 2-8 per 1,000 bed days-further analysis ongoing. Falls with harm are below the 30% national metrics. • Malnutrition Universal Screening Tool (MUST) and Nutrition metrics are seeing some improvement with support from the Service Improvement Team for this quality improvement (QI) project and development of a reporting dashboard. • MIAA report for Quality Spot Checks has provided 'substantial' assurance - an improved position from the previous 'limited' assurance reported in January 2024. • Positive safety work ongoing in Whiston Emergency Department (ED) including National	Assurance

	Early Warning Score (NEWS) improvements, ambulance turnaround times and Triage times.
	• There were no mixed sex breaches in May 2025
	• There has been a continued reduction in complaints compliance; this is due to a focus on breached cases. There has been a reduction in year on year second stage complaints. Turnaround plan proposed and monitoring of actions through divisional performance reviews.
	• Maternity – Two moderate harms remain under investigation. One baby requiring cooling – no delays in care noted.
	• IPC: Below threshold for Clostridioides difficile (C Diff), Klebsiella and Escherichia coli (E coli). One case of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia reported in month at Southport site unavoidable following review. Increase in Pseudomonas reported in month with ongoing monitoring.
	• Mortality data reporting to Nov 2024:
	  • Hospital Standardised Mortality Ratio (HSMR) Rolling 12 month ending Nov 24: 90.1 for MWL, 91.6 for Southport and Ormskirk sites and 89.6 for Whiston, St Helens and Newton sites. Year to date (YTD) HSMR remains positively low at 90.4 for MWL, 86.6 for Southport and Ormskirk sites and 91.7 for Whiston, St Helens and Newton sites.
	  • Summary Hospital-level Mortality Indicator - Deaths associated with hospitalisation (SHIMI) 1.02, within tolerated margins.
	• Sepsis:
	  • February 2025 - Advancing Quality data presented. Actions to improve performance against sepsis metrics detailed, including improved triage performance, staff education, identification of designated doctor in ED to support prescribing and/or assessment.
	  • Electronic screening tool under consideration.
	  • Sepsis Red Flag triggers audited by sepsis team in May, reporting more than 50% patients received antibiotics within one hour and 81% within second hour.
	• ED Triage metrics:	

	• to be included next month in the Cardiopulmonary Resuscitation (CPR). Triage actions are seeing a demonstrable positive impact. Consideration being given to also including maternity Triage in future Quality Committee Performance Report. • Letters sent to GPs following out-patient appointments: assurance given urgent letters are turned around within 48hrs with remaining letters just outside the seven days target, but within 14 days • Audiology compliance improved and reporting 100% against three metrics. • Benchmarking and regional Advancing Quality (AQ) rankings: MWL - Whiston 8th and Southport 5th out of 16 trusts.	
Adult and Children Safeguarding Annual Report 2024-25	• 2023/24 workplan was achieved, with two areas still in progress. • Training compliance consistently above 90% other than level 3 Safeguarding Adult and Children's training. • Safeguarding Adults: 5% increase in safeguarding concerns raised to the Adult Safeguarding teams and a 9% increase in referrals to the local authority, in comparison to 2023-24. 13% increase in deprivation of liberty safeguards (DoLS) applications compared to previous year. 104 Section 42 enquiries detailed, noting not all substantiated. All follow the Patient Safety Incident Response Framework (PSIRF) process. • Safeguarding Children: Reduction in children's referrals, noting decrease attributed to change of process in Sefton. • Pilot commenced to extend Mental Health Act administration by Merseycare across MWL. • Domestic Abuse and Sexual Abuse – service challenges and mitigations noted. Risk Assessments / Multi agency risk assessment conference (MARAC) attendance detailed. • Children and Adolescent Mental Health Services (CAHMS) – 4.6% decrease in attendances, noting more timely assessments and reduction in crisis admissions. • No PREVENT referrals in year. • Safeguarding Risk Register: Three risks noted and further suggested assurances proposed.	Assurance

	• 2025/26 Safeguarding workplan detailed and case studies also noted. • Safeguarding team capacity and increase in activity discussed.	
Patient Safety Report (incl. Chair's Assurance Report).	• No new Patient Safety Incident Investigations (PSII) reports were commissioned during April. • A reduced number of incidents reported in April (2,278) expected against the implementation of InPhase with assurance increase in numbers being noted in May. • 5,7 falls per 1,000 bed days for the month of April. Falls incidents across MWL noted. Updated falls strategy and forward plan incorporating NICE guidelines and cross-system review to be reported to Committee in Q2. • PSII incidents: Top 5 categories noted. • Five category 2 or above Hospital Acquired Pressure Ulcers reported in April. • Comprehensive InPhase training in place across MWL. • Invasive Procedures Development Group and Intravenous Therapy Group have commenced. • Committee noted Patient Safety Council assurance reports.	Assurance
Freedom to Speak Up Report.	• Report received for Q3 and Q4. • 87 referrals raised in reporting period. • 10% increase across the year in concerns raised. • Themes and trends remain unchanged from previous reports, citing inappropriate attitudes and behaviours interlinked with workers safety and wellbeing. • 17% concerns raised in Q3 and 15% in Q4 were anonymous. • Most concerns raised by Nurses and Midwives workforce group, which is proportionate to headcount. • No incidents reported regarding 'detriment due to speaking up' within Q3/Q4. • Feedback received: Overall positive feedback with one concern recognised against the Freedom to Speak Up (FTSU) process which was related to expectations. • Changes because of staff speaking up detailed. • Equality, Diversity, and Inclusion (EDI) data now included in the report, no specific themes.	Assurance

	• MWL has 36 FTSU champions, with four recruited and inducted in Q3/Q4. • Q3 audit on FTSU Champion awareness reported positively with overall awareness of where to find FTSU resource. Rolling program of audits in place. • Trust FTSU week in October 2025 to provide awareness and engagement with staff. • Trust hosting FTSU Northwest conference in November 2025.	

Patient Experience Report (Incl. Chair's Assurance Report).	• Reporting period March to May 2025 using available data.
	• Patient Experience Tendable Audits:
	  • 69 audits completed across MWL in adult inpatient areas.
	  • Improving compliance and 51% increase in completion. Patient Experience Champions are helping to improve staff engagement.
	  • One area below target and receiving focus is ensuring patients receive discharge booklets. An action plan is in place to improve and sustain an improvement.
	  • Focused improvement work in ED for 'Waiting Times' has seen a slight improvement in performance.
	  • Corridor Care Red Lines audits have commenced in both EDs. Results will be reported to a future Quality Committee.
	  • Patient and relatives report 100% against kindness and compassion and standards of care reports positively.
	• Friends and Family (FFT): Improved compliance in May 2025 in positive ratings with all areas above internal targets. ED, Inpatients and Postnatal all slightly above internal target for negative ratings.
	• National Inpatient survey (2024/25) results received and reporting and action plan to be shared.
	• 29 Quality ward rounds completed. Plan to introduce specialty areas e.g. Theatres, ITU and ED.
	• First hybrid meeting of the MWL Patient Participation Group has been held to facilitate trust-wide participation.
	• Fifth issue of MWL Patient News now available and has been shared with stakeholders.
		Assurance

	• Celebrated Experience of Care week in March with a focus on ***#Hellomynameis*** campaign and celebration of nominated Patient Experience Heroes across MWL. • Update on Spiritual Care team & facilities provided. • Audit of dementia friendly environments at Whiston Hospital results to be shared through Dementia and Delirium Strategy Group. • Dementia Action week held in May to raising awareness about dementia and timely diagnosis. • Patient Experience Council assurance reports noted. • Macmillan posts currently under assessment to understand the implications against non-recurrent funding. • Patient Portal Quarterly Update noted, impact of hubs on DNA rates discussed.	

Alerts:

- None

Decisions and Recommendation(s):

The Committee recommend the Safeguarding Annual Report for 2024/25 and the 2025/26 workplan to the Board.

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 June 2025
Agenda Item	**TB25/050 (7.5)**		
Committee being reported	Strategic People Committee		
Date of Meeting	18 June 2025		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose

Workforce Principles	• A paper was presented which provided a summary of the Workforce Principles in place across the Trust to support senior leaders and managers to meet the requirements set out in the 2025/2026 operational planning guidance.
	
	• The principles specifically relate to ensuring we are effectively managing our resources while ensuring we prioritise quality and safety.
	
	• The 2025/26 Workforce Principles and Vacancy Control oversight processes are supported and underpinned by a robust risk assessment process that address the below factors:
	  • Statutory & Regulatory Compliance
	  • Productivity & Capacity
	  • Patient Experience and care
	  • Patient & Staff Safety
	  • Equality Impact
	  • Financial & Strategic Alignment
	
	• The impact of the principles and additional controls ensure a reduction in premium pay costs will be monitored through the Trusts existing governance structures with assurance through Executive Committee and Strategic People Council to Trust Board.
		Assurance

Workforce Dashboard	The Committee noted the following performance: • Mandatory Training - The Trust continues to exceed its mandatory target at 89.5% against a target of 85%. The Executive Committee is due to receive a proposed consolidated Training Needs Analysis (TNA) for all MWL in June 2025 which will set align the core mandatory training.	Assurance

	• Appraisals - The Trust is no longer meeting its appraisal target however this is due to us entering the new appraisal window for 2025/2026. Current appraisal compliance has reduced in May 2025 to 74.2%. The 2025/2026 appraisal window opened on 01 May and support, training and guidance is available to support with high quality appraisals. • Sickness - In-month sickness continues to be above target, at 5.9% against the 5% target. This is a slight reduction of 0.1% compared to Health Care Assistant (HCA) sickness continues to positively reduce in month by a further 0.4% (8.4%). • The top three reasons for sickness in April continue to be stress, anxiety and depression, gastrointestinal and musculoskeletal (MSK). • Turnover- In month turnover continues to be below our target of 1.1% at 0.6%.	
Growing for the Future Operational Delivery Plan (Trust)	The Committee received the 2025/26 delivery plan for the "Growing for the Future" pillar of the 2025-2028 People Plan. The priorities are: • Growing our relationships with local communities, schools and colleges to develop health workers of the future. • Continuing to develop and improve our recruitment practices and processes. • Developing and embedding training and development pathways across all levels and professions. • Developing a flexible and adaptive workforce fit for the future. • Delivering comprehensive, accessible, and innovative education opportunities that support the ongoing development of students and staff.	Assurance
Education Annual Report	The Committee received the 2024/25 Clinical and Medical Education Services update. The paper outlined the achievements of the service, notably: • Improvements and Innovation with Medical Devices, the Preceptorship Programme and a significant reduction in the turnover of newly registered staff. • Delivery of the Healthcare Academy supporting Healthcare Support Workers. • Quality Assurance and Governance: Robust evaluation mechanisms, feedback systems, and governance frameworks to monitor educational quality and respond to national, regional and local	Assurance

