Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 30 July 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	**1.**	**Employee of the Month (July 2025)** *Purpose: To **note** the Employee of the Month presentations for July*	Film	Chair *(15 mins)*
10.15	**2.**	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.30	**3.**	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB25/053 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 25 June 2025*	Report	
	6.	**TB25/054 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
10.40	**7.**	**TB25/055 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*	Report	P Williams obo S o'Brien L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Reports				
11.10	**8.**	**TB25/056 Committee Assurance Reports** 8.1. Executive Committee 8.2. Quality Committee 8.3. Strategic People Committee 8.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper G Brown C Spencer obo L Knight C Spencer *(40 mins)*
Other Board Reports				
11.50	**9.**	**TB25/057 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register*	Report	N Bunce *(10 mins)*
12.00	**10.**	**TB25/058 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
12.10	**11.**	**TB25/059 Aggregated Incidents, Complaints and Claims Report (Q1)** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for Q1*	Report	P Williams obo S O'Brien *(15 mins)*
12.25	**12.**	**TB25/060 Learning from Deaths Quarterly Report Q3 2024/25** *Purpose: To **note** the Learning from Deaths Quarterly Report*	Report	P Williams *(10 mins)*
12.35	**13.**	**TB25/061 Infection Prevention and Control Annual Report 2024/25** *Purpose: To **approve** the Infection Prevention and Control Annual Report 2024/25*	Report	S Redfern obo S O'Brien *(10 mins)*
12.45	**14.**	**TB25/062 Informatics Reports** 14.1. Data Security and Protection Toolkit (DSPT) 14.2. Information Governance Annual Report 2024/25 *Purpose: To **note** Cyber Assurance Framework (CAF) Toolkit Results and the Information Governance Annual Report*	Report	M Gandy *(10 mins)*

12.55	**15.**	**TB25/063 Emergency Planning Response and Resilience (EPRR) Annual Report 2024/25** *Purpose: To **approve** the EPRR Annual Report 2024/25*	Report	L Neary *(10 mins)*
13.05	**16.**	**TB25/064 Revised Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) Partnership Agreement** *Purpose: To **approve** the revised Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) Partnership Agreement*	Report	N Bunce *(10 mins)*
Concluding Business				
13.15	**17.**	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.20	**18.**	**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 24 September at 10:00		**13.30 close**
15 minutes lunch break				

Chair: Steve Rumbelow

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

Title of Meeting	**Trust Board**		**Date**	30 July 2025
Agenda Item	**TB25/000**			
Report Title	Patient Story - The positive impact of the new Activities Co-ordinator role at Newton Hospital			
Executive Lead	Sarah O'Brien; Chief Nurse			
Presenting Officer	Yvonne Mahambrey; Quality Matron, Patient Experience.			
Action Required		**To Approve**	X	**To Note**

Purpose

To present a patient's experience at Newton Community Hospital utilising the Activities Co-ordinator in the achievement of holistic care to patients with a focus on improving wellbeing, increasing social interaction and cognitive stimulation.

Executive Summary

Intermediate care involves the multidisciplinary provision of rehabilitation and support to patients following injury and/or a period of illness who require further therapy intervention to maximise their potential for independence and quality of life upon discharge.

National Institute for Health and Care Excellence (NICE) Guidance (NG74) states that intermediate care should be tailored to the individual patient's social, emotional, cognitive and communication needs and abilities. The benefits of inpatient intermediate care in the older person population include improved function, decreased need for admission into long-term care facilities and decreased mortality.

If there is a lack of meaningful activity for patients during admission for intermediate care, it can lead to feelings of boredom, alienation from patients' usual roles and routines, diminished sense of self and feelings of passivity and disengagement. To address this and NG74, the role of activities co-ordinator was developed, and implementation was supported by the Integrated Care Board (ICB).

The patient was admitted to Newton Hospital for rehabilitation following treatment at Whiston Hospital. At that time the patient was very withdrawn and annoyed with herself at finding herself hospitalised. She was usually very sociable and enjoyed keeping busy, and enjoyed social activities such as bingo, quizzes, board games, the outdoors and crosswords. The patient agreed to join group activities and one-to-one sessions with the Activity Co-ordinator.

Working together with the patient, the Activities Co-ordinator tailored their one-to-one sessions to the patient's interests and hobbies; the patient's favourites were playing dominoes and enjoying being mobilised outside in her wheelchair to enjoy the hospital gardens reminiscing about their previous career, hobbies, holidays, wedding and honeymoon. The patient fed back that it was nice to have someone to talk to, and that she'd like to continue with more individual sessions.

The patient also participated in many group activities and socialising with other patients. Building a rapport with other patients, who would meet with her in-between group activities for a chat. The patient stated that the group activities gave her something to "look forward to" and that it helped to alleviate the "boredom" of being in hospital in-between rehabilitation sessions and that she felt that the ward staff "couldn't do enough"

Lessons Learned From this Initiative:

- A welcome letter has been devised for patients as part of their welcome pack on admission to introduce the Activities Co-ordinator and inform patients about the role.
- Recognising that some patients have visual and hearing impairments and sometimes struggled with some of the activities has reinforced the importance of making group activities inclusive to all patients who may have very differing needs of support.
- The importance of multi-disciplinary teamwork to facilitate ward activities.
- The importance of active listening during one-to-one activities supports patient wellbeing that extends far wider than physical rehabilitation goals.
- Holistic care is not only about physical health.
- How focussed and meaningful activities can be a springboard to improving patients holistic wellbeing.
- Reasonable adjustments such as providing one-to-one support to patients during group sessions, using a projector for bingo or using large print bingo cards or removing visual rounds from quizzes ensures that patients who have hearing and/or visual impairments can also participate in and enjoy social activities.
- Information cards have been devised for patients at the start of group activities so that they are informed about the purpose of the group activity.

Next Steps:

- There is currently some ward reconfiguration in progress at Newton Hospital, so the group activities have been re-located to the dining room and outside when the weather permits. In recognition of how impactful this work is the staff have limited disruption during the building works.
  The Activity Co-ordinator role has now been introduced to Duffy Suite at St Helens hospital to increase the number of patients positively impacted by the activity co-ordinator role.

Financial Implications
None as a direct result of this paper.

Quality and/or Equality Impact
Not applicable

Recommendations
The Board is asked to note the Patient Story.

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

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 25 June 2025
(Approved at Trust Board on Wednesday 30 July 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
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
Malise Szpakowska	MS	Chief People Officer
Rani Thind	RT	Associate Non-Executive Director
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Daniel Adshead	DA	North West Territory Sales Manager, Styker, Surgical Technologies (Observer via MS Teams)
Chris Higginbotham	CH	North Regional Sales Manager, Styker, Surgical Technologies (Observer via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager
Marie Wright	MW	Halton Council Representative (Stakeholder Representative)

Apologies

Name	Initials	Title
Steve Connor	SC	Non-Executive Director

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for June 2025 was Jayne Gore, Matron, Urgent Treatment Centre, Newton Hospital and the Board watched the film of LB reading the citation and presenting the award to Jayne. **RESOLVED:** The Board **noted** the Employee of the Month for June 2025 and congratulated the winner
2.	**Chair's Welcome and Note of Apologies**
	2.1. SR welcomed all to the meeting and in particular DA and CH who were attending the meeting as observers. Additionally, SR welcomed MW who would be attending future Board meetings as the Halton Council Stakeholder Representative. 2.2. SR reported that this would be LB's last Board meeting in her role as Acting Director of Nursing, Midwifery and Governance and thanked her for her hard work and commitment to MWL over the past 15 months and noted that LB would remain with the Trust as a key part of the senior nursing leadership team. 2.3. It was noted that HS would be leaving the meeting at 13:00 to attend a University Senate meeting. 2.4. SR acknowledged the following awards and recognition for Trust staff and services: 2.4.1. Five members of staff were recognised in the prestigious King's Birthday Honours List for their services to the community: • Rev Martin Abrams, Spiritual Care and Chaplaincy Manager, Southport Hospital, has been awarded a Member of the Order of the British Empire (MBE) for his ongoing service to the community including his unwavering support to those affected by the Covid-19 pandemic and the tragic events in Southport in July 2024. • Also recognised as recipients of a Medal of the Order of the British Empire (BEM) for their services to the community: ○ Dr Chris Goddard, Consultant in Anaesthetics and Intensive Care ○ Dr George Bramham, Acute Care Common Stem Doctor ○ Liz Parsons, Theatre Practitioner, ○ Martin Johnson, Operating Department Practitioner They were key members of the emergency response and surgical team at Southport Hospital who provided immediate care to those affected by the tragic incident.

	2.4.2. The Procurement Team won two awards: • The Public Sector Procurement Team of the Year - Purchase to Pay Network. The nomination covered the broad scope of challenges the team has faced whether that be organisational change, supply shortages, department restructures, new legislation, systems and still maintain excellent metrics and CIP performance etc. • The Procurement team also won the "Regional Procurement/Logistics Excellence Award" at the Health Care Supply Association (HCSA) North 2.4.3. Volunteer Anne Handley, Whiston Hospital, was nominated for a BBC Radio Merseyside "Make a Difference Award". The award recognised individuals and groups who make life better for people in our communities. Anne had worked as a volunteer since 2017 across a number of services including Chaplaincy and the Neonatal Unit. 2.4.4. Marshalls Cross Medical Centre has been shortlisted in this year's HSJ Patient Safety Awards. The team has been recognised in the Primary Care Initiative of the Year category for implementing a digital first approach to triage. 2.4.5. The annual British Burns Association Conference took place at the beginning of June and members of the Mersey Regional Burns Centre multi-disciplinary team showcased the team's collaborative work and innovative projects. 2.4.6. Professor May Ng OBE, Consultant Paediatric Endocrinologist at Ormskirk Hospital, has been appointed Professor of Child Health at Edge Hill University. 2.4.7. Molly Pendleton, Dietetic Assistant at Whiston Hospital, has been awarded Quality Improvement Champion at the recent Cheshire and Merseyside Allied Health Professionals (AHP) Support Worker event. 2.4.8. St Helens Sexual Health Team was nominated in two categories at the National Diversity Awards taking place on 19 September: • Emma Cuerden, Health Improvement Specialist, is nominated as a 'Positive Role Model - LGBT category'. • Over the Rainbow, an LGBT support group, run by Emma and the Health Improvement Team, has also been nominated in the 'Community Organisation - LGBT category'. Apologies for absence were **noted** as detailed above
3.	**Declaration of Interests**
	3.1. There were no new declarations of interests made in relation to the agenda items.
4.	**TB25/047 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 28 May 2025 and approved them as a correct and accurate record of proceedings **RESOLVED:**

	The Board **approved** the minutes from the meeting held on 28 May 2025
5.	**TB25/048 Matters Arising and Action Logs**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. **RESOLVED:** The Board **approved** the action log
Performance Reports	
6.	**TB25/049 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for May 2025 was presented.
6.1.	**Quality Indicators**
	6.1.1. LB and PW presented the Quality Indicators. 6.1.2. LB highlighted the following: • The inpatient Family and Friends Test (FFT) recommendation rate in May 2025 was 94.3% (target 90%). • The nurse staffing fill rate was 98.7% (target 90%). LB commented that there was rightly increased scrutiny and challenge about staff rostering as a result of the financial pressures, but the commitment to maintaining safe staffing levels continued. • The rate of patient falls resulting in harm across all Trust sites was 0.14 per 1,000 bed days in April. The independent review of the Trust's falls policy and practices by an external subject matter expert had found that the Trust was in the acceptable range of between two and eight falls per 1,000 bed days with 5.8 falls per 1,000 bed days. Different metrics could be used to measure the number of falls in different settings, and this was being explored for MWL. The final expert review report would be presented to Quality Committee, once received. • The pressure ulcers rate was 0.08 per 1,000 bed days in March and the 2024/25 outturn performance was 0.13. • LB noted the internal audit (MIAA) quality spot check audits of harm free care on the wards, which included pressure ulcers, nutrition and hydration, had received substantial assurance, which was an improvement compared to previous years. • There had been 11 cases of Clostridioides difficile (C.Diff) (17 year to date (YTD) and 16 cases of Escherichia coli (E.coli) (28 YTD) reported in May 2025. Trajectories for both infections had been received from NHS England (NHSE) and the Trust was currently below the thresholds for both. These would now be added to the IPR.

	• Infection, Prevention and Control (IPC) remained challenging following the outbreak of Norovirus at Southport Hospital, and as a result of an increased number of patients with Covid-19 infections. • Complaints response performance was 47.2% in May (target 80%) compared to 46.5% in April. There had been a focus on reducing the number of complaints that had already breached the time limits, mainly within the Medicine and Urgent Care and Surgery Divisions. Improvement plans had been agreed with these divisions and were being monitored at Divisional Performance Review meetings. • The improvement work that had been undertaken in the Emergency Department (ED) at Whiston Hospital, which focussed on ambulance handover times, triage time, long waits and ready for discharge patients, would improve patient experience and the improvements in performance in these areas would be triangulated with complaints and incident data. 6.1.3. PW highlighted the following: • No never events, still births or neonatal deaths had been reported in May 2025. • The latest reported Hospital Standardised Mortality Ratio (HSMR) included data up to November 2024. The in-month figure was 84.2 and the YTD figure was 90.4 (89.6 for Whiston and St Helens Hospitals and 91.6 for Southport and Ormskirk Hospitals). • All diagnosis groups that had a greater than expected mortality had been reviewed through the Learning from Deaths process and no areas of concern were highlighted. • The Standard Hospital Mortality Indicator (SHMI) was 1.02 in December 2024 and remained within the expected range. 6.1.4. CS reflected on the increase in Covid-19 infections and asked if there had been a corresponding increase in staff sickness absence, and whether there would be any further promotion of the staff vaccination programme for Covid-19 and flu. MS responded that there had been a slight increase in Covid-19 sickness absence over the preceding week and that the vaccination programme for Covid-19 and flu for 2024/25 had now ended. MS noted that there was a national review of staff vaccination rates as a result of falling take up rates and any lessons learnt would be applied to the 2025/26 vaccination campaign.
6.2.	**Operational Indicators**
	6.2.1. LN presented the operational indicators and reported that Urgent and Emergency Care (UEC) performance had continued to improve in May. 6.2.2. LN highlighted the following: • The 4-hour mapped performance for MWL in May 2025 was 79.5% against the national target of 78%. This compared to 75.4% nationally and 73.7% for Cheshire and Merseyside (C&M). This performance has been sustained over the preceding five months. There has also been a

corresponding reduction in the number of 12-hour waits in the ED from 18.9% in April to 16.4% in May. The national target for 12-hour waits in 2025/26 was 10% and Southport ED was slightly above target and whilst Whiston was still over target this had reduced significantly. The Trust was the third best performing Trust in C&M for 12-hour waits.

- 56.1% of ambulance handovers had been achieved in 30 minutes in April and LN reported that performance had continued to improve in May.
- The national target for ambulance handovers remained 15 minutes and LN was assured that the systems and processes that the Trust had implemented for early warning and escalation would support the achievement of this.
- The national 45 minutes rescue and release scheme that had been due to be implemented on 01 June was delayed to 01 August.
- A new triage assessment process had been introduced at Whiston ED and there had been an improvement in triage times. This was one of the Trust's strategic objectives for 2025/26.
- Non-Criteria to Reside (NCTR) patient numbers had reduced to 19.1% (target 10%). Improvement plans were in place with system partners and there was an increased Integrated Care Board (ICB) focus on these improvements following the appointment of the C&M Chief System Improvement and Delivery Officer. The number of patients with NCTR at Southport Hospital had improved as the IPC outbreaks had been resolved and patients could be discharged.
- There had been a reduction in the non-elective length of stay, occupancy of the discharge lounge and percentage of discharges by midday.

6.2.3. NB reflected on the improved ambulance handover times and asked what would happen if the Trust was not able to achieve handover within 45 minutes once the national rescue and release scheme was introduced. LN responded that North West Ambulance Service NHS Trust (NWAS) was reporting that patients would be left in the ED and while the relationship between NWAS and MWL had improved, the risk remained. However, Trust plans were in place and there was time to learn lessons from regions where the scheme had already been implemented. A process mapping exercise to improve escalation processes had been completed and one of the mitigations was to keep the EDs as decongested as possible and this relied on effective patient flow as the Trust had no capacity to open or staff additional beds. RC commented that if the hospital and EDs were full, patients would have to remain in the care of the ambulance crews as there would be no physical space to leave them in the ED and to do so would be unsafe. LN responded that as the rollout had been pushed back to 01 August this would allow additional time for the Trust to scenario test and plan the escalation response with system partners. LN stressed the importance of both the Trust and system response to achieve this target. The continued reduction in NCTR patients as well as the various improvements introduced by the Trust had seen a decrease in corridor care. RC commented that it was important to continue to remind system colleagues of the impact rates of NCTR patients

on bed occupancy and subsequently on patient flow in ED. LN agreed to reiterate this at the next UEC Board.

6.2.4. GB commended the improved ambulance handover times and asked whether this had resulted in an increase in ambulances diverting from other EDs that were not achieving the same improvements, and if there was a system to the workload between neighbouring trusts. LN responded that there was an increased risk of patients asking to receive treatment at MWL as well as individual ambulances choosing to come to MWL sites if the waiting times were lower, but that the NWAS operating model in C&M did not include official hospital diverts, although this did happen in the other Northwest ICBs. In preparation for August, trusts were sharing learning and any best practice.

6.2.5. CE commented that this would be critical to ensure that these processes were sufficiently robust and resilient to cope with winter pressures.

6.2.6. MG agreed with GB's comment and asked whether NWAS would reconsider batch diverts for C&M as they would be helpful at times of increased demand. LN responded that NWAS was not supportive of this in the C&M region and that, at the recent Ambulance Group meeting she attended, they had presented evidence that indicated that ambulance diversions were unlikely to achieve the desired outcomes for the Ambulance service. However, LN commented that she believed batch diverts were a tool to maintain patient safety at times of increased demand and should be one of the NWAS contributions to the C&M winter escalation plans. RC commented that it was possible for NWAS to predict problems as their data could highlight any increase in the 'stack' and allow for activity to be redistributed if there was capacity elsewhere before a Trust escalated to OPEL 4. Additionally, the effectiveness of see and treat by NWAS and the use of alternatives to attendance to the ED would be crucial to reducing ED attendances, and this was a fundamental part of the C&M Urgent and Emergency Care plan. If these initiatives were successful EDs would have more capacity to accept the ambulance handovers.

6.2.7. LN then highlighted the key points in relation to Elective Care targets for 2025/26:

- There had been an improvement in 18 week referral to treatment pathway (RTT) performance to 64.7% in May 2025 against the 2025/26 operating plan target of 63.7% by March 2026.
- In May 2.8% of patients on the waiting list were waiting longer than 52 weeks to be treated, against a target of less than 1% to be achieved by the end of 2025/26. MWL was the second-best performing Trust in C&M.
- In May the Trust had 2,090 patients who had waited over 65 weeks. Three specialities were particularly challenged: Plastics, Vascular, and Ears, Nose and Throat (ENT). The Vascular and ENT services were delivered through service level agreements (SLA) with NHS University Hospitals of Liverpool Group (UHLG) and depended on their capacity. LN reported

that she was meeting again with UHLG to agree ways to improve performance.

- The Theatres Improvement Programme continued with positive impacts, especially on the St Helens site.
- Diagnostic performance was 85.3% in May (target 95%) and a detailed presentation had been delivered at the recent Finance and Performance Committee which highlighted that the main area of concern was non-obstetric ultrasound, which had experienced a significant increase in the volume of patients referred, and this had contributed to the increase in six week breaches. There were plans in place to address this issue. This included the increase in capacity as current vacancies had been recruited to. The Trust had also reached out for mutual aid and there was an agreement in place to utilise the Paddington Community Diagnostic Centre (CDC) and Clatterbridge Cancer Centre NHS Foundation Trust, with other areas continuing to be explored. It was forecast that performance would improve in the next three months.
- Performance against the 62-day cancer standard had decreased in April to 81% (target 85%). National performance was 69.39% and C&M performance was 76.1%.
- Performance against the 28-day cancer standard had decreased to 68.2% in April from 74% in March (target 77%) and this was driven by two specific tumour sites (skin and lower gastrointestinal (GI) at Southport Hospital). A deep dive into the lower GI tumour site had highlighted issues around the triage process. The process had now been changed to follow the Whiston and St Helen's model and improvement had been seen within two weeks. The dermatology service at Southport and Ormskirk Hospitals had historically been closed to routine referrals. One of the big opportunities for the service was the use of skin analytics using artificial intelligence to triage a patient with two or less skin lesions, which would reduce the number of patients needing to be referred to the cancer pathways. LN advised that the C&M Provider Collaborative had analysed the benefits of skin analytics which had shown that in April 2025 there had been 297 unnecessary face to face consultation appointments. By aiming to send 80% of referrals to skin analytics it was believed that there would be a reduction of 8,700 unnecessary face to face consultation appointments a year, thereby freeing capacity to treat patients with cancerous lesions.
- A Cancer Summit was scheduled for July 2025 and would focus on progressing the alignment of pathways across the MWL hospital.

6.2.8. RT reflected on the differences in performance between the Whiston and St Helens sites and the Southport and Ormskirk sites and asked whether issues with 62 day cancer performance related to referrals to tertiary centres or SLAs, or if the challenges were now internal. LN responded that from a skin and lower GI perspective the high volumes at diagnostic stage continued to pose a challenge as patients would then be referred to tertiary providers or another Trust would deliver care under an SLA. RT commented that the capacity for endoscopy at Southport and Ormskirk sites had increased so it

	was disappointing to see that lower GI had not improved and asked if the issues related to the front end triage and patient appointments, either staffing or processes. LN responded that the triage process at Southport and Ormskirk had been changed recently, and patients were now being triaged by the Endoscopy nurse, and this was in line with the process at Whiston and St Helens sites. RT asked whether the leadership team had been aligned and LN confirmed that the leadership team had been aligned from an operational and nursing perspective, however the process of the recruitment of Clinical Directors (CD) for specialities was still to be completed. RT then asked if there was a team in place at Southport and Ormskirk sites who were able to highlight any patients that had breached, and LN confirmed that there was a single tracking process across MWL for all cancer patients. 6.2.9. HS reflected on the anticipated reduction in the number of unnecessary dermatology consultations following the introduction of skin analytics and asked if there was data available about the 'false negative' rates. PW responded that the data from the trial period had not been released yet but assured that while all images were digitally analysed, patients referred with potential cancer also had a face to face review at the moment until there was more evidence from the skin analytics trials. PW noted that in the early phase trials there had been a very low false negative rate and this was one of the reasons why C&M had moved forward with the project. PW reported that regarding the published data about the performance of the Skin Analytics tool, was a negative predictive value of 99.8. This compared favourably to face-to-face dermatology assessments, which had a negative predictive value of 98.9%. Furthermore, all cases reported as negative by skin analytics currently undergo a secondary review by a dermatologist. In approximately 10% of these cases, a biopsy was requested and it had been found that the original skin analytics initial assessment had been accurate. HS acknowledged the positive results associated with the use of the Skin Analytics tool and inquired about the communication strategy for its rollout to General Practitioners (GPs). PW responded that the implementation and communication process would be led by the C&M ICB. HS emphasised the importance of ensuring that communications included clear information about the system used to manage the tool, particularly in cases where a negative result was flagged and that a follow-up was still recommended
6.3.	**Workforce Indicators**
	6.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for appraisals was 74.2% (target 85%) at the end of the first month of the annual appraisal window for Agenda for Change staff, that was due to close in September. Performance was slightly below trajectory but recovery actions were in place and it was reported that many appraisals had been booked. • The compliance rate for mandatory training was 89.5% (target of 85%). • Sickness absence was above target at 5.9% in May. This was a small increase from the same period in 2024/25. The latest benchmarking data

	was for January, however the ICB had undertaken local work on benchmarking and it was anticipated that this information would be published in the near future. Welcome back conversations remained a priority action to help reduce sickness absence. Within the overall figures there had been continued improvement (reduction) in the Health Care Assistants (HCA) sickness absence rates. • Staff turnover remained static at 0.6% (target 1%).
6.4.	**Financial Indicators**
	6.4.1. GL presented the financial indicators and reminded the Board that the Trust had resubmitted a deficit plan of £10.7m for 2025/26 in May 2025. The assumptions underpinning this plan were: • Non-recurrent deficit support of £30.2m • Delivery of £48.2m recurrent Cost Improvement Programme (CIP) • Realisation or reallocation of strategic opportunities of £8m • Realisation or reallocation of system led cost reductions of £27m. 6.4.2. GL noted that the strategic opportunities and the system led cost reductions were profiled to be delivered in quarter three and four. At the current time there were tangible plans in place to deliver improvements of only £3.7m in these categories. 6.4.3. GL highlighted that the current plan breached the Trust's statutory break even duty which would trigger an automatic recovery plan. 6.4.4. At month 2 an adjusted deficit position of £11.4m had been reported which was in line with plan. 6.4.5. GL highlighted the following: • The Trust had successfully delivered £7.4m of CIP YTD against the £48.2m plan. • Cash balances at M2 were £3.7m. • The capital delivery plan was behind plan and the Trust had delivered £1.5m against a plan of £64.6m including revaluation of leases. 6.4.6. GL highlighted the following risks: • There were currently no signed contracts with the ICB in place and formal offers were outstanding, however, it was anticipated that contract negotiations would be concluded shortly. • There was still a significant gap in the actions being taken by the ICB for the strategic and system led CIPs. This had been escalated as a risk to the ICB. • The Trust had received notification that there was a potential for deficit funding to be withheld if the system was behind plan which would create a significant cash risk for MWL. The Trust was due to receive £7.5m of deficit support funding in Q1. If the deficit funding was withdrawn going forward this would put £22m cash at risk past the end of July.

	6.4.7. GB expressed her concern about the non-recurrent deficit support being withheld and asked whether this would only apply to this financial year. GL responded that this was dependent on the three year recovery plan but agreed that this remained a risk as the Trust's income assumptions were tied to the performance of the whole system. GL noted that the Board had approved the 2025/26 financial plan with its high risk CIP on the assumption of receiving the deficit support funding. 6.4.8. SR commented that the Trust had delivered a good performance for the start of the financial year, however, it would become more challenging to deliver the plan as the year progressed and asked if it had been clear when the Board approved the plan that the deficit funding could be withdrawn if the system financial performance was behind plan. GL clarified that the caveats had been set out after the Board had approved the MWL financial plan, and these also included contract sign off, delivery of activity plans, and CIP performance as well as financial performance. GL noted that MWL was achieving its financial plans and CIP and the deadline for contracts to be finalised had not yet passed, but he felt NHSE had not been assured that there were robust plans in place to deliver the system level CIP, particularly in relation to the Urgent and Emergency Care (UEC) savings. CS asked whether the Board could challenge the withdrawal of the deficit funding. RC responded that the deficit funding was allocated to the ICB and did not take into account the performance of individual providers within the system. SR noted that the new NHS 10 year plan may change this emphasis with more financial freedoms for high performing trusts. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB25/050 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. RC presented the Executive Committee Assurance report from the meetings held in May 2025 and noted that any bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. Additionally, the meeting had received assurance reports from the weekly vacancy control panel. 7.1.2. RC highlighted the following items from the report: • The 2023/24 Corporate Benchmarking data was still being analysed where the Trust was above the average cost and Digital and Technology had been the area of focus in May. • An MWL Performance Management Framework to create the Divisional Performance Reports and hold Divisional Performance reviews had been approved.

- The Committee had reviewed the impact of reducing the Urgent Treatment Centre (UTC) opening hours to 08:00 to 20:00 which was in line with plans for all the UTCs in C&M. The activity profiling demonstrated there was very little activity between 20:00 and 22:00, and staffing the UTC across these extended hours had become increasingly challenging. The Committee had therefore approved the reduction in opening hours to 12 per day.
- The Committee had reviewed the remit for the Vacancy Control Panel and agreed MWL Workforce Principles to support the divisions and services to ensure consistency in relation to vacancies and authorisation of premium payments.
- The Committee had reviewed and supported the draft Quality Account 2024/25.
- The Committee had reviewed the updated business case for the Laboratory Information Management System (LIMS). The system was being hosted by Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) and was being highlighted as an area of improvement and a blueprint for any future system level agreements.
- The Committee had received an update on the implementation of a system for Inter-speciality Referrals from the ED. This had been a recommendation in the Care Quality Commission (CQC) inspection report. The current EPR provider was unable to provide a solution so an in-house process was being developed.
- The Committee had received the Nurse Safe Staffing Establishment Review which provided an overview of the Nurse staff establishment for each ward and approved a small number of changes based on patient acuity and safety.
- The Committee had reviewed and endorsed the Lead Employer (LE) People Plan 2025-2028, which had subsequently been presented to the Strategic People Committee.
- The Committee had received proposals for a MWL Bed Strategy which outlined the options for the best utilisation of available beds across the MWL sites and commissioned in the community. Further work had been requested to understand the staffing implications.
- The Committee had approved the establishment of the Finance Improvement Group (FIG). The FIG would subsume the functions of the Premium Payments Scrutiny Council which was abolished.
- The Committee had received an update on the Outpatients Transformation Project and RC noted that this was an area where the processes could be made more efficient and the available outpatients space across the MWL sites used more effectively.

7.1.3. The Committee had received several IPC reports including:

- The Aseptic Non-Touch Technique (ANTT) Training Implementation Plan
- The deep dive into the Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) case notes review.
- The IPC Board Assurance Framework (BAF).

7.1.4. NF enquired about staff perceptions regarding the implementation of vacancy controls and whether there had been any resistance. RC responded that, during the initial phase while the process was being refined, it had felt somewhat cumbersome and this had been acknowledged. However, a revised process has been implemented, which included a risk assessment for each vacancy and this was provided to the Vacancy Control Panel who were able to make more informed decisions about the impact of not filling the post, ensuring that appropriate vacancies were being approved. Managers understood the reasons for the vacancy controls, but the situation was challenging, and difficult decisions were being made. NF commented that considering the current challenges there were still over 12,000 vacancies on NHS Jobs across the NHS. NB noted that this would include clinical roles.

7.1.5. RT reflected on the MSSA case notes review and commented that the number of patients that had MSSA listed as a cause of death on the death certificate felt high, however, the report had noted that the Trust was not an outlier. RT asked what metric was used as the benchmark. PW confirmed that the benchmark was the number of MSSA infections per 1,000 bed days as this was what the Trust could influence. RT asked whether these deaths had undergone a Structured Judgement Review (SJR) which had led to plans to reduce the number of infections. PW responded that all Staphylococcus Aureus infections were serious and both MSSA and Methicillin-Resistant Staphylococcus Aureus (MRSA) carried the serious risk of mortality, which was why the focus was on preventing avoidable infections. These deaths were subject to an SJR if they fell within the selection criteria, however, all sepsis deaths were reviewed when there was more than expected. PW noted that all MRSA and MSSA infections were investigated to see if IPC practices could be improved and to identify if the deaths were avoidable. RC noted that, following the increase in the number of reported cases compared to the preceding year, a deep dive had already been requested by the Quality Committee. RC also highlighted that of the 90 cases, 52 were hospital acquired cases and 38 were community onset, and this would need to be triangulated with the mortality data.

Action

The Director of Infection, Prevention and Control to present the MSSA deep dive report at the Quality Committee in September 2025.

7.1.6. RT reflected on the extension to the former St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O) Managed Equipment Service (MES) contracts, so the end dates could be aligned, and asked if there were any risks associated with this. RC responded that there were no risks associated with the replacement of diagnostic equipment or from a diagnostic capability perspective. The alignment of the contracts had been agreed to allow time for the options to be explored to determine the best way forward for MWL.

The remainder of the report was **noted.**

7.2.	**Audit Committee (including approval of annual accounts)**
	7.2.1. CS, on behalf of SC, presented the Audit Committee Assurance Report (including the approval of the annual report and accounts) for the meeting held on 18 June and highlighted the following: • The Committee had received an overview of the external audit findings to date, as well as the draft Annual Auditors report from Grant Thornton (GT). • GT had provided assurance that the external audit was progressing on schedule, and it was noted that GT was expecting to deliver an unmodified opinion at the end of June 2025. • The Annual Auditors report contained four minor improvement recommendations as well as the associated management responses. • The Trust had successfully met its breakeven duty for the financial year 2024/25. However, the financial position for 2025/26 has been identified as significantly constrained, highlighting the limited flexibility available. GT had highlighted that if the Trust failed to meet its breakeven duty in 2025/26 this would trigger three year plans as well as a qualification on the accounts. • The Committee had received the Head of Internal Audit Opinion, which confirmed that the Trust had received substantial assurance for the financial year 2024/25. • The Committee had reviewed the draft Annual Report and draft Annual Governance Statement for 2024/25 and recommended the reports to the Board for approval. • The Committee had reviewed and approved the annual accounts for 2024/25. • The Committee had received the Annual Meeting Effectiveness Review Assurance Report and the Annual Review of the Register of Interests report. 7.2.2. GL reported that GT had now concluded the external audit and had subsequently requested that two additional minor audit findings be included in the report. The first finding related to the floor areas to be updated for Whiston and St Helens hospital sites, which changed the valuation of the asset. A management response had been submitted advising that this would be concluded. The second was related to the revaluation of leases and was a technical adjustment. Currently it was assumed that leases would roll over into 12 months and would be reviewed at the end of the lease and this was standard practice. GT had recommended that contracts be reviewed in real time instead of assuming that a lease would be reviewed in 12 months. This would result in a non-material value within the accounts; however the management response was that the current accounting of the leases treatment was sufficient. 7.2.3. The Board accepted the Audit Committee recommendation to approve the 2024/25 final annual report and accounts.

	The remainder of the report was **noted**
7.3.	**Charitable Funds Committee**
	7.3.1. HS presented the Charitable Funds Committee Assurance Report for the meeting held on 05 June 2025 and formally acknowledged the contributions of the Head of Charity, particularly in enhancing the professionalism of the Charity and in advancing efforts to raise its public profile. 7.3.2. HS highlighted the following: • The Committee had received the Head of Charity report which provided an update on staff engagement activities as well as the live appeals. • The Committee had received the summary of applications received since April 2025 and it was noted that 12 awards totalling £68,500 were granted. • The Committee approved the Band 5 Fundraising Manager role, noting this was an amendment to the existing Band 4 position. The remainder of the report was **noted**
7.4.	**Quality Committee**
	7.4.1. GB presented the Quality Committee Assurance Report for the meeting held on 17 June 2025 and noted that several items would be discussed in reports later on the Board agenda and would therefore not be covered in this report 7.4.2. Other items to highlight were: <u>Corporate Performance Report (CPR)</u> • PW had provided a verbal update on the actions to improve performance for the sepsis metric and the inclusion of this metric in the CPR had been discussed. <u>Patient Safety Report</u> • There had been no new Patient Safety Incident Investigations (PSII) reports commissioned in April 2025. • There had been a reduction in the number of reported incidents in May, following the implementation of the new InPhase system in March, however, it was anticipated that reporting levels would return to expected norms as staff became more familiar with the new system. A comprehensive training programme was in place across the Trust to familiarise staff with the new system. • The Invasive Procedures Development Group and the Intravenous Therapy Group had met. The Invasive Procedures Development Group had been created to review the never events in this area. <u>Freedom to Speak Up Report for Q3 and Q4</u> • There had been a 10% increase over the year in the number of concerns raised and GB noted that this was not seen as a negative. • The themes and trends remained unchanged from previous quarters and included inappropriate attitudes and behaviours linked with workers safety and wellbeing.

- Feedback on the Freedom to Speak Up (FTSU) process had been mainly positive. There had been one incidence of negative feedback, however, it was thought that this was linked to the expectations of the FTSU process rather than the actual handling of the case.
- The Equality, Diversity and Inclusion (EDI) data was being included in the report and no specific themes had been highlighted.
- The Trust currently had 36 FTSU Champions including the four champions that had been recruited and inducted in Q3 and Q4.
- An Audit in Q3 had highlighted good levels of awareness of the FTSU Champions and how to access FTSU resources.
- The Trust FTSU week would take place in October 2025.
- The Trust would be hosting the FTSU Northwest Conference in November 2025.

<u>Patient Experience Report</u>

- The report provided a summary of the patient experience work taking place.
- A total of 69 audits were completed across the adult inpatient areas on all hospital sites. The results had indicated improved compliance against patient experience metrics in all areas, except discharge booklets. A targeted effort was now being made to ensure that patients consistently received these booklets. The Committee had been assured by the action plan that was in place to drive and sustain improvement in this area.
- Focused improvement work had taken place in ED to improve communication with patients about waiting times, and this had led to increased patient satisfaction ratings.
- The Committee has requested that results of the Corridor Care Red Lines audits that were taking place in the ED be presented at a future meeting.
- The patient and relatives report had reflected 100% compliance for kindness, compassion and standards of care.
- The results for the 2024/25 National Inpatient Survey had been received and the benchmarking and action plans would be presented at a future Quality Committee.
- The MWL Patient Newsletter was available and had been shared with stakeholders.
- The Trust had celebrated an Experience of Care week in March with a focus on the ***#Hellomynameis*** campaign.
- The Committee had received an update on the Spiritual Care team and the spiritual care facilities available to staff on each site.
- The Macmillan cancer nurse posts were under review due to the non-recurrent funding from the Charity.