	Key Performance Indicators (KPI's). • Integrated Clinical Training: Accessible learning opportunities across MWL sites. • Program and Curriculum Alignment: Education delivery that is aligned with service needs & national curricula (e.g., General Medical Council (GMC) standards, NETS, Healthcare Academy), ensuring students and trainees meet required competencies and outcomes. It was also noted that over the next 12 months there is a priority to fully integrate Education Services across the MWL footprint, creating a unified model that is equitable, efficient, and future-focused that champions education through.	
Volunteers Operational Plan - Annual Update	The Committee received the 2024/25 Volunteer Operational Plan. Notable achievements include: • The Volunteer service have been streamlined for a consistent MWL approach. Work continues to develop and promote the volunteer service and the benefits to patients and colleagues. • A Recruitment, Selection and Management of Volunteers policy was introduced in March 2025, replacing previous legacy policies. • Processes, policy and role reviews has been completed, and the Volunteer system review is on-going. Membership of National Association of Voluntary Services Managers (NAVSM) and NHS Forums in place. A draft Operational plan for 2025-28 was also presented aligned to 2025-2028 People Plan and identified the following priorities: • The introduction of adjustments passports for our volunteers that need them • To share our volunteer stories recognising their contribution • To engage and receive feedback from our volunteers through surveys and forums • To support our volunteers who want to pursue a career in healthcare • To provide regular training opportunities to our volunteers to enhance the roles they undertake.	Assurance
Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Report from the People Performance Council and that the New Parent Support Leave and Pay Policy had been approved.	Assurance

Terms of Reference for Approval	The Strategic People Committee approved the People Performance Council Terms of Reference.	Decision
Alerts:		
None.		
Decisions and Recommendation(s):		
• The Strategic People Committee approved the People Performance Council Terms of Reference.		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 June 2025
Agenda Item	**TB25/050 (7.6)**		
Committee being reported	Finance & Performance Committee		
Date of Meeting	19 June 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Chief Finance Officer Update	• Trust is still in discussions with Integrated Care Boards (ICB) about contracts for 2025/26 with some high level issues currently unresolved including realignment of API contracts across the system. • Update provided following the impact of the government spending review on the NHS. • National ambition to go further on reductions in temporary staffing usage with agency use eliminated by the end of the government's term of office. • New method for calculating implied productivity has been released by the national team.	Assurance
Integrated Performance Report Month 2 2025/26	• Bed occupancy averaged 104.4% in May equating to 75 patients. This resulted in a General and Acute (G&A) bed occupancy of 98.1%, significantly higher than the target of 92%. • Average length of stay for emergency admissions remains high at 8.2, 9.8 at Southport and Ormskirk sites and 7.6 at St Helens, Whiston and Newton sites, the impact of Non-Criteria to Reside (NCTR) patients remains high in May, being 19.1% at Organisation level (18.9% St Helens, Whiston and Newton and 19.6% Southport and Ormskirk sites). This prevented the closure of any further escalation beds, which is critical to the Cost Improvement Programme (CIP) assumptions. • 4-Hour performance was 74.4% in May, below National performance 75.4% and ahead of	Assurance

	C&M 73.7%. Mapped performance was 79.5%. • 18 Week performance in May for MWL was 64.7%. National Performance (latest month April) 59.7% and Cheshire and Merseyside (C&M) performance 58.0% • The Trust had 2,090 x 52-week waiters at the end of May, 221 x 65 week waiters and 6x 78 week waiters. • Diagnostic performance for May for MWL had reduced to 85.3% which remained ahead of national performance 78.8% but below C&M performance of 89.9% and target (95%). • Cancer performance for MWL in April deteriorated to 68.2% for the 28-day standard and to 81% for the 62 day standard.	
Finance Report Month 2 2024/25	• The approved MWL financial plan for 2025/26 is a deficit of £10.7m, 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 M2 deficit of £11.4m 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 M2, the target has been achieved with £7.4m delivered. • M2 agency costs equate to £2.5m, a 33% reduction from M2 2024/25. • The Trust had a closing cash balance of £3.7m and anticipates a closing cash balance of £2.5m at the end of the year including the deficit support funding. The Trust plan included £30m of revenue support funding. • Aged debt has remained consistent with M1, 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.	Assurance
Month 2 2025/26 CIP Programme Update	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, this equates to 5% for all departments.	Assurance

Corporate Services - Procurement CIP update	• At M2 56 schemes have been delivered with a further 50 schemes at finalisation stage. Current delivered/low risk schemes have a value of £24m in year equating to 50% of the target. • Procurement update included local department 5% efficiencies alongside an overview of the Trust wide procurement workstreams including contract management and streamlining of products used. • Procurement department won two external awards in June for the work undertaken.	
Diagnostic Targets Review	• Update received on current diagnostic performance against targets, detailing the reasons for the deterioration in performance. • Actions to recover performance detailed along with detailed discussion about performance metrics used to review and develop actions on a rolling basis.	Assurance
Assurance Reports from Subgroups:	• CIP Council • Capital Planning Council • Estates & Facilities Management Council • IM&T Council update	Assurance
Alerts		
Finance Report Month 2 2024/25 Work ongoing across system to develop plans to support the delivery of the £35m of system led strategic opportunities/cost reductions to be realised or reallocated by C&M during 2025/26. Timeliness and assurance of delivery remains a high risk to the delivery of the Trust's financial plan, and the Committee wished to alert the Board that as yet there is no agreed plan or trajectory for how and when this will be delivered.		
Decisions and Recommendation(s):		
The Board note the report		

Title of Meeting	**Trust Board**		**Date**	25 June 2025
Agenda Item	**TB25/051**			
Report Title	Fit and Proper Person Chair's Annual Declaration			
Executive Lead	Steve Rumbelow, Chair			
Presenting Officer	Steve Rumbelow, Chair			
Action Required		**To Approve**	**X**	**To Note**

Purpose

To provide assurance to the Board that the Trust has met the requirements of the *NHS England Fit and Proper Person Test Framework for board members* and is compliant with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Executive Summary

All Trust Board members must meet the requirement of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulations) as a 'fit and proper person'. This has been the case since the introduction of the regulations in 2014 but the regime was strengthened by NHS England in 2023 through the introduction of the Fit and Proper Person Test Framework (the Framework) in response to the Kark Review (2019).

The Framework requires NHS organisations to demonstrate on an annual basis that a formal assessment of fitness and properness for each Director has been undertaken. Evidence should also be provided that appropriate systems and processes are in place to ensure that all new and existing Directors are, and continue to be, fit and proper (that is, the Directors meet the requirement of Regulation 5), and that no appointments breach any of the criteria set out in Schedule 4 of the regulations.

This declaration certifies that the appropriate checks are carried out on all new Directors as part of the recruitment process and a process is in place to complete the annual FPPT. This includes carrying out the following checks:

- Training and development
- Last appraisal and date
- Disciplinary findings
- Grievances against the Board member
- Whistleblowing claims against the Board member
- Behaviour not in accordance with organisational values
- Disclosure and Barring Service (DBS check)
- Professional register check
- Settlement agreements
- Insolvency check
- Disqualified Directors Register check
- Disqualification from being a Charity Trustee check
- Employment Tribunal Judgement check
- Social Media check
- Self-attestation form signed
- Reviewed and signed off by the Chair (or Deputy Chair, in the case of the Chair)

The Chair reviews the declarations and results of the annual FPPT and provides assurance to the Board that the organisation continues to meet the requirements. The Chair also signs an Annual Declaration which is submitted to the NHS England Regional Director.
Financial Implications
No financial implications
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the Fit and Proper Person Chair's Annual Declaration

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

Annual NHS Fit and Proper Persons Test Outcomes

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Mersey & West Lancashire Teaching Hospital NHS Trust	Richard Fraser	June 2024 – May 2025

Part 1: FPPT outcome for board members including starters and leavers in period

Non-Executive Directors			
Name	**Date of appointment (Start Date)**	**Position**	**Outcome**
Gillian Brown	01/09/2019	Non-Executive Director	Confirmed Fit & Proper
Steve Connor	01/02/2024	Non-Executive Director	Confirmed Fit & Proper
Claudette Elliot	01/04/2025	Non-Executive Director	Confirmed Fit & Proper
Neil Fletcher	01/04/2025	Associate Non-Executive Director	Confirmed Fit & Proper
Lisa Knight	01/07/2019	Non-Executive Director	Confirmed Fit & Proper
Stephen Rumbelow	01/05/2025	Chairman	Confirmed Fit & Proper
Professor Hazel Scott	01/11/2023	Non-Executive Director	Confirmed Fit & Proper
Carole Spencer	01/05/2024	Non-Executive Director	Confirmed Fit & Proper

Non-Executive Directors			
Name	**Date of appointment (Start Date)**	**Position**	**Outcome**
Charanjiv Rani Thind	28/09/2021	Associate Non-Executive Director	Confirmed Fit & Proper

Executive Directors			
Name	**Date of appointment (Start Date)**	**Position**	**Outcome**
Lynne Barnes	11/04/2024	Acting Director of Nursing, Midwifery and Governance	Confirmed Fit & Proper
Nicola Bunce	10/07/2017	Director of Corporate Services	Confirmed Fit & Proper
Robert Cooper	06/06/2016 (CEO from 01/12/2024)	Chief Executive	Confirmed Fit & Proper
Malcolm Gandy	01/04/2024	Director of Informatics	Confirmed Fit & Proper
Gareth Lawrence	01/04/2022	Chief Finance Officer	Confirmed Fit & Proper
Lesley Neary	01/07/2023	Chief Operating Officer	Confirmed Fit & Proper
Anne-Marie Stretch	07/07/2003	Deputy Chief Executive / Director of HR (stepped down from role as Director of HR in May 2024)	Confirmed Fit & Proper
Malise Szpakowska	01/06/2024	Chief People Officer	Confirmed Fit & Proper
Dr Peter Williams	01/07/2022	Chief Medical Officer	Confirmed Fit & Proper

Other Directors			
Name	**Date of appointment (Start Date)**	**Position**	**Outcome**
Linda Buckley	01/10/2021	Managing Director CMAST	Confirmed Fit & Proper
Dr Kate Clark	01/07/2023	Director of Strategy	Confirmed Fit & Proper
Wayne Longshaw	18/07/2016	Director of Integration	Confirmed Fit & Proper
Susan Redfern	01/12/2024	Director of Infection Prevention and Control	Confirmed Fit & Proper
Ann Marr	01/12/2024	Executive Lead of the Provider Collaborative (CMAST)	Confirmed Fit & Proper

Leavers				
Name	**Date of appointment (Start Date)**	**Position**	**Date of leaving and reason**	**Board member reference retained**
Geoffrey Appleton	01/07/2022	Non-Executive Director	30/06/2024 End of Term	Yes
Ian Clayton	26/09/2019	Non-Executive Director	November 2024 RIP	No
Richard Fraser	01/05/2014	Chairman	30/04/2025 End of Term	No
Paul Growney	01/09/2018	Associate Non-Executive Director	31/08/2024 End of Term	Yes
Ann Marr	January 2003	Chief Executive	30/11/2024 Resignation	Yes
Susan Redfern	May 2013	Director of Nursing Midwifery and Governance	30/11/2024 Resignation from Board	Yes

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
No inspections in 2024/25				

Part 3: Declarations

DECLARATION FOR MERSEY & WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST 2025				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Deputy Chair / Non-Executive Director	Gillian Brown	30/04/2025	Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	No	

As Chair of Mersey and West Lancashire Teaching Hospitals NHS Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	10/06/2025
For the regional director to complete:	
Name:	
Signature:	
Date:	

Title of Meeting	**Trust Board**		**Date**	25 June 2025
Agenda Item	**TB25/052**			
Report Title	Adult and Children Safeguarding Annual Report 2024/2025			
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 provide assurance regarding the Trust's safeguarding provision.

Executive Summary

The Safeguarding annual report for 2024/2025 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 01 April 2024 to 31 March 2025. The purpose of the annual report is to inform the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Board of safeguarding activity, providing assurance that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2023); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

The Care Quality Commission (CQC) fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.

Safeguarding activity is subject to external oversight and scrutiny by the CQC, NHS England and the Integrated Care Boards (ICB), and by the Local Safeguarding Children Partnerships (LSCP) and Safeguarding Adults Boards (LSAB).

The Safeguarding Teams are multi-functional providing both operational and corporate responsibilities across all Trust sites. Following the transition to MWL the safeguarding resource has been maintained across sites. The teams have worked collaboratively to review and harmonise policies, processes and procedures. The Whiston site team support the key adjoining boroughs of St Helens, Knowsley and Halton, with Southport and Ormskirk sites teams supporting Sefton and West Lancashire. Key Performance Indicator (KPI) templates have been aligned into a joint submission and have been supported by a joint business meeting with St. Helens and Sefton Designated Nurses.

The Safeguarding Teams play an active role in internal and external reviews, decision making and outcomes; ensuring relevant information is shared and lessons learnt are embedded across the organisation.
From the quarterly submissions of KPIs, the Trust achieved a RAG rating of green in all areas other than achieving 90% training compliance in all levels, and delays in the timeframe for the completion of Children in Care Initial Health Assessments.

Financial Implications	
None resulting from this report	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Adult and Children Safeguarding Annual Report 2024/2025	
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
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Adult and Children Safeguarding Annual Report 2024/2025

Authors: Sharon Seton, Anne Monteith

Assistant Directors of Nursing Safeguarding

Contents

Glossary of terms

AED	Accident and Emergency Department
ASC	Adult Social Care
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CE	Child Exploitation
CP	Child Protection
CQC	Care Quality Commission
CP-IS	Child Protection Information System
CSC	Children's Social Care
CSAP	Children's Safeguarding Assurance Partnership
CSPR	Child Safeguarding Practice Review
DBS	Disclosure and Barring Scheme
DARDR	Domestic Abuse Related Death Review
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
ESR	Electronic Staff Records
ICB	Integrated Care Board
IDVA	Independent Domestic Violence Advisor
ISVA	Independent Sexual Violence Advisor
KPI	Key Performance Indicator
LD	Learning Disability
LA	Local Authority
LADO	(Local Authority) Designated Officer
LSAB	Local Safeguarding Adult's Board
LSCP	Local Safeguarding Children's Partnerships
MACE	Multi Agency Child Exploitation
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHSE	National Health Service England
PMRT	Review when baby born not alive from 22 weeks or dies within 28 days
RAG	Red / Amber / Green
Section 42 Inquiry	Safeguarding Adults investigation coordinated by the Local Authority
S47	Investigation when suspect child at risk of or is suffering harm

1. EXECUTIVE SUMMARY

1.1 The safeguarding annual report for 2024/2025 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 1st April 2024 – 31st March 2025. The purpose of the annual report is to inform the Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Quality Committee of safeguarding activity, providing assurance that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

1.2 All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2023); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

1.3 The CQC fundamental standards require the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse, and that internal processes are in place to reduce the potential for abuse.

1.4 Safeguarding activity is subject to external oversight and scrutiny by the Care Quality Commission (CQC), NHS England and the Integrated Care Boards (ICB), and by the Local Safeguarding Children Partnerships (LSCP) and Safeguarding Adults Boards (LSAB).

1.5 The Safeguarding Teams are multi-functional providing both operational and corporate responsibilities across all Trust sites. Following the transition to MWL the safeguarding resource has been maintained across sites. The teams have worked collaboratively to review and harmonise policies, processes and procedures. The Whiston site team support the key adjoining boroughs of St Helens, Knowsley and Halton, with Southport and Ormskirk sites teams supporting Sefton and West Lancashire. Key Performance Indicators (KPI) templates have been aligned into a joint submission and have been supported by a joint business meeting with St. Helens and Sefton Designated Nurses.

1.6 The Safeguarding Teams play an active role in internal and external reviews, decision making and outcomes; ensuring relevant information is shared and lessons learnt are embedded across the organisation.

1.7 From the quarterly submissions of KPIs, the Trust achieved a RAG rating of green in all areas other than not achieving 90% training compliance in all levels, and delays in the timeframe for the completion of Children in Care Initial Health Assessments.

2. INTRODUCTION

2.1 As detailed in the Safeguarding Children and Young People; Roles and competencies for healthcare staff intercollegiate document (2024) robust internal governance processes are in place to safeguard children and adults with an Executive lead, Named Doctors, Named Nurses for Safeguarding Children, Named Nurses Safeguarding Adults and Named Midwifes being in post. In accordance with LSCP's child death processes and detailed in Working Together to Safeguard Children (2023), the Trust has allocated Doctors for child deaths, who are Paediatric Consultants, and take a lead role in the child death review process.

2.2 The Safeguarding Teams continue to strive for continuous and sustained improvement in relation to the provision of up-to-date safeguarding policies, training delivery and compliance and the provision of safeguarding support and advice.

2.3 A "think family" approach is promoted to ensure that staff consider the impact of safeguarding on wider family members including children and adult dependents.

2.4 The Safeguarding Teams predominantly support 10 adjoining area Safeguarding Boards (5 adults and 5 children). The St Helens and Knowsley sites work closely with St Helens, Knowsley and Halton, and Southport and Ormskirk sites with Sefton and West Lancs. However, there is also involvement on a wider footprint for additional workstreams such as referrals, multi-agency meetings and contribution to reviews.

2.5 The Safeguarding Boards/ partnerships have statutory functions to ensure that organisations and agencies work effectively to protect children and vulnerable adults who may be at risk of abuse. The key agencies who attend the Boards and Sub-groups are Health, police, Local authority and Education with additional representation such as the Fire Service, Healthwatch and the voluntary sector.

Table 1: **Key Achievements in 2024-2025 against the work plan for the previous reporting period**

Work plan	Update	
We will develop ways of working to enable the submission of a MWL KPI submission to St. Helens Place	Completed and one MWL submission from Q1 24/25	
We will continue to align policies and processes and documentation	Completed and all safeguarding polices, and SOPs aligned	
We will work review the governance of safeguarding reporting	Completed and reporting quarterly to Quality Committee and the Divisional Quality and Governance meetings	
We will work to develop an MWL annual report	Completed and MWL report submitted for 2023 2024	
We will complete the ICB Safeguarding Commissioning Standards in Q3 and develop relevant action plans	During this reporting period additional evidence has been provided to the ICB	
We will deliver the action plan of the MIAA Audit	Completed and all actions delivered	
We will extend the Mental Health Administration SLA across all sites	Pilot of extension to include all sites commenced	
We will review and where possible harmonise the audit plans across sites	Completed, audit plan reviewed by the Named Nurses and were possible harmonised	
We will harmonise the Training Needs Analysis (TNA) for all safeguarding training	Completed for all staff groups	
We will collaborate with the digital team to develop digital and new ways of working	DoLS and associated capacity assessment reviewed and updated	
We will collaborate with BI colleagues to enhance safeguarding reporting and monitoring	BI report set up to identify victims of domestic abuse who have attended Southport and Ormskirk sites to enable scrutiny of records and reduce missed opportunities to provide domestic abuse support.	

We will update the daily restrictive practice form in accordance with ADASS recommendations	Completed	
We will revise MCA documentation to align to the most current case law	Updated as required and reviewing possibility of a digital solution	
We will support the implementation of the new children's Social Care referral process in Sefton, and other improvements within the Local Authorities	Completed and new process implemented. The process required changes to internal referral process at Southport and Ormskirk sites	
We will support the implementation of the new MARAC process in Lancashire, and other improvements within the Local Authorities	Completed and new process implemented	

3. GOVERNANCE ARRANGEMENTS

3.1 During this year following a review of internal reporting arrangements as MWL, the decision was made that the safeguarding quarterly reports would be submitted to the Patient Safety Council quarterly rather than to the Quality Committee; with a summary included in the Patient Safety Council report to Quality Committee.

3.2 During this period quarterly KPI data was submitted to the Integrated Care Board (ICB) St. Helens Place and scrutinised by the Designated Nurses, after which assurance reports were provided and shared with the Designated Nurses Sefton Place. The Assistant Directors of Safeguarding and Named Nurses attended quarterly business meetings with the Designated Nurses for St. Helens and Sefton.

3.3 The Safeguarding Adult and Children Teams support collaborative working relationships with other departments in the Trust including Patient Safety, Complaints, Human Resources for cases that meet safeguarding thresholds. The teams provide representation at internal meetings including Harm-Free Care, HAPU, Patient Safety, Community Patient Safety Panel, Falls, Departmental, Child Death Reviews. As the Divisional Governance processes are evolving there will also be representation at appropriate meetings. The Safeguarding Children's Team provide supervision in line with the supervision policy. A suite of safeguarding policies is harmonised and in date.

4. ENGAGEMENT WITH EXTERNAL PARTNERS

4.1 The Assistant Directors of Safeguarding provide membership at the relevant LSABs and LCSPs. Membership at the Boards ensures that the Trust is sighted on and able to contribute to all aspects of the national and local safeguarding agendas, and attending the Boards allows the Trust to influence the local and national agenda. It further allows the Trust to develop policies and practices that are aligned to the Local Safeguarding Boards/Partnerships.

4.2 The Assistant Directors of Safeguarding, Named Nurses and Safeguarding Practitioners represent the Trust at local Board sub-groups and at wider safeguarding partnership meetings. Attendance at the groups allows the Trust to have up-to-date knowledge and informs areas for focus within the team's strategic agenda. Membership allows the team to be part of the development of all aspects of safeguarding and ensures that Trust processes are in line with partner agencies, whilst meeting the standards required by the LSABs and LCSPs.

4.3 The Safeguarding Children Teams provide representation for the management of child deaths, reporting to, attending and contributing to the Child Death Overview Panel (CDOP) and associated subgroups, internal review panels and external multi agency meetings.

4.4 The Safeguarding Teams endeavour to ensure 100% representation at all requested strategy meetings, child protection conferences and core group meetings when relevant to attend. Reports for these meeting may be provided verbally, written or via email, as requested. The Safeguarding Teams support the Safeguarding Adult review (SAR) and Child safeguarding Practice review (CSPR) process and Domestic Abuse Related Death Reviews (DARDR) also known as Domestic Homicide Reviews (DHRs), by providing requested chronologies; panel membership; ensuring participation at practitioner events. The Safeguarding Teams contribute to other multi agency meetings such as MACE and MARAC either through attendance or information sharing. Prior to the meetings the team complete all requests for information within the given timeframe, and subsequent actions from these meetings are completed. The Safeguarding Team will support clinical staff to complete court reports, and ensure all reports are quality assured prior to submission.