7.4.3. RT thanked PW for his update on sepsis at the Committee and commented that due to the multiple levels of care involved it was nearly impossible to have an action plan in place for all metrics. PW responded that he would be attending the monthly Sepsis Steering Group which had been created following the discussion at Quality Committee. This would create a more formal improvement function as well as ensuring that the action plan was met. One of the metrics that the Group would monitor was to ensure that all

	patients with a working diagnosis of sepsis received appropriate timely antibiotics in line with the National Institute for Health and Care Excellence (NICE) guidelines. It was noted that this was also a Trust objective. The remainder of the report was **noted**.
7.5.	**Strategic People Committee**
	7.5.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 18 June 2025 and highlighted the following: • The Committee had received the Growing for the Future Operational Delivery Plan which was a pillar of the 2025-2028 People Plan and included the following key priorities: ○ Growing relationships with local communities, schools and colleges to develop health workers of the future. ○ Developing a flexible and adaptive workforce fit for the future ○ Delivering comprehensive, accessible, and innovative education opportunities that supported the ongoing development of students and staff. • The Committee had received the 2024/25 Clinical and Medical Education Services Annual Report which outlined the achievements of the service. The priority for the service over the next 12 months would be to integrate the education services across MWL. • The Committee had received the 2024/25 Volunteers Operational Plan Annual Update which highlighted their achievements. Additionally, the draft 2025-28 Operational Plan, which was aligned to the 2025-2028 People Plan, was presented. The Trust's commitment to supporting the volunteers was noted. • The New Parent Support Leave and Pay Policies had been approved at the People Performance Council. • The Terms of Reference (ToR) for the People Performance Council were approved. The remainder of the report was **noted**.
7.6.	**Finance and Performance Committee**
	7.6.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 19 June 2025. The Committee had reviewed the Finance and Performance CPR and monthly finance report, but the key points had already been discussed in earlier reports on the Board agenda so would not be repeated. 7.6.2. Other points to highlight from the report were: • The Committee noted that the Trust was still in discussion with the ICB regarding the contracts for 2025/26 with some high level issues still to be resolved. • The Committee had noted the strong performance in the M2 finance report. The plan included £35m of system led strategic

	opportunities/costs reductions that would need to be realised or reallocated by C&M in 2025/26, however, the plan for the delivery of these savings was still outstanding. This was a significant risk that was outside of the Trust's control, however, the Trust was contributing positively to the development of these plans, wherever possible. • It was noted that the Trust had achieved the CIP target for M2 of £7.4m. The Committee had received the Corporate Services; Procurement CIP update and it was noted that the plan included local department efficiencies of 5% as well as an overview of the Trust wide procurement workstreams. • The Committee had received the Diagnostic Performance Targets Review which provided an update on current diagnostic performance and analysed the reasons for the deterioration. Non-obstetrics ultrasound was the main driver due to the large volumes, and the change in capacity had a disproportionate effect overall. Additionally, several other modalities had displayed a similar combination of demand growth and capacity loss. A comprehensive action plan was presented, and it was acknowledged that adopting a more anticipatory approach to modelling the combined effects of capacity and demand would be essential in mitigating the risk of underperformance in the future. 7.6.3. The Committee had received Council Assurance Reports from the CIP Council, Capital Planning Council, Estates & Facilities Management Council, and IM&T Council, with no issues escalated. 7.6.4. The Committee alerted the Board to the ongoing risk associated with system-wide efforts to develop plans aimed at delivering £35m in strategic opportunities and cost reductions, to be realised or reallocated by C&M during the 2025/26 financial year. The Committee emphasised that the timeliness and assurance of delivery remained a significant risk to the achievement of the Trust's financial plan. Furthermore, it was noted that, to date, no agreed plan or trajectory has been established outlining how and when these savings will be delivered. The remainder of the report was **noted**. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
8.	**TB25/051 Fit and Proper Person Chair's Annual Declaration**
	8.1. SR presented the Fit and Proper Person Chair's Annual Declaration which provided assurance to the Board that the Trust met the requirements of the NHS England Fit and Proper Person Test Framework for Board members and was compliant with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

	8.2. It was noted that as part of the annual process, the Chair had ratified the declarations and checks for all Board members and the Deputy Chair had ratified the declarations and checks for the Chair. 8.3. SR reported that Ann Marr had been included on the Annual Fit and Proper Persons Test Outcomes list twice, first as a leaver from the MWL Board and then as the Executive Lead of CMAST as MWL hosted the post. 8.4. NB requested that the report be amended to clarify that AMS had retired solely from her position as Director of Human Resources but remained Deputy CEO. **Action** Report to be amended. **RESOLVED:** The Board **noted** the Fit and Proper Person Chair's Annual Declaration
9.	**TB25/052 2024/25 Safeguarding Annual Report (Adults and Children)**
	9.1. LB presented the 2024/25 Safeguarding Annual Report (Adults and Children) which provided an overview of safeguarding activity across the Trust, and assurance that the Trust fulfilled statutory requirements. LB noted that the report had been presented at Quality Committee and had been updated to include feedback in relation to 'right care right place'. 9.2. The Safeguarding Team operated in a highly complex environment working with six PLACEs, two ICBs, two fire services, two police services and numerous charities. The Trust was also part of ten different Children & Young People's Partnerships. 9.3. The Safeguarding team had delivered the workplan for 2024/25. 9.3.1. LB also highlighted the following from the report: • A Training Needs Analysis to harmonise safeguarding staff training across MWL had been completed. The Trust had consistently achieved more than 90% compliance for all safeguarding training in 2024/25 except Level 3 Safeguarding (adult and children). • The Trust was compliant with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Training. • The number of adult safeguarding concerns raised in 2024/25 had increase from 2,416 in 2023/24 to 2,540 in 2024/25 (5% increase). • There had been an increase in the number of applications for a DoLS authorisation across all sites from 3,836 in 2023/24 to 4,325 in 2024/25 (13% increase). It was noted that more authorisations had been completed at Southport and Ormskirk hospitals (2,635) compared to the Whiston, St Helens and Newton Hospital sites (1,690) and this was likely due to the higher proportion of elderly patients accessing services at the Southport and Ormskirk sites. 622 of the concerns raised had required a

referral to the local authority (LA), however, not all these referrals would progress to a safeguarding enquiry under S42 of the Care Act (2014). Most of the referrals related to third party discharges.

- The number of referrals to Children's social care (CSC) had decreased to 577 in 2024/25 compared to 758 in 2023/24. It was noted that a different referral model had been introduced by the Sefton LA and this had affected the volume of referrals to CSC.
- There had been significant activity, relating to issues of patient neglect or self-neglect, in addition to domestic and sexual abuse.
- Independent Domestic Violence Advisor (IDVA) and Independent Sexual Violence Advisor (ISVA) roles were commissioned by West Lancashire Local Authority as fixed-term posts resulting in turnover of staff in these posts as people left to secure substantive roles.
- The Safeguarding Team has been actively involved in domestic homicide reviews and child safeguarding reviews, as well as the recent practice review following the Southport incident in July 2024, which would be subject to an independent public inquiry.
- A Children and Adolescent Mental Health Services (CAMHS) Team, providing a 24-hour service for children and young people attending the Trust, was now provided by Mersey Care NHS Foundation Trust to all the MWL EDs As a result, response times for a CAMHS intervention had reduced to four hours.
- A variation in performance for health reviews for looked after or in care children in different LAs had been identified and it had been noted that there were plans in place to improve this.
- The SLA for Mental Health Act administration services had previously presented challenges; however, these issues now appeared to be resolved. The model in place at the Southport and Ormskirk sites was being adopted across the rest of MWL.

9.4. LB expressed her thanks to the Safeguarding Team for their outstanding work and acknowledged the difficult cases being dealt with in relation to both patients and staff. GB agreed with LB's comments and noted the Quality Committee had discussed the increasing workload for the Safeguarding Team and recognised the need for this to be kept under review.

9.5. RT asked if all unexpected deaths of patients who had a learning disability were subject to a Structured Judgement Review (SJR). PW confirmed that this was one of the mandatory categories for SJR and that the reviews were being undertaken and agreed to review the presentation of the quarterly learning from deaths reports to highlight the deaths from the mandated categories that had been reviewed. PW noted that, during his tenure as Chief Medical Officer, he had not been aware of any such cases. To provide further assurance, PW proposed that the Learning from Deaths team be asked to review all previous cases involving patients with a diagnosed learning disability.

ACTION

	PW to request that the Learning from Deaths Team review previous SJRs of unexpected deaths of patients with a learning disability. **RESOLVED:** The Board **noted** the 2024/25 Safeguarding Annual Report (Adults and Children)
Concluding Business	
10.	**Effectiveness of Meeting**
	10.1. SR commented that having now chaired two Board meetings he felt confident that all Board members felt able to raise concerns. NB noted that it was accepted good governance practice to include the opportunity to review the effectiveness of each meeting, in case there were any comments or concerns which was why this was included as a standard agenda item.
11.	**Any Other Business**
	11.1. PW referred to RT's earlier observation regarding the number of MSSA-related deaths and advised that during the meeting he had reviewed the case mortality rates for both MSSA and MRSA, noting that approximately 22% of patients who developed either form of bacteraemia subsequently died. The figures in the report had equated to a 25% mortality rate, which was higher than the nationally published case fatality rate, although PW noted that the national data had been published several years ago and there was no benchmarking data available for 2024/25. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.39 The next Board meeting would be held on **Wednesday 30 July 2025 at 10.00**

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	✓	✓	A									
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	✓	✓	✓									
Marie Wright			✓									
✓ = In attendance A = Apologies												

Trust Board (Public)
Matters Arising Action Log
Action Log updated 25 July 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~~ SoB	~~July-25~~ Sept-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 Update: Update to be included in the Maternity and Neonatal Assurance Report to Quallity Committee in September.	~~LB~~ SoB	~~July-25~~ Sep-25		Report to be presented at Quality Committee
12	25/06/2025	**TB25/050 Committee Assurance Reports** 7.1 Executive Committee	The Director of Infection, Prevention and Control to present the Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) deep dive to the Quality Committee in September 2025.	SoB	Sep-25		Delegated to Quality Committee (September 2025)
13	25/06/2025	**TB25/051 Fit and Proper Person Chair's Annual Declaration**	NB requested that the report be amended to clarify that AMS had retired solely from her position as Director of Human Resources Update The report has been updated.	RW	Jul-25		**Completed**

14	25/06/2025	**TB25/052 2024/25 Safeguarding Annual Report (Adults and Children)**	PW to provide assurance that any avoidable deaths involving patients with a diagnosed learning disability are appropriately flagged and reflected in future learning from Deaths reports <u>Update</u> PW to provide an update under Agenda Item TB25/060.	PW	Jul-25		**On agenda**

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 July 2025
Agenda Item	**TB25/055**			
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 11 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	Mar-25	86.8	100	90.4	Best 30%
FFT - Inpatients % Recommended	Jun-25	94.2%	90.0%	94.0%	Worst 40%
Nurse Fill Rates	May-25	98.9%	90.0%	98.8%	
C.difficile	Jun-25	10		30	
E.coli	Jun-25	11		39	
Hospital Acq Pressure Ulcers per 1000 bed days	Apr-25	0.11	0.00	0.11	
Falls ≥ moderate harm per 1000 bed days	May-25	0.11	0.00	0.12	
Stillbirths (intrapartum)	Jun-25	0	0	0	
Neonatal Deaths	Jun-25	0	0	0	
Never Events	Jun-25	1	0	1	
Complaints Responded In 60 Days	Jun-25	58.8%	80.0%	51.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	May-25	65.6%	77.0%	66.8%	Worst 10%
Cancer 62 Days	May-25	79.9%	85.0%	80.4%	Best 10%
% Ambulance arrival to vehicle handover: <45 mins	Jun-25	91.8%		87.3%	
A&E Standard (Mapped)	Jun-25	78.9%	78.0%	79.3%	Best 20%
Average NEL LoS (excl Well Babies)	Jun-25	3.8	4.0	3.9	Best 30%
% of Patients With No Criteria to Reside Discharges Before Noon	Jun-25	21.2%	10.0%	20.7%	
G&A Bed Occupancy	Jun-25	20.3%	20.0%	20.3%	
Patients Whose Operation Was Cancelled	Jun-25	98.2%	92.0%	98.2%	Worst 30%
RTT % less than 18 weeks	Jun-25	1.1%	0.8%	1.0%	
18 weeks: % 52+ RTT waits	Jun-25	64.8%	92.0%	64.8%	Best 30%
	Jun-25	2.6%	1.0%	2.6%	Worst 40%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jun-25	73.8%	85.0%	73.8%	
Mandatory Training	Jun-25	89.8%	85.0%	89.8%	
Sickness: All Staff Sickness Rate	Jun-25	6.1%	5.0%	6.0%	
Staffing: Turnover rate	Jun-25	0.6%	1.1%	0.6%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jun-25		17,913	2,421	
Cash Balances - Days to Cover Operating Expenses	Jun-25	3.6	10		
Reported Surplus/Deficit (000's)	Jun-25		-16,148	-14,593	

Board Summary - Quality

Quality

Mortality – Data covers deaths in Trust until March 2024. The final HSMR for the full year (24-25) for MWL was 90.4. This means that using the HSMR risk model that the Trust had 9.6% less deaths than expected, given the age, diagnosis, comorbidities, deprivation status of our patients. Individual alerting diagnosis groups have a casenote review to ensure no areas of concern. The latest SHMI data for 12 month period ending Feb-25 is 1.03.

Clostridium difficile infection - There were 8 HOHA and 2 COHA cases at MWL in June. There has been 30 healthcare-associated cases YTD and the Trust us above NHSE threshold by 3 cases.

The CDI Improvement Plan is ongoing, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training. Work continues with Facilities and nursing colleagues to improve assurance regarding environmental and equipment cleanliness.

E coli - There were 11 healthcare-associated cases in June, 3 HOHA and 8 COHA. YTD there has been 39 healthcare-associated cases which is one case above NHSE threshold, but equal to the same period last year. The organisational focus on hydration for all patients and timely specimen collection for prompt diagnosis will support ongoing improvements in prevention of UTIs, AKI and E coli bloodstream infections.

Patient Falls – An external review of Trust falls process is currently underway, the outcome and recommendations from this review along with the newly published NICE guidance will inform the update of the Trust falls strategy , which is currently under review.

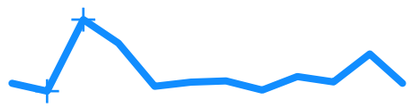
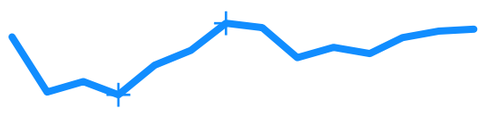
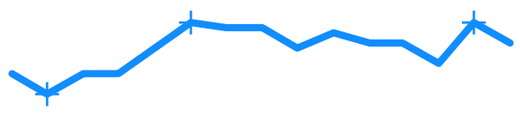
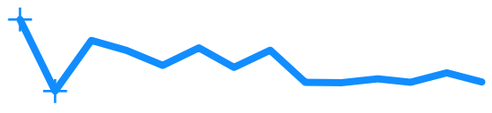
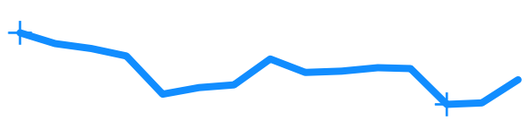
Never event – A Never Event was reported in Jun (YTD 1). Immediate actions have been taken across wards. As per Trust PSIRP this incident will undergo Patient Safety Incident Investigation (PSII) to be aggregated with other incidents for joint learning.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Mar-25	86.8	100	90.4	Best 30%	
FFT - Inpatients % Recommended	Jun-25	94.2%	90.0%	94.0%	Best 50%	
Nurse Fill Rates	May-25	98.9%	90.0%	98.8%		
C.difficile	Jun-25	10		30		
E.coli	Jun-25	11		39		
Hospital Acq Pressure Ulcers per 1000 bed days	Apr-25	0.11	0.00	0.11		
Falls ≥ moderate harm per 1000 bed days	May-25	0.11	0.00	0.12		
Stillbirths (intrapartum)	Jun-25	0	0	0		
Neonatal Deaths	Jun-25	0	0	0		
Never Events	Jun-25	1	0	1		
Complaints Responded In 60 Days	Jun-25	58.8%	80.0%	51.5%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E: 4-Hour performance decreased in June, achieving 73.9% (all types). Trust performance is below National (75.5%), and ahead of C&M (73%). The Trusts mapped 4-Hour performance achieved 78.9%.

Patient Flow: Bed occupancy across MWL averaged 103.3% in June equating to 61.8 patients - lowest occupancy reported since August 2023. There was a peak of 99 patients (40 at S&O, 61 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 11% higher than last June, driven by a 16% increase in 0 LOS activity, and a 6% increase in 1+ day LOS activity. Southport had a 95.4% increase in 0 LOS from June 24 to June 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 8.9 at S&O and 7.5 at StHK, with an overall average of 7.9 days, the impact of non CTR patients being 21.2% at Organisation level, 2.1% higher than May and 0.9% higher than June 2024 (19.2% StHK and 24.7% S&O).

Elective Activity: The Trust had 1,958 52-week waiters at the end of June, (360 S&O and 1598 StHK), 198 65-week waiters and 6 78-week waiters.
The 52-week position is a decrease of 132 from May and the 65-week waiters have decreased by 23 from May to June.
18-Week performance in June for MWL was 64.8%, S&O 66% and StHK 64.2%. This was ahead of national performance (latest month May) of 60.9% and C&M regional performance of 59.1%.

Cancer: Cancer performance for MWL in June deteriorated further, at 65.6% for the 28 day standard (target 77%), with Southport achieving 45.9% and St Helens performance being 77.7%. Latest published data (May) shows national performance of 74.8% and C&M regional performance of 71.8%. Performance for 62-day decreased, achieving 79.9% (target 85%), with Southport achieving 66.1% and St Helens 86.1%. C&M performance was 75% and National 67.8%. 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.

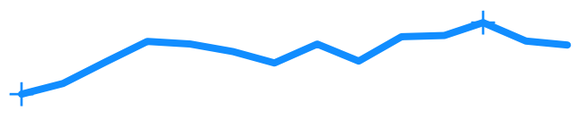
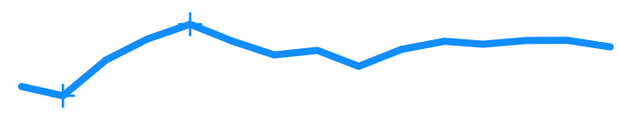
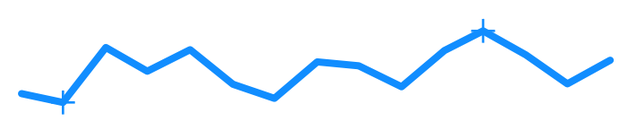
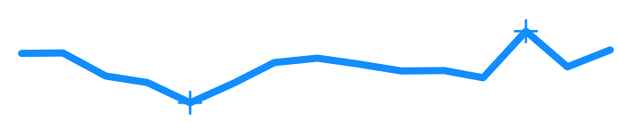
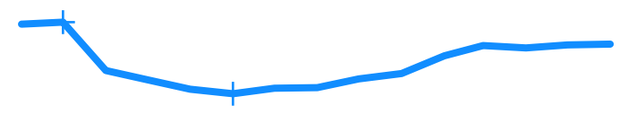
Diagnostics: Diagnostic performance in June was 86.9% for MWL, failing to achieve the 95% target, with S&O achieving 94.8% and StHK 83.4%. MWL performance is ahead of national performance (latest month May) of 78% and C&M regional performance of 88%.

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	May-25	65.6%	77.0%	66.8%	Worst 30%	
Cancer 62 Days	May-25	79.9%	85.0%	80.4%	Best 20%	
% Ambulance arrival to vehicle handover: <45 mins	Jun-25	91.5%		87.3%		
A&E Standard (Mapped)	Jun-25	78.9%	78.0%	79.3%	Best 20%	
Average NEL LoS (excl Well Babies)	Jun-25	3.8	4.0	3.9	Best 30%	
% of Patients With No Criteria to Reside	Jun-25	21.2%	10.0%	20.7%		
Discharges Before Noon	Jun-25	20.3%	20.0%	20.3%		
G&A Bed Occupancy	Jun-25	98.2%	92.0%	98.2%	Worst 30%	
Patients Whose Operation Was Cancelled	Jun-25	1.1%	0.8%	1.0%		
RTT % less than 18 weeks	Jun-25	64.8%	92.0%	64.8%	Best 30%	
18 weeks: % 52+ RTT waits	Jun-25	2.6%	1.0%	2.6%	Worst 40%	

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 89.8% 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 being in the appraisal window for 2025/2026. Current appraisal compliance has reduced in June 2025 to 73.8%. The 2025/2026 appraisal window opened on 1st May and support, training and guidance is available to support with high quality appraisals along with regular compliance information being shared with Divisions.

Sickness -In June sickness continues to be above target and has increased to 6.13% against the 5% target. This is an increase of 0.2% compared to May.

The top 3 reasons for sickness continue to be 1) Stress, Anxiety & Depression, 2) Gastrointestinal and 3) MSK. A sickness absence improvement plan is in place 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.

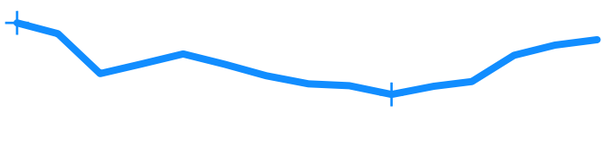
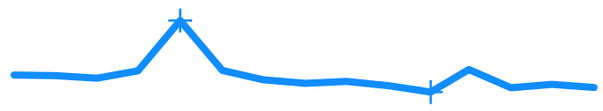
Turnover- In month turnover continues to be below our targe of 1.1% at 0.6%.

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	Jun-25	73.8%	85.0%	73.8%		
Mandatory Training	Jun-25	89.8%	85.0%	89.8%		
Sickness: All Staff Sickness Rate	Jun-25	6.1%	5.0%	6.0%		
Staffing: Turnover rate	Jun-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 3, the Trust is reporting an adjusted position of £14.6m deficit, excluding deficit funding the adjusted position is £22.1m, £1.6m better than 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 3, the Trust has successfully transacted CIP of £12.5m year to date, £1.5m above plan. The recurrent full year effect of delivered schemes is £12.0m (25% of the £48.2m recurrent target).
Cash - At the end of M3, the Trust's cash balance was £9.4m, higher than anticipated due to early payment of lead employer invoices.

Integrated Performance Report

Integrated Intelligence & Improvement Service

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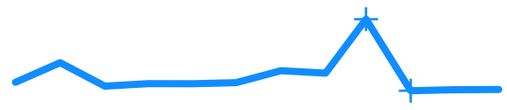
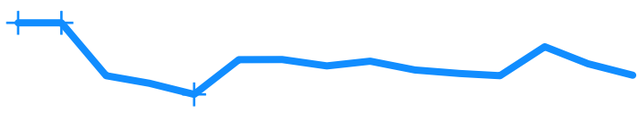
Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Jun-25		17,913	2,421		
Cash Balances - Days to Cover Operating Expenses	Jun-25	3.6	10			
Reported Surplus/Deficit (000's)	Jun-25		-16,148	-14,593		

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy STHK

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	Mar-25	79.2	100	89.3	
FFT - Inpatients % Recommended	Jun-25	94.5%	94.0%	93.7%	
Nurse Fill Rates	May-25	97.5%	90.0%	97.3%	
C.difficile	Jun-25	7		21	
E.coli	Jun-25	6		26	
Hospital Acq Pressure Ulcers per 1000 bed days	Apr-25	0.13	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	May-25	0.16	0.00	0.10	
Stillbirths (intrapartum)	Jun-25	0	0	0	
Neonatal Deaths	Jun-25	0	0	0	
Never Events	Jun-25	0	0	0	
Complaints Responded In 60 Days	Jun-25	62.5%	80.0%	52.2%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	May-25	77.7%	77.0%	78.6%	
Cancer 62 Days	May-25	86.1%	85.0%	86.2%	
Ambulance arrival to vehicle handover: % <45 mins	Jun-25	87.0%		82.0%	
A&E Standard (Mapped)	Jun-25				
Average NEL LoS (excl Well Babies)	Jun-25	3.8	4.0	3.8	
% of Patients With No Criteria to Reside Discharges	Jun-25	19.2%	10.0%	20.0%	
Before Noon	Jun-25	19.5%	20.0%	20.1%	
G&A Bed Occupancy	Jun-25	98.6%	92.0%	98.5%	
Patients Whose Operation Was Cancelled	Jun-25	1.1%	0.8%	1.1%	
RTT % less than 18 weeks	Jun-25	64.2%	92.0%	64.2%	
18 weeks: % 52+ RTT waits	Jun-25	3.1%	1.0%	3.1%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jun-25	75.6%	85.0%	75.6%	
Mandatory Training	Jun-25	89.5%	85.0%	89.5%	
Sickness: All Staff Sickness Rate	Jun-25	6.1%	5.0%	6.2%	
Staffing: Turnover rate	Jun-25	0.6%	1.1%	0.6%	

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

Board Summary

Legacy S&O

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	Mar-25	108.5	100	93.7	
FFT - Inpatients % Recommended	Jun-25	93.1%	90.0%	94.9%	
Nurse Fill Rates	May-25	100.3%	90.0%	100.3%	
C.difficile	Jun-25	3		9	
E.coli	Jun-25	5		13	
Hospital Acq Pressure Ulcers per 1000 bed days	Apr-25	0.08	0.00	0.08	
Falls ≥ moderate harm per 1000 bed days	May-25	0.00	0.00	0.16	
Stillbirths (intrapartum)	Jun-25	0	0	0	
Neonatal Deaths	Jun-25	0	0	0	
Never Events	Jun-25	1	0	1	
Complaints Responded In 60 Days	Jun-25	55.6%	80.0%	50.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	May-25	45.9%	77.0%	46.8%	
Cancer 62 Days	May-25	66.1%	85.0%	66.9%	
Ambulance arrival to vehicle handover: % <45 mins	Jun-25	99.1%		96.4%	
A&E Standard (Mapped)	Jun-25				
Average NEL LoS (excl Well Babies)	Jun-25	3.8	4.0	4.0	
% of Patients With No Criteria to Reside Discharges	Jun-25	24.7%	10.0%	21.9%	
Before Noon	Jun-25	21.2%	20.0%	20.6%	
G&A Bed Occupancy	Jun-25	97.3%	92.0%	97.5%	
Patients Whose Operation Was Cancelled	Jun-25	1.1%	0.8%	0.8%	
RTT % less than 18 weeks	Jun-25	66.0%	92.0%	66.0%	
18 weeks: % 52+ RTT waits	Jun-25	1.5%	1.0%	1.5%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jun-25	69.9%	85.0%	69.9%	
Mandatory Training	Jun-25	90.2%	85.0%	90.2%	
Sickness: All Staff Sickness Rate	Jun-25	6.1%	5.0%	5.7%	
Staffing: Turnover rate	Jun-25	0.4%	1.1%	0.5%	

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 July 2025
Agenda Item	**TB25/056 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the three Executive Committee meetings held in June 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were three Executive Committee meetings held during June 2025, due to the Board time-out held on 19 June. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The weekly vacancy control panel decisions were also reported, at each Committee meeting. There were no team-to-team meetings in June.		
05 June 2025		
Senior Leadership Group Proposals	• The Chief Finance Officer introduced a proposal from some of the senior operational managers and Deputy Directors to establish a Senior Leadership Group (SLG), to provide a forum for sharing information, development, peer support and as a sounding board for the Executive team. • Committee agreed the proposals, clarifying the SLG was not a decision-making body or a formal part of the Trust corporate governance structure, but recognising the need for senior managers to have a forum to share views and develop proposals. • There would also be a regular dialogue between the Executive Committee and the SLT and periodic reviews of its effectiveness.	Assurance
Maternity Patient Survey Action Plan – quarterly progress report	• The Acting Director of Nursing, Midwifery and Governance presented the update on the action plan developed in response to the 2024 maternity patient survey. • Progress had been made to enable birthing partners to stay overnight, with the purchase of recliner chairs for the delivery suite.	Assurance

	• Senior walkabouts and in-house surveys were being undertaken, supported by the patient experience team. • The implementation of a single Maternity Information System (MIS) had not yet been achieved, but a plan is in place to implement Badgernet by March 2026. • Committee also received an update on the engagement with patients who would be invited to participate in the 2025 Maternity Survey. • An Induction of Labour podcast was being produced to provide more information to patients and their families about the process.	
Cheshire and Merseyside (C&M) Financial Control Oversight Group (FCOG) Feedback	• Committee discussed the latest FCOG meeting with the Integrated Care Board (ICB) Chief System Improvement and Delivery Officer. • Several proposed changes had been discussed at the C&M Medical Directors and Chief Nurse forums, and how these were being taken forward. • The FCOG meetings continue to take place every two weeks.	Assurance
Corporate Cost Reduction Target 2025/26	• The Chief Finance Officer summarised that the NHS England (NHSE) corporate cost reduction target for MWL in 2025/26 was a 50% reduction in the cost growth since 2018/19, which equated to £4.3m. • The 2025/26 Cost Improvement Programme (CIP) target for corporate services of 5% represented a £5.59m reduction in costs and therefore covered the NHSE target. • The savings achieved to date were £3.95m, with a further £1.64m to be identified to meet the Cost Improvement (CIP) target.	Assurance
Financial Improvement Group (FIG)	• The Chief Finance Officer presented the weekly FIG update detailing progress on the agreed actions for each Division.	Assurance
12 June 2025		
Diagnostic Performance	• The Chief Operating Officer introduced the report on current performance and activity trends. • Non-compliance with the national access targets for diagnostics since March 2025 had been driven by the increased demand for non-obstetric ultrasound (NOUS) which made up 52% of the total diagnostic activity. The increased demand was driven by inpatient and GP referrals.	Assurance

	• Additional sonographers had been recruited and were due to start in post by July, which would increase capacity and reduce waiting times. • There was also increased demand for CT scans and capacity concerns for Dexa and urodynamics which were being addressed. • Committee reflected on changing clinical practice based on national guidance, such as the head injury pathway that was driving some of the increase in demand. • The Trust was utilising Community Diagnostic Centre capacity and mutual aid wherever possible. • Committee requested regular progress reports to monitor the impact of the planned actions on performance.	
Care Quality Commission (CQC) Well Led	• The Director of Corporate Services presented proposals to increase awareness of the CQC Well Led quality statements amongst senior managers.	Assurance
Communications and Media Report Q4 (2024/25)	• The Deputy CEO introduced the report which detailed communications team and media activity in Q4 (2024/25). • The monthly CEO blog and stakeholder briefings had been launched and been well received • There had been Trust involvement in 27 media enquiries and 15 proactive press releases. • Social media following had continued to grow with a further 1,200 followers in the quarter. • Committee also noted the Communication and Media teams' support for several internal campaigns and events during the period.	Assurance
Theatre Management System	• The Director of Informatics presented an evaluation of the different theatre management and booking processes in place at the legacy Trust sites and a summary of the national guidance in this area. • It was agreed that a business case was required to set out the implications, costs and benefits of moving to a single system for MWL, and this was scheduled to be presented in July.	Assurance
Care Coordination/Urgent and Emergency Care (UEC) Programme	• The Committee received a a report detailing the C&M proposals for care coordination and standardisation of Urgent Community Response (UCR) services to reduce non-elective demand. • Planning for Neighbourhoods in support of the expected NHS 10 year plan, had also commenced with the Place partnerships.	Assurance

	• Committee agreed the importance of the Trust influencing this agenda for the MWL catchment population and to continue to advocate for standardisation across all places/Local Authorities	
Freedom of Information (FOI) Report	• The Director of Informatics presented the FOI report. In 2025/26 there had been 142 new FOI requests which contained 1,249 individual questions to answer. 77 of the FOIs had been responded to and the remainder were still live. • Compliance with the 20 day response target remained below target, with actions in place to improve • One FOI response had been referred to the Information Commissioners Office (ICO) in this period	Assurance
Patchwork Escalated Shifts	• Committee reviewed the financial control process for escalated rate shifts via the patchwork system and agreed additional steps to be implemented to increase grip and control.	Assurance
Integrated Performance Report (IPR)	• Committee reviewed the IPR ahead of finalising the Committee Performance Reports.	Assurance
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the RMC assurance report for June. • In Phase was now becoming more embedded and 1,001 risks had been transferred from the legacy trusts' Datix systems. • 20 risks had been escalated to the Corporate Risk Register, although there were still several unapproved high risks awaiting Director review. • There was assurance that normal monthly risk reporting would resume from Q2.	Assurance
26 June 2025		
CQC Diagnostic Imaging Inspection Report	• The Acting Director of Nursing, Midwifery and Governance presented the CQC report that had been undertaken in accordance with the Ionising Radiation Medical Exposure Regulations (IRMER) at Whiston Hospital. • The report was not rated and had been positive with three recommendations relating to the clarity of policies and guidance for staff. • Committee reviewed and approved the action plan that had been developed in response to the recommendations.	Assurance
2025/26 Contract Negotiations	• The Chief Finance Officer briefed the Committee on the 2025/26 contract negotiations with the ICB,	Assurance

	reminding members that these would be the first contracts agreed since the Covid-19 pandemic. • The intention was to link the payment schedules to the approved activity templates, but this was proving challenging • Two areas of concern were ongoing payments for the Community Diagnostic Centre (CDC) at Southport and the Targeted Investment Fund (TiF) theatre and ophthalmology schemes for which the Trust had received national capital. • Meetings with the ICB continue.	
Draft Framework for Caring for Mental Health Patients	• The Committee reviewed the draft framework designed to educate staff on the Trust's legal responsibilities in the care of patients detained under the Mental Health Act. • This had been developed in response to reported incidents to ensure the Trust complied with its legal responsibilities and best practice guidance. • Committee commented on the document, supporting the principle and direction of travel to have an overarching framework with annual delivery plans to target support and training for frontline staff. • It was agreed the document should be progressed via the Clinical Effectiveness Council.	Assurance
Car Parking Charges 2025/26 Review	• The Director of Corporate Services presented the annual review of car parking charges for staff and patients/visitors to ensure the car parks generated sufficient income to cover the costs of provision. • The proposal to increase staff car parking charges in line with the recently announced annual pay awards was approved. It was agreed that this would be enacted from September 2025, after the pay award had been paid. • The proposal to complete the alignment of patient and visitor car parking charges across the MWL hospital sites was approved.	Approval
July Trust Board Agenda	• The Director of Corporate Services presented the draft Trust board agenda from the annual work plan and action log. • The Learning from Death Annual Report was deferred to September and the timescales for Board approval of the Winter Plan and Emergency Preparedness, Resilience and Response (EPPR) compliance assessment were clarified.	Assurance

	• The Committee selected the Employee of the Month from the nominations received during June.	
Digital Update	• The Director of Informatics reported on the work with the existing Electronic Patient Record (EPR) supplier to improve the systems as much as possible in the period leading up to the implementation of the single MWL EPR. • The introduction of ambient AI had been discussed to support outpatients. • Committee requested a timetable for the delivery of each of the projects.	Assurance
Appraisal and Mandatory Training Compliance (May 2025)	• The Chief People Officer presented the report. • Appraisal compliance was 74.2% at the end of Month 2 of the appraisal window. • Mandatory training compliance was 89.5% and compulsory training 81.2% • Each Director continued to receive monthly reports detailing compliance for each of their teams and for each training subject to ensure appropriate action is taken to achieve compliance.	Assurance
Partnership Update	• The Director of Integration presented the report which detailed the approach each place was taking to the development of Neighbourhood Health. • Committee also discussed opportunities for vertical integration across more of the MWL catchment to replicate the benefits experienced in St Helens.	Assurance
Finance Improvement Group Assurance Report	• Committee reviewed the assurance reports from the FIG meetings held on 11 and 25 June. • There was agreement that the reports needed to be developed to provide assurance on delivery of the agreed schemes. • Committee discussed the relationship between the FIG and Divisional Performance Review meetings, to ensure they were complimentary and added value.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
Investment decisions taken by the Committee during June 2025 were: • None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 July 2025
Agenda Item	**TB25/056 (8.2)**		
Committee being reported	Quality Committee		
Date of Meeting	22 July 2025		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes and Action Log	• The minutes of the Quality Committee meetings held in May and June were approved • There were four actions due for completion in July and all were approved as completed.	Assurance
Quality Committee Corporate Performance Report (CPR).	• Committee reviewed the Quality Committee Performance Report and noted the following: • There had been one Never Event in June: Patient administered wrong dose of insulin. The error had been immediately recognised and there was no patient harm. Rapid interventions had been actioned and the Patient Safety Incident Investigation (PSII) was being completed with early organisational learning commenced. • Malnutrition Universal Screening Tool (MUST) compliance had improved to 88.1% • The other nutrition metrics had dipped in month but continued an improving trend. • The impact of the safety improvement work with the Whiston Hospital Emergency Department (ED) had resulted in National Early Warning Score (NEWS) observations improvements, and reductions in triage times. • Committee had noted the new Ambulance 45 minutes release to rescue target would come into effect on 01 August and expressed concern about the risk for patients left in the department. • There had been one mixed sex breach at the Southport site on the Short Stay Unit (SSU), which was corrected as soon as recognised. • Complaints response compliance had improved to 58.8% (target 80%) and there had been a 20% reduction in new complaints. Complaints are	Assurance

	now performance managed via the divisional performance reviews (DPR). • Family and Friends Test (FFT); Maternity recommendation scores had dipped in month and were below target. • Maternity – one Intensive Care Unit (ICU) admission for patient admitted via Accident and Emergency (A&E) in second trimester. One intrauterine death – diverted from another provider reporting reduced fetal movements • Clostridioides difficile (C Diff) ten cases in month (27 Year to Date (YTD)). • Escherichia coli (E coli) 11 cases in month against the trajectory of 12 for June 25 (39 YTD). Committee noted the 2025/26 NHSE England (NHSE) threshold level had been reduced by 10% • Klebsiella; seven and above the monthly trajectory (nine cases YTD) • Pseudomonas aeruginosa; three cases in June (eight YTD). • Methicillin-Resistant Staphylococcus Aureus (MRSA): one reported in month at Southport site, deemed unavoidable following reviews. • Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) Bacteraemia's; eight cases reported in June 2025 (18 YTD). • Hospital Standardised Mortality Ratio (HSMR) for March 2025 86.8 and for 2024/25 90.4. • Summary Hospital-level Mortality Indicator - Deaths associated with hospitalisation (SHIMI): 1.03 for Feb 2025 within tolerated margins. • It was reported that April 2025 data for intravenous (IV) antibiotics delivered within one hour/ three hours for suspected sepsis had increased to 71.9.% which included increased sample size for improved accuracy in reporting (this would be reported in the next CPR)	
Clinical Effectiveness Report (Inc. Chair's Assurance Report)	• Committee received the reports from the Clinical Effectiveness Committee (CEC) meetings in June and July and noted – • 12 policies /clinical guidelines approved • Do Not attempt Cardiopulmonary Resuscitation (DNACPR) training video now available via Moodle and Electronic Staff Record (ESR).	Assurance

	• National Emergency Laparotomy Audit (NELA) monthly updated noted an increase in cases reported in May. • The Divisions are working to increase the number of Department of Medicine for Older People (DMOP) reviews of patients aged 65 +. • Positive further recruitment to three Consultant Histopathologist vacancies. • Improvement in histopathology turnaround times noted due to recent recruitments - 70% of cases on cancer pathway now reported within seven days. • Research and development team; MWL ranked eighth on the new Research Delivery Network, Northwest dashboard and first for the number of responses to the Patient Research Experience Survey (PRES). Strategic funding secured for band 6 Research Nurse for Marshalls Cross GP Practice. • Intensive Care National Audit and Research Centre (ICNARC) quarterly report for Whiston site with all values within 95% predicted range. • Q4 and Q1 continued improvement in VTE risk assessments however remains below target. Continued roll out of Venous Thromboembolism (VTE) risk assessment via Electronic Prescribing and Medicines Administration (EPMA). • Both aseptic units had been audited and had plans in place to maintain a low-risk classification. • Surgical mortality rate for MWL is 0.85% (2.4 - 3.0% Nationally) with complication rate below national levels. • Committee had been assured by the plans to recruit to vacancies in anaesthetists. • Replacement of the pharmacy robot on the Southport site remains a risk; now awaiting approval at Capital Council for the 2025/26 capital programme. • There were no alerts from the council assurance reports to the committee.	
Care Quality Commission (CQC) Quarterly Report	• Quarter 1 report - Trust maintains overall outstanding CQC rating. • Two planned inspections took place in Q1; ○ Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Whiston site took	Assurance

	place 30 April 2025. Not rated, all actions completed and report published. ○ St Helens Urgent Treatment Centre (UTC) inspected 08 May: Draft report received for factual accuracy checking. • A planned inspection of nuclear medicine (Whiston site) notified for 05 August 2025. • CQC engagement meeting took place 23 June and included a Southport Hospital site visit, and briefed on Shaping Care Together (SCT) consultation • CQC Well Led preparedness action plan being progressed. • 11 CQC enquiries received in Quarter 1. Three remain open. • MIAA ward quality spot check audits received substantial assurance. • Ward Accreditation programme remains focused on improving Infection Prevention & Control (IPC), Safeguarding and Safety Culture. • Quality Ward rounds and Ward Accreditation process being rolled out to specialist areas. Three wards have now been awarded 5-star accreditation.	
Patient Safety Report (Inc. Chair's Assurance Report) – May 2025 Data	• One Never Event • Ten incidents escalated to the Patient safety Panel • 2,545 incidents reported across MWL with a positive increase as InPhase becomes embedded. 77.25% of incidents involve patients and 27 incidents resulted in Moderate or above harm. 209 incidents related to the administration of May. • Internal validation of pressure ulcers for April completed with majority being non-hospital acquired. • One fall graded as severe harm; committee requested further assurance of the actions taken to prevent the fall as well as completion of best practice actions after the fall. • The Patient Safety Council assurance report for July was noted. There were no alerts to the Committee.	Assurance
Infection Prevention & Control Annual Report	• Statutory annual report for 2024/25 was received and the committee was assured by the reporting, delivery of the 2024/25 action plan and proposed workplan for 2025/26. Some minor changes	Assurance

	were requested to clarify some of the information in the report for the Board. • The Quality Committee recommend the 2024/25 IPC Annual Report to the Board for approval.	