5. TRAINING COMPLIANCE

5.1 Across all sites in this period a compliance of greater than >90% was achieved consistently throughout the year other than in level 3 safeguarding adult and children's training. This has

been attributed to clinical pressures and turnover of staff, mental capacity training has been maintained greater than 90%.

5.2 In Q4 the Executive Board was compliant at 100% as of March 2025

Table 2: Trust Safeguarding Training Compliance 2024 - 2025

Competency	Q1	Q2	Q3	Q4
Safeguarding Adults Level 1	95.9%	94%	93.5%	93.6%
Safeguarding Adults Level 2	93.9%	93.9%	93%	93.6%
Safeguarding Adults Level 3	83.9%	87.9%	88.8%	86.7%
Safeguarding Children Level 1	94.3%	94.4%	93.6%	94.3%
Safeguarding Children Level 2	92.6%	94.7%	92.1%	92%
Safeguarding Children Level 3	84.4%	85.3%	90.2%	89.7%

Table 3: Mental Capacity Act and Deprivation of Liberty Training 2024 – 2025

Competency	Q1	Q2	Q3	Q4
Mental Capacity	93.1%	93.6%	92.5%	93.6%

5.3 Each month the Departmental Managers receive the Trust compliance report, and the Divisions can monitor compliance levels for their areas; the Safeguarding Team also send monthly reminders to staff who are highlighted as non-compliant.

5.4 This year provided opportunity for further harmonisation of the mode of delivery for training with e-learning for all levels of training except for Level 3 Safeguarding Adult Training which continues to be delivered face to face due the unavailability of a suitable E learning Package.

5.5 Further alignment of the E Learning for Health training modules and implementation of the harmonised TNA is planned in 2025/2026.

5.6 In addition to the training above the Safeguarding Teams delivery bespoke training including:

- Medical and Nursing Induction and preceptorship programmes, covering general safeguarding, MCA and DoLS.

- Bespoke sessions to clinical areas and ward staff covering safeguarding, MCA and DOLS
- Bespoke sessions to Managers to support in the management of disclosures of domestic abuse from staff.
- Ad Hoc training to other staff groups is delivered as requested.

5.7 All relevant LSAB and LCSP training opportunities are shared through safeguarding ambassadors and leads, social media, Trust news and other relevant forums.

5.8 Relevant Safeguarding Team members attend an array of multi-agency training to maintain their compliance to level 4 training.

6. SAFEGUARDING ADULT ACTIVITY

6.1 For adult safeguarding referrals, other than in an emergency when the Local Authority (LA) 'duty team' will be contacted, staff complete a referral to the Safeguarding Adult Teams. All safeguarding concerns will be quality assured and reviewed prior to submission to the LA, again this excludes emergency safeguarding concerns out of hours.

6.2 The teams collate data regarding safeguarding referrals and safeguarding concerns raised within the Trust. The data is extrapolated from completed incident reports and databases and allows the team to identify areas of concern.

6.3 Across all sites in 2024/2025 there has been 2540 safeguarding concerns raised to the adult teams, including reports of domestic abuse and sexual abuse. This is a 5% increase in comparison to the previous year (2416).

6.4 In addition, across all sites there has been 4325 applications for a Deprivation of Liberty Safeguards (DoLS) authorisation, with a further 13% increase compared to the previous year (3836). It is noted within the data that there are more authorisations completed on Southport and Ormskirk sites than Whiston and St Helens sites (2635 v 1690), this is likely to be secondary to the population and a higher number of elderly patients accessing those sites. Each of these authorisations is processed and quality assured by the Safeguarding Teams prior to submission to the relevant LA.

6.5 Across all sites 622 of the concerns raised required a referral to the LA, a 9% increase compared to the previous year (572). It is worth noting that not all referrals to the LA would have progressed to a safeguarding enquiry under S42 of the Care Act, (2014).

Table 4: Number of Adult Social Care Referrals

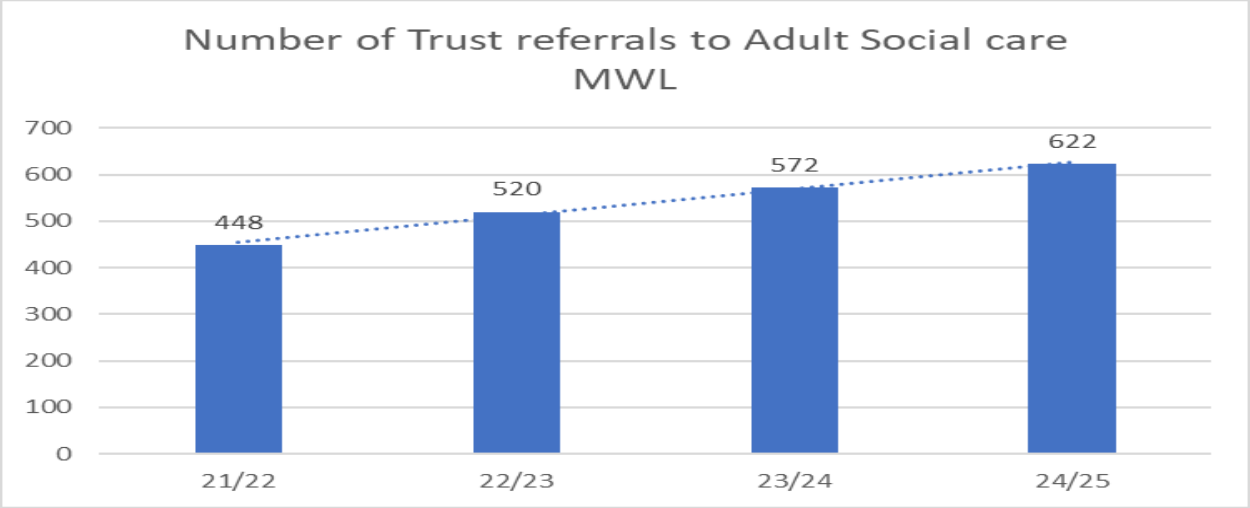
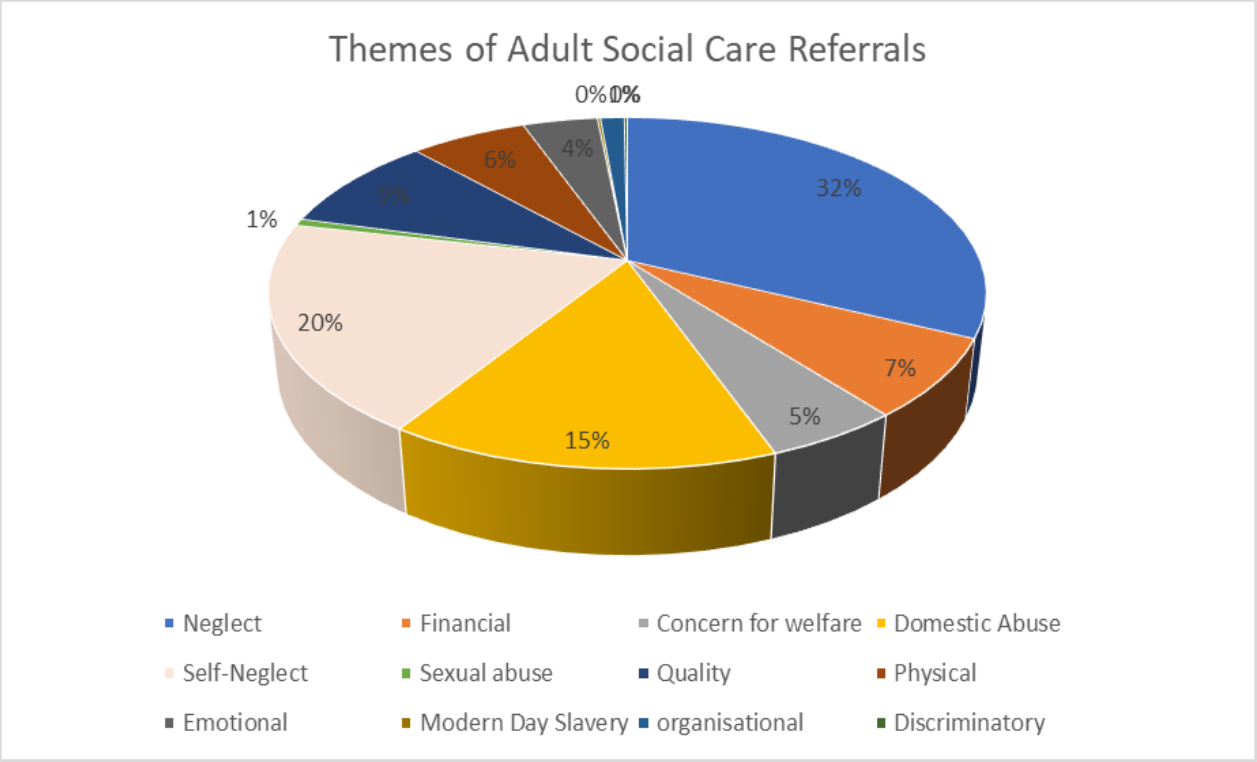


Table 5: Themes of Adult Safeguarding Social Care Referrals



6.6 From the above neglect and self-neglect account for over 50%, with domestic abuse accounting for 15%. Using the self-neglect alerts added to the patient's electronic patient record, in the next reporting year the possibility of creating a Business Intelligence (BI) report for missed opportunities when attending the Trust is being explored.

6.7 Meeting Attendance

Table 6: Number of Adult Strategy Meetings Attended

MWL	Q1	Q2	Q3	Q4	Total
Strategy Meetings	16	12	15	15	58

6.8 The adult teams attend several meetings with partners to discuss and review any current or ongoing risks to individual patients/individuals, these include LA Strategy meetings, best interest meetings, multi-agency risk management meetings and discharge planning meeting.

6.9 Section 42 Enquiries

As well as completing safeguarding referrals, the Safeguarding Teams coordinate. safeguarding concerns raised against the Trust, known as Section 42 (S42) enquiries. The LA, under Section 42 of The Care Act, has the authority to request partners to investigate concerns raised.

6.10 All S42s against the Trust are sent either via the associated LA Safeguarding Teams to the Adult Safeguarding Teams, who oversee the investigation and liaise with the LA regarding the outcomes. In this reporting period across all sites there were 104 enquiries or requests for information received. Feedback regarding the outcome is not consistently shared with the Trust, although it is known for the Southport and Ormskirk sites 22.7% were substantiated, 9% partially substantiated, 27.3% unsubstantiated, 9 % inconclusive with an outcome still required for 32%. Feedback is not consistently provided for referrals submitted from the Whiston and St. Helens sites.

6.11 The themes from the S42s remains relatively consistent and are mostly in relation to concerns raised by external partners during the discharge process and hospital acquired pressure ulcers. The main learning from enquiries relate to incomplete communication, including lack of information sharing such as discharge checklist and summaries, body maps, transfer letters, notification to care homes/care providers regarding the date of discharge, failure to request further assessments from Adult Social Care when care needs are known, or lack of referrals to community colleagues. There are also re-occurring themes regarding medication errors on discharge, and decision specific capacity assessments not being completed where there is reason to doubt capacity.