Alerts:
• None
Decisions and Recommendation(s):
The Trust board note the report.

Committee Assurance Report			
Title of Meeting	Trust Board	**Date**	30 July 2025
Agenda Item	**TB25/056 (8.3)**		
Committee being reported	Strategic People Committee		
Date of Meeting	23 July 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Workforce Dashboard	Mandatory Training - The Trust continues to exceed its mandatory target at 89.8% against a target of 85%. All staff groups are above the Trust's target with the exception of Medical and Dental (80.4%). Appraisals - The Trust is no longer meeting its appraisal target; however, this is due to entering into the new appraisal window for 2025/2026. Current appraisal compliance has reduced in June 2025 to 73.8%. The biggest in month reduction is on Whiston, St Helens and Newton sites (75.6% June, compared to 77.6% May). Sickness – In month sickness continues to be above target, at 6.13% against the 5% target. This is an increase of 0.2% compared to May. Vacancy – Overall the Trust's vacancy position is positively below the target of 8% (6.4%) with all reported staff groups within tolerated thresholds with the exception of Health Care Support Workers (HCSW) with 12.3% vacancy rate. Time to Hire (T2H) – In month T2H is at 58 days against the target of 40 days. Turnover - In month turnover remains static at 0.6% against our target of 1.1%. The 12 month rolling turnover is 10.7% against a 13.2% target. Health Work and Well Being (HWWB) – The did not attend (DNA) rate for HWWB is slightly exceeding the target of 10% at 11%. Total amount of appointments booked was 766 with DNA's accounting for 84 of	Assurance

	those. The type of appointment with the highest amount of DNA was Management Referrals with 57 Appointments (68% of all DNA appointments).	
Trust Objectives 2025/26 – Quarter 1 Update	The Q1 update outlined the progress made toward the 2025/26 Trust objective of "Developing Organisational Culture and our Workforce". It provides assurance that key actions are underway and aligned with the Trust's priorities to foster a positive, inclusive, and high-performing workplace culture.	Assurance
HR Commercial Services Objectives 2025/26– Quarter 1 Update	This is the first year that the Lead Employment and Employment Services objectives have been aligned to the Trust's Corporate Objectives categories. The Q1 update plan provided assurance that to the 2025/26 HR Commercial Services Objectives are being progressed to plan.	Assurance
Guardians of Safe Working (GOSW) Annual Reports (Lead Employer)	The Guardians of Safe Working (GOSW) for GP Resident Doctors, Public Health & Trusts with less than 10 Resident Doctors and also the GOSW Doctors and Dentists in Training from trusts April 2024 – March 2025 provided assurance that the Lead Employer is: • Complying with its contractual obligations under the 2016 terms and conditions (T&Cs). • That doctors and dentists in training are not working excessive hours and are getting appropriate access to educational opportunities. • Working with NHS Employers to understand the implications of the implementation of the new NHS exception reporting rules being reformed, with changes taking effect on 12 September 2025. The reforms, agreed upon by the British Medical Association (BMA) and NHS Employers, aim to improve how doctors report deviations from their work schedules and ensure that work schedules remain fit for purpose. Key changes include new fines for employers who fail to provide timely access to exception reporting systems and for those who improperly share exception report information.	Assurance
Guardian of Safe Working Annual Reports (Trust)	The Guardian of Safe Working provided assurance with the overall safety of working hours in the Trust for trainees under the 2016 contract based on evidence from the exception reports for last 12	Assurance

	months reporting period which include noting that no fines had been issued during this reporting period.	
Staff Survey Action plan 2025	The presentation provided an update on actions from the 2024 Staff Survey. Each of the four Divisions have been presented with the key outcomes from their staff survey results by the end of March 2025. The Divisions have been asked to engage with their teams on areas where they would be able to make a significant impact on their staff. To support the targeted approach Divisions were provided with detailed team level breakdowns of the data to support decision making.	Assurance
MWL Values/Culture Update	MWL continues to prioritise a culture where staff feel valued, supported, and connected. Through the delivery of our People Plan priorities, including the Culture and Engagement Plan, we have refreshed induction, and wellbeing initiatives and continue to champion a culture of openness, kindness and inclusivity. Early feedback from the new refreshed corporate induction programme the "MWL Warm Welcome Event" has been overwhelmingly positive, with participants highlighting: • The executive involvement, • The welcoming environment, • The clarity and professionalism of the session delivery.	Assurance
Staff Story – Lead Employer (LE)	The Committee heard insights into the employment and training journey of a Lead Employer Resident Doctor who has had a long-term role as a BMA Representative and been part of the North West Local Negotiating Committee (LNC). The staff story highlighted: • The benefits of a Lead Employer arrangement to the colleagues in training. • The importance of clear and regular communication and engagement processes. • Benefits of support systems and streamlined processes reducing duplication and how this supports improving the working lives of colleagues in training.	Assurance

	• Areas the lead employer can improve in the future. There will also focus on other actions from the 2024 staff survey which will include: • The introduction of a pulse survey aligned to the LE annual survey. • Holding virtual surgeries/road shows for resident doctors to meet with the LE raising MWL lead employer profile so that colleagues in training not familiar with our model understand how and when to contact us for support. • Continuing to build relationships with Hosts (specifically primary care). • Continuing to explore automation opportunities to improve the employment experience for our resident doctors.	
Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the People Performance Council, HR Commercial Services Council, and Employee Relations Oversight Group.	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	30 July 2025
Agenda Item	**TB25/056 (8.4)**		
Committee being reported	Finance & Performance Committee		
Date of Meeting	24 July 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Chief Finance Officer Update	• PWC turnaround work across the system is ongoing with scrutiny meetings held reviewing the M3 financial position and progress on delivering plans to date. • Outstanding item disputed in the 2025/26 commissioner contracts, ongoing discussions with NHS England (NHSE) and Integrated Care Board (ICB) regarding appropriate funding. • National consultation on amendments to the pricing of cataracts.	Assurance
National Oversight Framework	• Update presented on the emerging information relating to the newly published NHS Oversight Framework. • Initial numbers presented to committee along with details of the technical methodology used. • Noted the ambition and link to the 10-year Health Plan.	Assurance
PWC Rapid Financial Diagnostic	• Outputs of the PWC rapid diagnostic undertaken on the M1 financial data including system wide and trust specific elements. • Outlined actions taken to date and link in with ongoing system Turnaround work commissioned by NHSE and undertaken by PWC.	Assurance
–Cheshire and Merseyside (C&M) ICB Cost Improvement Programme (CIP) Risk Review	• Outputs of the C&M ICB CIP Risk Review undertaken on the M1 financial data including system wide report and trust specific elements. • Outlined actions taken to date and link in with ongoing system forecasting work commissioned by NHSE.	Assurance
Integrated Performance Report Month 3 2025/26	• Bed occupancy averaged 103.3% in June equating to 61.8 patients. This resulted in a General and Acute (G&A) bed occupancy of	Assurance

	98.2%, significantly higher than the target of 92%. • Average length of stay for emergency admissions remains high at 7.9, 8.9 at Southport and Ormskirk sites and 7.5 at St Helens, Whiston and Newton sites, the impact of non-criteria to Reside (NCTR) patients remains high in June, being 21.2% at Organisation level (19.2% St Helens, Whiston and Newton and 24.7% Southport and Ormskirk sites). • 4-Hour performance was 73.9% in June, below national performance 75.5% and ahead of C&M 73%. Mapped performance was 78.9%. • 18 Week performance in June for MWL was 64.8%. National Performance (latest month May) 60.9% and C&M performance 59.1% • The Trust had 1,958 x 52-week waiters at the end of June, 198 x 65-week waiters and 6x 78-week waiters. • Diagnostic performance for June for MWL had increased to 86.9% which remained ahead of national performance 78% but below C&M performance of 88% and target (95%). • Cancer performance for MWL in May deteriorated to 65.6% for the 28-day standard and to 79.9% for the 62-day standard.	
Finance Report Month 3 2025/26	• The approved MWL financial plan for 25/26 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 M3 deficit of £22.1m (excluding deficit support funding) which is £1.6m better than 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 M3, the target has been exceeded with £12.5m delivered to date, £1.5m above plan. • At M3 agency costs equate to £3.9m, a 36% reduction from M3 2024/25.	Assurance

	• The Trust had a closing cash balance of £9.4m which was higher than anticipated due to early payment of lead employer invoices. Cash remains constrained. Revenue support funding is being sought from NHSE due to the withdrawal of deficit support funding from the system. • Aged debt has further reduced; work is ongoing to reduce this further. • The capital plan for the year totals £64.6m which includes Private Finance Initiative (PFI) Lifecycle and IFRS16 Lease Remeasurement.	
MWL Forecast	• Committee received an update on the M3 forecast outturn position excluding deficit support funding and setting out the forecast run rate and associated actions needed to meet the financial plan. • While there have been no system efficiencies with clear, fully worked up plans shared to date, the Trust is working on local mitigations which reduce the risk of non-delivery which assured the committee progress, internally, was being made. The Committee was not assured of the pace of change outside of the Trust	
Cash	• Committee received an update on the cash position including the emerging risk from the removal of deficit support funding from the system. • Committee acknowledged that requesting cash support was necessary and discussed the current and potential mitigations in place.	
Month 3 2025/26 CIP Programme Update Medicine & Urgent Care CIP update	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, this equates to 5% for all departments. • At M3 70 schemes have been delivered with a further 71 schemes were at finalisation stage. Current delivered/low risk schemes have a value of £33.9m in year equating to 70% of the target and £22.2m recurrently, 46% of the target. • Division update outlined current progress in delivering 25/26 target including specialty specific CIP meetings with clinical leads driving forward idea generation. • 64% of recurrent schemes delivered or low risk with further opportunities identified. • Discussion around red rated schemes with an outline of the work ongoing to deliver these.	Assurance

Whole Time Equivalent WTE changes/plan	• Progress made in converting variable staffing to substantive with this work ahead of plan, including reductions in overtime. This reflects the positive impact of controls implemented. • Significant progress in support to clinical staff group which has a large impact on wtes, additional work in other staff groups which will have a further impact on the financial position.	
Benchmarking Update	• Committee reviewed the Trust submitted Corporate Benchmarking data relating to 2024/25 against the data submitted for 2023/24. • Outputs being used to inform national views around opportunity for cost reduction. • Professional leads across the system working together to ensure content of submissions is consistent across organisations.	
Cancer Targets Performance Review	• Update received on current performance against targets, detailing the reasons for the deterioration in performance. • Cancer Summit held in person with over 70 attendees across all tumour groups representing clinical and operational stakeholders from the Trust and external partners. • Deep dives undertaken for all pathways with the skin pathway presented to committee including overview and actions being taken to improve.	Assurance
Assurance Reports from Subgroups:	• Procurement Steering Council Update • CIP Council Update • Capital Planning Council • Estates & Facilities Management Council Update • IM&T Council update	Assurance

Alerts

Finance Report Month 3 2025/26

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 of the work is a risk to Trust delivery of financial plan. While the Trust is working on potential internal mitigations and these have reduced the risk, the Committee wished to alert the Board that there is no agreed plan or trajectory for how and when the system opportunities will be delivered. The Committee was assured on the progress and actions being undertaken internally, however the remained a financial challenge in the forecast outturn that would need to be mitigated.

Decisions and Recommendation(s):
The Board note the report

Title of Meeting	**Trust Board**		**Date**	30 July 2025
Agenda Item	**TB25/057**			
Report Title	Corporate Risk Register (July 2025)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide an overview of the Trust's risk profile and the risks that have been escalated to the Corporate Risk Register (CRR) via the Trust's risk management systems

Executive Summary

1. Risk Management Systems

The MWL Risk Management Framework has been in place since 2023, however the new single electronic system for managing risks, incidents, claims and complaints was implemented in March 2025. This new system (InPhase) replaced the legacy Trust Datix risk management systems. The implementation of the new system required risks to be transferred to InPhase, aligned to the MWL operational management structures and then re-scored. This process highlighted several duplicate risks across the legacy Trust risk registers that have been combined. The Implementation phase is now complete, and normal reporting has been resumed.

Throughout the changeover period the process of reporting new risks has remained accessible to all staff, and risks have continued to be actively managed, with the Risk Management Council continuing to meet each month to review the risk profile of the organisation, support risk leads with the implementation and develop the reporting functionality to meet the organisation's needs.

This report provides an overview of the risks reported across MWL, and those risks that have been escalated to the CRR.

The CRR is usually reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive and Board, if necessary. The risk management process is overseen by the Risk Management Council, which reports to the Executive Committee providing assurance that risks -

- have been identified and reported
- have been scored in accordance with the standard risk grading matrix.
- initially rated as high or extreme have been reviewed and approved by the relevant divisional triumvirate and lead director.
- have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level.

2. Risk Registers and Corporate Risk Registers

This report is a snapshot of the risk registers on 01 July 2025 and reflects risks reported and reviewed during June 2025.

Risk Register Summary (Appendix 1)
The total number of risks on the MWL risk register was 992 compared to 1,076 in January 2025. There are also 42 risks that have been transferred into InPhase but not yet scored. This process will be completed by August.

24 risks are escalated to the CRR compared to 17 in January.

Nine new escalated risks are reported on the CRR in July compared to January and two risks have been closed or de-escalated from the CRR.

Financial Implications
None as a direct result of this report

Quality and/or Equality Impact
Not applicable

Recommendations
The Board is asked to note the Corporate Risk Register (July 2025).

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

Appendix 1

Corporate Risk Register Report – July 2025

1. Risk Register Summary for the Reporting Period

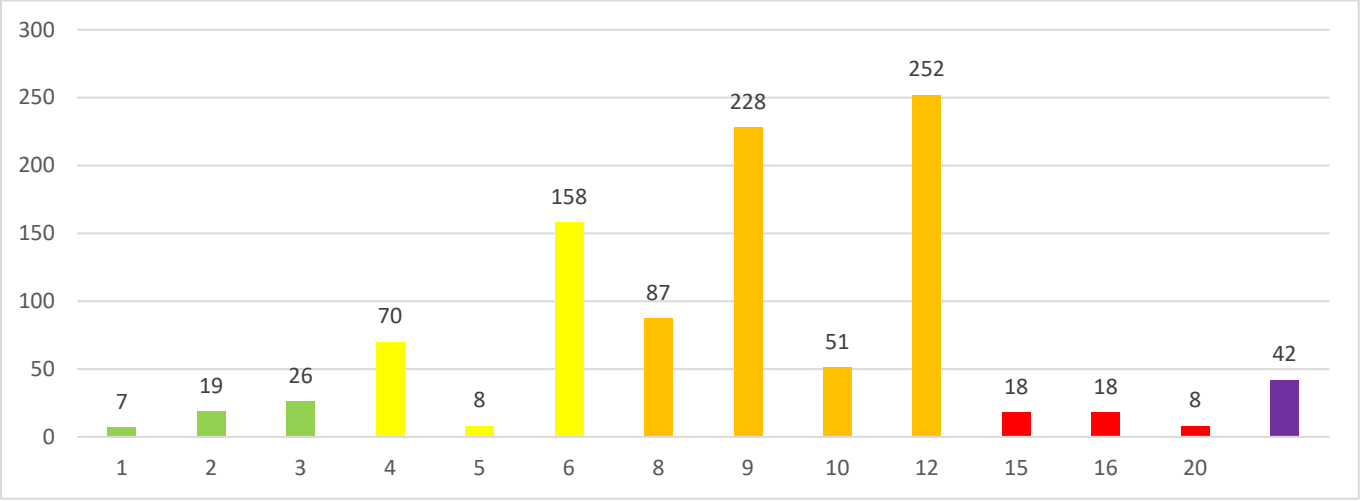
This table provides a high-level overview of the "turnover" in the risk profile of the **MWL** sites compared to previous reporting periods.

MWL RISK REGISTER	Current Reporting Period (July 2025)	Comparison to last Board Report in January 2025	Previous Reporting Period (May 2025)
Number of new risks reported	65	28	40
Number of risks closed or removed	88	39	
Number of risks overdue for review	243	241	129 (1 overdue, remainder no date)
Number of Tolerated Risks	20	17	
Total Number of InPhase reported risks	**992***	**1,076***	**873**

*January = 1,032 scored and approved risks with 44 awaiting review. July = 950 scored and approved risks with 42 awaiting review.

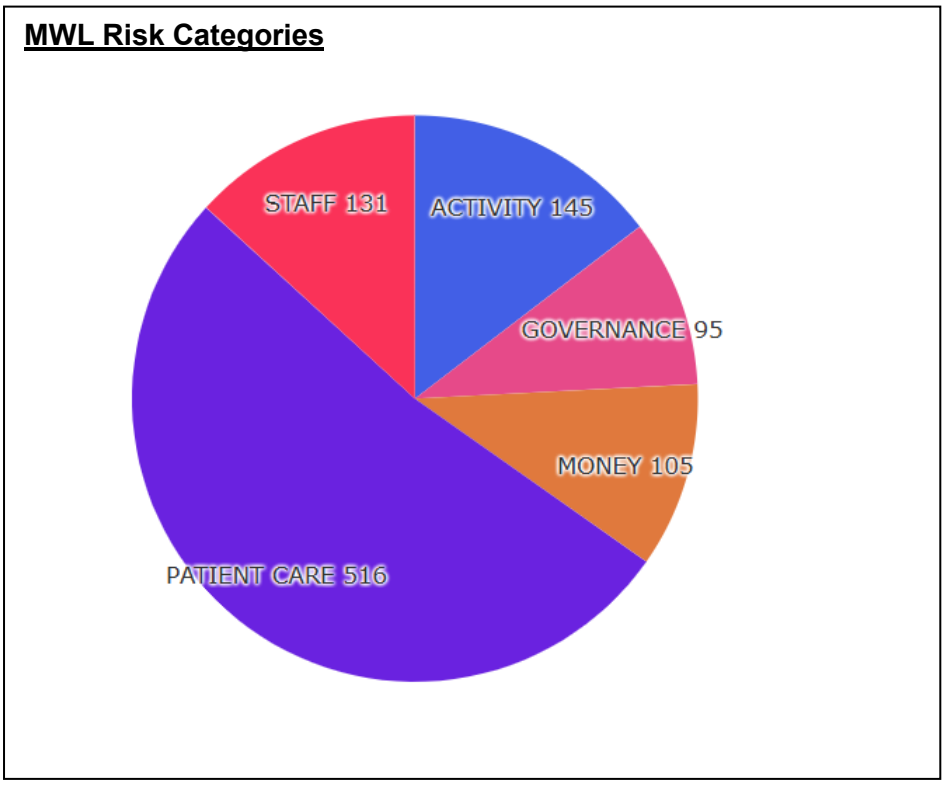
2. Risk Profiles

MWL Risk Profile



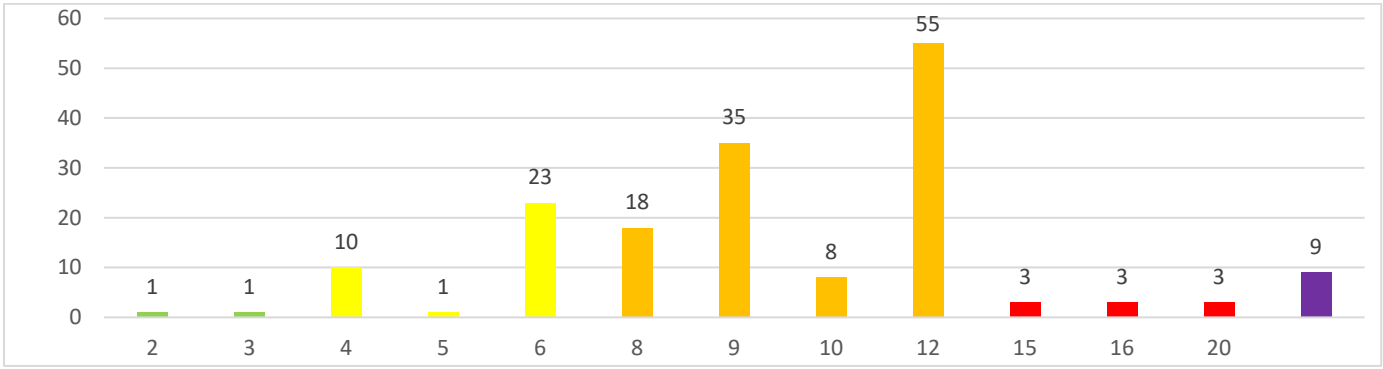
**42 are unscored risks*

The chart below shows the categories of risk



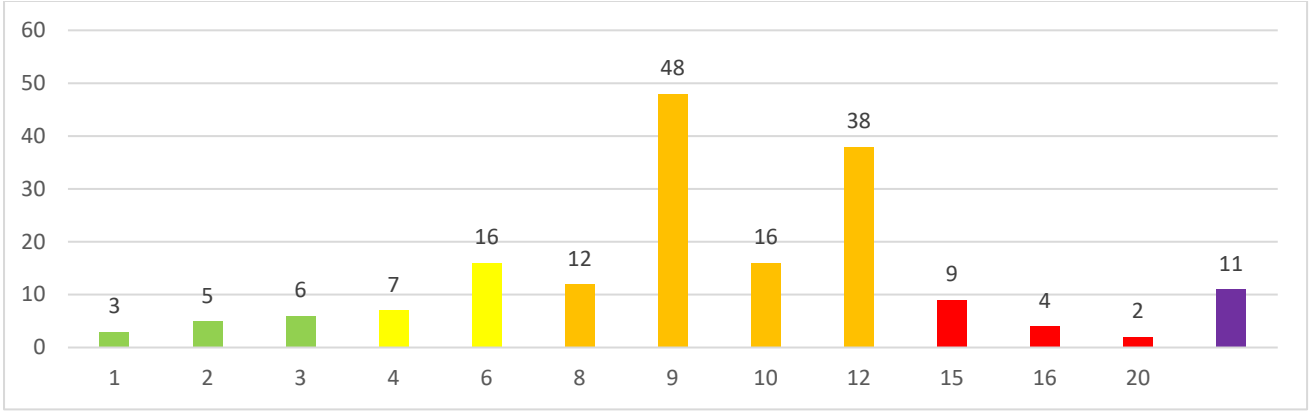
The risk profiles for each of the Trust Care Groups and for the collective Corporate Services are:

Surgical Division (170)



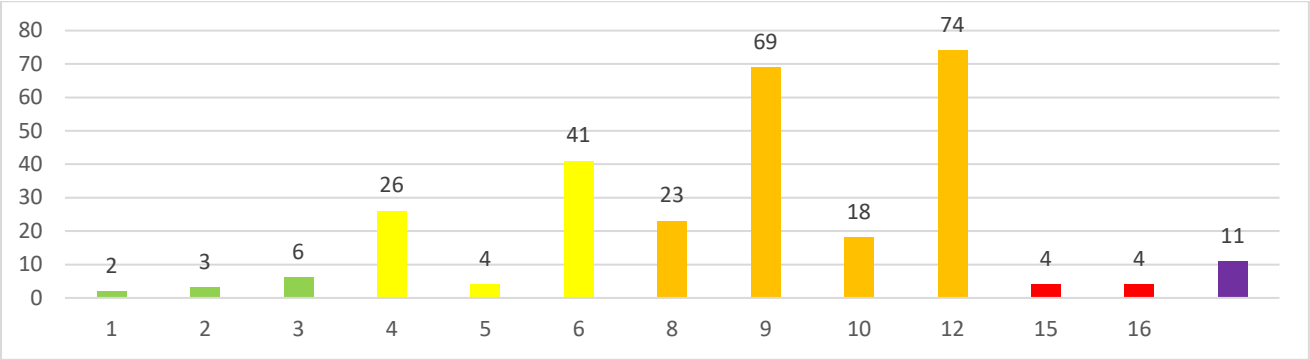
**9 unscored risks*

Medicine & Urgent Care Division (177)



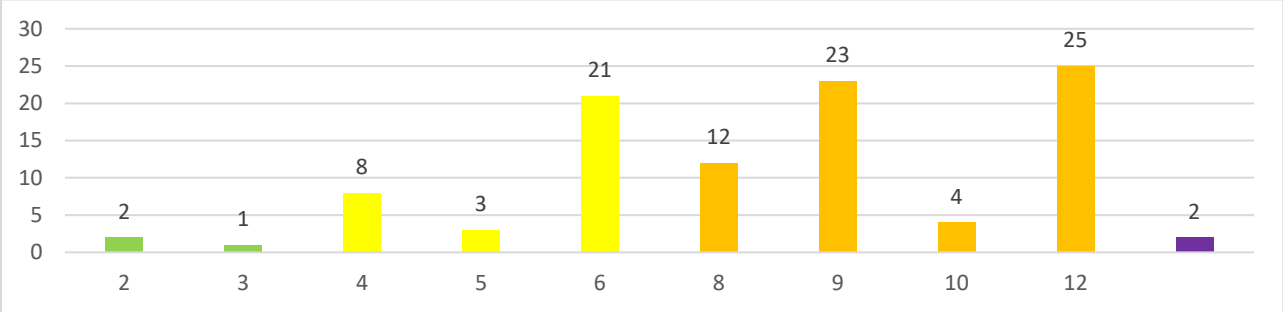
**11 unscored risks*

Community & Clinical Support Services Division (285)



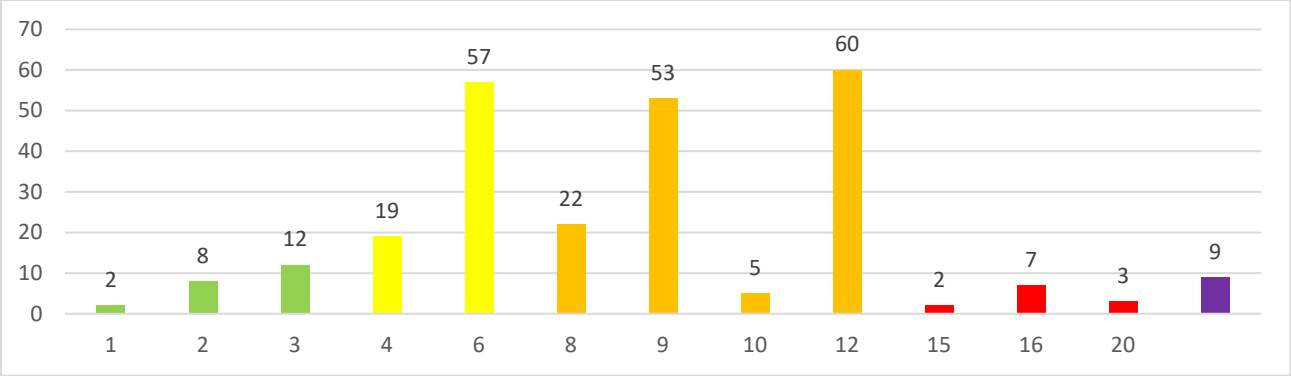
**11 unscored risks*

Women & Children's Division (101)



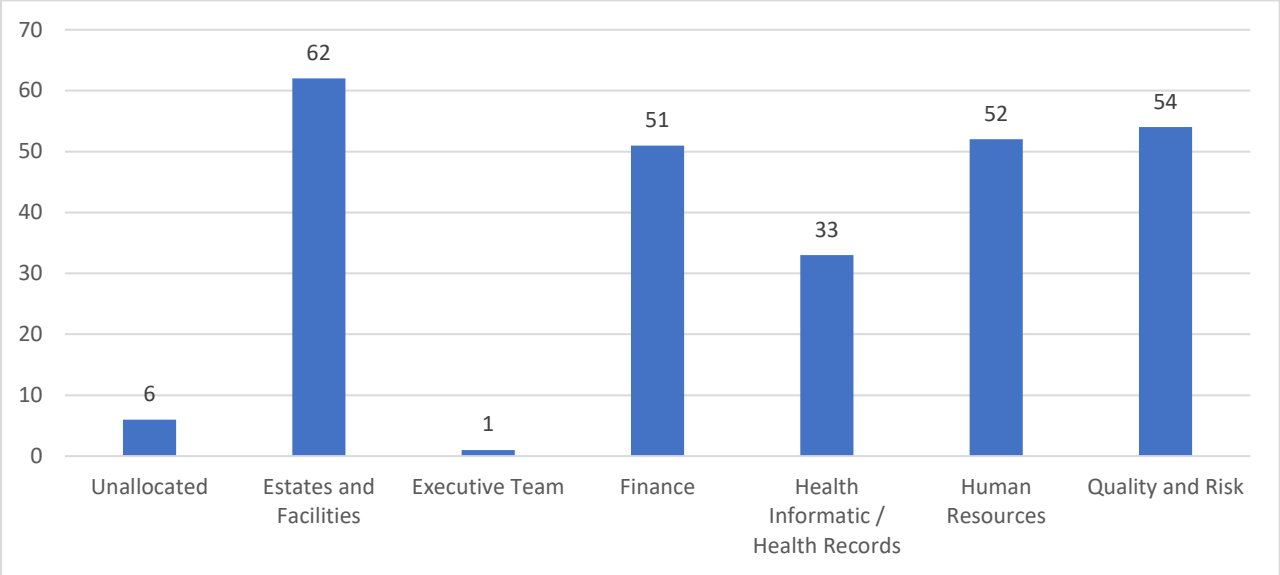
**2 unscored risks*

Corporate (259)



**9 unscored risks*

The split of the risks across the corporate departments is:


70
60
50
40
30
20
10
0
62
51
52
54
33
6
1
Unallocated
Estates and Facilities
Executive Team
Finance
Health Informatic / Health Records
Human Resources
Quality and Risk

3. Corporate Risk Register (risks approved as scoring 15 or above)

Risk No	MWL Risk Id	Legacy Risk ID	Title	Risk Owner	Opened	Next review date	Grade	Specialty	On CRR in January 2025
1	30	1152	Risk to quality of care, contract delivery and finance due to increased use of bank and agency	Malise Szpakowska	29 Mar 2022	31 Jul 2025	16	Human Resources	Yes
2	33	2572 (#2537)	Malfunction and failure of the ADS (Automatic Dispensing System) Pharmacy Robot – Southport Hospital	Lesley Neary	11 Jan 2023	10 Jul 2025	16	Pharmacy	Yes
3	47	762	Potential risk of the Trust not being able to provide safe levels of staffing	Malise Szpakowska	19 Mar 2025	31 Jul 2025	16	Human Resources	Yes
4	80	2432	Southport and Ormskirk Hospital sites critical Estates infrastructure	Nicola Bunce	25 Mar 2025	30 Jul 2025	20	Estates and Facilities	Yes
5	263	3959	Patients having more than one hospital number in the legacy EPR systems	Malcolm Gandy3	05 Apr 2024	15 Aug 2025	15	Pathology	Yes
6	319	4062	Interventional Radiology consultant cover	Lesley Neary	11 Apr 2025	15 Aug 2025	16	Radiology	No
7	361	1772	Risk of Malicious Cyber Attack	Malcolm Gandy3	12 Oct 2016	30 Aug 2025	16	Health Informatic / Health Records	Yes
8**	400	2668	Audiology Work areas Ormskirk District Hospital	Lesley Neary	04 Dec 2023	30 Jun 2025	15	Head and Neck	No
9	428	3251	Trust Solution for Outpatient Letter Printing - End of Life/Un-supported	Malcolm Gandy3	21 Oct 2021	30 Jul 2025	16	Health Informatic / Health Records	Yes
10	445	4224	Endoscopy Booking Team staffing levels	Lesley Neary	04 Dec 2024	08 Aug 2025	16	Gastroenterology	No
11	521	2601	Inability to provide out of hours anaesthetic support for a 2nd time critical emergency at Ormskirk Hospital	Peter Williams3	25 May 2023	30 Jun 2025	20	Anaesthetics	Yes

12	565	2786	The ward has no working fob access to the unit to restrict and manage access (a subset of risk 80)	Nicola Bunce	28 Apr 2025	30 Jul 2025	16	Spinal	Yes
13	587	2590	ENT Provision Service	Lesley Neary	02 Nov 2023	30 Jun 2025	16	Head and Neck	Yes
14	591	2123	Ophthalmology waiting list	Lesley Neary	28 Apr 2025	30 Jun 2025	16	Head and Neck	No
15	630		Trust running 2 legacy EPR systems until the single EPR for MWL can be procured	Malcolm Gandy3	30 Apr 2025	30 Sep 2025	15	Health Informatic / Health Records	No
16	663	4194	Underperformance on variable activity - In Year	Gareth Lawrence	17 Oct 2024	30 Jul 2025	16	Finance	No
17	758	2812	Fragile Services	Kate Clark	07 Feb 2025	25 Jul 2025	16	Executive Team	Yes
18	791	3850	Delivery of Dietetic services to children and young people	Lesley Neary	06 May 2025	13 Aug 2025	15	Therapies	Yes
19**	861	4218	CPE screening within MWL not being in line or compliant with national requirements	Sarah O'Brien	15 Nov 2024	22 Aug 2025	20	IPC	No
20	914	1263	Risk of increased bed occupancy and reduced patient flow due to UEC demand	Lesley Neary	13 Apr 2015	30 Jul 2025	20	General Medicine	Yes
21	925	4126	Back log patients on the partial booking list at Southport hospital	Lesley Neary	01 Aug 2024	25 Jul 2025	20	Medicine for Older People and Stroke	No
22	978	3527	Delivery of care for plastic surgery patients in North Wales	Lesley Neary	15 Sep 2022	30 Jul 2025	20	Burns and Plastics	Yes
23	1044	4179	Whiston Decontamination Unit FC4 Washer Disinfectors	Nicola Bunce	02 Oct 2024	30 Jul 2025	16	Theatres	No
24	1125	2750	Data Quality and Patient mismatch errors	Malcolm Gandy3	04 Sep 2019	07 Jul 2025	15	Health Informatic / Health Records	Yes

Blue text = new CRR risks added since the last board report

**Not formally approved by the lead Director and score to be reduced at next review

4. Risks removed or downgraded from the CRR since January 2025

Risk No	Risk Description	Previous Score
3574 (legacy STHK Datix)	Patients in Careflow with on open referral but no future activity	15
2774 (legacy S&O Datix)	Limited mechanical ventilation on the Spinal Injuries Unit	16

Title of Meeting	**Trust Board**			**Date**	30 July 2025
Agenda Item	**TB25/058**				
Report Title	Board Assurance Framework (July 2025)				
Executive Lead	Nicola Bunce, Director of Corporate Services				
Presenting Officer	Nicola Bunce, Director of Corporate Services				
Action Required	X	**To Approve**		**To Note**	

Purpose

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

Executive Summary

The MWL BAF is reviewed four times a year, the last review was in April 2025, and this review captures the changes that have occurred during Q1 (2025/26).

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

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

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

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

Proposed changes to risk scores.
BAF 4 – in light of the critical stage of the Shaping Care Together (SCT) Programme and the importance of maintaining public /stakeholder confidence at this time, it is proposed that this risk score be increased to 16 during the period of public consultation.