6.12 Themes are discussed at both Corporate Nurse Meetings and Ward Managers and Matrons meetings. Across sites all outcomes are shared with the wards, and the Ward

Managers are responsible for the action plans to improve practice. Concerns raised against the Trust can be discussed at the relevant weekly Patient Safety Meetings. S42 enquiries requiring a detailed report and action plan can be presented to the relevant Harm Free Care meeting to provide oversight of the investigation, learning and subsequent actions.

6.13 Making Safeguarding Personal

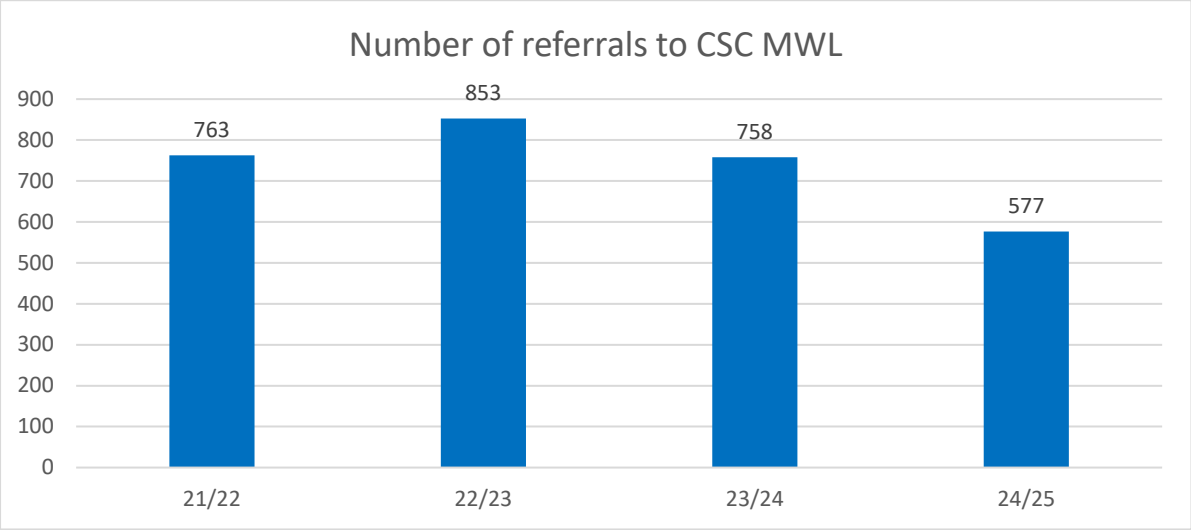
Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 58 individuals who had capacity and decided to refuse intervention; therefore, a referral was not made. This is comparable with 62 individuals in the previous year.

7. SAFEGUARDING CHILDREN ACTIVITY

7.1 Referrals to Children's Social Care

During 2024/2025 there were 577 referrals to Children's social care (CSC), the table below represents the data in comparison to previous years.

Table 7: Number of Children's Social Care Referrals



7.2 It is noted that the number of referrals (577) has decreased since 2023/2024 (758). This is attributed to a change in the referral process for Sefton LA, who introduced a 'conversational model' of referral. The impact is such that a direct conversation is undertaken with the frontline

staff and with the Social Worker who has access to additional information. This conversation may reduce the risk perceived and potentially lower the identified 'Level of Need' threshold. The Children's Team at Ormskirk have oversight of this and continue to monitor cases and outcomes. The team has no cause for concern that referral opportunities are being missed with the implementation of the new model.

7.3 CSC do not routinely share the outcomes of referrals therefore for 2024/2025 it not known exactly how many of the Trust's referrals proceeded to a 'child in need' and or Section 47 (S47) Child protection enquiry, however for outcomes that have been received across all sites, 333 progressed to either Early Help, Child in Need or S47. It is recognised that the LA may report an outcome as 'no further action,' however this may be after the LA undertaking some initial enquiries and gathering information from other agencies, it does not indicate the referral was inappropriate. It is worth noting even if the Safeguarding Teams receive the initial outcome, they will not always know the end outcome of the child and family assessment or S47.

7.4 Meeting Attendance

7.5 The teams provide 100% attendance at meetings where it is relevant and appropriate for the Trust to be represented. It is worth noting the number of records checked for each meeting is significant, as it includes reviewing the childrens', parents' and significant other records. These meetings have included but not limited to those in the table below.

Table 8: **Number of meetings attended**

MWL Activity	22/23	23/24	24/25
Strategy Meetings	253	338	288
CP Conferences (Initial & Review)	137	195	131
Pre-birth assessment meetings	337	420	467

7.6 Previously, there was a significant disparity in the process for Child Protection Conference invites for Sefton Children's Social Care, where invites for all meetings were sent to the Children's Safeguarding Team based at Ormskirk. The Local Authorities serving the Whiston and St. Helens sites send invites only when there is identified involvement, such as when a woman is booked for ante-natal care, or a child has a chronic or long-term health condition managed by practitioners at the Trust. As a result, the team based at Ormskirk, were receiving more than 200 invites per quarter, with requirement to attend a minimal number. Working with colleagues in the LA this has been reviewed, and the process across all sites harmonised.

8. SUDDEN UNEXPECTED DEATH IN CHILDREN (SUDiC)

8.1 The Trust meets its requirements in relation to the national and local child death processes as per Working Together to Safeguard Children Statutory Guidance, 2023. This involves relevant notifications to the Police, Children's Social Care and HM Coroner in the first instance, and subsequent information sharing processes include community partners, G.P, Child Death Overview panel (CDOP) and the ICB. All cases are reviewed by a Paediatric Consultant independent to the case and an internal Child Death Review Meeting is held which identifies any areas of learning as well as good practice. The Safeguarding Children Teams provide representation at strategy and rapid review meetings for the purpose of sharing relevant information and to inform the decision-making process.

8.2 The CDOP panel has responsibility to review all child deaths (up to the age of 18); the panel has an independent chair with representation from police, health (including public health), education, and social care. The purpose of the panel is to:

- Analyse and review information to determine any contributing or modifiable factors and to identify any learning that may prevent future deaths or promote the health, safety and well being of children.
- Make recommendations to all relevant organisations where actions have been identified.
- Contribute to local, regional and national initiatives to improve learning from deaths.

8.3 During 24/25 there were a total of 10 Child deaths within the Trust. It must be noted the teams are informed of a significant number of other child deaths via the CDOP process, which require a review of clinical records to identify any Trust involvement with the child.

9. DOMESTIC ABUSE and SEXUAL ABUSE

9.1 There is recognition that domestic abuse (DA) covers a range of behaviors, and relationships, and is recognised within The Care Act 2014 as a standalone category of abuse. The Domestic Abuse Act 2021 provides a legal definition of 'Domestic Abuse'. It emphasises that DA is not just physical violence, but it can also be emotional, controlling, coercive and economic abuse. Following the publication of the Act, the team updated the Domestic Abuse Policy accordingly.

9.2 At the Southport and Ormskirk sites DA was supported by two Health Independent Domestic Abuse advisors (HIDVAs) up to September 2024. Their role has been pivotal to

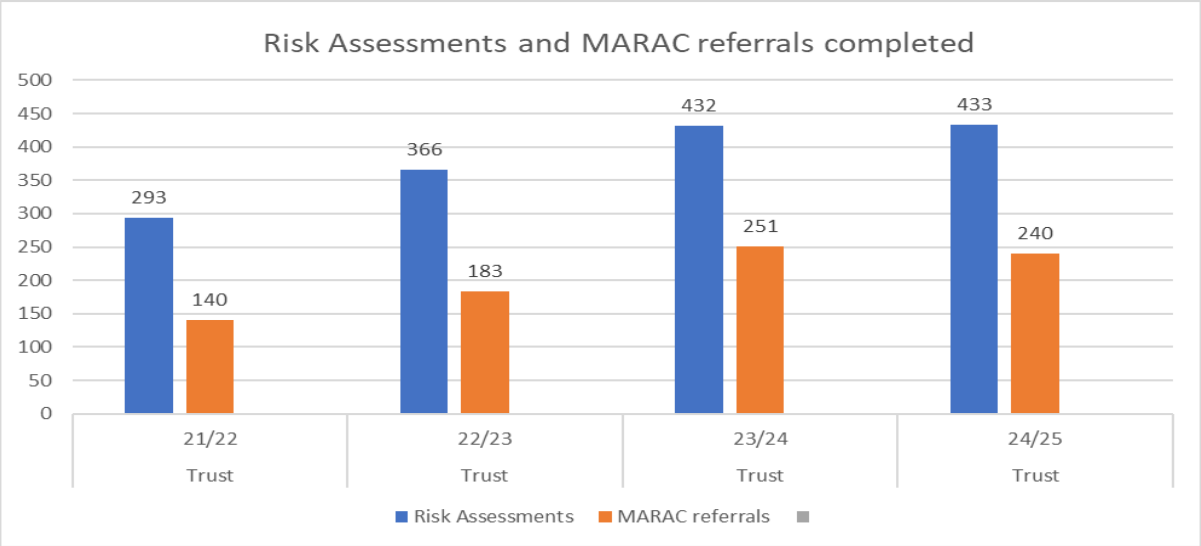
managing cases of DA and increasing the awareness and reporting of DA. The HIDVAs developed the service providing risk assessments, safety planning and onward referrals for both patients and staff victims of DA. Due to the short-term external funding for these posts, both HIDVA's left to take up permanent positions within Local Authorities. Initially a reduced DA service at Southport and Ormskirk sites was managed by the Safeguarding Adults Team. From January 2025 until March 2026 the HIDVA funding has been utilised to increase the capacity in the Team. Furthermore, the funding has been used to enable one Safeguarding Practitioner to commence their IDVA training this year, and for another to apply in 2025. This will seek to continue the delivery of an enhanced, high-quality service for individuals experiencing domestic abuse.

9.3 The Safeguarding Teams attend or share information at local relevant bi-weekly/monthly Multiagency Risk Assessment Conference meetings (MARAC), which are undertaken when there is an immediate risk of serious harm or death to the victim. The teams receive the information via MARAC coordinators and complete a review of all individuals listed within the case summaries. If individuals are known to the Trust any relevant information will be shared at the meeting.

9.4 DA Risk Assessments & Referrals

When there is a concern or disclosure of actual or suspected domestic abuse, staff use a domestic abuse risk assessment to determine the most appropriate referral. For high-risk cases a referral to the local MARAC is completed by the Safeguarding Team following a review of the risk assessment and the patient record, with engagement of the victim where possible.

Table 9: Risk assessments and referrals to MARAC



9.5 Whilst victims of DA are referred to the Team based at the Southport and Ormskirk sites, staff are not always completing the DA risk assessment in a timely manner or before the patient has left the Trust. The Named Nurses across sites are collaboratively reviewing how learning can be shared across all sites. Positively, a completed audit has demonstrated an improvement in the quality of information when DA assessments are completed, and an audit across all sites will be completed in 25/26.

9.6 The staff member should explain the reason for completing the risk assessment and attempt to gain consent from the victim to share information with other agencies if appropriate. If this consent is not given the staff member should explain that information can be shared without consent if the victim is deemed to be high risk or if there are concerns in relation to Child Protection.