Financial Implications

None as a direct result of this report

Quality and/or Equality Impact

Not applicable

Recommendations

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

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

Appendix 1

Board Assurance Framework Quarterly Review – Q1 2025/26

BOARD ASSURANCE FRAMEWORK 2025-26									
BAF	Risk Description	Exec Lead	Inherent	Risk Score					Target
				July 24	Oct 24	Jan 25	April 25	July 2025	
1	Systemic failures in the quality of care	Chief Medical Officer/Chief Nursing Officer	20	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	5
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Chief Finance Officer	20	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	10
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	16	16 ↔	20 ↑	20 ↔	20 ↔	20 ↔	12
4	Failure to maintain patient, partner and stakeholder confidence in the Trust	Deputy CEO	16	12 ↔	12 ↔	12 ↔	12 ↔	16 ↑	8
5	Failure to work in partnership with stakeholders	Chief People Officer/ Deputy CEO	16	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	8
6	Failure to attract and retain staff with the skills required to deliver high quality services	Chief People Officer	20	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	10
7	Major and sustained failure of essential assets and infrastructure	Director of Corporate Services	16	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	8
8	Major and sustained failure of essential IT systems	Director of Informatics	20	16 ↔	16 ↔	20 ↑	20 ↔	20 ↔	8

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

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

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Medical Director/Director of Nursing

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

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

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

Exec Lead: Director of Finance

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty. • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders. • Failure to deliver strategic financial plans. • Failure to control costs or deliver CIP. • Failure to implement transformational change at sufficient pace. • Failure to continue to secure national PFI support. • Failure to respond to commissioner requirements. • Failure to respond to emerging market conditions. • Failure to secure sufficient capital to support additional equipment/bed capacity. • Failure to obtain sufficient cash balances. • Failure to obtain on going transaction support. • Failure to deliver financial plans. **Effect:** • Failure to meet statutory duties. • NHSE Single Oversight Framework rating. **Impact:** • Unable to deliver viable services. • Loss of market share External intervention	• Annual operational and financial plan • System financial plan • Annual Business Planning • Annual budget setting • CIP plans and quality impact assurances processes • Monthly financial reporting • Service line reporting • 3-year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • Provider Licence Conditions • Service Improvement Team capacity to support delivery of CIP and service transformation • Signed Contracts with all ICBs and Spec Comm • Premium/agency payments approval and monitoring processes • Internal audit • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Conflict of interest declarations • Benchmarking and reference cost group	**LEVEL 1** Operational Assurance • Monthly divisional performance meetings • Finance Improvement Groups • CIP Council Meetings • Agency and locum spend approvals and reporting process. • Operational planning • Premium Payment Scrutiny Council • Vacancy control panel **LEVEL 2** Board Assurance • Finance and Performance Committee and reporting Councils • Annual Financial Plan • Audit Committee • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT, corporate benchmarking, ERIC) • Internal Audit Programme • ~~CQUIN Monitoring~~ **LEVEL 3** Independent Assurance • ICB & NHSE monthly reporting and review meetings • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit reports including VfM Assessment • Head of Internal Audit Opinion • NHSE scrutiny of cash applications • NHSE segmentation rating	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, considering current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites.	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances. At the earliest opportunity move back to longer term financial planning with rolling plans for 3 – 5 years. Development and delivery of the 3 year financial recovery plan, aligned to the ICB recovery plan (March 2028) Assurance that the ICB UEC improvement plan will deliver tier 3 CIP savings targets in 2025/26 Agree contracts with the C&M ICB for 2025/26	Deliver the agreed 2025/26 operational and financial plans, including the CIP target (March 2026) Deliver the 2025/26 Capital Programme (March 2026) Cash Management Plans for 2025/26 (March 2026) Work with ICB and NHSE financial improvement programmes to achieve the 2025/26 financial plan (March 2026)

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Failure of external parties to deliver required social care capacity **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Patients treated in ED or escalation beds. **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Negative impact on patient outcomes and experience	• NHS Constitutional Standards • Divisional activity profiles and work plans • System Winter Plan • Divisional Performance ~~Monitoring~~ Review Meetings • ~~Team to Team Meetings~~ • ED RCA process for breaches • Tumour specific cancer waiting time recovery plans • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events • Bed occupancy rates • Number of super stranded /patients who no longer meet the criteria to reside	**LEVEL 1** Operational Assurance • Winter resilience plans • ~~Divisional Finance and Performance meetings~~ Financial Improvement Groups • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans • ~~Weekly performance review meetings~~ • Monthly Executive Committee Divisional Performance Reviews **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance monthly oversight meetings	Implementation of routine capacity and demand modelling A defined preferred option and capital secured for Shaping Care Together programme. Implementation of CDC at Southport and Ormskirk sites. ~~Undertake lessons learnt review – internal and system wide, following the UEC critical incident, to be presented at Executive Committee and system wide workshop in May 2025.~~	Assurance that there is sufficient system response to operational pressures and reducing the number of patients who no longer meet the criteria to reside. ~~UEC/ED – GIRFT and ECIST support continues (Revised to June 2025)~~ Continue to deliver Productive Partners recommendations to improve elective activity productivity and maximise capacity (Revised to August 2025) C&M UEC Improvement Programme for 2025/26 to enable MWL to decrease escalation capacity and improve patient flow, achieve ambulance handover targets, reduce 12-hour breaches and improve ED waiting times (March 2026) 2025/26 Winter Plan - for board sign off in July 2025 and testing September 2025. To include Winter Plan BAF Assurance Statements (September 2025)	Deliver the internal transition and transformation programme to address fragile services by service integration and alignment across MWL (Revised to December 2025) Deliver the 2025/26 elective recovery, and ED, diagnostic and cancer waiting time targets set out the national planning guidance (March 2026)

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

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff. • Increased external scrutiny/review. **Impact:** • Reduced financial viability and sustainability. • Reduced service safety and sustainability • Reduced operational performance. • Increased intervention	• Communication, Media and Public Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR/FOI • Board media roundups and flash briefings • Work with ICB and NHSE communications teams	**LEVEL 1** Operational Assurance • Winter plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • Daily/weekly media briefings and board flash reports for urgent issues • Quarterly communications and media reports **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways • Provider representative at Place quarterly ICB performance meetings • Provider Collaboratives		Creation of good working relationships with new Healthwatch/PBP areas post transaction. Complete the stage 2 NHSE assurance process for the SCT Pre-Consultation Business Case (PCBC) and plan for period of public consultation July – September 2025 (Revised to October 2025) Engagement with the system wide CIP and service change programmes to deliver the C&M financial plan for 2025/26 (March 2025)	Develop the MWL Communications, Media, and Public Engagement strategy for approval by the Trust Board (revised to October 2025) Complete the SCT programme of public engagement events (September 2025)

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Deputy CEO/Chief People Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media. • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. **Effect:** • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff. **Impact:** • Unable to reach agreement on collaborations to secure sustainable services. • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff. • Failure to win new contracts. Increase in complaints and claims	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • Place Director Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board • ~~Involvement in Halton and Knowsley PBP development~~ • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • MWL Hospitals Charity annual objectives • Regular meetings with local MPs, OSCs etc. • Equality impact assessments • Anchor institution development plan	**LEVEL 1** Operational Assurance • ~~LUHFT Partnership Board~~ • ~~North Mersey Ophthalmology Steering Group~~ • Shaping Care Together Programme • Membership of CMPC • Capital Planning Council • ED&I Steering Group • Monitoring of NHS Choices comments and ratings • Review of digital media trends • Healthwatch feedback • Patient Experience Council **LEVEL 2** Board Assurance • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • Quality Account • Annual staff engagement events programme **LEVEL 3** Independent Assurance • NHSE review meetings • Participation in C&M ICB leadership and programme Boards • Collaborative working with Place Directors to develop plans for PBPs • Membership of St Helens People Board • OSC attendance/presentations	Health inequalities improvement objectives to be agreed with each Place and the ICBs	**C**&M Integrated Care System performance and accountability framework ratings and reports Develop and maintain good working relationships with each Place Partnership, ICB and Primary Care Network Maintain effective working with Place leads to take forward the UEC improvement programme workstreams and reduce the % of NCTR patients in acute beds. Work effectively with stakeholders to implement the NHS 10-year plan and develop neighbourhood model for the MWL footprint.	Continue to work with the SCT programme and other system partners to reduce the number of legacy S&O Trust fragile services (On-going) Engage with the transition of NHSE to DHSC and what this means for the local system infrastructure and responsibilities - including the impact on system engagement and decision making (March 2027) Maintain engagement with all patients and staff with an interest in the Shaping Care Together (SCT) programme (On-going)

BAF 6 Failure to attract and retain staff with the skills required to deliver high quality services

Exec Lead: Chief People Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation Loss of market share	• Trust brief live • MWL News • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Workforce & Development Operational Plan • Learning and Organisational Development Operational Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Operational plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • Trust Values • Medical Workforce OD plan • Talent Management action plan • Equality, Diversity, and Inclusion Operational plan	**LEVEL 1** Operational Assurance • Finance Improvement Group ~~Premium Payments Scrutiny Council~~ • Monitoring of bank, agency and locum spend • Workforce operational plans and information dashboards • Vacancy control panel **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council and HR Commercial Services Council • Finance and Performance Committee • Committee Performance Report • Staff Survey • Monthly monitoring of vacancy rates Labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group • MWL People Plan 2025-2028 **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report	~~Improve ease with which staff can move roles internally (March 2025).~~ ~~Review of education structure across MWL and complete Integration (revised to April 2025)~~ Monthly Provider Workforce Returns (PWR) ~~Development of a workforce information dashboard to support divisional oversight of key workforce metrics (Revised to June 2025)~~ Achieve bronze level Northwest Anti-Racism Framework (revised to November 2025) Delivery of the Sexual Safety charter action plans and policy (revised to September 2025)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (On-going) ~~Approval of the MWL People Plan 2025 – 2028 (April 2025)~~	Continue to provide the necessary support for organisational change to implement the remaining management structure for the MWL integrated operating model (continues into 2025/26) Delivery of the 2024 staff survey action plan and engagement events (March 2026) Continue Healthcare Support Worker quarterly recruitment events for each hospital site for substantive and bank staff (on-going) Complete single temporary workforce resourcing solution for MWL. Model approved July 2025 for implementation by Q3 (Revised to November 2025) Deliver the agreed 2025/26 workforce plans to support the operational and financial targets set out in the National Planning Guidance (March 2026) Deliver the agreed Trust EDI priority developments 2025-2028 (March 2029)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • Statutory safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data **LEVEL 3** Independent Assurance • Authorising Engineer Appointments • Authorising Engineer Audits • Condition surveys • Premises Assurance Model (PAM) benchmarking • Model Hospital • PLACE Audit Results and benchmarking • Building Safety Act • ERIC/PAM benchmarking	Maintain up to date 10-year strategic estates development plans for MWL to support the Trusts service development and integration strategies. Development of an Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	Develop the final business case to fully implement National Standards of Cleaning across MWL (re based budgets to be agreed for 2025/26) ~~Implementation of the national Hospital Food Review recommendations and mandatory standards (Gap analysis being undertaken)~~ Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 and draft legislation not yet published.	Deliver the agreed capital programme for 2025/26 (March 2026) Deliver the agreed backlog maintenance reduction programme for 2025/26 (March 2026) Deliver the PFI lifecycle programme for 2025/26 agreed with NewHospitals (March 2025/26) Single MWL Green Plan 2025 -2028 (November 2025)

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

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

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

Title of Meeting	**Trust Board**	**Date**	30 July 2025
Agenda Item	**TB25/059**		
Report Title	Aggregated Incidents, Complaints and Claims Report (Q1)		
Executive Lead	Sarah O'Brien, Chief Nursing Officer		
Presenting Officer	Peter Williams, Chief Medical Officer		
Action Required		**To Approve**	X **To Note**

Purpose

The aim of this paper is to provide the Board with a closure report on the management of incidents, complaints, concerns and claims during Quarter 1 2025/26.

Executive Summary

Incidents

- 7,269 incidents reported in Q1 2025/26 across MWL
- 5,590 patient safety incidents reported in Q1
- 85 patient safety incidents were graded as moderate harm or above during Q1
- Highest number of incidents reported relate to:
  - Accidents including slips, trips, falls, and collisions were the highest reported incidents in the combined data (995)
  - Pressure Ulcers including non-Trust acquired wounds were the second highest reported Trust wide (915)

Complaints & Patient Advise and Liaison Service (PALS)

- The Trust received 125 first stage complaints in Q1
- The Trust received 21 stage 2/reopened complaints in Q1
- The Trust closed 135 complaints in Q1
- Clinical treatment was the main reason for complaints, in line with previous quarters
- Emergency Department remained the main areas to receive complaints
- The Trust received 1,131 PALS contacts in Q1 (not including signposting)

Claims & Inquests

- In Q1 2025/26 the Trust received 8 new claims, and 42 requests for records
- The Trust received 20 new inquests, and 20 inquests concluded
- No Prevention of Future Death (PFDs) were issued during that period

Financial Implications

None as a direct result of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Aggregated Incidents, Complaints and Claims Report (Q1).

Strategic Objectives

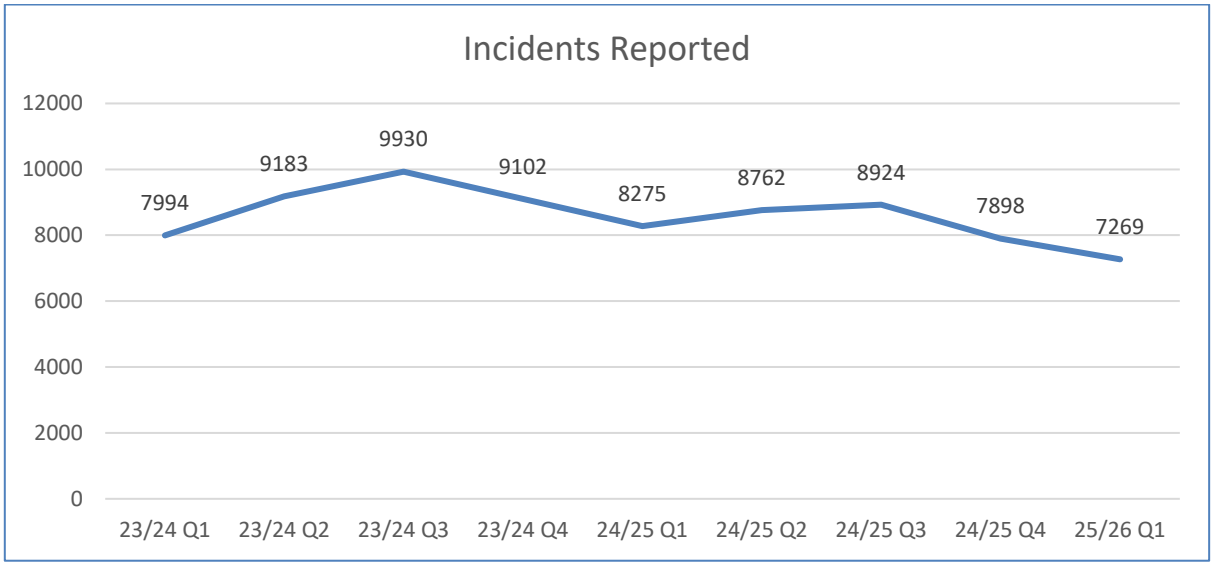
X	**SO1** 5 Star Patient Care – Care

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

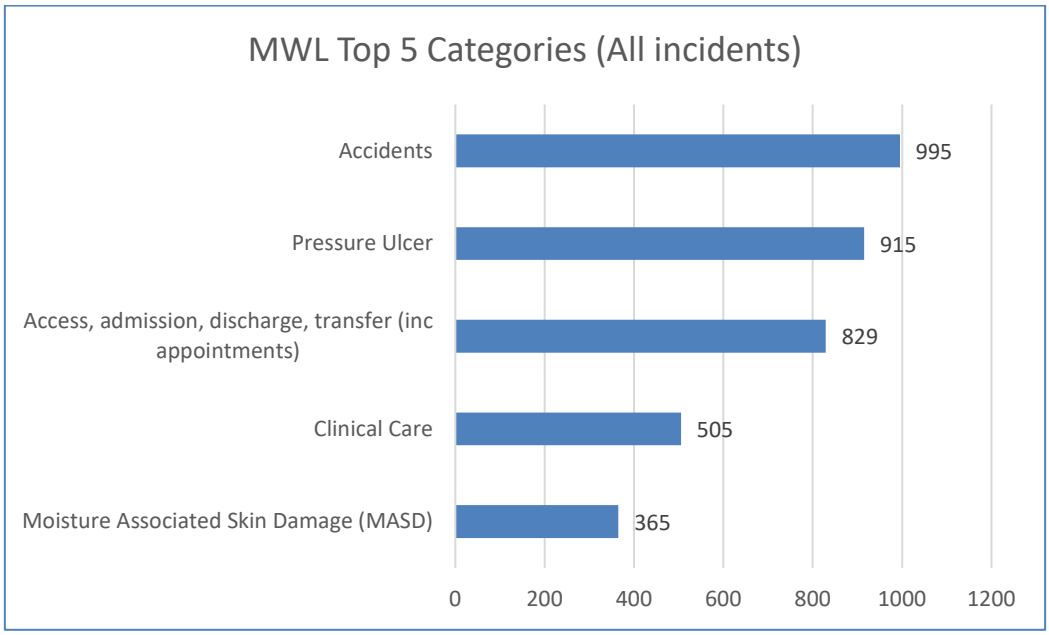
1. Introduction

This paper includes reported incidents, complaints, PALS contacts, claims, and inquests during Quarter 1 2025/26, highlighting any trends, areas of concern and the learning that has taken place. In March 2025 the Trust moved to a new Incident Reporting System, InPhase, which brought all sites onto one reporting platform to record incidents, complaints, PALS, and claims.

2. Incidents



MWL Q1 incidents reported	
5,590	Incidents affecting patients
574	Incidents affecting staff
1,056	Incidents affecting the Trust or other organisation (examples include bed availability; notifications of staffing levels; delayed discharges; equipment issues and queries raised by system partners)
49	Incidents affecting visitors, contractors or members of the public



- There was a slight drop in incidents reported across MWL in Q1 2025/26 (7269) compared to Q4 2024/25 (7898)
- Accidents – which includes slips, trips and falls incidents – were the highest reported incidents (995).
- Pressure ulcers were second highest reported (915), with moisture associated skin damage as the fifth highest category (365).

2.1. Incidents by harm category

The table below illustrates incidents by harm for Quarter 1 2025/26.

In Q1 there were four deaths recorded across all sites which is an increase from Q4 2024/25 and variation is noted compared to the previous quarters. The percentage of severe incidents and deaths against the total of all patient incidents is 0.32% for Q1 2025/26 compared with 0.23 % for the year 2024/25. This will be monitored in the coming quarters.

The deaths in Q1 2025/26 relate to a delay in diagnosis, a delay in treatment, a fall and an inappropriate discharge. All incidents are subject to trust investigation to identify learning and improvement.

MWL	24/25 Q1	24/25Q2	24/25 Q3	24/25 Q4	25/26 Q1
Moderate	37	35	33	54	67
Severe	15	9	9	6	14
Death	0	2	4	2	4
Total	52	46	46	62	85

2.2. PSII incidents and Learning

The management of patient safety includes identification, reporting, and investigation of each incident, and the implementation of any recommendations following investigation, dissemination of learning to prevent recurrence, and implementation of changes in practice when required. Please see table below.

Q1 2025/26	Total
Learning Reviews	1
Expanded Learning Reviews	6
MDT / AAR	1
Number of Patient Safety Incident Investigations (PSII) commissioned	2

- There were two PSIIs commissioned for Q1 2025-26.
- The first PSII refers to a medical device related skin injury and the second PSII refers to an incident meeting the Never Event criteria with the wrong device used for insulin administration leading to an overdose – low harm to patient.

2.3. Duty of Candour

Duty of Candour has been completed for all incidents where the harm was identified and validated by the responsible manager as moderate or above or for incidents identified for PSIIs. Under the Health and Social Care Act 2008 Regulations 2014: Regulation 20 requires NHS providers to comply with Duty of candour principles as soon as reasonably practicable after becoming aware that a notifiable safety incident by notification of the incident and providing reasonable support. A "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in the death of the service user, where the death relates directly to the incident, or severe harm, moderate harm or prolonged psychological harm to the service user.

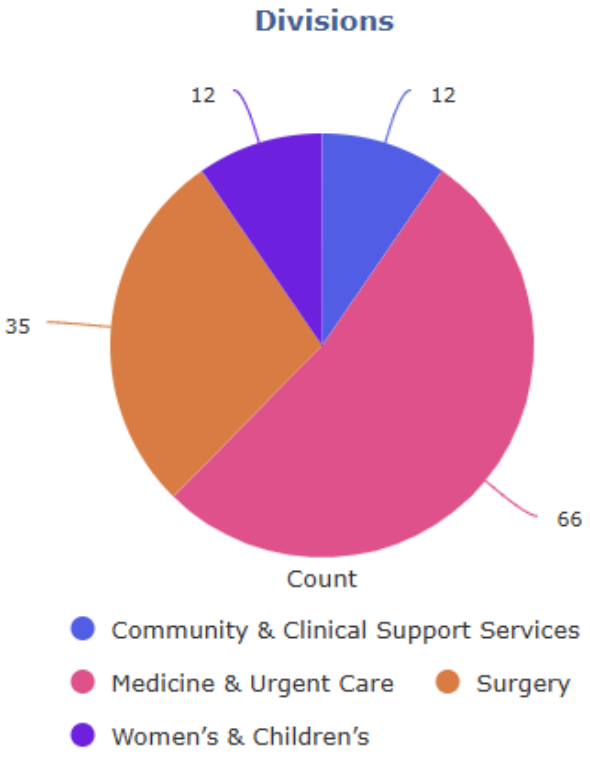
3. Complaints

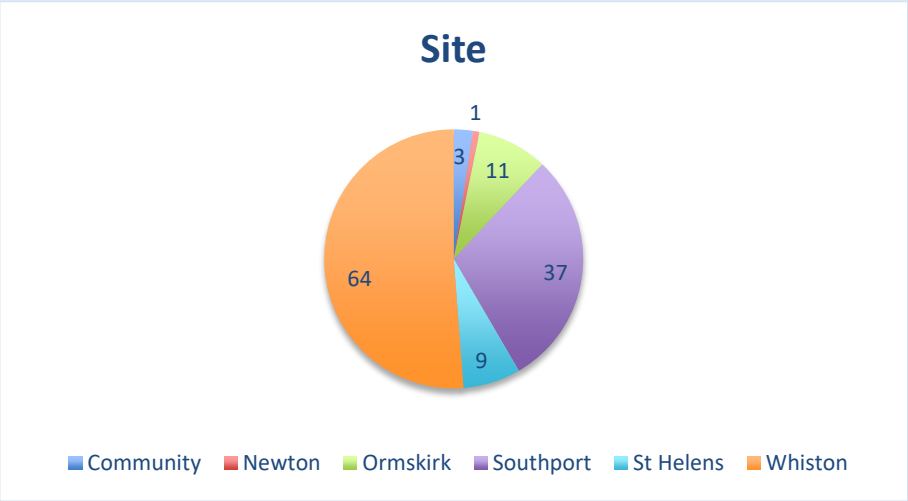
Closed Complaints	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
Not Upheld	44	22	12	22
Partially Upheld	94	86	79	89
Upheld	18	25	16	24
Total	**156**	**133**	**107**	**135**

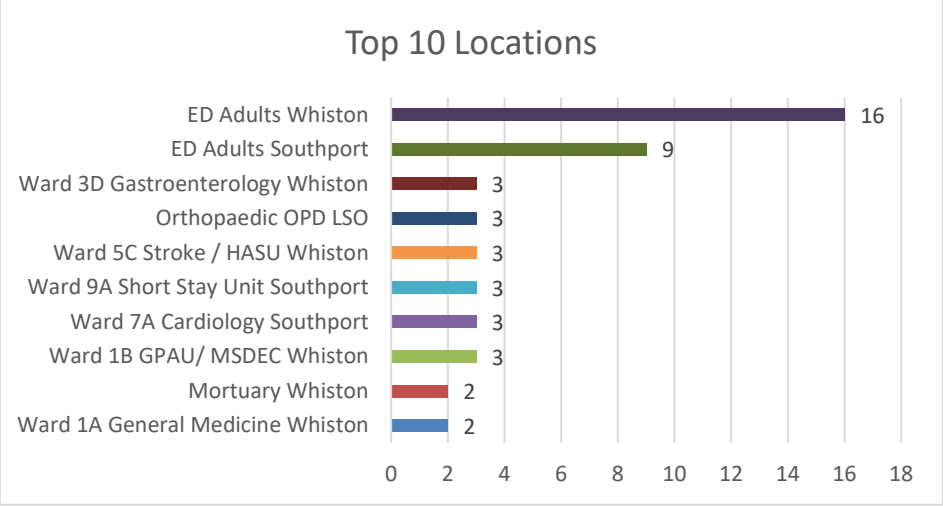
Themes of Closed Complaints (Top 5)	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
Clinical Treatment	68	69	63	61
Patient Care (Nursing)	11	18	20	19
Values & Behaviours	12	14	6	2
Communication	19	21	14	14
Admission & Discharge	8	0	1	9

*Figures at time of reporting from InPhase

- Work is continuing to improve compliance against the Trust 60 day response time. Of the 135 closed complaints in Q1, 63 were aligned to complaints that had breached the 60 day target.
- The Trust received 125 new complaints in Q1, a decrease to the 133 received in Q4.
- The charts below depict the Trust Sites and divisional breakdown of the 125 first stage complaints received in Q1.







- The Trust received 21 stage 2/reopened complaints in Q1

Site	Total 2nd Stage/Reopened
Community	0
Ormskirk	1
Southport	3
St Helens	3
Whiston	14
Total	21

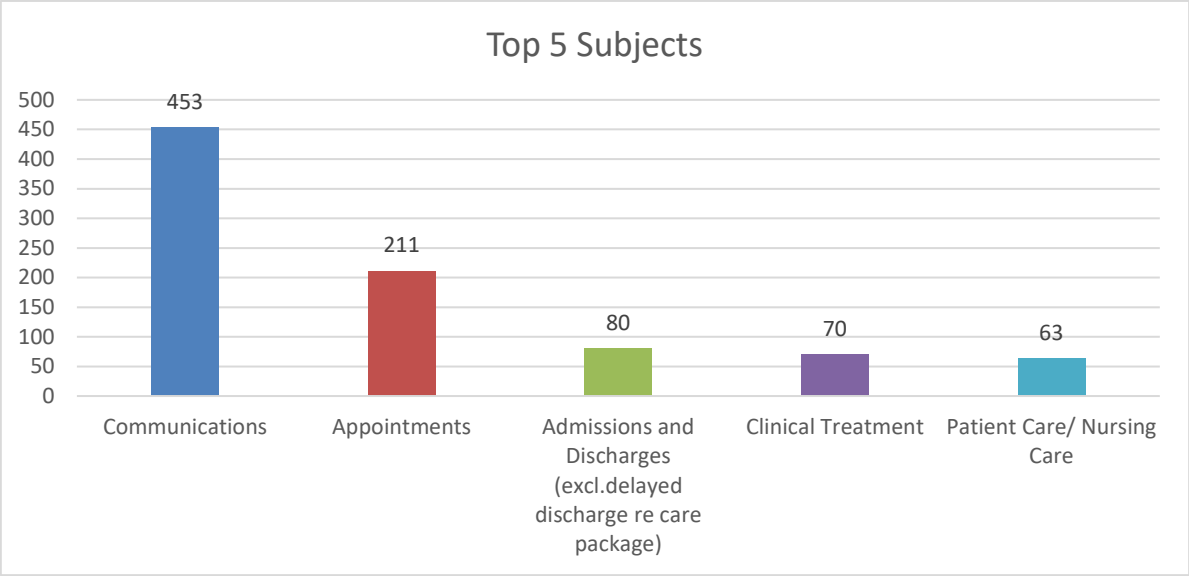
- Work continues around defining responsibilities and expectations with Corporate and Directorate Leads within the divisions around improving response times and quality of statements for complaints responses.

4. Patient Advice and Liaison Service (PALS)

PALS Contacts	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
Number of contacts received	1115	1,179	997	1,131

*Figures at time of reporting from InPhase

PALS Contacts by subject



5. New Clinical Negligence Claims

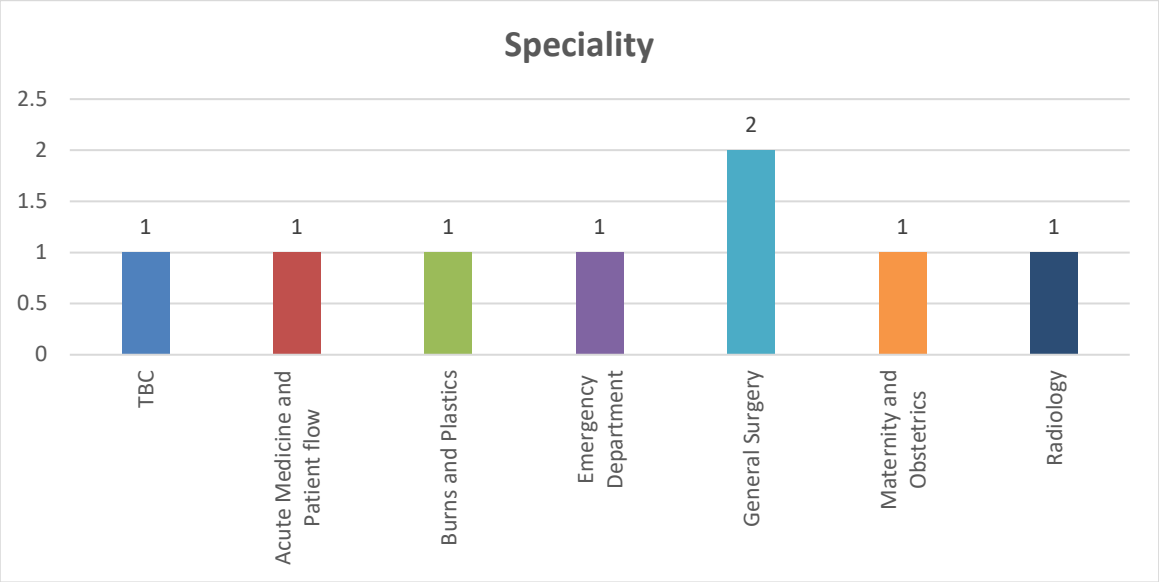
The Trust received eight new claims during Q1 – two in April, three in May and three in June. This is a significant reduction on Q1 in 2024/25 (20) and Q1 of 2023/24 (17). Quarter on quarter comparison is used as a more reliable comparator to take into account seasonal differences and other variable factors such as workforce impact.

Of the claims received, seven were entirely new, and the eighth resulted from a previous request for the patient records.

The Trust received 42 requests for records during Q1. This is almost half the figure from the previous quarter (78) and lowest number of requests since Q1 of 2023/24.

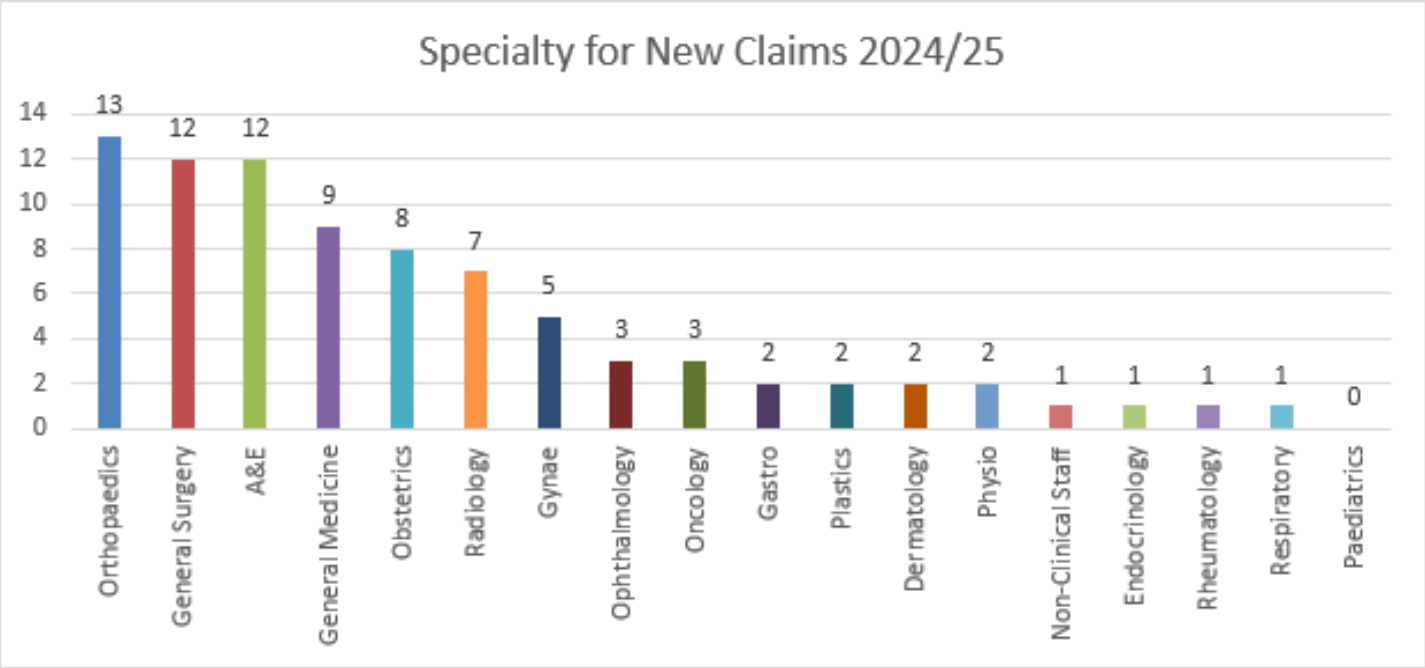
It is of note that the increased number of record requests seen since Q2 2023/24 appears to be returning towards expected numbers, with no corresponding increase in the number of new claims.

5.1. New claims by speciality

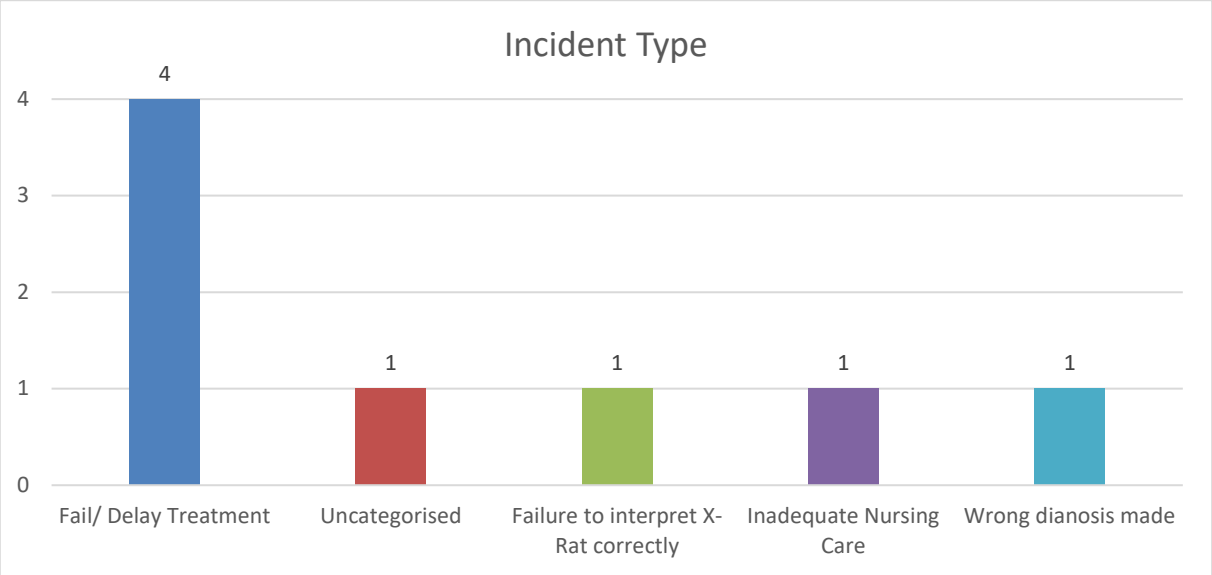


General surgery had the highest number of claims in Q4 2024/25, and this is repeated in Q1 2025/26. General Surgery is one of the areas highlighted as within the 4th quartile for claims in the recent Getting It Right First Time (GIRFT) data report, and we have commissioned Hill Dickinson to provide us with an analysis of those claims from a learning perspective

The chart below provides data on all claims by speciality in the previous 12 months. For Q1 2025/26, no speciality is an outlier compared to 2024/25 data.



5.2. New claims by main reason



The main causes of claims during quarter 1 were failure/delays in treatment with four claims in total. This is consistent with previous quarters as failure/delays in treatment are the highest reported type of clinical negligence claims. One claim remains uncategorised by speciality and type and will be assigned in Q2.

5.3. Lessons Learned from Closed Claims

The Trust closed 34 claims in Q1. Some of these concluded due to inactivity, but a number were settled, or the claimant has chosen not to pursue them. No matters reached trial in Q1.

The following learning examples have been identified from three claims closed in Q1:

- The claim related to the still birth of a baby.
  There was an alleged failure to undertake serial scans and retesting of carbon monoxide levels by MWL**.** The Trust made an admission regarding failure to undertake scans only and Liverpool Women's Hospital were also a defendant.

  The Perinatal Mortality Review Tool advised of the following actions after lessons learned which have been implemented
  - Developed a standard of practice for thrombocytosis.
  - Reviewed the criteria for consultant led clinic referral.
  - Fed back to the ultrasound department in relation to the rejection of the scan being inappropriate.

- There was a breach of duty, following a delay in performing and reporting an MRI scan and a subsequent delay in performing a surgical biopsy which resulted in a breach of the 62 day national target for diagnosis and start of treatment.

  Learning and Actions were as follows.
  - When patients are referred under the two-week rule the focus should remain on ruling out the cancer diagnosis.

- Tracking team to review processes for escalation of patients whose investigations are delayed due to capacity issues.
- Review of capacity for radiology and theatre to be undertaken by the Trust.
- Cancer tracking team to review communication processes.
- Raise awareness across the Trust regarding the accurate completion of imaging requests.

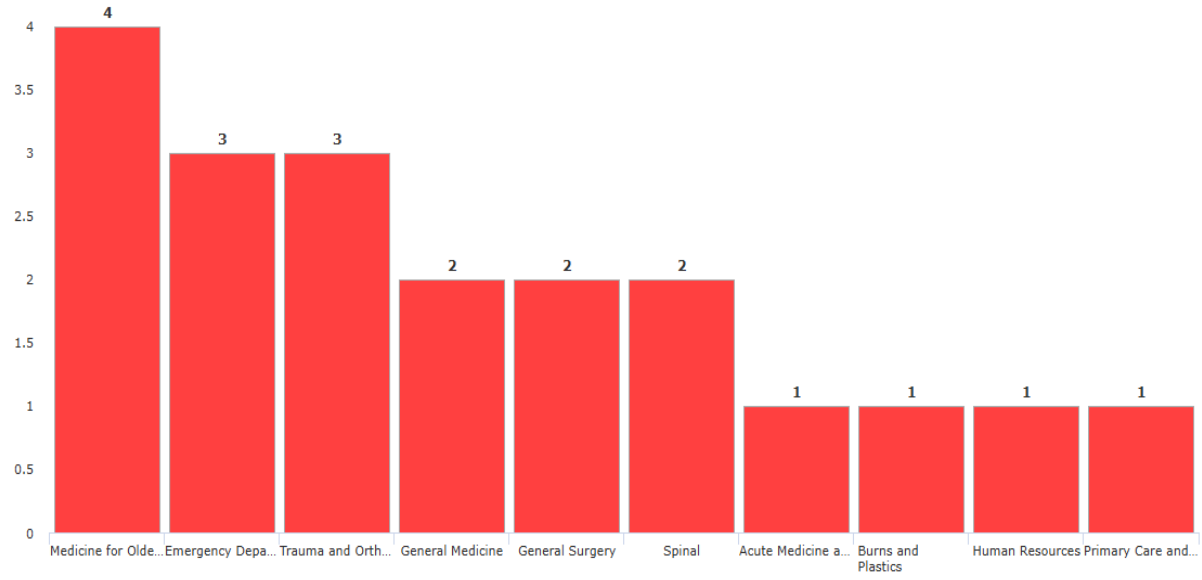
- Incorrect interpretation of a Computed Tomography (CT) scan which meant the claimant was not referred to the lung shadow clinic.

  Learning and Actions were as follows.
  - The importance of the British Thoracic Society (BTS) guidelines reiterated within Radiology and also Trust wide to ensure that regular follow-up imaging is achieved when necessary.
  - An audit completed to determine current compliance in Radiology with following the BTS guidelines with regards to the management of pulmonary nodules.
  - Share the case at the regular radiology discrepancy meeting (REALM).

6. Inquests
6.1. New Inquests

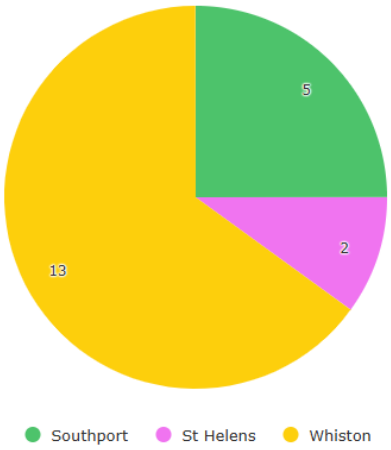
20 new inquests were opened in Q1. This is slightly below the average number per quarter, which is around 30.

These inquests are broken down by department as follows:



The HR inquest relates to a staff death with the Trust as a lead employer.

And by site as follows:



St Helens inquests:

- Patient 1 - presented as a self-referral at the St Helens site and was transferred to Whiston and later died at Liverpool Heart and Chest Hospital.

- Patient 2 - attended St Helens for a CT diagnostic and became unwell, triggering a MET call and transfer to ED at Whiston where they died.

6.2. Closed inquests

The Trust closed 20 inquests in quarter 1. This is less than usual. A number of inquests have had to be adjourned, mostly because of other interested parties not being ready for the hearing.

The Trust has not received any Prevention of Future Death (PFD) notices since July 2023.

None of the coroners who presided over the inquests heard in Q1 required additional assurance around lessons or learning from the Trust.

6.3 Senior Coroner

The Senior Coroner for Sefton, St. Helens and Knowsley has announced they will be retiring in September 2025. The new coroner is currently the area coroner for Liverpool.

7. Recommendations

It is recommended that the Board note the report and the learning from recent inquests and claims.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	30 July 2025
Agenda Item	**TB25/060**			
Report Title	Learning from Deaths Q3 2024/2025			
Executive Lead	Peter Williams, Chief Medical Officer			
Presenting Officer	Peter Williams, Chief Medical Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

MWL total number of deaths
Quarter 3 - 657

At Whiston and St Helens Hospitals

Total deaths with a Structured Judgement Review (SJR) Q2	21
Total deaths outstanding review Q2	45
Total deaths with an SJR Q3	57
Total outstanding review Q3	44
Total Amber SJRs Q2	0
Total Red SJRs Q2	0
Total Amber SJRs Q3	0
Total Red SJRs Q3	0

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

At Southport and Ormskirk Hospitals

Total Number of CRR Q3	221
Total Red CRR Q3	0
Total Amber CRR Q3	2

Financial Implications

None

Quality and/or Equality Impact	
Learning from Deaths contributes to the Trust's continuous learning culture.	
Recommendations	
The Board is asked to note the Learning from Deaths Report Q3 2024/25	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Learning from Deaths Q3 2024/2025

1. Whiston and St Helens Hospitals (W&StH)

W&StH - Reviews carried out Q2 July 2024 – September 2024

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
45 *(21)*	16	5	3	0	0

W&StH - Reviews carried out Q3 October 2024 – December 2024

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
57 *(44)*	3	3	1	0	0

2. Southport and Ormskirk Hospitals

S&O – Reviews carried out Q3 2024/2025 October – December 2024

No. of reviews	Green	Green with learning	Green with positive feedback from the bereaved	Amber	Red
SJR 0	Due to the switch to reporting systems, no SJRs could be completed using InPhase. One case was referred from the ME office for review for death of an LD patient. No concerns were identified in this review.				
Medical Examiner Reviews (includes 2 direct coroner referrals) 221	175	8	37	1	0

NHS	DOD	Ward	Summary	CRR Rating	Comments
4423096404	19/10/24	7A	Family concerns regarding ward nursing care	AMBER	Complaint investigation completed and partially upheld. Issues fed back to ward at safety huddles and in ward meetings
4640079877	20/11/24	7B	No Capillary Blood Glucose (CBG) measurement taken at triage in a diabetic admitted with hyperglycaemia.	GREEN WITH LEARNING	Ambulance CBG used. Repeated on VBG at 60mins. Issues did not contribute to patient's death
4408177482	21/12/24	9B	No admission ECG on a pt presenting with decompensated CCF	GREEN WITH LEARNING	No chest pain or suspicion of ACS. Known severe LVSD presenting with decompensation. Issues did not contribute to patient's death
4242411634	5/10/24	ITU	49 year male admitted vomiting blood	GREEN WITH LEARNING	Death registered by coroner: 1a) Upper Gastrointestinal Haemorrhage 1b) Cirrhosis

					HMC investigation discontinued after PM. Case reviewed by clinical lead for gastroenterology and Critical Care Lead. Initial treatment of UGI bleed appropriate. Transfer to UHA for OGD was not possible due to clinical condition. The event was deemed to be non-survivable Work ongoing to establish UGI bleeding rota for Southport Hospital.
6182835672	30/11/24	7A	58yr old with learning disabilities, myotonic dystrophy, home NIV, recurrent aspiration pneumonia brought into ED with chest pain,	GREEN	Death registered by coroner: 1a) Sudden Arrhythmic Death 1b) Myocardial Fibrosis 1c) Myotonic Dystrophy 2) Lower Respiratory tract Infection. No concerns raised during review
4708250053	16/12/24	Ward 1	93-year-old lady attended ED with increased confusion. Mould on the walls at home, no central heating	GREEN	Referred to HMC due to: Unknown cause of death Concern regarding care in community and unsafe discharge Death registered by coroner: 1a) Upper Gastrointestinal Tract Haemorrhage 2) Valvular and Ischaemic Heart Disease, Type 2 Diabetes Mellitus Coroner's investigation discontinued after PM, Community issues managed by WL Safeguarding. Trust investigations found no issues.

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

3. Key learning points

<table>
<tr><td>Update 26</td><td><u>Sepsis of uncertain origin</u>

When patients preset with sepsis of uncertain origin, it is essential to do a thorough assessment to identify the source of their infection as this allows antibiotics to be tailored appropriately. Assessment should include a skin survey, including removal of any wound dressings / compression bandages. It is also important to consider whether there are any indwelling devices (including prosthetic joints, pacemakers, etc, that may have become infected.</td><td><u>Careflow Alerts</u>

It is important to review all careflow alerts when patients are admitted to hospital. MRSA/VRE/CPE alerts should trigger review of antibiotic prescribing to ensure that there is appropriate cover for resistant organisms. Failure to do so risks delay to appropriate antibiotic prescription.</td></tr>
<tr><td>Update 25</td><td><u>Know your Pathways</u>

Trust pathways have been developed following local and national guidance of significant events and learning within the healthcare environment. It is imperative that staff familiarise themselves with what pathways are available within their field of practice, then follow them accordingly. They are there to protect our patients and you.</td><td><u>Communication with families / carers</u>

At times of high emotion and distress, it may be that families and carers do not take in what is happening to their loved one and may not be able to comprehend a poor prognosis, this is even more challenging over the phone. Staff must remain aware of verbal of physical cues from families / carers suggesting key messages haven't been fully appreciated, so the communication can be reinforced accordingly</td></tr>
<tr><td>Update 24</td><td><u>Imaging with contrast</u>
Inpatients who receive imaging with contrast are at a higher risk of renal complications if their fluids are not correctly managed. Please consider IV fluids for these patients as they are particularly vulnerable</td><td rowspan="2"><u>Observe caution in the use of Lorazepam in the elderly.</u>

Click here

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

Start low and go slow

Haloperidol or Lorazepam if haloperidol contraindicated</td></tr>
<tr><td>Update 24 Cont.</td><td><u>DNACPR communications on Transfer</u>

On a transfer form there is a specific box to indicate a DNACPR in place, this must be ticked and they must ensure the lilac form is prominent at the front of the case</td></tr>
<tr><td colspan="3">Further updates can be found on the intranet Learning from Action</td></tr>
</table>

Learning into Action

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

W&StH Coroners Cases – Q3 2024/25	
Inquests	80
PFD (Preventing Future Deaths Order)	0
S&O Coroners Cases – Q3 2024/25	
Inquests	50
PFD	0

END

Title of Meeting	**Trust Board**		**Date**	30 July 2025
Agenda Item	**TB25/061**			
Report Title	Infection, Prevention and Control Annual Report 2024/25			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Sue Redfern, Director of Infection, Prevention and Control			
Action Required	X	**To Approve**		**To Note**

Purpose

To present the 2024/25 Infection Prevention and Control (IPC) Annual Report to Trust board for approval. The report was presented and discussion at Quality Committee on 22 July 2025. The report provides assurance that the Trust is taking the necessary action to monitor and prevent hospital acquired infections.

Executive Summary

This is the second Infection Prevention and Control (IPC) Annual report for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). The previous IPC annual was reported to Trust Board in October 2024.

The Infection Prevention Annual Report is a two-part document; Part 1 outlines the developments and performance related to Infection Prevention (IP) activities during 2024/25 and Part 2 (Appendix 2) is the annual work plan for 2025/26 which aims to reduce the risk of healthcare associated infections (HCAIs). The report identifies the achievements and challenges faced in-year and the Trust's approach to reducing the risk of HCAI for patients.

The IPC programme is based around compliance with:

- The Health and Social Care Act 2008 (amended 2015) – Code of Practice on the prevention and control of infections and related guidance (also known as the Hygiene Code)
- Infection Prevention & Control Board Assurance Framework (October 2023 V1.8) Antimicrobial Stewardship

Key highlights

- Infection prevention and control is a statutory duty of the Trust Board, and an annual report must be made annually on performance in the previous year.
- Health care associated infections (HCAIs) are reported every month via the Corporate Performance Report (CPR) and the Board, via the Quality Committee, also gains assurance via regular in-depth reports of the actions taken and lessons learnt.
- The Trust continues to have appropriate arrangements in place for the prevention and control of infections in accordance with Health and Social Care Act 2008.
- The Infection Prevention Team (IPT) is led by Sue Redfern as Director of Infection Prevention and Control (DIPC). Following her retirement from the Director of Nursing, Midwifery and Governance role in December 2024, Sue has continued in the designated DIPC role and is supported by a Consultant Nurse and a Consultant Microbiologist/ Infection Control Doctor at the Whiston, St Helens and Newton sites and locum Consultant Microbiologist for the Southport and Ormskirk sites. In addition to the antimicrobial Pharmacists.
- The DIPC is accountable to the Trust board and must ensure the organisation has effective systems in place for preventing, detecting, and controlling healthcare-associated infections, as per the Health and Social Care Act 2008, specifically the Code of Practice.

- During 2024/25 MWL sites have exceeded the thresholds as set out in the NHS Standard Contract for Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridioides difficile (C.diff). This reflects the national picture across acute trusts, with all adult acute trusts in the region exceeding the thresholds for Clostridioides difficile.
- Escherichia coli (E. coli), Klebsiella and Pseudomonas bacteraemia MWL were below the threshold set.
- MWL was an outlier for rates of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia, extremely disappointing that there were six methicillin-resistant staphylococcus aureus (MRSA) bacteraemia. Actions have been taken following these as part of the Trust's commitment to learning from incidents
- Of the six cases, there were four cases of MRSA bacteraemia at Whiston Hospital and two cases at Southport Hospital. Three of the cases were identified as unavoidable, as there were no lapses or gaps in care that contributed to the infection. Two cases were deemed avoidable one of which related to a Peripherally Inserted Vascular Cannula (PIVC) associated infection, and the second case related to wound care management.
- An MWL PIVC Improvement Plan was developed and implemented in 2023/24 and was continued into 2024/25. This included the implementation of a single Trust system and process for Aseptic Non-Touch Technique (ANTT), cannula insertion and ongoing PIVC monitoring documentation, and the development of effective audit processes to support sustainable improvement. Task and Finish Groups were used to implement these actions.
- A zero-tolerance approach to MRSA bacteraemia and reduction in avoidable health care associated infections will remain a Trust priority within the Quality Account 2025/26.
- Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia - there is no national objective set for MSSA bacteraemia, however the Trust participates in the national mandatory surveillance of MSSA bacteraemia.
- The Trust reported were 90 healthcare associated MSSA bacteraemia cases which is an increase of 31 (35%) cases compared to the previous financial year. Surveillance is undertaken on all healthcare-associated cases, and the main source of infection is from skin and soft tissue e.g. leg ulcers.
- A deep dive review of all 90 cases was undertaken was commenced in Q4 to inform organisational learning and improvement. Themes indicated that the majority of MSSA cases were in older adults with multiple comorbidities, with a range of infection sources including wounds, vascular access devices, respiratory and deep sources.
- C.diff - in 2024/25, the Trust exceeded the NHSE standard contract threshold by one case. The combined MWL Trust threshold was for no more than 113 cases in 2024/25. There were 114 cases in year.
- E. coli - both sites were below the E. coli bloodstream infection threshold of no more than 171 cases in 2024/25. There were 158 cases in year which is 13 cases below the NHSE threshold.
- Klebsiella - The NHS Standard Contract for 2024/25 outlines the Klebsiella threshold for MWL for no more than 49 cases in year. At year end there were 47 cases, two cases below threshold
- Carbapenemase Producing Enterobacterales (CPE) - there was no CPE bacteraemia cases in 2024/25 (hospital or community acquired). However, in May 2024 the Whiston site experienced an increased incidence of CPE including two CPE colonisation outbreaks.
- The IPT has continued to undertake surveillance and contact tracing for Mpox, chickenpox, measles and Tuberculosis (TB).
- Hand hygiene continues to be strongly promoted throughout the Trust. Monthly audits of hand hygiene were undertaken on all wards throughout the year. Covert hand hygiene surveillance has also been undertaken.
- Orthopaedic Surgical site infections (SSI) surveillance: there were nine Surgical site infections (SSI). The infections related to:

- five hip infections out of 600 procedures which equates to a rate 0.83% of infection, which is below the national expected rate of 1%. Whiston site was an outlier for hip infection rate in Q1 and actions have been taken to address this.
- four knee infection out of 693 procedures which equates to 0.57% rate of infection, which is below the national expected rate of 1%.

- Outbreaks: there were a total of 128 outbreaks across MWL sites, the majority of these were due to SARS-CoV and Norovirus.

Part 2 - the MWL IPC forward plan for 2025/26.

Financial Implications
None as a direct consequence of this paper.

Quality and/or Equality Impact
Not applicable

Recommendations
The Board is asked to approve the Infection Prevention Control Annual Report 2024/25.

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

Mersey and West Lancashire Teaching Hospitals

Infection Prevention Annual Report

2024-2025

CONTENTS

1. Introduction

Mersey and West Lancashire Teaching Hospitals Trust is committed to leading on and supporting initiatives to reduce Health Care Associated Infections (HCAI). Good infection prevention control (IPC) practice is essential to ensure that people who use the Trust's services receive safe and effective care. Effective IPC practices require the hard work and diligence of all grades of staff, clinical and non-clinical. Good practice must be applied consistently by everyone. Effective prevention and control of infection is embedded as part of everyday practice and always applied consistently by everyone. The infection prevention and control agenda face many challenges including the ever-increasing threat from emerging diseases, antimicrobial resistant micro-organisms, growing service development in addition to national targets and outcomes.

The publication of the Trust's annual report is a requirement to demonstrate good governance and public accountability. In addition, it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention Team (IPT).

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections, requires all providers of health and social care to have appropriate resources, processes and systems in place to minimise the risk of infection to patients and staff. The current Infection Prevention Team (IPT) establishment requires review and investment to enable the team to provide a service of appropriate level and quality for the Trust to comply with its obligations.

The Board of Directors and ultimately the Chief Executive, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC). All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC

The single most important reason for Infection Prevention and Control (IPC) is to prevent morbidity and mortality associated with nosocomial infections. Each year, hundreds of thousands of people suffer the consequences of nosocomial infections, ranging from the inconvenience of taking extra medications to death. Beyond the human cost is the important economic burden that these infections place on society, including not only the obvious increase in health care resource use but also indirect costs associated with the increased use of antibiotics.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable Healthcare Associated Infections (HCAIs).

The publication of the IPC Annual Report is a requirement in accordance with Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. It will be publicly available on the Trust website to demonstrate effective governance and public accountability.

The IPC Forward Plan relates to the 10 criteria outlined in the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

This report consists of two parts: the performance related to Infection Prevention and Control (IPC) and exception reporting during 2024/25, and the broad plan of work for 2025/26 to reduce the risk of HCAIs.

There are national annual contractual reduction objectives for Clostridioides difficile (C. difficile) infections and gram-negative blood steam infections (GNBSIs). Zero tolerance to MRSA bacteraemia remains in place. These are included in the six infections that are subject to mandatory reporting to United Kingdom Health and Security Agency (UKHSA) listed below:

- Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia
- Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia
- C. difficile infections
- Escherichia coli (E. coli) bacteraemia
- Klebsiella spp. bacteraemia
- Pseudomonas aeruginosa bacteraemia

2. Context

In July 2023/24 the integration of St Helens and Knowsley Teaching Hospitals and Southport and Ormskirk Hospitals was transacted. This single larger organisation, Mersey and West Lancashire NHS Teaching Hospitals Trust (MWL) is committed to providing reliable standardised care for its acute, intermediate, community and primary care services.

Despite the organisation's commitment to deliver clean safe care, it is relevant to note the context of working within the current NHS system of high bed occupancy, staffing pressures, the increased incidence of infections, and how the activity/length of stay in the Emergency Departments has contributed to the pressure on the delivery of clinical care and the ability to minimise the risk of healthcare associated infection.

During the previous financial year 2023/24, Improvement Plans for PIVC care, E coli bacteraemia and C. difficile infection were developed and implemented. The E coli Improvement Plan was closed in 2024/25 following more than a year of sustained improvement, while the other improvement plans continue. Reducing Staphylococcus aureus (MRSA/MSSA) bacteraemia is also a Trust Quality objective as laid out in the Quality Account 2024/25.

The Trusts vision is to provide 5-star patient care so that patients and their carers receive services that are safe, person-centred and responsive, aiming for positive outcomes every time. The mission and vision have remained consistent and embedded in the everyday working practices of staff throughout the Trust, where delivering 5-star patient care is recognised as everyone's responsibility.

3. Governance and Monitoring

3.1 Governance.

During 2024/25, the Trust maintained its compliance with the criteria set out in the Health and Social Care Act Code of Practice (2008). The annual plan for IPC for 2024/25 set out the proposed activities for the IPCT ensuring that we continued to meet the expected requirements and standards outlined by regulation and legislation. The plan also accounted for locally agreed actions, as well as internal programmes of work that we planned to deliver throughout the year. We have on-going action plans focusing on the prevention and management of HCAIs and Antimicrobial stewardship (AMS) across our hospitals, and these underpin the programmes of work referenced in this report. The plan is reviewed annually through the quality governance framework to assess impact and provide assurance. Progress on actions

is also followed up by regular operational meetings. While the Trust has many examples of excellent work and high-quality care, it recognises that there is more to do to achieve its goals and ambitions. The IPC annual plan and associated action plans support the Trust to deliver its strategic objectives.

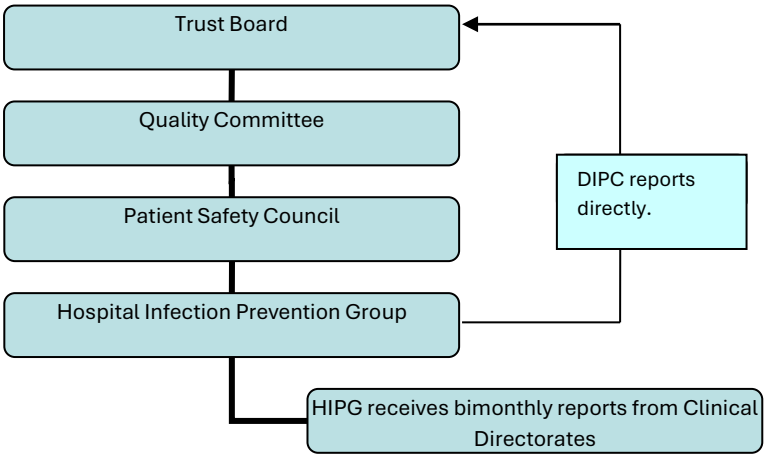
The Board of Directors has collective responsibility for keeping the risk of infection to a minimum and recognises its responsibility for overseeing IPC arrangements in the Trust.

The DIPC is accountable to the Trust board and must ensure the organisation has effective systems in place for preventing, detecting, and controlling healthcare-associated infections, as per the Health and Social Care Act 2008, specifically the Code of Practice. The DIPC delivers the annual HCAI reduction report and annual plan to the Board of Directors based on the national and local quality goals.

The IPT is led by Sue Redfern, Director of Infection Prevention and Control (DIPC). Following her retirement from the Director of Nursing, Midwifery and Governance role in December 2024 Sue has continued in the designated DIPC role and is supported by a Consultant Nurse and a Consultant Microbiologist/ Infection Control Doctor at STHK sites and locum Consultant Microbiologist for the Southport sites. In addition to the antimicrobial Pharmacists.

The IPC team supports or chairs several governance and operational meetings to provide oversight and engagement with clinical and corporate services. The Hospital Infection Prevention Group (HIPG) provides a strategic meeting to support the delivery of a zero-tolerance approach to avoidable HCAIs, whilst the divisional management teams are responsible for the delivery. Figure 1 outlines the IPC governance structure at MWL.

Figure 1. IPC Governance



3.2. External agency support and oversight

Colleagues from the Integrated Care System (ICS) are members of HIPG. The ICS also receives quarterly reports as part of the Quality Schedule reporting. The IPC Team proactively contribute to the Cheshire and Merseyside HCAI collaborative and Place, Quality Assurance forums.

3.3. Risk register

The IPC risk register identifies risks to the organisation in relation to IPC measures and practices. As in previous years the key risks in 2024/25 included the lack of side room capacity (Southport site), limitations of the estates structure, risk of suboptimal practice relating to vascular access, fragility of antimicrobial supply chain to support effective treatment plans,

staffing, new and emerging infections and outbreak management. Risks are monitored monthly and reviewed at the Trust's Hospital Infection Group meeting on a bimonthly basis and risks are escalated via the Risk Management Council to Executive committee and Trust board.

3.4. Freedom of information (FOI) requests

There have been no FOI requests related to IPC during 2024-25.

3.5. IPC Board Assurance Framework (IPC BAF)

NHS England updated the IPC Board Assurance framework (BAF)[1] in August 2023, which was developed to support healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control Manual (NIPCM)[2] and other related infection prevention and control guidance. The BAF is structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection[3] which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[4]. The Trust's IPC BAF has been aligned across the organisation to provide assurance against these requirements. This was revised and presented to the Executive Committee in March 2025.

The review indicated that 41 of the 52 key lines of enquiry are rated green, with 11 rated partially compliant. This included harmonisation of policies and leaflets, ANTT and IPC training being below 85%, compliance with National Standards of Healthcare Cleanliness standards (which is being embedded), estates and preventative planned maintenance due to spatial constraints and financial investment. The Trust is sighted on the gaps and there are no indicators that are non-compliant (red rated).

4. Infection Prevention Team

The IPT works primarily on a site-based model with matrix working responsibilities across the sites.

The current total MWL IPT establishment including ICNs, administration and audit support is 14.4 WTE (inclusive of 0.8 band 7 vacancy).

MWL: 1 WTE Band 8C, Consultant nurse working across all sites.

STHK sites:

- 1.0 WTE Band 8B Lead Nurse
- 2.8 WTE Band 7 Specialist Nurse IPC (0.8 currently vacant following retirement)
- 2.0 Band 5 Infection Prevention Nurse
- 1.0 Band 4 Infection Prevention Secretary
- 0.6 WTE Band 3 Surveillance Assistant

Southport and Ormskirk sites:

- 1.0 WTE Band 8A Matron

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[1] NHS England » National infection prevention and control
[2] NHS England » National infection prevention and control
[3] Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)
[4] Regulation 12: Safe care and treatment - Care Quality Commission (cqc.org.uk)

- 2.8 WTE Band 7
- 1.0 WTE Band 3 Support Worker
- 1.0 Band 4 Administrator

The IPT provides a clinical support service during weekdays from 8.30am to 5pm, with on-call provision at Southport and Ormskirk sites at weekends. Out of hours there is an on-call service provided by medical microbiologists for urgent IPC advice.

A business case is in development to support the IPT with the increase in activity across the MWL sites and infection prevention related workload including data analyst support.

5. Health Economy Engagement

The Consultant Nurse IPC continues to attend the North Mersey Infection Prevention and Control and Antimicrobial Resistance (IPC and AMR) Group (previously GNBSI Group). The Group was established across the North Mersey health economy to drive forward the ambition to support a reduction in healthcare associated Gram-negative bloodstream infections (GNBSI) and a reduction in antimicrobial resistance to antibiotics.

The Trust is also collaborating on an ICB-led North Mersey IPC/AMR action plan, with a focus on reducing E coli BSIs and hydration. The Lead Nurse Infection Prevention at STHK sites continues to attend the Halton and Warrington System-wide Collaborative, Infection Prevention Group, with GNBSI BSI reduction as a priority. The group aims to provide the opportunity for the Health and Local Authority partners across the North Mersey place to enter constructive dialogue with regards to the IPC and AMR improvement plan.

The Consultant Nurse IPC represents the Trust at an NHSE-led Cheshire and Merseyside IPC provider collaborative (CMAST) which commenced in 2024/25. The purpose of this Efficiency at Scale IPC Collaboration Group is to:

- Ensure consistency of IPC reporting across providers in Cheshire and Merseyside (C&M), including provider performance, adherence to national guidance and best practice identified.
- Support the levelling-up agenda of IPC provision across providers in C&M and identify the consequences of gaps in IPC provision.
- Support the mitigation of risks relating to IPC provision across C&M.
- Bring together IPC subject matter experts across providers in C&M.
- Ensure lessons learned from Covid-19 pandemic are captured, reflected upon and built into business as usual, together with ensuring the C&M system is prepared for future IPC challenges.

The first improvement project on C difficile was completed in 2024/25, with the production of a C difficile toolkit covering diarrhoea management, cleaning and AMS. The group will be focusing on developing a CPE Toolkit and formulary of cleaning products in 2025/26.

The NHS Cheshire & Merseyside System Quality Group is regularly attended by the Consultant Nurse which fosters collaborative engagement and sharing of organisational lessons and best practice across the regional health economy.

The Consultant Nurse IPC is an expert member of the national NHS Supply Chain Infection Prevention & Control (IPC) Clinical Council, to advise on product specifications and support clinical engagement for products and services that require specific clinical input from an IPC perspective. In 2024/25 this included wipes for surface cleaning and disinfection and the Hand Hygiene Framework and associated products and services.

The IPC Team attends Northwest IPC Regional Network Meeting, which is led by NHSE, and focuses on education and training, UKHSA updates on national/regional surveillance of HCAIs and infectious diseases and lessons from outbreaks and incidents. The group will also discuss their local interpretation of national guidance, such as PSIRF and the National Standards of Healthcare Cleanliness.

6. Surveillance

The IPT undertakes continuous surveillance of target organisms and alert conditions. Pathogenic organisms or specific infections, which could spread, are identified from microbiology reports or from notifications by ward staff. The IPT advises on the appropriate use of infection control precautions for each case and monitors overall trends.

These alerts include positive Clostridioides difficile, new CPE colonisations, bloodstream infections and MRSA colonised patients; additionally test results which indicate potential for cross infection and a need to alert ward staff and conduct follow up visits are highlighted. All inpatients identified for follow up are visited and records are reviewed by the team.

The Trust has the ICNet surveillance system, and it has been used at the legacy sites for many years. In addition to submitting data to support the national HCAI objectives for C. difficile infection, MRSA bacteraemia and gram-negative bacteraemia (GNBSIs) including E. coli, Klebsiella spp. and Pseudomonas aeruginosa, the Trust also submits data to the UK Health Security Agency (UKHSA) on MSSA. The data is submitted by the 15th day of each month to UKHSA via an online Health Care Associated Infection Data Capture System (DCS). The trust is fully compliant with data submission.

This reporting process requires the IPT to review and analyse data from several IT systems and learning reviews to provide current and accurate compliance data, to formulate assurance reports and actions required to address areas for improvement.

6.1 Achievements against the National HCAI thresholds

The NHS Standard Contract 2024/25 includes quality requirements for NHS trusts to minimise rates of both C. difficile and GNBSIs to threshold levels set by NHS England[5]. They are inclusive of all healthcare associated infections (community onset healthcare associated, and hospital onset healthcare associated).

- Hospital-onset healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)

- Community-onset healthcare associated (COHA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

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

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

[5] https://www.england.nhs.uk/wp-content/uploads/2021/08/PRN00150-NHS-Standard-Contract-2024-25-Minimising-Clostridioides-difficile-and-Gram-negative-bloodstream-infect-1.pdf

Key changes from the 2023/24 thresholds:

Due to increasing trends, a more ambitious threshold (for most trusts) of a 5% reduction for C. difficile (compared to one case count historically). This also improves the alignment between trust and ICB thresholds.

In addition to trust thresholds, publication of thresholds at ICB-level (previously published at sub-ICB level, which has then been aggregated to ICB).

Recalculating the baseline (2023/24) figures for all trusts to reflect definition change - where a patient has been admitted directly after attendance to A&E, the decision to admit is the admission date rather than the inpatient admission date. As a result of this definition change, case classifications will change from community-onset to hospital-onset.

Figure 2 outlines the Trust performance against these thresholds in 2024/25. The Trust ended the year below NHSE threshold for E coli, Klebsiella and Pseudomonas bacteraemia, and one case above threshold for C. difficile infection. There were six MRSA bacteraemia in year and a notable increase in MSSA bacteraemia cases.

Figure 2. HCAI performance against NHSE thresholds 2024/25

MWL data	HOHA	COHA	Total	
MRSA	4	2	6	Above
MSSA	52	38	90	No external threshold. Internal threshold 10% reduction (not met)
CDT	87	27	114	Above threshold (x 1 case)
E coli	92	66	158	Below threshold (x 13 cases)
Klebsiella	24	23	47	Below threshold (x 2 cases)
Pseudomonas	9	5	14	Below threshold (x 2 cases)

7. Mandatory Reporting

7.1 MRSA bacteraemia

A zero-tolerance approach is still in place to support no MRSA bacteraemia with the Trust Quality Objective outlining measures to address learning from cases to reduce MRSA bacteraemia at MWL. In 2024/25, there were 6 MRSA bacteraemia reported at MWL. There were 4 cases at Whiston site, 1 case at Southport site and 1 case at Ormskirk site.

Figure 3. Hospital associated MRSA bacteraemia 2024/25

Case	Attribution	Site	Source	Avoidable
1	HOHA	Whiston	Cannula	Yes
2	COHA	Ormskirk	Episiotomy	No
3	HOHA	Southport	Sacral wound	Yes
4	HOHA	Whiston	Hand wound	Potentially
5	HOHA	Whiston	Deep source	No
6	COHA	Whiston	Unknown	No

All cases of hospital-associated MRSA bacteraemia were investigated using the IPC Infection Prevention Learning Review (IPLR) process, which is aligned with the national PIR (Post Infection Review) process. This in-depth review helps to identify the source of the infection and gaps or lapses in clinical care which may have contributed to the infection. Duty of candour was ensured, and improvement plans were developed to address the learning with oversight via divisional governance processes and at HIPG.

Three of the six cases were considered unavoidable with several good practice points identified on IPLR. However, there was wider Trust learning, such as the adequacy of ward stock of MRSA suppression treatment to support timely commencement of therapy, timely specimen collection and body mapping of wounds and skin breaks and the reliability of wound care.

Two were deemed avoidable due to contributory gaps and lapses in care; a peripheral cannula-associated infection and another in a sacral pressure ulcer.

One case was considered potentially avoidable as the patient was colonised with MRSA on admission in a preexisting wound. However, but the IPLR panel concluded that blood culture contamination due to inadequate ANTT practice was also a potential source.

A zero-tolerance approach to reduction in avoidable (no lapses of gaps in care) bloodstream infections remains a Trust priority within the Trust Objectives and Quality Account 2025/26. The measures that will be used to support this ambition are:

1) Deliver the agreed Peripheral Intravenous Cannula (PIVC) Improvement plan.
2) Achieve minimum aseptic non-touch technique compliance of 85% for Level 1 (theory) and Level 2 (practical).
3) 90% compliance with visual infusion phlebitis (VIP) monitoring
4) Align ANTT training and competencies across MWL and achieve 85% compliance for Level 1 (theory) and Level 2 (practical).

The Peripheral Intravenous Vascular Cannula (PIVC) Improvement Plan, which was implemented in Q4 2023/24. This includes the development of a single Trust system and process for ANTT, cannula insertion and ongoing monitoring documentation, and the development of effective audit processes to support sustainable improvement.

A regular PIVC spot check audit of clinical areas was included in the IPC Team audit plan for 2024/25 for inpatient areas at Whiston, Southport and Ormskirk sites, with timely feedback to clinical and divisional teams, to support improvement. A target of minimum 90% compliance with VIP monitoring was set. Figure 4 outlines the quarterly compliance across MWL. At the end of 2024/25 the Trust was just below target, achieving 89% compliance for VIP monitoring.

Figure 4. VIP compliance 2024/25

	Q1	Q2	Q3	Q4
PIVC VIP monitoring	86.9%	85.5%	82.3%	89%

Ward managers and matrons also undertake monthly Nursing Care Indicator audits to provide assurance regarding cannula care and IPC indicators as part of the monthly Tendable audit programme. This also contributes to the outcome of the ward accreditation ratings.

7.1.1 ANTT

In 2024/25 an MWL Mandatory Training harmonisation project commenced and focused on alignment of ANTT across the organisation as a priority. This included alignment of the delivery model, frequency and staff groups who require training. This means that Level 1 theory e-learning and Level 2 practical assessment compliance can now be monitored across all sites for applicable clinical staff.

Level 1 compliance improved throughout the year to 92% at the end of Q4 and this is above the Trust target of minimum 85% compliance. However, Level 2 practical assessment which was 70.9% at STHK sites during that period.

From Q1 2025/26 Level 2 compliance can be monitored at S&O sites following alignment of legacy ESR systems and the training needs analysis for all clinical staff.

In Q4, and the senior nursing team, ward manager/matron meetings, medical fora and all staff at Trust Brief Live have been advised of the need to prioritize the Level 2 practical training. ANTT compliance will be monitored at divisional IPC meetings with assurance to HIPG.

Figure 5. ANTT compliance

Measurement Quality Account		S&O	STHK	MWL
Achieve minimum aseptic non-touch technique compliance of 85% for Level 1 (theory) and Level 2 (practical).	**Q1 Level 1**	72.3%	92.7%	91.7%
	Q1 Level 2	-	69.2%	-
	Q2 Level 1	83.5%	93.9%	93.2.%
	Q2 Level 2	-	71.4%	-
	Q3 Level 1	81.4%	92.7%	91.9%
	Q3 Level 2	-	69.2%	-
	Q4 Level 1	80.8%	92.6%	91.8%
	Q4 Level 2	-	70.9%	-

7.1.2 MRSA screening compliance

Although there is a focus on reporting MRSA bacteraemia there is the potential for patients to become colonised with MRSA whilst in hospital, without infection. The IPT reviews all MRSA positive patients to advise regarding IPC measures currently in place and additional actions required to reduce the risk of bacteraemia and onward transmission.

The Trust has a policy in place which is aligned to best practice for MRSA screening and suppression guidance and continues to use a robust approach to screening the majority of patients, either pre operatively or on admission and patients who have a length of stay for 30 days or more are also screened. MRSA admission screening compliance is monitored on a monthly basis and reported wihtinh the Trust Quality objective.

The target for MRSA screening is 95% of eligible patients requiring screening and the Trust achieved this overall for 2024/25.