9.7 The following guidance will be used to determine whether or not a victim is referred to the local MARAC:

- An incident within the last 3 months, and
- Visible high risk (using MERIT/DASH), or
- Professional judgement and/or
- Escalation (incidents may not meet high risk threshold but are occurring more often and causing concern).
- Incident of non-fatal strangulation/suffocation.

Or, if an incident occurred longer than 3 months ago:

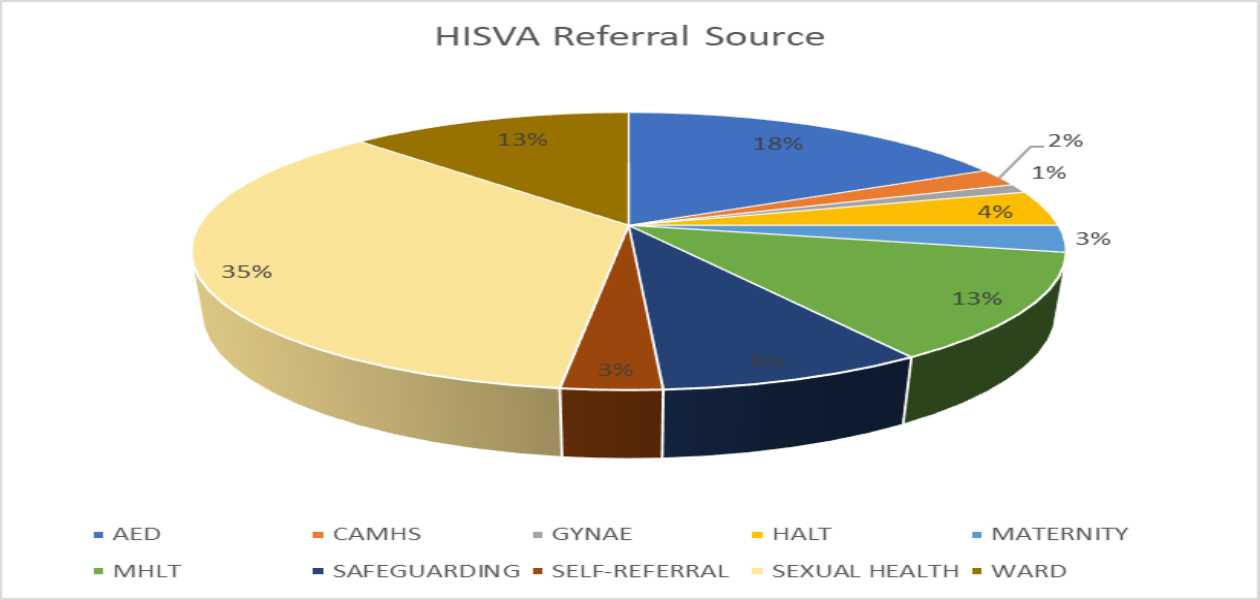
- Professional judgement and/or
- Pattern of behaviour historically linked to a recent event that may cause concern (for example, a recent release from custody and contact being made with the victim).
- ANY instance of abuse between the same victim and perpetrator(s), within 12 months of the last discussion at MARAC.
- Incident of non-fatal strangulation/suffocation.

9.8 The Safeguarding Teams also provide support to staff who are the victim of domestic abuse, as well as advice to managers and HR colleagues.

9.9 Health Independent Sexual Violence Adviser (ISVA) (SOUTHPORT AND ORMSKIRK sites only)

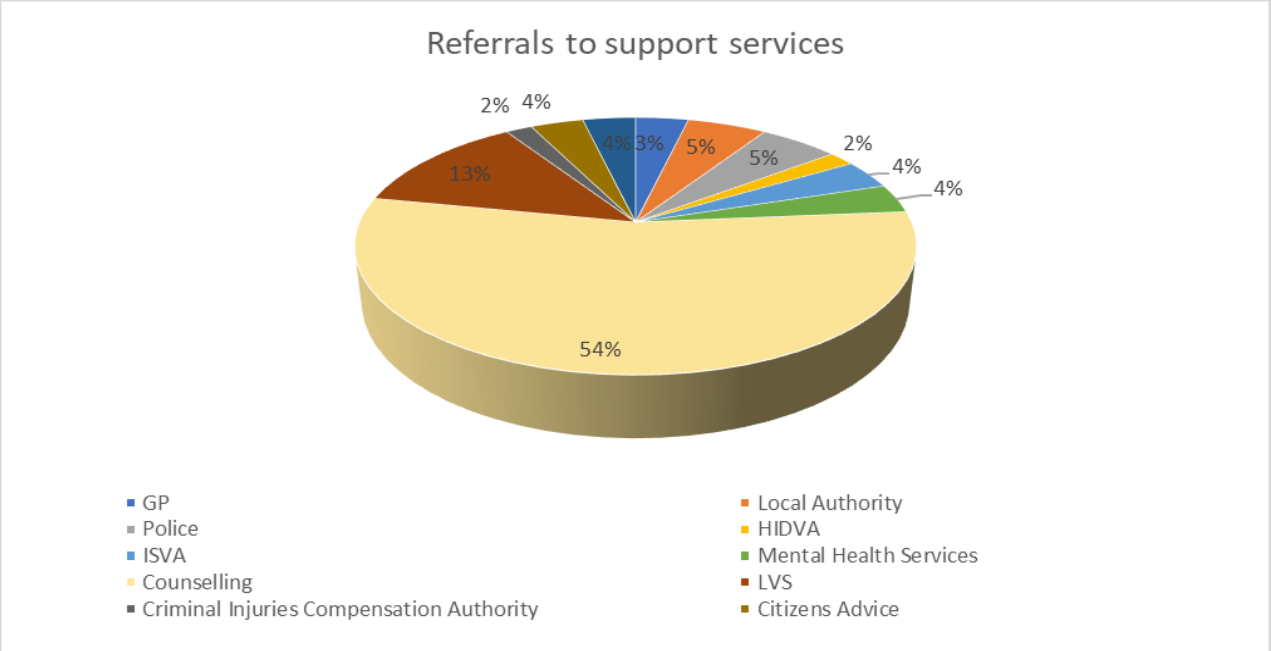
The Health Independent Sexual Violence Adviser (ISVA) is based within the Safeguarding Team. The role provides specialised support to victims of sexual abuse, male or female, aged 16 years and above, who have recently or in the past been subjected to any form of sexual abuse. In this year there have been 96 referrals from a range of sources. This is a reduction of 50% in referrals from the previous year. This is attributed to the HISVA leaving her post in August 2024, and recruitment delayed due to the outcome of the funding decision for the HIDVA, which was confirmed in March 25. This post will be recruited to in Q1 25/26.

Table 10: HISVA Referral Source



9.10 From the patients attending the SOUTHPORT AND ORMSKIRK sites with reports of sexual abuse, 47% reported incidents within the previous 10 days with the remaining 53% reporting less recent incidents.

Table 11: HISVA Referrals to Support Services and Partners



10. DOMESTIC ABUSE RELATED DEATH REVIEWS (DARDR's) or Domestic Homicide Reviews (DHR)

10.1 During this year the Trust has been notified of 13 potentials reviews for which information requests were received. To date MWL have received confirmation that 9 are progressing to DARDR's / DHR's and 4 are awaiting confirmation. The Trust has provided the required Internal Management Review (IMR) and chronology reports to support the review process. Where there is Trust involvement, representation will be provided by the Safeguarding Team.

10.2 While for some the cause of death is still to be shared, at this time it is known two cases were recorded as death by suicide, one was recorded as accidental death, and one was a result of advanced illness, for which abuse prevented potential treatment. All were significant victims of domestic abuse leading up to their deaths.

10.3 There are five remaining reviews currently awaiting initial panel meetings. Currently it is known the Trust will be required to provide representation for at least two of the cases due to significant involvement.

10.4 The Trust continues to provide representation by attending the panel meetings for 4 reviews dating back to 2023/2024.

10.5 The Trust has received confirmation that DARDR 15 has been approved by the Home Office, and the full report will be shared once the final action plan has been approved by all agencies.

11. CHILD SAFEGUARDING PRACTICE REVIEWS (CSPRs) and SAFEGUARDING ADULT REVIEW (SARS)

11.1 The Assistant Directors of Safeguarding and the Named Nurses attend and support local SAR and CSPR sub-groups and represent the Trust at relevant panel meetings.

11.2 Regarding CSPRs the Trust has provided information and chronologies for 12 rapid reviews and attended relevant panel meetings. There is Trust involvement with 4 cases, and 2 have progressed to a CSPR, although one is awaiting the outcome of the Police investigation. Appropriate learning will be shared internally.

11.3 Regarding SAR referrals, these are submitted to the relevant Safeguarding Adult Review Group, who triage and decide if a review is to be undertaken, when it will be transferred to the LSAB for completion. Across all sites there have been 8 requests for information in relation to potential Safeguarding Adult reviews for Lancashire, Sefton, Oldham and Wirral.

11.4 In addition to this, the Safeguarding Adults Teams have submitted 3 referrals for consideration of a SAR to St. Helens, Lancashire and Sefton. One reflected self-neglect, and another neglect, and the other related to a care home resident with a severe learning disability, who has since died, being subjected to a serious physical assault from another care home resident. Two cases are not proceeding to a SAR, however, the case for the assault in the care home is proceeding to a SAR.

11.5 The Safeguarding Team seek to review all learning from local SARs and CSPRs, and as a result will adapt processes and policies, documentation, training and share information to relevant staff.

12. MENTAL CAPACITY ACT and DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

12.1 The Mental Capacity Act 2005 (MCA) is an integral piece of legislation used by healthcare professionals. In 2009, DoLS was bolted onto the MCA 2005 to create a procedure enshrined in law to deprive people, who are assessed as lacking capacity, of their liberty (in their best interest). Any patient over the age of 18, who lacks capacity to consent to their arrangements (i.e. admissions to hospital), who is subject to continuous and effective supervision and control and is not free to leave, is defined as ‘deprived of liberty,’ and therefore a DoLS is required to safeguard their human rights.