Figure 6. MRSA Screening Compliance Q1-4 2024/25

Measurement Quality Account		S&O	STHK	MWL
Achievement of 95% for MRSA screening	Q1	94%	98.6%	96.3%
	Q2	94.3%	98.6%	96.5%
	Q3	92.4%	95.3%	93.4%
	Q4	93.2%	93.7%	93.4%

Screening of patients admitted as emergencies was an area of focus for the IPT and Emergency Department at the Southport site in 2024/25. Moving forward this will also be monitored within the newly established divisional governance meetings.

7.2 MSSA bacteraemia

There is no national objective set for MSSA bacteraemia, however the Trust participates in the national mandatory surveillance of MSSA bacteraemia. There were 90 healthcare associated MSSA bacteraemia cases at MWL during the reporting period 2024/25. This was an increase of 31 (35%) cases compared with 2023/24.

UKHSA Cheshire and Merseyside HCAI data indicates that for the first 3 quarters of 2024/25. MWL was above the Cheshire and Merseyside rate for MSSA (Figure 7). From Jan-Mar 2025, the rate of MSSA bacteraemia at MWL was equal to the C&M rate of 17.9 cases per 100,000 bed day. This represents the lowest quarterly rate for MWL during the 2024/25 reporting period.

Figure 7. MSSA rates per 100,000 bed days

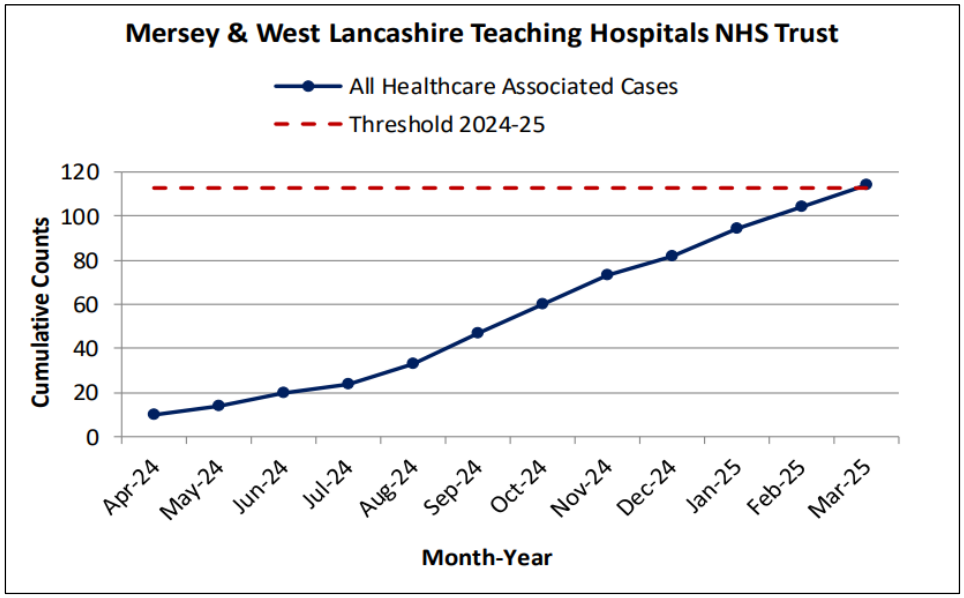
Rate per 100,000 bed days	Apr-Jun 2024	Jul-Sep 2024	Oct-Dec 2024	Jan-Mar 2025
Cheshire & Merseyside	17.2	17.2	19.0	17.9
MWL	22.8	18.4	23.3	17.9

All MSSA cases are subject to the IPLR process to clarify the sources of infection (e.g. cannula, wounds) and to lessons for improvement. As MSSA cases have increased significantly compared to the same period of 2023/24, a deep dive was commenced in Q4 to inform organisational learning and improvement. Themes indicated that the majority of MSSA cases were in older adults with multiple comorbidities, with a range of infection sources including wounds, vascular access devices, respiratory and deep sources e.g. bone and joint and endocarditis. Sources of infection ranged from urine, wounds, discitis and endocarditis which is consistent with UKHSA surveillance data. A trust wide improvement plan has been developed which will be monitored via the divisional assurance processes with oversight from HIPG and Quality Committee.

7.3 Clostridioides difficile

The NHS Standard Contract thresholds for CDI for MWL for the period 2024/25 was for no more than 113 cases in year. The Trust reported 114 cases (87 HOHA, 27 COHA) which is 1 case above the NHSE threshold. This is equal to the 2023/24 outturn.

Figure 8. MWL healthcare-associated *C. difficile* April 24-Mar 25



Whiston and St Helens sites had 64 healthcare-associated cases (47 HOHA 17 COHA) (Figure 9) which is a reduction of 10 cases compared to the previous financial year. This reduction is predominantly related to COHA cases.

Legacy Southport and Ormskirk sites had 50 hospital-associated cases (40 HOHA, 10 COHA). There were 40 cases at these sites during the previous year.

Figure 9. CDI cases Q1-Q4 by attribution and legacy sites 2023/24 and 2024/25

Financial Year	Attribution	STHK	S&O	Total MWL cases
2023-24	HOHA	46	31	77
	COHA	28	9	37
		74	**40**	**114**
2024-25	HOHA	47	40	87
	COHA	17	10	27
		64	**50**	**114**

Figure 10 outlines the legacy Trust C difficile performance for the previous four financial years against NHSE thresholds.

Figure 10. MWL healthcare-associated *C. difficile* by legacy Trust 2021-2025

Financial Year	STHK Threshold	STHK Actual	S&O Threshold	S&O Actual	Combined Threshold	Total cases
2021-22	54	54	27	43	NA	97
2022-23	56	57	49	48	NA	105
2023-24	46	74	39	40	85	114
2024-25	-	64	-	50	113	114

UKHSA data indicates that in Q1 and Q2 2024-25, MWL were a low outlier in terms of *C. difficile* rates (Figure 11). In Q3 and Q4 the Trust remained below the Cheshire and Merseyside rate, with comparable acute providers as high as 50 per 100,000 bed days in C&M in Q4.

Figure 11. *Clostridioides difficile* rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 24	Jul 24-Sep 24	Oct 24-Dec 24	Jan-Mar 2025
Cheshire & Merseyside	36.3	40.1	37.4	31.4
MWL (combined)	18.2	24.8	31.3	28.6

The CDI improvement plan was developed at the end of 2023/24 and focuses on the key areas of environmental and equipment cleanliness, robust diarrhoea management, antimicrobial stewardship and improved awareness among clinical staff. This improvement plan remains on track and is monitored through the Hospital Infection Prevention Group with Director of Infection Prevention and Control (DIPC) oversight, while providing assurance to Quality Committee.

Themes from learning reviews (previously RCA) remain largely unchanged from previous years. The most common learning is regarding compliance with the SIGHT mnemonic protocol, which relates to timely stool testing, isolation, appropriate PPE use and hand hygiene. Other examples of learning identified in individual cases were timeliness of sampling, isolation, environmental cleaning, estates and antimicrobial prescribing. Approximately a quarter of hospital-associated cases had no lapses in care identified.

A cross-site review of the legacy RCA processes following cases of HCAIs was undertaken and a new MWL process aligned to PSIRF (Patient Safety Incident Response Framework), and an improvement focus was implemented, while maintaining ownership within clinical and divisional teams. The new process is similar to the existing incident review mechanisms within divisions, with support by IPCT, microbiology and pharmacy. This Infection Prevention Learning Review (IPLR) process has been undertaken on all CDI and HOHA bloodstream infections since April 2024, with revised documentation to optimise the IPLR process. This has assisted with thematic reviews across MWL, to identify further areas for improvement regarding healthcare-associated infections.

The Consultant Nurse IPC is a representing the Trust at the Cheshire and Mersey IPC Provider Collaborative (CMAST). The first improvement project was completed in Q3, with the development of a C difficile Toolkit, which includes standardisation of the approach to diarrhoea management and testing, cleaning and Antimicrobial Stewardship (AMS).

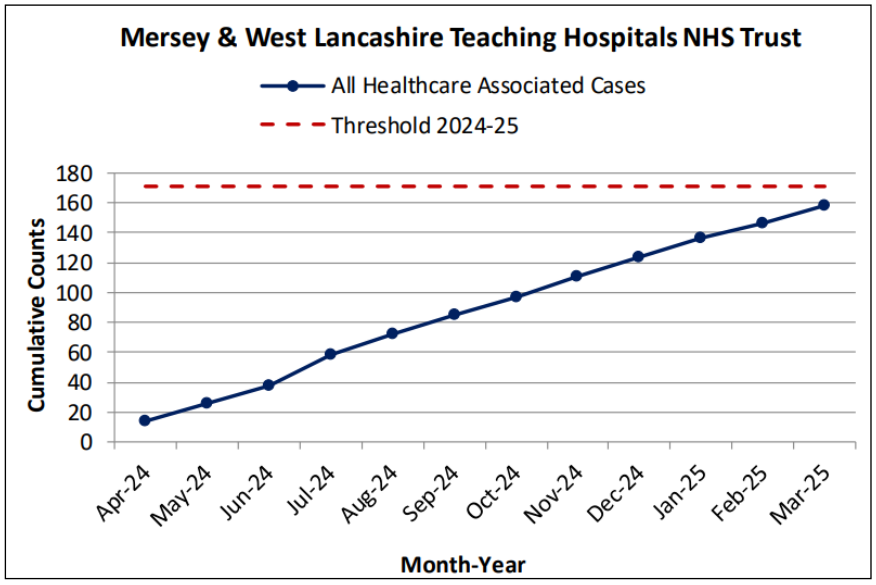
7.4 E. coli bacteraemia

E. coli bloodstream infections represent approximately 55% of all GNBSIs. Many cases continue to be from a urinary source and are in older people 80+ years old. Less common sources include hepatobiliary, respiratory, and skin and soft tissue. It was also noted that patients were more likely to have had recent hospital admission, with comorbidities and frailty.

The NHS Standard Contract for 2024/25 outlined the E. coli threshold for MWL for no more than 171 cases in year. There were 158 cases in year (92 HOHA, 66 COHA) which is 13 cases below the NHSE threshold, and 13 cases below the previous year's outturn.

The approach was outlined in the E coli Improvement Plan. As these are also the patients who may benefit most from the Trust priority of improving hydration, to reduce the incidence of dehydration, UTI, and systemic infection the improvement plan dovetails with the Nutrition and Hydration Strategy. The Lead Nurse IP is a key member of the Fluid balance Focus Group and the Nutrition & Hydration Group. A food and drink strategy has been developed with key stakeholders to support the need for improvement. Findings from the fluid balance audits has resulted in a regular focus on nutrition and hydration on senior nurse walkarounds and other senior nursing fora. The E. coli Improvement Plan was closed in Q3 2024-25 as all actions were completed, although the organisational focus remains on hydration and timely specimen collection.

Figure 12. MWL healthcare-associated *E. coli* April 24-Mar 25



In 2024/25 legacy STHK sites had 104 cases (66 HOHA, 38 COHA). Legacy Southport and Ormskirk sites had 54 hospital-associated cases (26 HOHA, 28 COHA).

During 2024-25 MWL rate of E coli per 100,000 bed days has been below the C&M rate for all four quarters as outlined in Figure 13.

Figure 13. E coli rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 2024	Jul-Sept 2024	Oct-Dec 2024	Jan-Mar 2025
Cheshire & Merseyside	37.7	43.4	35.5	33.8
MWL Trust	34.6	42.4	35.0	30.4

7.3.1 Health Economy Engagement GNBSI/AMR

The Consultant Nurse IPC continues to attend the North Mersey Infection Prevention and Control and Antimicrobial Resistance (IPC and AMR) Group (previously GNBSI Group). The Group was established across the North Mersey health economy to drive forward the ambition to support a reduction in healthcare associated Gram-negative bloodstream infections (GNBSI) and a reduction in antimicrobial resistance to antibiotics.

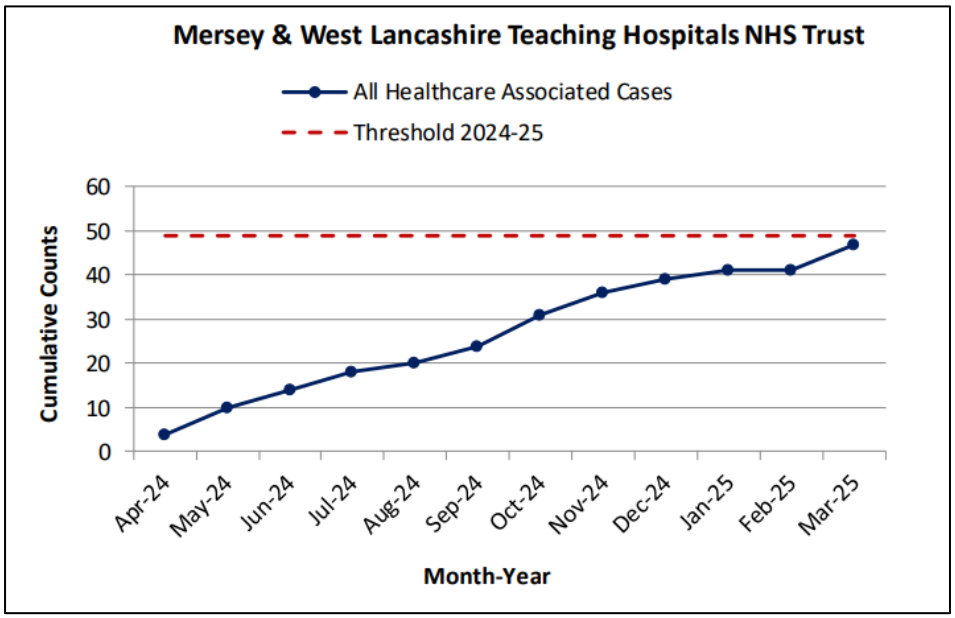
The Trust is also collaborating on an ICB-led North Mersey IPC/AMR action plan, with a focus on reducing E coli BSIs and hydration. The Lead Nurse Infection Prevention at STHK sites continues to attend the Halton and Warrington System-wide Collaborative, Infection Prevention Group, with GNBSI BSI reduction as a priority. The group aims to provide the opportunity for the Health and Local Authority partners across the North Mersey place to enter constructive dialogue with regards to the IPC and AMR improvement plan.

7.4 Klebsiella spp. bacteraemia

Klebsiella species are commonly associated with a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis.

The NHS Standard Contract for 2024/25 outlines the Klebsiella threshold for MWL for no more than 49 cases in year. At year end there were 47 cases, 2 cases below threshold. This compares to 34 cases at the same time last year. The HOHA cases have had an IPLR, and the findings are fed back at the IPLR panel. Themes to date include hepatobiliary, urinary, joint and prosthetic sources of infection.

Figure 14. MWL healthcare-associated *Klebsiella species* April 24-Mar 25



During 2024-25, the MWL rate of Klebsiella per 100,000 bed days been below the C&M rate for all four quarters.

Figure 15. *Klebsiella spp*. rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 2024	Jul-Sept 2024	Oct-Dec 2024	Jan-Mar 2025
Cheshire & Merseyside	17.6	17.9	18.0	13.8
MWL Trust	12.8	9.0	13.4	7.2

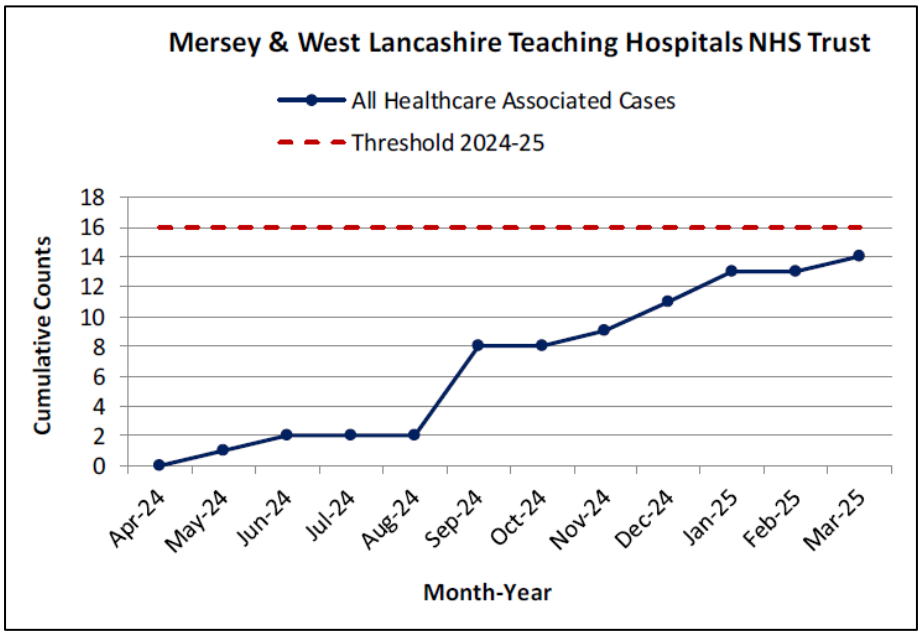
During 2024-25 MWL rate of Klebsiella per 100,000 bed days has been below the C&M rate for all four quarters as outlined in Figure 15.

7.5 Pseudomonas aeruginosa

Pseudomonas is a type of bacteria that is found commonly in the environment, including soil and in water. Of the many different types of Pseudomonades, the one that most often causes infections in humans is called Pseudomonas aeruginosa, which can cause significant infections.

To the end of 2024/25 there were 14 cases across MWL, with 3 cases in Q4. The Trust is below NHSE threshold by 2 cases, which was for no more than 16 cases in 2024/25.

Figure 16. MWL healthcare-associated *Pseudomonas aeruginosa*



The Trust is below the C&M rate for the previous four quarters as outlined in Figure 17.

Figure 17. *Pseudomonas aeruginosa* rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 2024	Jul-Sept 2024	Oct-Dec 2024	Jan-Mar 2025
Cheshire & Merseyside	3.6	7.1	5.2	4.3
MWL Trust	1.8	5.5	2.8	2.7

8. Carbapenemase Producing Enterobacterales (CPE)

Enterobacterales are bacteria that usually live harmlessly in the gut of humans and animals. They include species such as Escherichia coli, Klebsiella spp. and Enterobacter spp. However, these organisms are also some of the most common causes of infections, including urinary tract infections, intra-abdominal and bloodstream infections.

Enterobacterales producing acquired Carbapenemase are referred to as CPE. KPC, OXA-48-like, NDM, VIM, and IMP enzymes are the most prevalent enzymes in the UK. Gut colonisation with CPE (i.e. presence of the bacteria in the bowel) is associated with an increased risk of development of invasive infection, including blood stream infection, with these antibiotic-resistant bacteria. Increasing prevalence of gut colonisation with these bacteria within the patient population will inevitably lead to an increase in difficult-to-treat infections.

Carbapenemase Producing Enterobacterales (CPE) are highly antibiotic-resistant bacteria which can spread rapidly in healthcare settings (including as demonstrated by recent outbreaks within MWL) and lead to poor clinical outcomes because of limited treatment options. The increased incidence of CPE has significant cost and operational implications, as demonstrated by our recent outbreaks.

Rapid detection of patients with CPE infection or colonisation is crucial to control the spread of these organisms and minimise not only the clinical harm to patients but also to reduce the adverse operational impact to the Trust as well as to reduce the risk to the healthcare economy. CPE outbreaks and infection can also lead to adverse publicity as seen recently at another UK NHS Trust and potential reputational damage.

The Trust had zero CPE bacteraemia during 2024-25. However, during May 2024, Whiston site experienced two incidences of increased CPE colonisation identified through the existing screening processes, there were no case of CPE bacteraemia. To address this several actions were implemented as per UKHSA Framework of Actions to contain CPE guidance including screening patients who have had an inpatient admission to this trust over the last 12 months. Ongoing surveillance remains in place.

UKHSA surveillance of CPE bacteraemia data indicates that the Northwest of England is the second highest region after London for reported isolates in 2024-25, with an increasing number of isolates being reported. An NHSE-led Cheshire and Merseyside IPC collaborative are coproducing a CPE Toolkit that will be implemented across providers in 2025-26.

9. Viral Respiratory Infections

Viruses are the most common cause of acute respiratory infections such as Covid-19, influenza, and respiratory syncytial virus (RSV). Although these viral infections can happen at any time of year, they are most common from September to March. Peak activity caused by influenza occurs during the winter months and Influenza A is more common than Influenza B in patients who require hospital admission.

The IPT detected and supported with the respiratory virus cases and outbreaks in 2024/25, in line with the Trust's Outbreak Policy and UKHSA guidance.

9.1 Covid -19

The Covid-19 pandemic caused by the SARS-CoV2 virus, continues to present in waves of infection. In 2024/25 there was a total of 1414 patients with Covid-19, known as either community or hospital onset cases. This included 842 cases diagnosed at St Helens and Knowsley sites and 572 cases at Southport and Ormskirk sites. This is a reduction in cases compared to 2023/24 when there were 1976 cases.

UKHSA definitions of Covid are as follows.

- COVID-CO: Community Onset - First positive specimen date ≤ 2 days after admission to Trust
- COVID-HOIHA: Hospital Onset - Indeterminate Healthcare Associated - First positive specimen date 3-7 days after admission.
- COVID-HOPHA: Hospital Onset - Probable Healthcare Associated - First positive specimen date 8-14 days after admission.
- COVID-HODHA: Hospital Onset - Definite Healthcare Associated - First positive specimen date 15 or more days after admission.

Figure 18 outlines the attribution of cases. Approximately 60% are community associated cases diagnosed within two days of hospital admission. 27% of the total cases were classed as definite or probable healthcare associated, while 11% were deemed indeterminate attribution according to UKHSA definitions.

Figure 18. Covid-19 cases 2024-25

	Hospital onset definitive	**Hospital onset probable**	**Hospital onset indeterminate**	**Community onset**
STHK sites	18.1% (n=152)	9% (n=76)	10.5% (n=88)	62.5% (n=526)
S&O sites	16.4% (n=94)	12.2% (n=70)	12.9% (n=74)	58.4% (n=334)
MWL	17.4% (n=246)	10.3% (n=146)	11.4% (n=162)	60.8% (n=860)

9.2 Influenza

The Trust has continued to see a high incidence of patients presenting with respiratory symptoms during the Winter of 2024/25, and an increase in Influenza compared to the previous winter. During the reporting period 2024/25, there was a total of 1,777 influenza cases reported at MWL.

Approximately 80% of cases were community-associated in patients who presented to hospital with symptoms.

STHK sites reported 893 flu cases

- Influenza A = 499
- Influenza B = 394

Southport & Ormskirk sites reported 884 flu cases

- Influenza A = 670
- Influenza B = 174

9.3 Respiratory Syncytial Virus

RSV is one of the common viruses that cause coughs and colds in winter and had an increased incidence among patients presenting to MWL in 2024/25. Although it usually causes a mild self-limiting respiratory infection in adults and children, it can be severe in infants and

older adults who are at increased risk of acute lower respiratory tract infection. In 2024/25 there was a notable increase in adults presenting to hospital with RSV infection.

At Southport and Ormskirk sites there were 413 cases of RSV detected in 2024/25, 85% of which were community-associated cases. Approximately half of the cases were in children and half in adults.

At STHK sites there were 1019 cases of RSV detected in 2024/25, of which approximately 90% were community-associated cases.

10. Measles

Measles is highly infectious, the most infectious of all diseases transmitted through the respiratory route. Measles can be severe, particularly in immunosuppressed individuals and young infants. It is also more severe in pregnancy, and increases the risk of miscarriage, stillbirth, or preterm delivery. The incubation period is typically around 10 to 12 days from exposure to onset of symptoms but can vary from 7 to 21 days. The period of infectiousness generally starts from 4 days before the rash and lasts up to 4 full days after the onset of rash

The transmission route of measles is mostly airborne by droplet spread or direct contact with nasal or throat secretions of infected persons; much less commonly, measles may be transmitted by articles freshly soiled with nose and throat secretions, or through airborne transmission with no known face-to-face contact

Since 2023, there was a resurgence of measles in England, to prevent and control potential measles outbreaks the Trust established a measles preparedness group, which focused on the patient pathway, patient testing, infection control precautions, staff vaccination and staff face fit testing. Measles guidance was developed and is available for staff on the intranet.

At the Whiston site in 2024/25 the IPT supported the management of 7 positive cases with 1 positive measles case at Ormskirk site.

11. Mpox

Mpox, previously known as monkeypox, is a viral illness caused by the monkeypox virus, a species of the genus Orthopoxvirus. There are two distinct clades of the virus: clade I (with subclades Ia and Ib) and clade II (with subclades IIa and IIb). In 2022–2023 a global outbreak of mpox was caused by the clade IIb strain.

Mpox spreads from person to person mainly through close contact with someone who has mpox, including members of a household. Close contact includes skin-to-skin (such as touching or sex) and mouth-to-mouth or mouth-to-skin contact (such as kissing), and it can also include being face-to-face with someone who has mpox (such as talking or breathing close to one another, which can generate infectious respiratory particles).

People with multiple sexual partners are at higher risk of acquiring mpox. People can also contract mpox from contaminated objects such as clothing or linen, through needle injuries in health care, or in community settings such as tattoo parlours.

During pregnancy or birth, the virus may be passed to the baby. Contracting mpox during pregnancy can be dangerous for the foetus or newborn infant and can lead to loss of the pregnancy, stillbirth, death of the newborn, or complications for the parent

The IPT working with Health Work and Wellbeing and Sexual Health leads, reviewed the Trust systems and processes and to ensure preparedness at MWL.
This included IPC precautions and contract tracing for clade I Mpox in patients who presented to MWL, and ensuring appropriate management of suspected mpox cases within clinical settings, including:

- Isolation of the patient
- Airborne Precautions and FFP3 fit testing
- Liaison with local infection prevention and control (IPC) teams
- Arrangements for discussion of the case with local infectious disease, microbiology or virology consultants
- Thorough cleaning and decontamination of rooms or areas where the suspected case has been

There was one confirmed and 4 suspected cases managed by the IPT in 2024/25. Appropriate contact tracing and screening isolation was undertaken and there was no onward transmission within the Trust.

On the 19 March 2025, The Advisory Committee on Dangerous Pathogens (ACDP) concluded that the evidence gathered by UKHSA for clade I mpox indicated that it no longer met the criteria of a high consequence infectious disease (HCID). Therefore, the Chief Medical Officers (CMOs) of the 4 nations have agreed that mpox will no longer be managed as an HCID within healthcare settings.

12. Tuberculosis

UKHSA's most recent data on tuberculosis (TB) revealed a rise in reported numbers in England by 13% in 2024 (5,480) compared to 2023 (4,850). This signals a rebound to above the pre-COVID-19 numbers, despite significant progress towards a decline in TB over the last few decades. Tuberculosis (TB) is an infection that usually affects the lungs. It can be treated with antibiotics but can be serious if not treated. There's a vaccine that helps protect some people who are at risk from TB.

During the period 2024-25 the IPT in conjunction with HWWB and TB nurses have coordinated the contact tracing for staff and patient contacts, following 5 confirmed and 4 suspected cases. The MWL TB Policy has been revised to support the management of related incidents.

13. Outbreaks

During 2024/25, the IPT supported the outbreak management of incidents predominantly caused by Norovirus, Covid-19 and Influenza (Figure 19). The Southport site was disproportionately affected by Norovirus outbreaks and estates constraints are a contributory factor to transmission of infection.

The IPT work closely with clinical teams, patient flow colleagues and facilities teams to reduce the risk of transmission through robust IPC control measures, while optimising patient flow and bed capacity. Identification of symptomatic patients, prompt isolation or cohorting of patients with the same infection, specimen collection and enhanced cleaning are overseen by the IPT. Enhanced domestic and nursing cleaning, and terminal cleaning at the end of outbreaks was undertaken using additional technologies such as hydrogen peroxide vapour and UV light.

The IPC Team also supported the management of incidents caused by TB, measles, suspected Mpox and Chickenpox and the related contact tracing, in line with the Trust's

Outbreak Policy and UKHSA guidance. Outbreak and incident management was also supported by UKHSA, NHSE and Place colleagues where required, such as a large CPE outbreak on the Whiston site, and with mpox and TB contact tracing.

Figure 19. Outbreaks by legacy Trust 2024/25

Organism	Outbreaks STHK sites	Patients affected	Outbreaks S&O sites	Patients
Covid-19	48	225	16	230
Flu A	14	62	9	173
Norovirus	13	124	25	401
CPE	2	30	-	-
C. difficile	1	2	1	4
Total	**77**	**443**	**51**	**808**

Outbreak meetings were held, with multidisciplinary team and Communications Team support. Business Intelligence supported contact tracing exercises for incidents caused by measles, mpox, chickenpox and TB. Visiting was restricted across the site, alongside a comms campaign on various media channels.

UKHSA confirmed that there is an increased incidence of TB nationally. The MWL TB and chickenpox policies, measles and mpox guidance have been revised to support the management of related incidents going forward.

14. Surgical Site Surveillance (SSI)

A surgical site infection (SSI) is an infection that occurs at the site of a surgical incision. It happens when microorganisms, usually bacteria, enter the body through the surgical wound and multiply, potentially leading to various complications. These infections can range from superficial skin infections to deep tissue or organ infections. SSIs are infections that develop within 30 days of surgery (or within a year if an implant is involved). Approximately 1-3% of surgical patients in the UK develop SSIs

Trusts are mandated by UKHSA that they are required to participate in orthopaedic surgical site surveillance. The Trust participates in this programme and submits data nationally and undertakes local surgical site infection surveillance for orthopaedic surgery.

The requirement is for each Trust to conduct surveillance for at least one orthopaedic category for one period in the financial year. The categories are:

- Hip replacements
- Knee replacements
- Repair of neck of femur
- Reduction of long bone fracture

The Trust participates in the mandatory UKHSA surveillance of elective orthopaedic surgery and submits data for hip and knee replacements for each quarter of the year.

During 2024-25, the Trust performed a total of 1,293 hip and knee procedures.

Figure 20. S&O: Total Knee Replacement (TKR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2024	31	1	3.2%
July- September 2024	42	0	0%
October – December 2024	40	0	0%
January – March 2025	47	0	0%
Total	160	1	0.62%

The annual SSI rate for year was knee surgery at S&O was 0.62% which is also below the national average of 1. It should be noted complex knee replacements are performed at the Whiston site.

Figure 21 -S&O: Total Hip Replacements (THR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2024	50	0	0%
July- September 2024	40	1	2.5%
October – December 2024	39	0	0%
January – March 2025	63	0	0%
Total	192	1	0.52%

Figure 22 STHK: Total Knee Replacement (TKR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2024	112	0	0%
July- September 2024	116	2	1.72%
October – December 2024	148	1	0.67%
January – March 2025	157	0	0%
Total	533	3	0.56%

The annual SSI rate for year was knee surgery at STHK was 0.56% which is below the national average of 1.

Figure 23 STHK Total Hip Replacements (THR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2024	74	2	2.7 %
July- September 2024	94	0	0%
October – December 2024	114	2	1.58%
January – March 2025	126	0	0%
Total	408	4	0.98%

The annual SSI rate for THR surgery at STHK was 0.56% which is also below the national average of 1.

In Q1 and Q3, Whiston site was identified as an outlier for Hip SSI with 2 out of 74 (2.7%) and 2 cases (1.58%) in Q3 patients developing infection. The Trust has responded to UKHSA with the findings of the reviews and the following actions were taken:

- RCA panels completed for all cases to check for themes.
- No themes were apparent during reviews – different consultants involved; no theatre issues noted.
- Dressing clinic continues to review all post operative wounds in designated room and designated staff.
- No changes in antibiotic usage.
- No other underlying ward infection issues.
- Complex patients being undertaken at Whiston site.
- Change of ward area on Whiston site with 4F being live from August 24 which house their own dressing clinics for joint patients. Aiming to reduce infections.
- One Together meeting held.

15. Audit

Audit is a key component of IPC to provide assurance that clean safe care is delivered at MWL. There is an extensive standardised IPC audit plan across all sites in the organisation. All audit tools and schedules have been reviewed and updated for the year both for inpatient and outpatient areas. Results are presented for monthly Hand Hygiene, Practice and Environment, and Nursing Care Indicator (cannula and catheter care and Bristol Stool Chart monitoring) audits.

Audit results remain below an expected standard, for basic IPC practices such as hand hygiene, bare below the elbow, appropriate PPE use and cleaning of patient equipment. Issues with clutter on wards linen trollies not being stripped down at the end of patient care and the need for more storage for patient equipment was noted.

At the Southport and Ormskirk sites, specific issues relate to outstanding estates issues, including taps with limescale, high level dust, damage to floors and walls.

16. Education & Training

All staff, including those employed by support services, must receive training in prevention and control of infection. Infection Prevention is included in induction programmes for new staff,

including support services. There is also a programme of on-going education for existing staff, including update of policies, feedback of audit results, with examples of good practice and action required to correct deficiencies, and Root Cause Analysis (RCA) reviews and lessons learned from the process and findings. Records are kept of attendance of all staff who attend Infection Prevention training/teaching programmes.

Infection Prevention Mandatory Training is delivered by e-learning. Level 1 training must be undertaken by all staff and level 2 must be completed by clinical staff.

Other Training Sessions/Courses included:

- Trust Induction
- Junior Doctors Induction
- Rotational Doctors Induction
- Infection Prevention Mandatory Update
- The IPT provide training sessions on the Band 5 and HCA rolling education programme.
- The IPT provide training for Student, Cadet and Bank Nurses
- The Team also provides additional ad hoc education sessions held in seminar rooms in the clinical areas. These sessions address current HCAI problems identified within the Trust. Topics have included MRSA, CDI and CPE

Link personnel meetings were held 2-3 monthly. Numerous topics were covered, including hand hygiene, CDI, MRSA, CPE, SARS- Cov2 etc. In addition, the link personnel have been encouraged to continue to undertake their own ward audits. Infection prevention audit Indicators are now embedded into the Tendable audit platform.

Since January 2025 there has been a roll out of infection prevention training aimed at the different nursing roles. Band 6 nurses training was completed in March 2025, Band 5 and HCA sessions are ongoing. These sessions have covered basic infection prevention principles, outbreak management, roles and responsibilities and cleaning. Sessions have been delivered on both Southport and Ormskirk sites with the aim of capturing as many staff as possible.

On the ward training has been delivered on various topics including diarrhoea management, MRSA, outbreak management to wards across the Southport and Ormskirk sites. Area specific training has been delivered on critical care as part of their monthly meetings. IPC link staff training also continues to be delivered on a bimonthly interval with 2 hours per session. Sessions have included hand hygiene and hand hygiene audits, pathology department, environmental cleanliness, MRSA and VRE.

The IPT have also been shadowed by Band 7 staff from ED which has enabled the team to offer guidance and support on the management of patients with loose stools, respiratory symptoms, and management of patients with MRSA.

The IPT have attended national meetings remotely, e.g. Infection Prevention Society (IPS), various meetings/study days throughout the year, including meetings of Northwest Infection Control Group (NORWIC).

Infection prevention mandatory training e-learning is available on Moodle (STHK sites) or ESR (S&O sites). Infection Prevention and Control – Level 1 is for non-clinical staff (to be completed every 3 years). Infection Prevention and Control – Level 2 is for clinical staff (to be completed annually).

Level 1 e-learning compliance was 94.1% at the end of the year 2024-25. Level 2 e-learning compliance for clinical staff remained at 81.2% with compliance below the Trust target of

minimum 85% compliance. This is an area of focus for divisional teams with regular assurance to HIPG.

Figure 24. IPC Mandatory Training Compliance

MWL	**Compliance**
IP level 1 (non-clinical)	94.1%
IP level 2 (clinical)	81.2%
STHK	
IP level 1 (non-clinical)	94.1%
IP level 2 (clinical)	79.2%
S&O	
IP level 1 (non-clinical)	94.2%
IP level 2 (clinical)	85%

17. Infection Prevention Policies

An MWL policy harmonisation plan was developed in 2024-25, with a delivery plan to align more than thirty IPC policies across the new Trust. Six polices remain under development, including two awaiting approvals at Patient Safety Council.

18. Estates & Facilities

At the heart of the new team's objectives is ensuring safe, effective and efficient patient care. An integral part of the team's work is close liaison with the Infection prevention team teams across the organisation.

Each member of the Estates and Facilities team including service partners receive relevant and appropriate infection prevention and control training. This ranges from mandatory training, work specific training e.g. procedures for conducting deep cleans auditing or testing water outlets to elements of infection control embedded within specialist training for Authorised Persons or engineers who work on the Trusts infrastructure such as ventilation.

Compliance with training targets is monitored internal by the senior leadership team at the senior leadership operational meeting and assurance reported through the Estates and Facilities Governance Council in addition to the Trusts HR governance meetings and Infection Prevention Committee.

The Estates and Facilities Senior Leadership team objectives have strong links to the IPC agenda, developing partnership working with the IPC team across the new organisation. To strengthen this partnership working approach the Estates and Facilities Matron who reports into the Deputy Director of Estates and Facilities from an operational perspective also reports into the Head of IPC for clinical professional development. Forging closer working relationships across the teams.

18.1 Estates and Facilities Matron

The E&F Matron works collaboratively with IPC colleagues to provide assurance around compliance with regulatory and internal standards, advocating for high standards of quality care for both patients and staff. This includes working closely with IPC colleagues to raise the cleanliness standards in conjunction with the National Standards of Cleanliness. Working

together to introduce a clinical cleaning schedule and ensure the relevant training is provided to clinical colleagues. Key workstreams during the reporting period have been: -

Key National & Local Drivers - The E&F Matron and is working with the Dementia & Delirium, Capital Projects team and IPC to develop and standardise an MWL ward-based dementia friendly template in conjunction with National and Local drivers and policies to enhance the patient experience whilst ensuring the Trust meets quality audits including CQC / PLACE and the Kings Fund.

Medical Device Service Provision - The Medical Equipment Library (MEL) team continue to swab bed frames, patient trolleys and foam mattress that are in bed stores daily, Monday - Friday, using adenosine triphosphate- a molecule (ATP) monitoring. (Readings > 50 are classed as a failure). These results are reported to the IPC group. As a result of the high level of contamination on bed frames / mattresses a task and finish group has been established with IPC and clinical colleagues. The clinical element of bed / mattress cleaning is outlined in the 50 Elements of the National Standards of Cleanliness and embedded in the clinical cleaning schedules which are held at ward level.