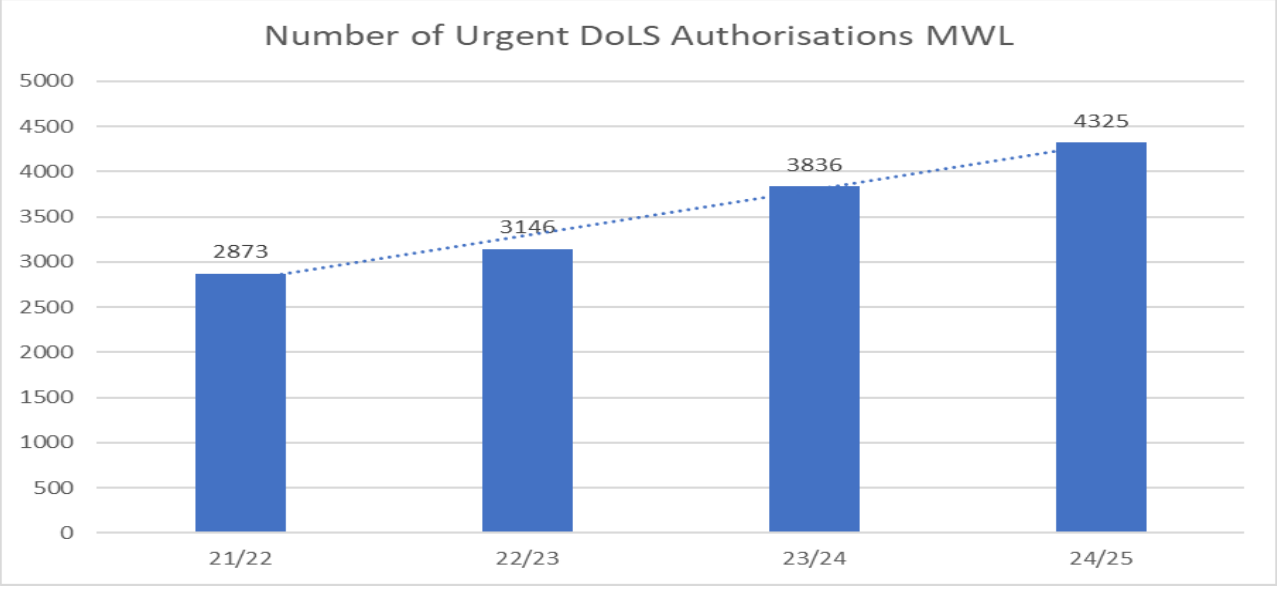
12.2 Adherence to the DoLS process poses a challenge not only for Acute Trusts but has also places a heavy burden on the Supervisory Body (LAs), who are required to complete Best Interest Assessments and authorise a considerable number of DoLS in the community, as well as the hospital setting. As a result, after 14 days patients are deprived of their liberty under the principle of best interests. This is detailed in the Trust risk register which refers to patients who are placed under an urgent 14-day DoLS authorisation, which expires before the Supervisory Body has been able to complete a best interest assessment.

12.3 The Safeguarding Teams have robust systems in place to monitor the DoLS process: all authorisations are checked and quality assured; if required the information is amended before submission to the Supervisory Body. Ward staff are required to review and record daily the restrictive practices in place, to ensure these are the least restrictive and proportionate.

12.4 The teams send an email regularly to the Supervisory Body, advising patients who no longer require a DoLS, and the patients who are awaiting a Best Interest Assessment. When the teams are aware they further escalate to the Supervisory Body, any patient who needs an urgent Best Interest Assessment for example, they strongly object to being in hospital, they are subject to a high level of restrictive practice, or they have been an inpatient for significant period.

12.5 Across all sites there has been 4325 authorisations for an urgent DoLS across all sites.

Table 12: Deprivation of Liberty Safeguards Applications



12.6 Those that are not authorised by the Supervisory Body are due to the patient being discharged before the assessment is undertaken; patients regaining capacity; patients who have deceased; the urgent authorisation lapses due to no assessment being undertaken by the Supervisory Body.

13. LEARNING DISABILITY

13.1 Patients who attend the Trust with a diagnosis of a Learning Disability or Autism should be able to expect high quality, personalised and safe care. The NHSE/I improvement standards for Acute Trusts include:

- Respecting and protecting rights of those with a Learning Disability, ensuring the Trust meets the Equality Act requirements, provides reasonable adjustments and flagging to identify patients and support the additional care required.
- Inclusion and engagement ensuring the patient, family and carers are all empowered and included in the care provided as a partnership
- Ensuring the workforce is resourced and skilled to care for those with a Learning Disability

13.2 Due to their experiences of both acute and chronic illness, people who are learning disabled have an increased attendance and admittance to acute general hospitals, and the demand from people with learning disabilities, their families and carers on specialist and general health service is expected to increase significantly in the future (Gates, 2011, as cited in Phillip, L. 2018).

13.3 The Learning Disability and Autism Practitioners (LDAP) demonstrate extensive value in relation to patient and care experience and providing staff support, developing relationships with the patient's family, and or carers.

13.4 The LDAPs have provided an extensive amount of support to ward staff; supporting ward-based care; the provision of reasonable adjustments; supporting DoLS and DNACPR decisions, facilitating a timelier discharge; providing ad-hoc learning disability and autism awareness sessions. They have established strong communications with community-based learning disability services, ensuring a collaborative approach to meeting the patient's care needs.

13.5 The LDAPs support the Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) agenda. The LDAPs ensures the Trust reports, within the required timeframe, the deaths of those with a learning disability and or autism. The LDAPs liaise with the LeDeR reviewer to provide the required information and following the LEDER review they feedback recommendations into the Trust Mortality Operational Group. This year the Trust submitted 30 LEDER notifications.

13.6 As per internal mortality review process, all deaths for LD patients receive a Structured Judgement Review. It has been noted that improvements are required regarding the lack of evidence within the medical notes for the consideration of the Mental Capacity Act, specifically in relation to DNACPR decisions. It has been further noted that inaccurate information has

been recorded on DNACPR forms. The Safeguarding Teams are working collaboratively to improve practice.

13.7 The LDAPs provide representation at local LeDeR steering groups, ensuring the Trust is sited on improvements required to improve the lives, and prevent unavoidable deaths of those with a learning disability and or autism.

13.8 The table below represents some of the activity undertaken by the LDAPs and the number of attendances to the Trust for those with an LD and or autism alert in their electronic patient record. To be noted the LDAP at Southport and Ormskirk sites only commenced in post from August 2022 and has undertaken maternity leave in 2024/2025, therefore data collection is incomplete. Since retuning in February 2025, the databases across sites have been harmonised. The numbers for attendances could in fact be higher as it relies on the person having an alert on their clinical record.

Table 13: LDAP Activity

MWL	Inpatients (excluding AED attendances)	Outpatients Attendances	Outpatient attendances with LDAP involvement	Information sharing contacts only
2023/24	986	1820	135 excluding SOUTHPORT AND ORMSKIRK	410 excluding SOUTHPORT AND ORMSKIRK
2024/25	1180	2501	176 excluding SOUTHPORT AND ORMSKIRK	577 excluding SOUTHPORT AND ORMSKIRK

14. MENTAL HEALTH

14.1 Mental Health Act Detentions

14.2 This year the Assistant Director of Safeguarding sought approval for the SLA with Mersey Care, who provide the Mental Health Act administration on the Southport and Ormskirk sites, to be extended to include all sites. A pilot was commenced in February 2025 and the Trust is awaiting updated costings for 2025/26.

14.3 To note there is a significant difference in the number of patients detained across sites which is partially attributed to a variance in process across sites, where at Whiston patients

awaiting a bed from an AED attendance are detained to an in-patient area within AED, while patients attending Southport AED are not detained while awaiting a mental health bed.

Table 14: MWL Number of Mental Health Detentions

MWL	Number of detentions
2023/24	152
2024/2025	140

14.4 Tribunal Applications

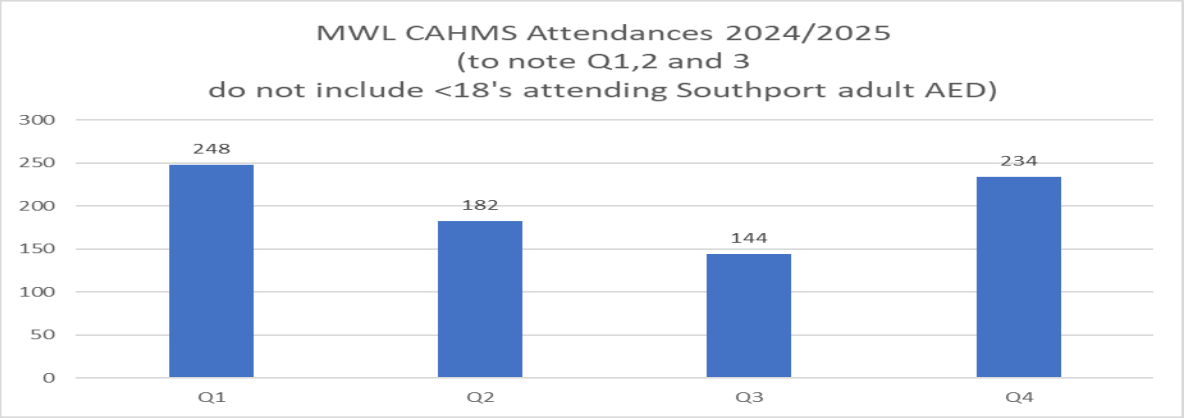
Across all sites there were 7 tribunals by patients detained to the Trust. Six of the tribunals were at the Whiston sites, and in the absence of a Mental Health Administrator the process was undertaken by the Safeguarding Team.

14.5 Children and Adolescent Mental health Services (CAMHS)

14.6 For sites covered by Merseycare the CAMHS response team now offer a 24-hour service to children and young people attending the Trust with a reduced response time of 4 hours. This year the offer in West Lancashire has been improved in that referrals will be actioned by the RAIST (Response and Intensive Support Team) with the expectation to avoid admission and undertake timelier assessments.

14.7 CAMHS attendance for this reporting period are detailed in the below. Over the year there has been a 4.6% decrease in attendances. This reduction is likely to be secondary to the increased service provision provided by Merseycare to support young people at home, avoiding crisis admissions to AED.

Table 15: Number of CAMHS Attendances



** To note Q1, Q2 and Q3 do not include <18's attending the Southport adult AED*

14.8 Trust Assurance

A Mental Health steering group commenced in 2024, chaired by the Head of Legal Services. The aim of this group is to ensure there is a consistent level of care for patient who attend with mental health problems, that staff are suitably trained to support and that national and local guidance including legislation is adhered to. A draft 3-year Mental health Strategy has been completed and is awaiting ratification.

14.9 Right Care Right Person (RCRP)

RCRP is an approach designed to ensure that people of all ages who have health and/ or social care needs, are responded to by the right person with the right skills to meet their needs. At the centre of the RCRP approach is a threshold to assist police in making decisions about when it is appropriate for them to respond to incidents, including those which relate to people with mental health needs. The threshold for a police response to a mental health-related incident is:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm

The Safeguarding Team regularly attend the RCRP tactical meetings and support with implementation including the revision of the Missing patient Standard Operating Procedure. The final stage of RCRP is due to be implemented in Jule 2025 and this relates to the Police support for the management of patients detained under S136 of the Mental Health Act, the aim is to reduce the Police resource currently utilised. This piece of work is being overseen by Cheshire and Wirral partnership with consultation and input from all Acute and Mental Health Trusts.

15. INITIAL HEALTH ASSESSMENTS (IHAs)

15.1 The Trust is commissioned to complete the Initial Health Assessments (IHA) for St. Helens and West Lancashire for children new into care, or children placed from other boroughs. IHAs are a statutory requirement and should be completed within 20 working days of a child entering the care system. The assessments are completed by the Community Paediatricians across the relevant site.

15.2 During 2024/25 for those completed for St. Helens, 58% of the 130 assessments were completed within timeframe. There has been an increase in compliance throughout the year with Q4 data equating to 89%; work has been completed to reduce breaches due to internal issues such as appointment capacity and administration process delays. Children not being

brought to appointments or appointments being rearranged continues to account for the highest number of breaches.