Bed Frame / Foam Mattress decontamination - Working towards a best practice MEL decontamination unit as part of NSOC and IPC recommendations and best practice. A working group has been arranged with, The Heads of Nursing, IPC, Matrons to discuss a robust process for the clinical cleaning responsibilities of bed frames & foam mattress.

Ward level Deep Clean & Maintenance Programme - Meetings have been attended with senior nursing and divisional colleagues, to establish access for a ward deep clean and maintenance works to be carried out. Conversations around access, flooring, painting replacement programmes have taken place subject to approval.

Introduction of an E&F annual radiator & vent cleaning schedule for the Southport and Ormskirk Hospital sites.

Environmental Audits - The E&F Matron is introducing a digital daily environmental check list to address any immediate concerns with regards to the estates and cleanliness of the hospital corridors. Any actions (e.g. lift out of action) are fed back via the daily E&F morning huddles and completion data to be monitored via the E&F Operational Meetings. In addition to this the E&F Matron is implementing a digital E&F 15 Step Challenge Quality assessing the environment from a patient's perspective using the NHSE toolkit. The E&F team & Matron continue to support IPC colleagues with the Environmental audits. Action planning and escalating where required.

18.2 Hospital Ventilation

The MWL Ventilation safety group meets monthly covering all acute and community sites across the Trust. This group receives regular reports from key stakeholders that identifies any actions taken and results for any ventilation works or testing during the period. This provides assurance that the Trust is compliant with relevant legislation. The Trust has an appointed Authorising Engineer (ventilation) to support the Ventilation Safety group.

All plant is maintained under a Planned Preventative Maintenance (PPM) schedule and is completed in adherence to the guidance set down within the Health Technical Memoranda (HTMs).

All tasks are monitored via the ventilation group which meets on a quarterly basis. Any non-compliances or faults are tracked on an action plan and are rectified within a timely manner. The users are notified should these non-compliances or faults pose a risk to staff or patient

safety. All specialist ventilation systems are subject to an annual validation programme, all systems are reported as compliant with the performance required by the HTM.

Key workstreams during the period have been: -

Agreed operating theatre ventilation re-verification has been undertaken and is monitored with contracts in place to carry out planned preventative maintenance on all air conditioning systems. The Trust's in house team and Vinci FM maintain all ventilation systems including

On the Whiston and St Helens Hospital sites Vinci on the Trusts behalf have completed a full gap analysis between the provision of systems currently within the hospital and the requirements of the revised HTM03-01. Work is underway to assess what if anything requires further alignment or derogation.

The group also discuss any construction projects that are ongoing withing the Trust taking a collaborative approach with IPC colleagues, authorising engineers and persons agreeing works needed or derogations that require logging within the organisation. Any items of concern raised by the groups are reported and discussed at the Estates and Facilities Governance Council with appropriate actions noted for assurance.

18.3 Water Safety

The Water Safety Group reports to HIPG and meets in line with its terms of reference. The Trust has an appointed Authorising Engineer (water) to support the Water Safety group. The water safety group receives regular reports from key stakeholders that identifies any actions taken and results for any water safety works. This provides assurance that the Trust is compliant with relevant legislation.

The flushing of underused outlets within all areas of the Southport and Ormskirk sites which is undertaken by Domestic and Estates teams and Operating theatre staff for their area and is monitored by the Estates and Facilities compliance Team on a weekly basis, with any issues escalated to the Water Safety Group members for immediate action. At the Whiston and St Helens Hospital sites the flushing of underused outlets is monitored by Vinci FM weekly and audited by the E&F team monthly, and any failures are raised with the ward or department.

The group also discuss any construction projects that are ongoing withing the Trust taking a collaborative approach with IPC colleagues, authorising engineers and persons agreeing works needed. Any items of concern raised by the groups are reported and discussed at the Estates and Facilities Governance Council with appropriate actions noted for assurance.

18.4 Cleaning Services

Cleaning is a top priority for the Trust and the team goal is to provide the cleanest and safest environment possible for patient's staff and visitors. Cleaning services are provided at the St Helens and Whiston Hospital sites as part of the PFI (Private Finance Initiative) partnership arrangement with New Hospitals through their service provider Medirest. On the Southport and Ormskirk Hospital site the in-house Domestic Services team provide the service with community properties providing this service through various landlords.

The teams across MWL have spent time reviewing cleaning standards and training staff in working methods and techniques keeping up to date in line with the clinical service requirements. The team continues to be involved with infection control meetings and audits to ensure the cleaning team is working in harmony with clinical staff to improve infection prevention and control. Trials of new equipment ranging from cleaning robots and new ultraviolet and hydrogen peroxide machines have been undertaken with significant investment

in preferred products. The introduction of new cleaning material and products continues to be standardised across the Trust.

The National Standards of Cleanliness (NSOC) 2021 have been mainly implemented across MWL with a current business case being under review to implement additional resources where and if required based on internal recommendations to the functional risk ratings. This standardised framework for detailing the required cleaning service in all healthcare premises and how the technical and the efficacy audits of the cleaning process should be conducted.

The standards reflect changes in methods of cleaning, infection prevention and control and the move to a risk-based assessment of cleaning and governance frameworks to be followed. They also include learning for cleaning services from the Coronavirus pandemic. The standards cover all cleaning, including clinical and specialist equipment and not only environmental cleaning.

Together with the Health and Social Care Act 2008 and associated regulations, these provide an assurance framework to support compliance with the core cleanliness standard and code of practice. Each ward or department have previously risk assessed in line with the NSOC guidance and allocated a Functional Risk rating which determines the % target score which should be achieved: -

Figure 25. NSOC risk ratings

2021 Risk rating and target
FR1 = 98%
FR2 = 95%
FR3 = 90%
FR4 = 85%
FR5 = 80%
FR6 = 75%

Over the past 12 months, the Estates and Facilities team has carried out NSOC audits—performance results are detailed in the dashboards below.

The graphs below show the average results of the NSOC audits undertaken by the Estates and Facilities team over the last 12 months.

Figure 26. STHK NSOC Scores per Functional Area

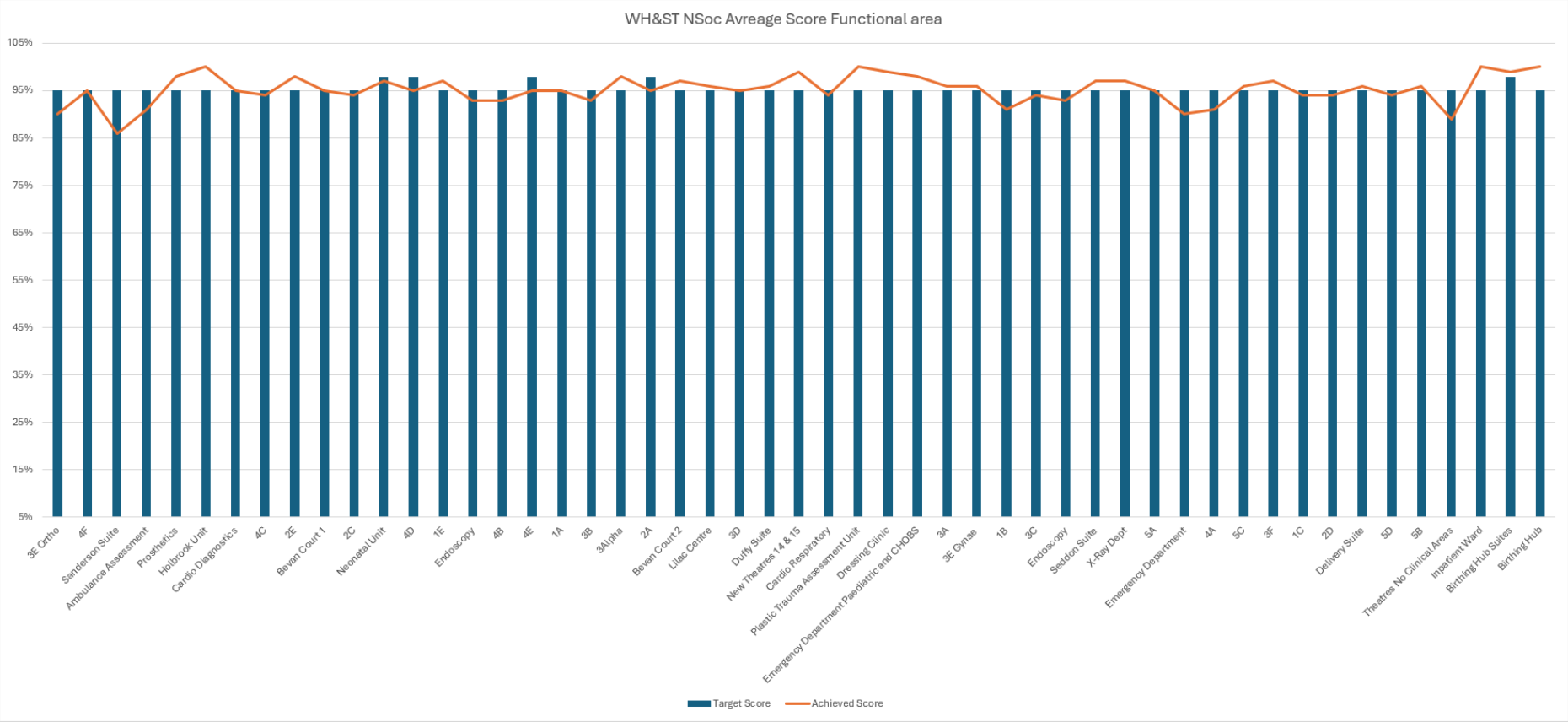
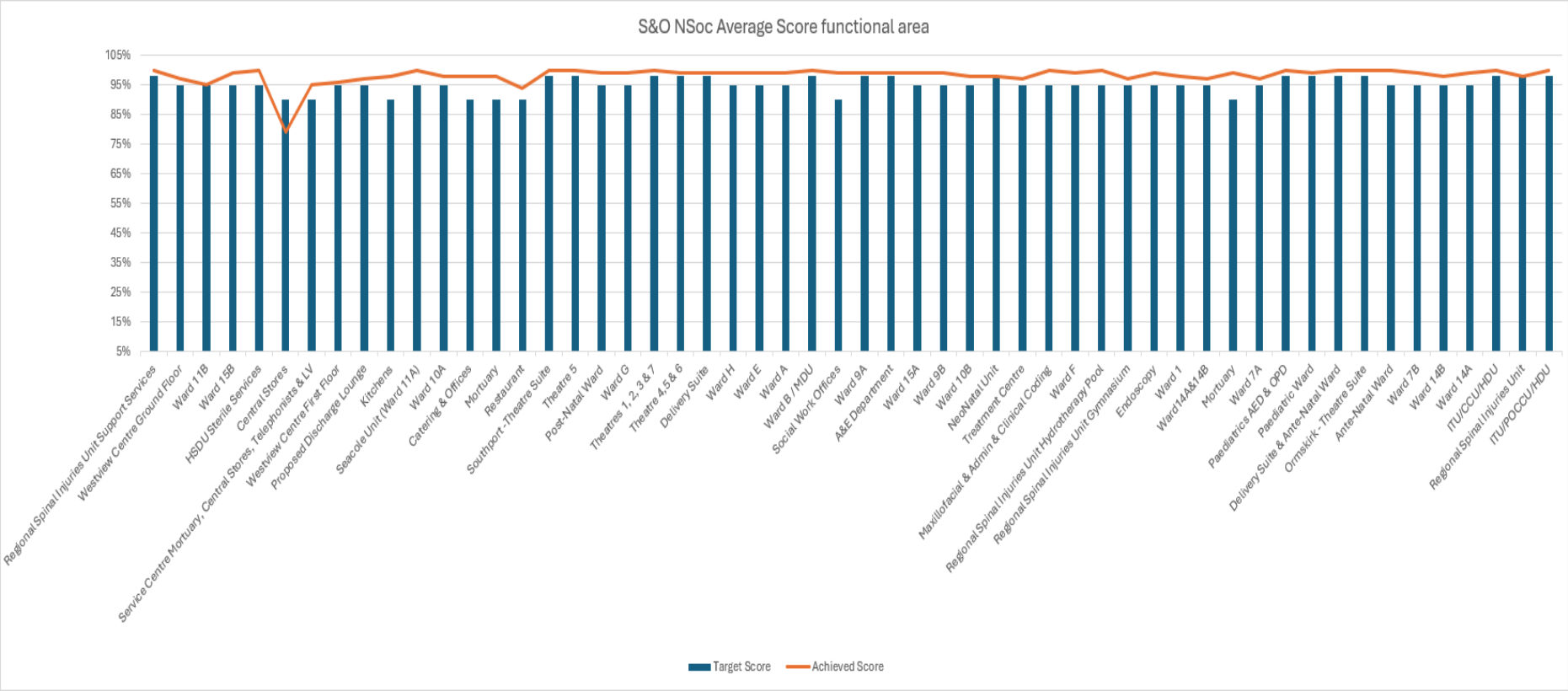


Figure 27. Southport and Ormskirk NSOC Scores per Functional Area



18.5 Waste Management

The Waste Group meets bimonthly and receives regular reports from key stakeholders that identify any actions taken and results for any waste stream. This provides assurance that the Trust is compliant with relevant legislation. The group look at the options available to reduce our carbon footprint whist still maintain the correct waste streams. The Waste Group reports to HIPG bimonthly.

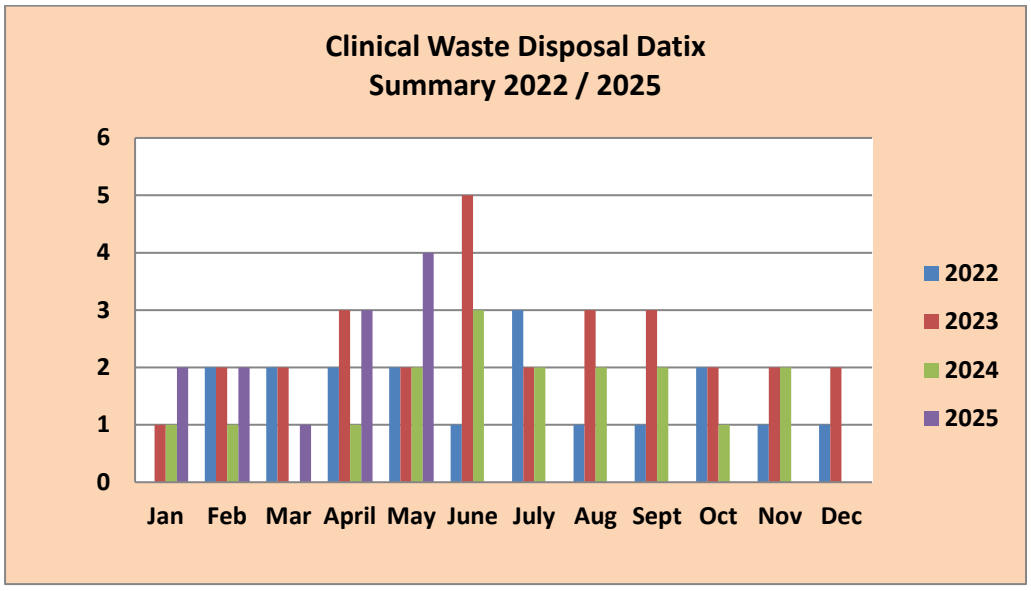
Healthcare waste pre acceptance audits were completed in August 2024 and are next planned for August 2025. Duty of care visits were completed at Suez (recycling and recovery of general waste) and Tradebe (clinical waste) and Sharpsmart (sharps waste). Improvements were noted within full process with the disposal and cleaning of the clinical waste bins. This remains a concern that is being addressed from the waste contractor SRCL. The internal clinical waste service on all sites has been running at a normal level in the last twelve months from the service providers. Communications have continued with all parties directly and at quarterly meetings. internal contingency plans have stayed in place to ensure that the hospital's clinical waste is moving freely

Staff Training - In House clinical waste disposal sessions are available through PowerPoint presentation for all staff. Training sessions explain the correct waste segregation and safe disposal of all types of waste.

The volume of waste disposed of is monitored monthly through the estates and facilities integrated performance report and any items for escalation are reported through to the estates and facilities governance council. The Trusts waste production and costs are monitored nationally through the organisations national estates returns.

A total of seventeen during 2024-25 waste breaches were reported at Whiston & St Helens Hospitals. Most breaches raised are due to staff mixing infectious waste (orange) with non-hazardous waste (tiger) bags (15) and 2 related to sharps bins not correctly closed. All Matrons and Ward Managers have been informed of the breaches and actions have been put in place to address this.

Figure 28. Waste incidents 2022-2025



19. Antimicrobial Stewardship

The overarching aim of antimicrobial stewardship (AMS) is to optimise safe, appropriate and economic use of antimicrobial agents to improve patient outcomes from infection whilst minimising negative consequences such as healthcare-associated infections and the development of antimicrobial resistance (AMR). The AMS programme allows us to control and maintain antimicrobial use and respond to the rising global resistance threat of AMR.

The AMS Pharmacy Team has continued to provide weekly stewardship ward rounds across multiple specialties at Whiston Hospital predominantly but not limited to all surgical wards, including a new antimicrobial ward round on 3A to review plastic surgery patients. Weekly stewardship ward rounds have also been continued to cover all other wards on a rotational basis according to identified areas of poor antimicrobial prescribing, as well as weekly *C.difficile* and OPAT ward rounds. Furthermore, Southport Hospital conducts weekly *C.difficile*, OPAT and Orthopaedic ward rounds. The Microbiology team conducts daily ITU ward rounds, and this is supported by the AMS pharmacist approximately three times a week.

Key Achievements:

- Continued to develop the STHK OPAT service since its formal launch in March 2023 including participation in the Cheshire & Mersey regional elastomeric group project hosted by Cheshire & Mersey ICB to facilitate the use of innovative antimicrobial drug delivery systems.
- Successful development and utilisation of EMIS within STHK OPAT team to allow for review and management of patients in a virtual ward setting.
- Developed an SOP for the refrigeration of elastomeric devices and completed validation for the ability of cool storage packaging to maintain the required temperature for transportation of elastomeric devices to patient's homes.
- Launch of Eolas as the new platform for the trusts antimicrobial policies requiring a labour-intensive switch from microguide. This has been launched across the whole of MWL with the scope to merge legacy antimicrobial policies
- Developed and launched an IV to PO decision support tool which has been integrated into the trust's antimicrobial guidelines on Eolas to aid prescribers in stepping down patients to oral antibiotics in a timely manner. The tool has audited on AMU and shown a 13% reduction in patients receiving IV antibiotics past the point at which they meet the oral switch criteria. The plan is for this to be used across the whole of MWL rather than just legacy STHK sites.
- Comprehensive review, update and merge of the trusts paediatric antimicrobial policy across MWL sites in conjunction with the UK Paediatric Antimicrobial Stewardship network guidelines, pending approval from Clinical Effectiveness Committee.
- Gentamicin guidelines for use in endocarditis have been updated to follow European Society of Cardiology (ESC) guidance. This will aim to support clinical staff due to the likelihood of reduced monitoring and dosing requirements.
- Development of a penicillin delabelling project aimed to reduce the number of inappropriate allergy labels. Approximately 1/3 of inpatients in Whiston hospital have a penicillin allergy documented as 'unknown' potentially putting them at risk of poorer outcomes, increased incidence of antimicrobial resistance and restricting their use of more effective treatment options.
- Development of SharePoint platform for collecting and analysing data for annual point prevalence audits at legacy STHK sites.
- Updated the SOP for reviewing ICM positive patients for inpatient and outpatient prescriptions as well as coordinating the switch to octenisan and mupirocin including amending ward stock and incorporating a new prescribing protocol within EPMA. For

legacy S&O sites, the generic labels have been updated so that they can be used for prescribing within the drug chart.
- Maintained one of the lowest levels of total consumption of ‘’watch’’ and ‘’reserve’’ antibiotics categories within the region.

Key challenges/issues:

- OPAT service growing since its launch in late 2023 with patient lists growing and permanent funding still to be attained. S&O sites also have an unfunded service with a Locum Microbiologist and 0.5 WTE AMS Pharmacist overseeing the clinic.
- Increasing use of broad-spectrum antimicrobials for multi drug resistant infections coupled with increasing winter pressures and the demand for more community-based services.
- To continue to reduce suboptimal prescribing and therapeutic drug monitoring and missed doses of antimicrobials through guideline expansion and innovation with the increased use of EPMA, networking and informatics initiatives. One example being the switch of gentamicin to 3mg/kg once daily dosing in endocarditis with reduced need for post dose levels and ongoing challenges associated with incorporation of gentamicin onto EPMA.
- Expanding the Whiston Pharmacy aseptic dispensing unit capacity to produce ready-made antimicrobials if capacity allows.
- AMT ward round audit data is recorded in an Access database which is currently unsupported
- Currently two audits being conducted at S&O sites regarding penicillin delabelling and the process for the review and treatment of *C.difficile* patients.

Actions taken to overcome challenges and issues:

- AMT continue to do targeted weekly antimicrobial stewardship ward rounds to tackle inappropriate antibiotic prescribing at ward level.
- Antimicrobial point prevalence audits to increase to every 6 months to look at areas of good practice and areas that require improvement regarding AMS – data has recently been collected and is being analysed.
- Development of EPMA data extraction reports to facilitate AMS initiatives.

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Forward plan 2025/2026:

- To review and publish updated versions of neonatal and adult antibiotic policies, these are both up for renewal in August 2025.
- To work with antimicrobial colleagues at S&O to continue the merge of antibiotic policies across MWL and develop a Trust AMR strategy and audit program.
- Continue to track developments of the gentamicin calculator and level interpreter both regionally and nationally.
- To roll out and promote the penicillin delabelling project trust wide following completion of the pilot study.
- To continue to work with the EPMA team and the clinical informatics pharmacist to incorporate AMMS strategies within EPMA and to continue to develop innovative automated crystal and CRD reporting. Work towards development of an antimicrobial dashboard.
- Engage with the Northwest Antibiotic Pharmacist Group and national AMS network to keep updated with AMS initiatives across the region that may be incorporated within MWL

- Continue to provide education to other healthcare professionals including junior doctors, pharmacists and nurses including incorporation into FY1 training sessions to target key issues identified with therapeutic drug monitoring of antimicrobials.
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20. Decontamination

The Trust Decontamination Policy sets out and defines the Trusts required expectations for ongoing regulatory compliance and approach to risk. Assurance reports are received by HIPG by the Decontamination Lead and from the Leads where decontamination is performed.

20.1 Endoscopy Decontamination Services

Both Whiston, Southport and St Helens Hospitals have centralised endoscope decontamination units. Each department provides decontamination services to Theatres, Endoscopy, Urology and ENT, plus an out of hours service is provided at Whiston. Normal operating hours are 8am to 9pm weekdays and 8am to 5pm weekends.

From April 2024 to March 2025 36,705 endoscopes were processed across both sites which is a 7% increase from the previous year. All equipment is maintained, tested and validated in accordance with the relevant HTM's. This is audited by the independent Authorising Engineer for Decontamination AE(D). Both departments are ISO 13685:2016 & MDR production Quality Certification Assurance registered and are audited annually by an external notified body.

Governance and assurance are reported to the Trust Decontamination Steering Group quarterly meetings. The Group will assess decontamination requirements and consider what aspects of best practice will be prioritised and should be implemented, based on improving patient outcomes, decontamination benefits, efficiencies, and risks.

Issues and any relative incidents associated with Instruments or Invasive Medical Devices are also raised at site quality and safety meetings or departmental governance meetings, which the Decontamination Teams are stakeholders or can be raised via the Trusts DATIX (now InPhase) system and where appropriate additionally discussed via the Water Safety and Ventilation Groups to Estates and Facilities when the subject matter is relating to environmental or plant equipment.

The Trust Decontamination Policy has been reviewed and updated to ensure that it meets and interprets appropriately the guidance of Health Technical Memorandum (HTM) 01-01(2016).

Flexible endoscopes are complex reusable instruments that require unique consideration with respect to decontamination. In addition to the external surface of endoscopes, their internal channels for air, water, aspiration and accessories are exposed to body fluids and other contaminants. In contrast to rigid endoscopes and most reusable accessories, flexible endoscopes are deemed as ‘heat labile and therefore, specialist chemical or cold decontamination processes must be undertaken as these devices cannot be autoclaved by steam at high temperatures in the same way as surgical instruments and other invasive medical devices are reprocessed.

In addition to the cold sterilisation, the Trust has Ultraviolet radiation to decontaminate Nas endoscopes & Transoesophageal echocardiography probes.

Decontamination of Flexible Endoscopes is undertaken is specialist environmentally controlled areas within the Endoscopy units and are subject to an annual Authorised Engineer Decontamination (AED) JAG audit.

Whiston Endoscope Decontamination Unit washer disinfectors and endoscope drying cabinets are now 15 years old and although still compliant to all relevant standards and

Health Technical Memorandum 01-06 the equipment is not efficient due to an increase in repairs and will need to undergo replacement in the near future. The risk of potential failure of the system is documented on the Trust Risk register.

To support the replacement of the endoscope decontamination equipment plans are ongoing to site a new endoscope decontamination unit on the ground floor of a new 4-storey building located on Whiston site which will see the Endoscopy Unit occupying the second floor enabling them to expand their treatment room capacity.

The Annual external IHEEM audit saw Whiston Decontamination Unit achieve an amber/green status. St Helens Decontamination Unit achieved a green status.

Testing, validation and service of the decontamination equipment is carried out on a weekly, quarterly and annual basis. Water testing of the washers and RO units is carried out weekly.

20.2 Instrument Tracking and Traceability

Health edge electronic track and trace system is utilised to ensure all stages of the endoscopes use and decontamination journey are recorded. This system is already being widely used across several neighbouring Trusts, providing the ability for each Trust to have instruments reprocessed at any facility as part of improved system resilience. This minimises any risk of patient cancellation or delays.

IHEEM/JAG External Audit - departments are audited annually, and recent audits saw Whiston Decontamination Unit achieve an amber/green status. St Helens Decontamination Unit achieved a green status

21. Health Work and Well Being

21.1 Vaccine Campaign

A co-administered vaccine model was offered with key staff targeted by roving flu clinics, available on all shift patterns including weekends, evening, and early mornings. However, the trust only achieved 37% which is consistent with comparator and national results.

Feedback from frontline staff indicated a reluctance to have a co administered vaccine. Some staff who have previously had flu vaccine declined for this year's campaign. Nationally it was recognised that it was extremely difficult campaign due to vaccine Fatigue. The system was time consuming to use and caused the time taken to administer to be longer.

Actions taken to overcome challenges and issues included engagement with clinical leads on best way to support the vaccine delivery model to ensure that front line HCW weekly data and targeted action plan were communicated to exec board for assurance. This approach will continue in 2025/26 campaign.

21.2 Sharps Safety

The main risk from a sharps injury is the potential exposure to infections such as bloodborne viruses (BBVs). This can occur where the injury involves a sharp that is contaminated with blood or a bodily fluid from a patient The Trust has an embedded process in place for risk assessment and management of staff who have had a needlestick injury

The trust reported 161 needlestick injuries and 26 blood/bodily fluid exposure incidents during 2024-25. investigations are completed for each incident and appropriate risk assessment undertaken as per Trust policy.

The Exposure to Body Fluids and Sharps Injury policy was harmonised in March 2024.

A policy rollout and NSI awareness campaign has been completed across all MWL sites, supported by completion of annual audit

Key Achievements:

- Needlestick (NSI) awareness campaign/ reforming of NSI group.
- The NSI policy was updated, resulting in NSI awareness campaign across the trust. covering key clinical sites, the outcome of this awareness and feedback has been positive. HWWB have taken the NSI awareness campaign into key clinical areas which had previously high NSI reporting stats.
- Supported the organisation with IGAS and MRSA outbreaks, supporting when staff swabbing, and assessment is required.
- HWWB present on the induction for doctors and preceptorship programme for newly qualified nurses and international nurses re NSI awareness
- NSI data: Working with in phase on the NSI reporting form and incident review to ensure data quality is correct and in line with HWWB reportable data.

21.3 Measles

Following on from the previous outbreaks HWWB continue to screen at-risk employees at pre-employment, and managers are advised accordingly if there is a risk so control measures can be implemented in a timely manner.

HWWB have screened staff in high-risk areas (as agreed by UKHSA) to ensure immunity to measles and minimise the risk of spread of measles. This was a targeted approach in Q2/3 2024/25 in response to the increased incidence of measles in the region. An in-depth audit of staff measles immunity status was completed to provide assurance of staff immunity. MDT approach with IPCT, Microbiology and clinical areas were required to ensure managers are aware of staff status updates and supported with advice and guidance

Roving venepuncture and vaccine clinics (inc evenings and weekends) were offered at key sites to support uptake and increase staff immunity. HWWB worked closely with managers to identify at risk staff and offer guidance to support them remaining in the workplace.

HWWB STHK have supported the swabbing of staff who were identified in any measles incidents and were able to support this swabbing by doing place-based swabbing across the different shift patterns and in person appointments in HWWB. HWWB have worked closely with key stakeholders to support all staff involved in outbreaks.

All staff who have social and direct contact with patients are required to provide evidence of 2x MMR vaccine or positive measles and rubella antibodies via blood test to gain HWWB clearance (as per DoH green book recommendations).

Those who are found to be not immune will be asked to attend for course of 2 MMR vaccines 4 weeks apart.

Staff, where the vaccine is contra-indicated, or staff who refuse the vaccine (as its not mandatory) the manager is advised to complete a risk assessment and use control measure to protect staff and patient.

Any staff who do not attend (DNA) x 2 for any vaccine this is now escalated to the People Performance Council and will be escalated to the care division leads. Staff who DNA for either bloods or vaccines managers should be advised to complete a risk assessment as their immunity status will be unknown.

21.4 Tuberculosis

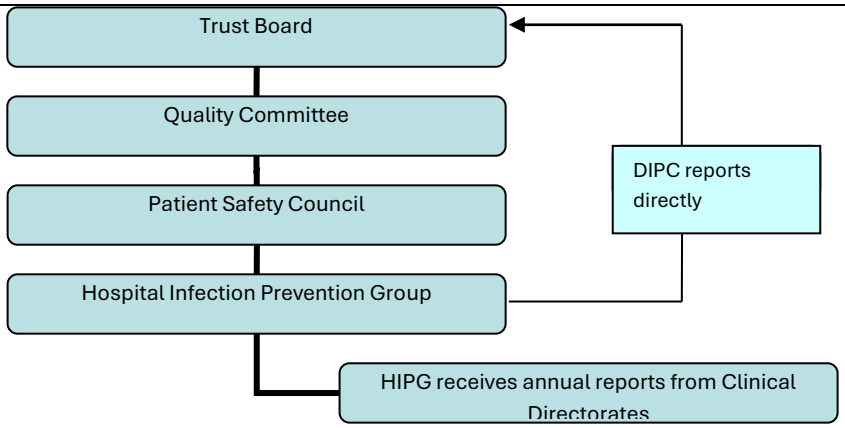
HWWB have worked closely with key stakeholders and worked as part of wider MDT to support staff who had been identified as contacts following community-associated TB cases. Over 200 staff have been contacted and screen by HWWB during this period.

ENDS

Appendix 1 TOR HIPG

Terms of Reference	NAME: HOSPITAL INFECTION PREVENTION GROUP (HIPG) FINANCIAL YEAR: 2025-26
Authority	To ensure that Mersey and West Lancashire NHS Teaching Hospitals Trust has effective systems in place to prevent and control healthcare-associated infections and to provide assurance to the Trust Board. To maintain an overview of infection prevention priorities within the Trust, and link this into the clinical governance and risk management processes.
Terms of Reference	1.To oversee the delivery of the Trust's HCAI objectives and IPC-related indicators 2. To approve and oversee the implementation of the IPC Annual Plan 3. To receive reports and assurance from subgroups, including, decontamination, water safety, ventilation safety and antimicrobial stewardship. 4. To identify key standards for infection prevention as part of the Trust's clinical governance programme. 5. To ensure that programmes for the prevention and control of infection, including education, are in place and working effectively. 6. To ensure that appropriate infection prevention policies and procedures are in place, implemented and monitored. 7. To ensure that robust plans for the management of outbreaks of infection are in place and to monitor their effectiveness. 8. To monitor surveillance of infection results e.g. mandatory surveillance, post-operative infection rates. 9. To highlight priorities for action in infection prevention management. 10. To agree the annual infection prevention audit programme and monitor its implementation. 11. To approve the annual infection prevention report, prior to its submission to the Trust Board. 12. To ensure that national guidance and best practice in infection prevention is implemented within the Trust. 13. To ensure the delivery of national infection prevention objectives e.g. UKHSA alerts / NICE guidelines /CQC reports/ High Level Enquiries. 14. To appraise innovative products regarding infection prevention 15. To monitor antimicrobial/disinfectant usage & expenditure patterns.
Review	In the fourth quarter of the financial year, the HIPG will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Terms of Reference.

Membership	**Core members** • Director of Infection, Prevention & Control (Chair) • Consultant Nurse IPC • Lead Nurse Infection Prevention • Matron IPC • Consultant Microbiologists & Infection Prevention Doctor • Divisional Directors of Nursing • PFI Contract and Performance Manager • Decontamination Manager • Antimicrobial Management Pharmacist • Health Work & Well-being representative • Estates and Facilities Manager • Medirest Manager (cleaning contractor) • Vinci Maintenance Services Manager • Head of Hard Facilities Management • Head of Soft Facilities Management • Consultant in Communicable Disease Control **In attendance** It is anticipated that the following senior officers will regularly attend: • Trust Infection Prevention Nurses • Community Infection Prevention Nurses • Director of Facilities and Contract • Clinical Procurement Specialist • Environmental officer • Health & Safety Advisor • Operational Services representative – Head of Patient Flow The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. In addition to formal members, the group shall be able to request the attendance of any other member of staff. Microbiology trainees are invited to attend the group as observers. Director of Infection Prevention and Control chairs the group. In the absence of the Chairman, the Deputy Chair shall be the Consultant Nurse Infection Prevention or Consultant Microbiologist. In the absence of both the Chair and Deputy Chair the remaining members present shall elect one of themselves to chair the meeting.
Attendance	It is expected that Core Members (or appropriate deputies) attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership (or appropriate deputies) must be present. To include at least one Infection Control specialist.
Accountability & Reporting.	The Hospital Infection Prevention Group was established by and is responsible to the Trust Board via the Patient Safety Council:

<table>
<tr><td></td><td> 
</td></tr>
<tr><td>Meeting Frequency</td><td>6 times a year</td></tr>
<tr><td>Agenda Setting and Minute Production and Distribution.</td><td>Agenda

Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Group and any other person required to attend prior to the meeting. Supporting papers shall be sent to Group members and to other attendees as appropriate, at the same time.

Regular reports received by HIPG.
<table>
<tr><th>Quality indicator report</th><th>Frequency of report</th><th>Reported by</th></tr>
<tr><td>Mandatory surveillance:
a. MRSA bacteraemia
b. C difficile infection
c. MSSA bacteraemia
d. Gram negative (E coli/Klebsiella/Pseudomonas aeruginosa) bacteraemia

e. SSI orthopaedics</td><td>At each meeting</td><td>Lead IPN/Consultant Nurse</td></tr>
<tr><td>Local surveillance results</td><td>As available.</td><td>Infection Prevention Nurses</td></tr>
<tr><td>External inspection reports and action plan progress (e.g. CQC)</td><td>As required (subject to reports being issued by external agencies)</td><td>Lead IPN/Consultant Nurse</td></tr>
<tr><td>Antimicrobial Management Team report
(To include audit results and action plans,
policy compliance and review)</td><td>At each meeting</td><td>Consultant Microbiologist and Antibiotic Pharmacist</td></tr>
<tr><td>Annual Report</td><td>Annual</td><td>DIPC or deputy</td></tr>
<tr><td>Reports from Medical & Urgent Care, Surgical, Women’s & Children’s and Community & Clinical</td><td>At each meeting</td><td>Divisional Directors of Nursing</td></tr>
</table></td></tr>
</table>

	Support Services Divisions (to include IPC audits, outbreaks & incidents)		
	Reports from community	At each meeting	Community Infection Prevention Nurses
	Report from Decontamination Lead	At each meeting	Decontamination Lead or Deputy
	Report from Water Safety Lead	At each meeting	Water Safety Group Representative
	Report from Trust Estates and Facilities	At each meeting	Trust Estates and Facilities manager
	Report from IV Access Group	At each meeting	IV access group representative
	Report from Waste Management Group	At each meeting	Environmental officer
	Report from HWWB	At each meeting	Lead Nurse HWWB
	Report from public health	At each meeting	Consultant in Communicable Disease Control

Minute Production and Distribution.

The Secretary shall minute the proceedings and resolutions of all meetings of the Group, including recording the names of those present and in attendance.

Minutes of Group meetings shall be circulated promptly to all members of the Group.

Document Tracking/Control	Documents submitted to the group should be identifiable by using a standard report cover sheet and structure.
Policy Management.	Policies approved by the committee must adhere to the overall guidance document “Document Control Policy” (Trust Policy on Policies). The Consultant Nurse/Lead Nurse Infection, Prevention & Control is responsible for ensuring that the Policy Checklist is completed in respect of each policy approved. All policies approved by HIPG will be taken to the Patient Safety Council for ratification prior to distribution.

Mersey and West Lancashire Teaching Hospitals NHS Trust

1. Executive summary

The annual programme of the Infection Prevention and Control (IPC) Service for April 2024-March 2025 sets out the proposed activities which will ensure that the programme of work continues to focus on two main areas: raising awareness of IPC through education and training and reducing the incidence of Health Care Associated Infection (HCAI). It also supports the Trusts continuing registration with the Care Quality Commission (CQC).This programme is based around The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Care Quality Commission core standards (2014), and the National Standards of Healthcare Cleanliness (NHSE 2021). Learning from incidents, complaints, root cause analysis (LPR)) and observation of care audits have also contributed to this programme.