15.3 For those completed for West Lancashire of the 49 assessments requests, 43% were offered an appointment within 20 working days. Of those who attended their appointment 17% had the assessment and the subsequent report completed within timeframe.

15.4 There were multiple external and internal factors relating to the breaches including late notifications from the LA, children not brought to appointments, and issues with appointment allocation secondary to gaps in medical staffing. Meetings are held regularly with the Designated LAC Nurse and the Commissioners to review the process and where possible to reduce breaches.

16. PREVENT

16.1Prevent is part of the Government's counter terrorism strategy, and as the name suggests it is the part of the strategy designed to identify people who may be vulnerable to radicalisation, before they commit any crime. LAs, Health, Education and the Police amongst others form the CHANNEL Panel, which considers every case referred, and determines which professionals should be engaged to intervene in addressing the individual's needs. The Safeguarding Teams attend the relevant Channel panel where those at risk of radicalisation are discussed and share relevant information for those being discussed.

16.2 The Trust has made no referrals made during this reporting period Under the PREVENT agenda.

Table 16: Prevent Training Compliance

As per the table below there are 2 levels of PREVENT training (staff will be allocated the relevant level as per role); positively, compliance has remained above 90% throughout the year.

Competency	Q1	Q2	Q3	Q4
PREVENT Level 1 and 2	92.9%	93.8%	92.6%	93.2%
PREVENT Level 3 and 5	92.4%	92.8%	90.7%	93.6%

17. MANAGING ALLEGATIONS

17.1 The Assistant Directors Safeguarding and Named Nurses continue to support the Trust with management of allegations. These cases may be allegations in relation to abuse or neglect of a patient, or concerns raised in relation to a staff member and their suitability to work with children and or vulnerable adults; this could include criminal activity, drug and alcohol issues or concerns of abuse to a child or family member.

17.2 All cases are assessed as a matter of urgency via an internal allegation meeting to consider any immediate restrictions that may be required to ensure patient safety; where applicable cases are progressed via the Trust Disciplinary Policy; referrals to relevant governing bodies and referral to the data barring service (DBS) is also considered.

17.3 During this reporting period 50 safeguarding concerns were raised from the Lead Employer, 35 of which required referral to the LADO. In addition, 13 trainees were supported as victims of domestic abuse. None of the cases resulted in dismissal, restrictions were put in place when required while investigations were completed, and where applicable a DBS referral was completed. As part of the process of returning trainees to practice the Assistant Director / Named Nurse Safeguarding Children will, where applicable meet with them to carry out assurance of safeguarding knowledge and consider any additional training needs.

17.4 For Whiston and St. Helens sites 77 staff concerns were raised to safeguarding team, 35 staff members were supported as victims of domestic abuse, where necessary allegations meetings were held to discuss any onward referrals and potential restrictions. With HR input when required.

17.5 For the Southport and Ormskirk sites 84 potential allegations were reviewed, with 56 requiring an internal safeguarding allegation meeting to review immediate actions and inform fact finding required.

17.6 In cases of potential harm to a patient was identified referrals were also made to the Local Authority Safeguarding Teams

17.7 The Trust made a referral to the LADO for 14 cases. The Safeguarding Teams are represented at all LADO meetings alongside Human Resource colleagues, to offer advice and support with what can be very complex cases requiring extensive investigation.

17.8 The data provided by Human Resources details 1 staff being removed from their employment with the Trust. Where required referrals were made to the DBS and / or regulatory bodies.

18. SAFEGUARDING AUDITS

Throughout this year the Safeguarding Teams have undertaken an array of audits across various sites in the Trust. A selection of the audits is detailed below. For those where

assurance is not achieved the teams will liaise with the clinical team regarding how improvements can be made.

Table 17:

Audit title	Findings
Audit of Compliance of Social Care Referrals	This audit gave assurance of good compliance in many of the standards with some areas of improvement identified.
Audit of Safe Sleep Discussions	There has been an improvement in Postnatal Safe Sleep messages. However, discussion within the antenatal period requires improvement.
Quality of Adult Social Care Safeguarding referrals	Significant improvement noted in the analysis of risk. The importance of ensuring details completed accurately and shared with the safeguarding practitioners.
Audit of Best Interest decision making evidence and documentation	Although improvements have been noted there are still improvements to be made with capacity assessments being completed, Best Interest decisions being recorded and documenting supporting evidence in consent form 4.
Audit of Quality of Adult Safeguarding Referrals	This audit evidenced full assurance with expected standards.
Audit of Quality of Domestic Abuse Risk Assessments completed	This audit evidenced significant assurance. An area of improvement identified was in relation to obtaining safe contact details to enable follow up with the victim on leaving hospital.
Quality of Children's Safeguarding Referrals	This audit has offered full assurance.
Under 18 Cas Card	This audit offers limited assurance regarding the use of the under 18 CAS card. However, on review of the records, a 100% completion of the paediatric liaison forms has ensured that the Safeguarding Children's Team has been made aware of these attendances and have then contacted social care to information share and make appropriate referrals
Audit of Compliance of Young Persons Drug and Alcohol screening Tool.	There is reasonable assurance that AED staff can identify when a young person's drug and alcohol screening tool is required. There was assurance staff have a good understanding that all drugs and alcohol require a screening tool.
Quality of capacity assessments for DoLS	Only 25% of the mental capacity assessments received were completed correctly. Ongoing bespoke training is being provided and a datix is being completed when the capacity assessment is not of the required standard. The team are working with the IT digital nurses to implement electronic DoLS authorisations

Completion of Safeguarding Actions for Adults Attending AED and identified as being at risk of self-harm	This audit limited assurance that those attending at risk of self-harm are being asked about domestic abuse and dependants and any safeguarding identified. Results of the audit have been shared with AED Managers. Completion of safeguarding routine enquiry to be highlighted at all training sessions with AED.
Assurance Audit of the All-Age Safeguarding Document completion in AED and actions taken	The audit provided full assurance, which is a significant improvement from previous audits.
Management of Domestic Abuse Audit	There has been a continued improvement in staff recognition and management of domestic abuse. This gives reasonable assurance that staff can support victims of domestic abuse by ensuring appropriate referrals are made, risk is reduced, and victims and children are safe from further harm.
Quality of capacity assessments for Deprivation of Liberty Safeguards Applications Audit	This audit demonstrated improvements required in the completion and quality of capacity assessments
Audit of MCA and DoLS Compliance for all Patients with a Known Impairment of Mind or Brain	The audit offered significant assurance, although improvements could be made in completing the daily restrictive practice form.
16–17-year-old walkabout	This offered full assurance that staff knew how to respond to safeguarding concerns for 16–17-year-olds in the adult wards.
Audit of Restrictive Practice for Patients with an identified Learning Disability	The audit showed use of the Hospital Passport and Rapid Risk Assessment has reduced, however. It is positive that even in the absence of completing the assessment, in 92% of cases reasonable adjustments were considered.

19. EXTERNAL SCRUTINY

19.1 Commissioning Standards

In 23/24 the Trust submitted the Cheshire and Mersey Commissioning Standards. This reporting year the Designated Nurses at St. Helens Place combined the previous two submission into one MWL submission.

The Assistant Directors Safeguarding have developed action plans for each site, as there are some differences with the action's required across the Trust. The action plans are monitored by the Designated Nurses with further evidence submitted with the KPIs quartile submission to St. Helen's Place.

19.2 Section 11 Scrutiny

This year St. Helens Safeguarding children's Partnership (SCP) and the ICB sort to reduce duplication for providers, by acknowledging the scrutiny already undertaken by the ICB in the commissioning standards submission. In view of this the requirement was for the providers, via the ICB, to submit only the commissioning standards action plans for any ambers and reds, recognising that ongoing scrutiny of the action plans is provided by the ICB.

20. RISK REGISTER

There were 3 risks relating to safeguarding in 2024/25:

- Lack of MHA Administration Service level Agreement (SLA) in place for the Whiston sites, which places the Trust at risk of non-compliance with the Mental Health Act, resulting in patients being detained unlawfully. This was closed following the implementation of an SLA from Mersey Care to provide the service on a trial basis. This has now been closed due to the completion of the SLA for MHA administration

- For the Southport and Ormskirk sites Lancashire LA is not undertaking Best Interest Assessments; therefore, once the urgent authorisation expires patients are detained under best interest. The LA has a process for prioritising their waiting list. The Trust has mitigation in place to ensure patients deprived of liberty are reviewed regularly and the levels of restrictions are reviewed daily. The LA is informed should the levels of restrictions increase, or the patient is no longer deprived of their liberty.

- The Southport and Ormskirk sites do not have a clinical photography team; as a result, photographs provided by the Trust for the purpose of child protection and criminal investigation processes and wound or pressure ulcer management do not represent the injury/harm/wound/pressure ulcer accurately. This is currently being explored by the Division, supported by the Chief Operating Officer, to expand the service across all sites.

21. SAFEGUARDING WORK PLAN 2024/2025

During 2025/26 the following will form the basis of the Safeguarding Team action plan

- Implement the digital DoLS process across all sites
- Update mental capacity assessment forms to be in line with current case law
- Explore a digital solution to support the quality of the capacity assessments completed
- Continue to harmonise audits across sites where possible
- Explore funding for additional posts such as the HIDVA and Emergency Department Navigator
- Harmonise learning disability and autism data collection and recording

- Explore the development of BI reports to support missed opportunity and to streamline processes for the Safeguarding Practitioners.
- Explore with Mersey Care the costings to extend the MHA administration SLA to all sites.
- We will work with the training department to implement the harmonised training needs analysis for all sites
- Work with the training department to harmonise training modules
- Review the learning disability risk assessment and associated processes
- Review with colleagues in AED how safeguarding process can be embedded in their documentation
- Monitor any changes to legislation and amend policy accordingly

22. CONCLUSION

22.1 Progress continues in the journey towards safeguarding being embedded in practice and considered everyone's business. The team work operationally within the Trust and engages extensively with external partners, given the nature of safeguarding being a multi-agency and multi-professional practice.

22.2 The Safeguarding Team oversees and monitors key areas to ensure appropriate referrals and actions are undertaken to safeguard the un-born, children, young people, and adults at risk of abuse. This has been enhanced by the additional roles of LDAP, HIDVAs, and HISVA. The Safeguarding Team will continue to improve and simplify processes, embed training into practice, ensuring quality referrals are undertaken, and enable staff to use their time with patients effectively to identify and manage safeguarding concerns.

22.3 The Safeguarding Teams on all sites have continued to demonstrate a high volume of activity in relation to Safeguarding Adults, Children and Unborn infants. This provides significant assurance that safeguarding continues as a priority across the organisation. There is evidence of commitment to multi-agency working demonstrated by the number of referrals to partner organisations and multi-agency meetings attended. Compliance with guidance and legislation can be demonstrated with the increase in the number of DoLS, domestic abuse risk assessments and referrals, and through the management of allegations against staff.

22.4 The teams across sites continue to work together to review and harmonise ways of working and safeguarding processes, including the safeguarding reporting process. Training

compliance has improved although there is still improvement required to achieve 90% in all areas.

23. RECOMMENDATIONS

The Committee is asked to recognise the achievements made by the Safeguarding Team in this reporting period outlined in the report and agree to the work plan for the year ahead.