Infection Prevention and Control Annual Work Programme 2025-26

	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
	1. Infection Prevention Team Staffing						
	DIPC - Director of Infection, Prevention and Control	Sue Redfern	Annual review of IPC establishment				
	Consultant Nurse IPC	Fionnuala Browne					
	IPC annual forward plan						
	Infection Control Doctor	Dr Kalani Mortimer					
	Lead Nurse IP	Claire Chalinor					
	Clinical Nurse Specialist Band 7	2.8 WTE	0.8 WTE vacancy				
	IP Staff Nurse Band 5	2.0 WTE					
	Audit and Surveillance Assistant	1.0 WTE					
	IP Secretary	1.0 WTE					
	Antimicrobial Stewardship Pharmacist	Andy Lewis, Elisha King, Jade Pickup					
	Southport & Ormskirk Sites						
	Infection Control Doctor	Vacant post	Locum Medical Microbiologist in post .				
	Clinical Nurse Specialist Band 7	2.8 WTE					
	Support Worker Band 3	1.0 WTE					
	IPC Administrator	Julie Halsall WTE					
	Antimicrobial Stewardship Pharmacist	Alex Priestman 0.5 WTE					
	Hospital IPC Group (HIPG)						
	The IPC Team via HIPG will report to the patient safety panel , Quality Committee and Trust board	DIPC. Consultant Nurse IPC . Infection Control Dr					
	HIPG meet six times per year	DIPC. Consultant Nurse IPC , Infection control Dr	TOR reviewed annually . Bimonthly report from key services , complinace against DH objectives				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4 and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**2. Surveillance**						
	Alert organisms	IPC Team, Microbiology	To maintain and alert Trust staff to risks associated with pathogenic organisms To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				
	Mandatory Reporting			**Q1**	**Q2**	**Q3**	**Q4**
	MRSA, MSSA, E. coli, Klebsiella, Pseudomonas aeruginosa bloodstream infection	IPC Team, Microbiology, Executive Review Panel	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases of all MRSA BSIs, MSSA and GNBSI HOHA cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG.				
	Clostridium difficile infection (CDI)	IPC Team, Microbiology	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG. To undertake a weekly ward round to review patients with CDI.				
	Carbapenem resistant Enterobacterales (CPE)	IPC Team	To manage patients with CPE colonisation as per policy Harmonise policies across MWL IT screening and risk assessment form in to be included in new Careflow (which will support monitoring of compliance)				
	Surgical Site Surveillance (SSI) Total hip and knee replacements	Orthopaedic Surgery	To support the orthopaedic team to review any learning from surveillance. To consider revisiting the One Together SSI improvement toolkit.				
	Respiratory Viruses e.g. influenza, Covid-19, RSV	IPC Team	To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**3. Hand Decontamination**						
	Continue to audit compliance with policy	IP Team	Report Trustwide Include in IPC Mandatory Training for all Trust staff Review potential approaches to undertake more objective audits, including the hand hygiene product provider, peer review and patients.				
	To undertake site survey for hand hygiene products with supplier of hand hygiene products, at MWL	IP Team	To optimise placement of products and standardisation of products. Site survey to be completed at STHK sites. Site surveys of all MWL sites to be reviewed and a plan established to refresh dispensers and signage.				
	To review RCN Gloves Off campaign post integration when the recommndation from the national IPC panel has been published late 2024/25	IP Team	To implement the Gloves Off campaign on the Critical Care Units. To further roll-out across other clinical areas following initial implementation, incorporating lessons learnt.				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**4. Policies and Patient Information Leaflets**						
	To agree plan for alignment of policies across MWL, prioritising harmonisation of high risk policies . (37)	DIPC	31/37 policies have been harmonised (2 pending and 4 are in progress). All reflect the requirements of the National IPC manual .				
	To provide advice and support on policies where IP is an integral component	IPT	IP review policies as part of the consultation process				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/Intravascular Access and Therapy**						
	Develop implementation plan for training	IPT/Training & OD	To establish frequency of training and and mode of delivery for key trainers and clinical staff.				
	Monitor Trust wide compliance	OD and subject matter expert (SME)	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training at STHK sites	IPNs, Nurse Consultant ICU	Key trainer training sessions are provided at agreed intervals.				
	To act as an advisory role for vascular access and therapy related issues at STHK sites	Nurse Consultant : MET IV access. IPNs, Nurse Consultant ICU	To provide expert advice on matters relating to vascular access and therapy. Provide report to HIPG. Lead IP nurse to co-chair IV Access and therapy Group with Nurse Consultant ICU				
	Facilitate annual Trust PIVC audit	IPT	Provide report to HIPG and PSC. Produce an action plan that will be monitored at the IV Group. Ward PIVC audits completed monthly on Tendable				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**6. Training**						
	IPC training to junior doctors, volunteers, student nurses, preceptors.	IPC Team	Ongoing				
	Mandatory training	IPT	12 month mandatory training is provided via an online video for clinical staff. 3 yearly mandatory training update for non-clinical staff is via e-learning. Induction training is online.				
	IPC Matron to complete Mary Seacole Programme	Matron IPC	To complete programme in 25/26.				
	Link Personnel	IPT	Quarterly face to face meetings				
	Antibiotic Prescribing	Antimicrobial Management Pharmacists, Medical Microbiologists	Junior doctor training (medical and surgical twice yearly), medical student teaching, medical staff induction.	STHK S&O			
	Keep IP staff updated with evidence based practice	IPT	Attend North West/ national Infection Prevention Society/ infection control conferences. Undertake webinars by accredited IP organisation e.g. Hospital Infection Society				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6 7, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**7.Audit**						
	To provide assurance to the Board and relevant committes of adherence to high quality IP practices	IPT	Reported to quality leads, matrons, ward managers, supports services, HIPG and				
	Annual Programme revised annually	IPT	Divsional IPC meetings implemented monthly				
	Use Tendable platform for IPC audits	IPT	To work with MWL digital leads to optimise this platfrorm for IPC audits				
	Further audits are undertaken by the IPT as the service requires	IPT	e.g. Commodes and dirty utility, flushing audit (augmented areas), Sharpsmart audit, ward kitchen audit, hand sanitiser placement, blood culture audit, deep clean audit.				
	Urinary Catheter care & maintenance point prevalence audit Q3-4	IPT	To undertake annualy across al inpatient areas				
	Vascular access devices point prevalence audit		To undertake annual poiunt prevelenec in Q4 across al inpatient . Monthly spot checks				
	Vascular access devices	IPT	VIP audits are undertaken if issues are identified through RCA. Monthly reporting via IP audit indicators and Tendable				
	Compliance with IP precautions including isolation, careplans, PPE etc	IPNs	Quarterly				
	Mattresses	TK	Audited bi-monthly on the inpatient areas by clinical teams. Recorded on tendable Reporting included in Divisonal IPC meetings with assurance to HIPG.				
	Blood culture contamination rates below 5%	KM	ED rates reported weekly to clinical leads. Trust rates reported monthly in IP report at STHK sites. Further rollout of BC training competency	2-6%			

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4, and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**8. Antibiotic Prescribing**						
	Participate in IVOS audit (IV to oral switch)	AMT	Report bimonthly to HIPG				
	Undertake weekly AMT wardrounds on medical and surgical wards at STHK sites	AMT	Immediate feedback provided on wards, reported in IP monthly report				
	Undertake microbiology wardrounds on Critical Care, Orthopaedic Surgery, Spinal Unit and other ward rounds as staffing allows	Consultant Microbiologist, Southport Site	Immediate feedback provided on wards				
	Point prevalence audit of policy adherence, missed doses, antibiotic review and course lengths at STHK sites	Antimicrobial Management Pharmacists	Reported to Trust clincial leads and in IP monthly report				
	Antimicrobial expenditure information at MWL sites	Antimicrobial Management Pharmacists	Reported to HIPG and DTG				
	.Migiation of Microglide to EOLAS system go live set 2024 completed	AMT	live on system				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**9. Communications**						
	IPC Monthly Data Report	IPT, AMT	Unified IP monthly report, combining monthly reports for the medical and nursing staff				
	Communication with other Trusts and agencies such as UKHSA	IPT	To share information, best practice and lessons from incidents				
	IPC intranet website	IPT	To maintain and update Trust intranet site(s) with relevant and up to date information with Trust staff				
	Administration	JD	To provide administrative support including coordination of meetings, dairy management, data collection, minutes, ICNet administration				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4, 5, 8 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**10. Information Technology**						
	ICNet surveillance and case management system	IPT	Continue to use system to manage patients and to run reports. To introduce futher function to the system as they become available e.g. recent addition of outbreak module.				
	Tendable audit platfrom	IPT	To optimise the use of this digital platform for IPC audits, revised general IPC Team audit by in collaboration with Quality Matrons.approved June 2025				
	Electronic prescribing roll out on hold date to be confirmed	AMT	To optimise the functionality of the EPMA system				
	Careflow Connect	IPT	To optimise the IPC opportunities on this platform e.g. infection alerts and screening requirements.				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:							
1, 2, 3, 4, 5, 6, 9 and 10 **Trust Objectives:**	Develop IPC Resources for clinical areas	IPC Team	business case in progress re IPT and CPE				
	Reinvigorate IPC Link network with reps in all clinical depts	Matron IPC	bimonthly meeting and education events				

Infection Prevention Work Programme 2025/2026							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6,9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**12. Interface with relevant groups**						
	Care Group/Divisional meetings	ICNs	To provide expert advice and support as required				
	Decontamination	IPT	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Water Safety	KM	Attend Water Safety Meeting				
	Ventilation Safety	KM	Attend Ventilation Safety Meeting				
	Waste Management	IPT	To provide expert advice and support as required				
	Medical Devices Group	IPT	To provide expert advice and support as required				
	Estates & Facilities	IPT	To provide expert advice and support as required, for capital schemes, linen, catering and other elements.				
	Health & Safety	IPNs	To provide expert advice and support as required				
	Emergency Planning	IPT	To provide expert advice and support as required				
	Health, Work and Wellbeing	IPT	To provide expert advice and support as required				
	ICB meetings	IPT	To attend and provde assurance to commissioners related to IPC				
	NW IPC Regional Meeting	IPT	To engage with and share best practice with peers				
	CMAST	IPT	To provide expert advice and support as required				

Title of Meeting	**Trust Board**		**Date**	30 July 2025
Agenda Item	**TB25/062 (14.1)**			
Report Title	Data Security and Protection Toolkit (DSPT) 2024/25			
Executive Lead	Malcolm Gandy, Director of Informatics			
Presenting Officer	Malcolm Gandy, Director of Informatics			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide the Trust Board with assurance that the Trust operates within the parameters defined in the Data Security and Protection Toolkit (DSPT) and have completed the annual submission to demonstrate such compliance.

Executive Summary

This report summarises MWL's status against the Data Security and Protection Toolkit (DSPT) for 2024/25. The DSPT is a self-assessment tool that allows organisations to evaluate their data security and protection practices.

All organisations that have access to, and process patient / personal data and systems must use this toolkit to demonstrate that they are practising good data security, and that personal information is handled correctly and in line with cyber guidelines and data protection legislation.

The DSPT transitioned in September 2024 to align with the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF). This CAF-aligned DSPT aims to improve data security by emphasising informed decision-making and understanding of information risks within healthcare organisations. This is the first major change to the DSPT since its introduction in 2018, changing the assessment significantly to focus on cyber security instead of data protection.

The DSPT assessment was submitted at the end of June.

MWL was able to submit evidence items for all but one of the DSPT outcome categories. Therefore, the overall assessment for 2024/25 was "standards not met". To achieve a "standards met" rating **all** outcomes within the DSPT must be achieved.

It should be noted that due to the significant change to the CAF-aligned DPST, NHS England were expecting most organisations to not achieve "standards met" in year 1

To provide an additional level of independent assurance Mersey Internal Audit Agency (MIAA) have audited the outcomes and evidence used for the DPST submission. The audit outcome was 'Moderate Assurance', reflecting the one outcome category where further evidence and assurance is required (Multi-Factor Authentication).

Financial Implications

None directly from this report.

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

Data Security and Protection Toolkit 2024/25

Introduction

The Data Security and Protection Toolkit (DSPT) enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy.

In September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. This has led to NHS Trusts, CSUs, ALBs and ICBs seeing a different interface, which sets out CAF-aligned requirements in terms of objectives, principles and outcomes. The scope of the 24-25 DSPT includes additional cyber requirements, reducing the information governance requirements compared to the 23-24 DSPT.

The previous DSPT versions were based on the National Data Guardian ten data security standards (covering topics such as staff responsibilities and continuity planning (National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) and legal rules relevant to IG and personal data (UK General Data Protection Regulation 2016 and the Data Protection Act 2018).

All organisations that have access to and process patient / personal information must provide assurances that they are practising good data security and information governance and use the DSPT to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England (NHSE) standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health and Social Care (DHSC) policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

The new CAF-aligned DSPT is split into 47 contributing outcomes, each of which are supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'. This is a move away from evidencing against 'assertions.'

To achieve 'standards met,' NHS organisations will have to meet the expected achievement level set by NHSE for all the outcomes.

The DSPT submission date remains the end of June.

It has been recognised that the move to a CAF-aligned DSPT is a significant change and would be a considerable challenge for many NHS organisations as it represents an increase in the data security requirements for organisations. The main areas of uplift are in the requirements to protect organisations from cyber risks. There was an understanding by NHSE that it would take some time to meet all the outcomes, and it was expected that organisations would not be able to achieve "standard met" in 2024/25.

In addition, NHSE only recently clarified the requirements to achieve one of the 47 outcomes - B2.a Identity verification, authentication and authorisation which left little time for trusts to respond before the submission deadline.

Each outcomes category is supported by several objectives, which in turn require evidence against a series of principles.

Organisations which do not achieve standard met in 2024/25 are required to submit an Improvement Plan to NHSE setting out how they will meet all the outcomes 30th June 2026. These improvement plans will be subject to ongoing central monitoring, and once agreed by NHSE the organisation's 2024-25 DSPT Status will move to an 'approaching standards.' Categorisation, and once the plan is delivered it is expected that organisations will be able to achieve "standards met".

Having an agreed plan gives NHSE and DHSC, commissioners, stakeholders, service users and partner organisations confidence that the organisation understands what it needs to do to meet the cyber security and information governance standards, is committed to reaching the required achievement levels and is being monitored by NHSE to do so.

NHSE has agreed that due to the changes this year, organisations status will not be reported on the DSPT website until the improvement plans have been approved and the final classification for 2024/25 agreed.

Larg organisations, such as Acute Trusts, are required to have their DSPT submission externally audited to provide independent assurance of the accuracy.

Completion of the DSPT is a contractual obligation and failure to complete and publish the outcomes could result in financial penalties. The Information Commissioner has also indicated that satisfactory completion of the DSPT can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of the MWL 2024/25 DSPT Submission

MWL have completed the DSPT in time for the end of June 2024 submission date. The Trust has submitted 'standards not met.'

The Trust has provided evidence for all but one of the outcomes which has meant that the Trust could only be categorised as 'standards not met' at this stage.

The table below summarises the MWL results.

Objective	No of Principles	No of Outcomes	IG (Outcomes)	IT Security (Outcomes)	Data Quality (Outcomes)
A - Managing Risk	4	7	4	3	0
B - Protecting against cyber-attack and data breaches	6	20	2	18	0
C - Detecting cyber security events	2	7	0	7	0
D - Minimising the impact of incidents	2	5	1	4	0
E - Using and sharing information appropriately	4	8	7	0	1
TOTAL	18	47	14	32	1
Number Met		46 / 47	14 /14	**31 / 32**	1 / 1

Evidence was required from MWL's IT Security, Information Governance (IG) and Data Quality (DQ) teams, with IT Security were required to evidence 32 outcomes, IG – 14 and DQ 1.

Outcome not Achieved

Principle B2 - Protecting against cyber-attack and data breaches
Outcome B2.a - Identity verification, authentication and authorisation
You robustly verify, authenticate and authorise access to the information, systems and networks supporting your essential function(s).

For Principle B – Managing Risk - there are 20 outcomes and for one of these B2.a the Trust was unable to provide sufficient evidence.

Evidence required:
Organisations must enforce Multi-Factor Authentication (MFA) on all remote user access to all systems. Organisations must enforce MFA on all privileged user access to externally hosted systems. Organisations should enforce MFA on all privileged user access to all other systems except as permitted in the 'Exceptions' section of the MFA policy.

At the time of the DSPT submission the Trust did not have a stand-alone MFA Policy in place, which meant this outcome was not met. Because NHSE had only clarified the requirements for this outcome there was not sufficient time to develop an MFA Policy and obtain approval via the Trust governance framework.

Next Steps
The Digital team has already provided an Improvement Plan to NHSE (please refer to the Appendix 1) to meet this outcome.

As part of the plan and currently in progress by the Trust's IT Security team have:

- drafted an MFA Policy for review and approval at the IM&T Council on the 8th July 2025 and has subsequently been approved *(Appendix 2)*
- identified IT systems that are not MFA enabled and are carrying out risk assessments on each, which will be reviewed by the SIRO. These are legacy systems that are being risk assessed. All new systems do and will have MFA enabled. Would there have been any concerns with the legacy systems, this would have been picked up and addressed by MIAA in their report. No concerns raised given the additional security measures in place.
- created a criteria list which provides an audit of new IT systems being implemented
- created a work plan to identify the above work areas to ensure they are monitored and achieved (with dates where applicable)

NHSE is expected to review the improvement plans by September 2025 and if it is accepted the Trust categorisation will move to 'approaching standards, and MWL will have until 30th June 2026 (2025/26 DSPT submission deadline to demonstrate the actions have been delivered and the outcome met.

DSPT Approval

The SIRO has approved the submission of the DSPT for 2024/25 with the Trust at 'standards not met' with a supporting Implementation Plan.

Internal Audit

Mersey Internal Audit Agency (MIAA) carried out an audit of MWL's DSPT submission during two visits in March and June 2025 to assess the Trust's compliance against the new CAF aligned DSPT. MIAA reviewed 12 outcomes across the 5 objectives in the Cyber Assessment Framework. NHSE had mandated 8 outcomes to be audited, and Trusts were required to select a further 4 outcomes to be audited.

The audited outcomes for 2024/25 were

Area	Description
A1.a	You have effective organisational information assurance management led at board level and articulated clearly in corresponding policies.
A2.a	Your organisation has effective internal processes for managing risks to the security and governance of information, systems and networks related to the operation of your essential function(s) and communicating associated activities. This includes a process for data protection impact assessments (DPIAs).
A2.b	You have gained confidence in the effectiveness of the security and governance of your technology, people, and processes relevant to your essential function(s).
A4.a	The organisation understands and manages security and IG risks to information, systems and networks supporting the operation of essential functions that arise as a result of dependencies on external suppliers. This includes ensuring that appropriate measures are employed where third party services are used
B2.a	You robustly verify, authenticate and authorise access to the information, systems and networks supporting your essential function(s).

Area	Description
B4.b	You securely configure the network and information systems that support the operation of your essential function(s).
B4.d	You manage known vulnerabilities in your network and information systems to prevent adverse impact on your essential function(s).
C1.a	The data sources that you include in your monitoring allow for timely identification of security events which might affect the operation of your essential function(s).
D1.a	You have an up-to-date incident response plan that is grounded in a thorough risk assessment that takes account of your essential function(s) and covers a range of incident scenarios.
E2.a	You appropriately assess and manage information rights requests such as subject access, rectification and objections.
E2.b	You have a good understanding of requirements around consent and privacy, including the common law duty of confidentiality, and use these to manage consent.
E3.a	You lawfully and appropriately use and share information for direct care.

The audit resulted in an assessment of 'Moderate Assurance'. MIAA found that for outcome B2.a. the Trust did not have sufficient assurances in place (MFA Policy) and could therefore not award the Trust with 'Substantial Assurance.'

Moderate Assurance

Objective	Overall Assurance
A - Managing Risk	Met
B - Protecting against cyber attack and data breaches	Not Met (B2.a only)
C - Detecting cyber security events	Met
D - Minimising the impact of incidents	Met
E - Using and sharing information appropriately	Met

An assessment as to the veracity of the organisation's self-assessment / DSPT submission and the assessor's level of confidence that the submission aligns to their assessment of the risk and controls has been provided by MIAA. The Trust has achieved the following:

High Confidence

Recommendations received from MIAA Audit Report

MIAA have identified the areas that will require further attention in 2025-26, and these align to the Improvement Plan submitted to NHSE. Delivery of these actions will be monitored via the Information Governance Steering Group and the audit will be reported to the Audit Committee in September.

Conclusion

Although it is disappointing to submit ‘standards not met’ and only achieve an assurance rating of ‘moderate’ this is the Trust’s first completion of a CAF aligned DSPT, and all but one of the outcomes were achieved and the evidence used to support this assessment was assessed as being ‘high confidence’. This demonstrates that MWL continues to build and improve on the Information Governance and IT Security foundations year on year.

Appendix 1

Data Security and Protection Toolkit – B2.a. - Identity and Access Control Improvement Plan

Executive Summary

- The 2024/25 DSPT has adopted the Cyber Assessment Framework (CAF), increasing the security and governance requirements.
- The Trust was assessed against 12 outcomes (8 mandatory + 4 selected).
- 11 outcomes met the NHS England minimum profile.
- 1 outcome (B2.a – Identity and Access Control) did not meet the minimum profile and was rated High Risk.
- Overall assurance rating: Moderate
- Confidence in the Trust's self-assessment: High

Objective

To strengthen the Trust's identity and access management (IAM) controls, ensuring secure authentication, authorisation, and access review processes for systems supporting essential functions.

1. Governance and Oversight

Action	Description	Responsible Officer	Timeline	Progress
1.1	Appoint a lead for IAM improvements	Information Governance	Immediate	Completed – Assets Listed on Asset Register

Action	Description	Responsible Officer	Timeline	Progress
1.2	Contact IAM regarding the expected requirements around access management controls and account management	IT Security	Within 1 month	IAM have been contacted with the IT Security Audit. Awaiting response
1.3	Provide system owners with a standardised review for them to carry out and return to IG and IT Security.	System Owners, Information Governance, IT Security	2 months	Review has been emailed to the IAMs, they have been given a one month deadline.

2. Multi-Factor Authentication (MFA)

Action	Description	Responsible Officer	Timeline	Progress
2.1	Conduct a full audit of all systems supporting essential functions to identify MFA coverage gaps	IT Security	Within 2 months	Systems have been identified, and risk assessments have begun (see 2.3).
2.2	Ensure all external users coming inbound onto the network have MFA enforced by default	Network and IT Security	Within 2 months	Already enforced

Action	Description	Responsible Officer	Timeline	Progress
2.3	All privileged user accounts have MFA enforced by default	IT Security	Within 2 months	Already enforced
2.4	Enforce MFA for all remote access, including cloud-hosted and externally accessible systems. Risk assess those where MFA can't be enabled.	IT Security, Network, Infrastructure, ADO, SIRO	Within 6 months	Working with suppliers across the entire system list to implement MFA as quickly and securely as possible
2.5	Document and risk-assess any MFA exceptions, with annual review and mitigation plans	Information Governance, IT Security	Ongoing, first review 12 months after completion of initial review	Systems have been identified, a new risk assessment and process has been implemented. Risk assessments are underway and we have received several completed assessments which have now been recorded.
2.6	Implement the MFA risk assessment process Trust-wide	IT Security	Within 2 months	MFA Policy has been created and will be presented at IM&T for approval. A new MFA risk assessment has been created and is now in use.

3. Access Review and User Management

Action	Description	Responsible Officer	Timeline	Progress
3.1	Engage Information Asset Manager (IAMs) to conduct and document annual access reviews	IT Security	Within 3 months	Completed
3.2	Ensure all user and system accounts are reviewed for necessity and privilege level	System Owners	Within 3 months	
3.3	Eliminate or secure generic/service accounts with strong controls and monitoring for systems outside of IT ownership	System Owners	Within 4 months	
3.4	Eliminate or secure generic/service accounts with strong controls and monitoring for systems controlled by IT	IT Security	1 month	Already compliment

4. Policy and Standards Alignment

Action	Description	Responsible Officer	Timeline	Progress
4.1	Benchmark password and authentication policies against Trust Password Policy	System Owners, IT Security	Within 6 months	Work is already in progress and managed through the CAB. Currently on going.
4.2	Update policies to reflect best practices and ensure consistent enforcement across all systems	Policy Owners	Within 3 months	All relevant policies have been reviewed. New MFA Policy Created. Account Management Policy
4.3	Align all systems with the Trust's 12-character password policy and enforce MFA where required	System Owners, IT Security	Within 6 months	Work is already in progress and managed through the CAB. Currently on going.

5. Monitoring and Assurance

Action	Description	Responsible Officer	Timeline	Progress
5.1	Implement centralised logging and alerting authentication events, for external users accessing via the VPN.	IT Security	2 months	Completed

Action	Description	Responsible Officer	Timeline	Progress
5.2	Develop reports to monitor MFA adoption and access reviews	System Owners, IT Security and Information Governance	6 months	
5.3	Provide quarterly assurance reports to the IM&T	IT Security and Information Governance	Quarterly	MFA updates will feature in the monthly cyber report that the IT Sec team provide which is then presented at the monthly IM&T, this will be in place from August 2025 until completion of MFA enrolments.

6. Training and Awareness

Action	Description	Responsible Officer	Timeline	Progress
6.1	Deliver targeted training to IAMs on access review responsibilities	Information Governance	Within 2 months	IAM training is already in place. IAMs will be contacted for a refresher session.
6.2	Conduct Trust-wide awareness campaign on MFA and secure access practices	Comms, IT Security, Information Governance	Within 2 months	

Evidence of Implementation

- Completed access review logs signed by IAOs
- MFA audit reports and exception registers
- Updated IAM and password policies
- System compliance reports (MFA and password policy)
- Training attendance records and awareness materials
- Benchmarking report against Trust Policy

Multi-factor authentication (MFA) Policy

Version No: [Insert version number]

Document Summary:
This policy sets out the requirements for multifactor authentication and in which circumstances it must be enabled on digital systems.

Document status	Approved	
Document type	Policy	**Trust wide**
Document number	Document Control will provide document number if a new document	
Approving body	IM&T Council	
Date approved	21/07/2025	
Date implemented	21/07/2025	
Review date	***3 years from approval date** Click here to enter a date.	
Accountable Director	Director of Informatics	
Policy Author	Eric Phipps – Assistant Director of Informatics	
Target audience	Specific staff group	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information	
Title	Multi Factor Authentication Policy
Directorate	Informatics
Brief Description of amendments	
New policy due to national mandate requiring specific dedicated policy for this area. ***Please state if a document has been superseded.***	
Does the document follow the Trust agreed format?	Yes
Are all mandatory headings complete?	Yes
Does the document outline clearly the monitoring compliance and performance management?	Yes
Equality Analysis completed?	Yes
Data Protection Impact Analysis completed?	Yes

Section 2 – Consultation Information*			
*Please remember to consult with all services provided by the Trust, including Community & Primary Care			
Consultation Completed	☐ Trust wide ☐ Local ☐ Specific staff group		
Consultation start date	Click here to enter a date.	**Consultation end date**	Click here to enter a date.

Section 3 – Version Control		
Version	**Date Approved**	**Brief Summary of Changes**
	Click here to enter a date.	
	Click here to enter a date.	
	Click here to enter a date.	
	Click here to enter a date.	

Section 4 – Approval – *To be completed by Document Control*			
Document approved	☐ Approved ☐ Approved with minor amendments		
Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval		
Date approved	Click here to enter a date.	**Review date**	Click here to enter a date.

Section 5 – Withdrawal – *To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval
Date Withdrawn:	Click here to enter a date.

Contents

1. Scope

The Trust:

- **must** enforce MFA on all remote user access to all systems; and
- **must** enforce MFA on all privileged user access to externally hosted systems; and
- **should** enforce MFA on all privileged user access to all other systems;

2. Introduction

Multi-factor authentication (MFA) is widely recognised as one of the most effective ways to protect data and accounts from unauthorised access. This policy will ensure that MFA is used on digital systems throughout the Trust with particular requirements on accounts that are remotely accessible or have privileged access to systems.

Compromising user accounts is a starting point for many cyber security attacks. Common passwords can be breached with unsophisticated attacks, giving attackers easy access to an organisation's systems and enabling ransomware, and many people use the same or similar passwords on multiple accounts, making a compromise both easier and more damaging.

Users authenticate to systems by presenting proof of something they know (such as a password) something they have (such as a device), or something they are (biometrics). Multi-factor authentication (MFA) – the use of two or more of these authentication factor types – is an effective control against a wide range of account compromise techniques, stopping simple attacks altogether and making it much more difficult for even sophisticated attackers to succeed.

Industry research suggests that MFA can prevent 99.9% of account compromise attacks, and MFA is widely considered by cyber security authorities globally to be one of the most important controls that any organisation can deploy. Its use in the NHS will help protect patient data and organisations' capability to deliver patient care.

This policy sets out requirements for the use of MFA as a cyber security control to establish a consistent minimum expectation. These policy requirements are incorporated into the Data Security and Protection Toolkit (DSPT).

3. Statement of Intent

The objective of this policy is to promote and ensure widespread use of multi-factor authentication as a fundamental cyber security control, in order to manage the data security risks associated with user credential compromise.

4. Definitions

Term/Abbreviation	Definition/meaning
Root / Privileged / Super user	A user that is authorized (and therefore, trusted) to perform security-relevant functions that ordinary users are not authorized to perform.
DSPT	Data Security and Protection Toolkit
MFA	Multi Factor Authentication - a secondary method of proving who you are, this can be in the form of a phone call, text, authentication application.

5. Duties, Accountabilities and Responsibilities

5.1 Chief Executive

The Chief Executive as the Accountable Officer for the Trust has ultimate responsibility for ensuring that this Policy is implemented.

5.2 The Senior Information Risk Owner (SIRO)

The SIRO is an executive who is familiar with and takes ownership of the organisation's risks and acts as advocate for risk for the Board of Directors. The Director of Informatics is the designated SIRO for the Trust and will:

- Be accountable for the delivery of this Policy and related work programmes.
- Foster a culture for protecting and using data securely.
- Provide a focal point for managing information risks and incidents.
- Be concerned with the management of all information assets.
- Ensure that organisational information risk is properly identified, managed and that appropriate assurance mechanisms exist.

5.3 The Caldicott Guardian

The Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that the Trust satisfies the highest practical standards for handling patient identifiable information. The Assistant Medical Director has been designated Caldicott Guardian for the Trust and will:

- Be advisory, supporting the SIRO and Information Governance (IG) Team when necessary.
- Be the 'conscience' of the organisation.
- Provide a focal point for patient confidentiality and information sharing issues.
- Be concerned with the management of patient information.

5.4 Directors and Associate Directors

Directors and Associate Directors will have responsibility for the protection of person identifiable data and for helping to identify and manage any risk associated with this, within their own sphere of responsibility.

5.5 Divisions, Services, Departments

Are responsible for:

- Adhering to this Policy and ensuring Trust assets are used appropriately.
- Ensuring that their staff are made aware of their security responsibilities.
- Ensuring that their staff have attended the mandatory information governance training.

- Making information governance and measures to protect information, especially personal data, part of normal/everyday activity.
- Setting and driving forward a culture that properly values, protects and uses data both in the planning and delivery of Trust services.
- Adhering to information governance related policies and procedures.
- Ensuring breaches/near misses relating to information governance are reported using the Trust's incident reporting procedure.
- Informing the Data Protection Officer, Information Governance Lead, Caldicott Guardian or Senior Information Risk Owner of any information governance risks that need urgent attention.

5.6 All Staff

It is the responsibility of all staff to:

- Understand that the use of Trust IT equipment must be done for work purposes to minimise the risk of cyber threats.
- Be aware that they have a duty under legislation to protect information especially Person Identifiable Data.
- Report information governance incidents including near misses, using the Trust's incident reporting system and learn from information governance incidents to reduce risks in the future.
- Report network related breaches, incidents, risks, or concerns to the IT Helpdesk at the earliest opportunity.
- Ensure the proper use of Trust systems to prevent the introduction of malicious software on to the Trust's network and information systems.
- Ensure they do not share their network access password with other staff or third parties and ensure they change their password if they suspect it has been compromised.
- Ensure that the passphrase guidelines provided in this policy are followed for user accounts that they manage.
- Be familiar with the Trust's Information Governance policies and procedures and comply with these.
- Actively participate in the Trust's induction training and complete further/update training relating to information governance when requested.
- Report to line management any perceived information governance risks or issues in their area of work.

5.7 Cyber Security Team

- Responsible for identifying and keeping a register of all externally facing systems.
- Responsible for ensuring externally facing systems have MFA enabled.
- Identify any risks with systems that do not support this functionality and report via the IM&T council and log on risk management systems.
- Support new digital projects and ensure that this criteria is highlighted as part of data protection impact assessments.

6. Process

The Trust:

- **must** enforce MFA on all remote user access to all systems; and

- **must** enforce MFA on all privileged user access to externally hosted systems; and
- **should** enforce MFA on all privileged user access to all other systems;

except as permitted in the 'Exceptions' section of this policy.

'User' means any individual (other than a patient or person in care) or system process authorised to access an information system, and 'user accounts' therefore includes service accounts.

This policy requirement applies irrespective of whether Cyber Essentials Plus certification is held.

An organisation 'X' to which this policy applies **must** include all services for which it is the controlling recipient, so:

- services provided to X by suppliers and partners under contract are in scope for X
- services provided by X to a separate contracting authority are out of scope for X. (The contracting authority would be responsible for compliance with this policy, if it is an organisation to which the policy applies)
- services procured by X on behalf of other organisations are out of scope for X. (The recipient organisations would be responsible for compliance with this policy, if they are organisations to which the policy applies)

6.1 Exceptions

Permitted exceptions are as follows:

Ser	Exception	Remarks
General exceptions		
1	Unprivileged user account access from within the organisation's trusted corporate network	MFA is required for all user access originating outside the trusted corporate network

Ser	Exception	Remarks
2	Access to a system to which the same user has previously authenticated with MFA from the same device	MFA enforced on first access; user may then subsequently access the same system from the same device without MFA, for an organisation-defined period (session management)
3	Accounts used solely by patients or people in care	Not in scope of this policy. DCB3051 establishes standards for identify verification and authentication for patients and service users
Specific exceptions		
4	Accounts used by staff with disabilities that make MFA unusable	Consider disabilities equality as part of implementation planning and choice of factors
5	Access from specific trusted physical locations	Such as access from prisons and other sites with specific restrictions and compensating controls
6	Systems that cannot support any form of MFA	Federated authentication with an MFA-capable system is considered 'supporting MFA'
7	Situations in which MFA would create disproportionate clinical or operational risk or difficulty	Organisations **must** consider alternative controls and mitigations for the security risk

If the Trust applies any specific exception (serials 4-7 above) they **must**:

- understand, document, risk-assess, and receive SIRO all exceptions, with annual review.
- have and actively pursue plans to minimise or eliminate completely the exceptions; and
- retain documentary evidence for audit purposes and provide a summary within their DSPT submission.

6.2 Implementation

The Trust should firstly fully understand all systems that are externally available and if MFA is enabled. This should be documented.

No specific technical approaches to MFA are prescribed or prohibited, but illustrative options are listed below, given in approximate groups of weakest to strongest authentication security. This is not intended as an exhaustive list.

The Trust should use current good practice guidance, such as is published by the UK government, National Cyber Security Centre (NCSC) and the US Cybersecurity and Infrastructure Security Agency, to inform decisions on approaches and technologies, proportionate to the nature, connectivity and risks of organisational systems.

Strength	Authentication factor	Remarks
‘Basic’	SMS or voice message to trusted number	**Should not** be used unless no better alternative is available, due to susceptibility to unsophisticated attacks
'Better'	Mobile push notification	Number matching or equivalent two-way verification improves attack resistance
	One-time password (OTP) generated by application or hardware token	Time-based (TOTP) is more resistant to attack than HMAC-based (HOTP)
	Trusted end user device proved by a device certificate or similar	Non-exportable credentials are preferable
'Best'	Public key infrastructure (PKI), such as NHS Care Identity Service smartcard	Phishing-resistant
	FIDO / WebAuthn or U2F	

The Trust must not treat a second 'knowledge' requirement (such as security questions) as an additional authentication factor, except for one-time passwords or MFA recovery codes.

The Trust **must** consider their data protection obligations before deciding on approaches that collect or process additional personal data, such as personal contact details or biometric information.

The Trust should adopt an inclusive approach to MFA that does not expect staff to own or use a personal smartphone for work purposes, or to disclose personal contact information to their employers for MFA purposes.

Organisations may use other authentication services, such as NHS Care Identity Service 2 or NHSmail, to provide multi-factor authentication through federation.

7. Training

Information Governance Mandatory training must be completed by all staff which covers many elements of this policy.

8. Monitoring Compliance

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1.	MFA report to be brough annually to IM&T

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Cyber Assurance Meeting	Assistant Director of Service Delivery	IT Security Dashboard	Monthly	Quality assurance report	IT Security Team Infrastructure Team SIRO
IM&T Council	Assistant Director of Service Delivery	IT Security Dashboard	Quarterly	Cyber update report	IT Security Team Infrastructure Team SIRO

9. References/Bibliography/Relevant Legislation/National Guidelines

No	Reference
1.	NHS England Guidance to MFA Guide to multi-factor authentication (MFA) policy - NHS England Digital

2.	Data Security and Protection Toolkit DAPB0086: Data Security and Protection Toolkit - NHS England Digital
3.	Cyber Assurance Framework Introduction to the Cyber Assessment Framework - NCSC.GOV.UK

10. Related Trust Documents

No	Related Document
1.	Information Governance Policy
2.	Backup Policy
3.	Mobile Device Policy
4.	Network Security Policy
5.	Remote Access Policy

11. Equality Impact Assessment (EIA) Screening Tool

The EIA screening must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the beginning of the planning stage of any change process. Where the screening identifies that a full EIA needs to be completed, please use the full EIA template.

The completed EIA screening form must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to PatientEDI@sthk.nhs.uk for monitoring purpose for EIAs carried out on patient related functions.
If the assessment is related to workforce a copy should be sent to workforceedi@sthk.nhs.uk

If this screening assessment indicates that discrimination could potentially be introduced, then seek advice from the Head of Patient Experience and Inclusion via cheryl.farmer@sthk.nhs.uk for patient related functions or Head of Workforce Equality Diversity and Inclusion via darren.mooney@sthk.nhs.uk for workforce related functions.

A full equality impact assessment must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Title of function	MFA
Brief description of function to be assessed	The use of multi factor authentication
Date of assessment	19/06/2025
Lead Executive Director	Malcolm Gandy
Name of assessor	Stephen Brooks
Job title of assessor	Deputy Data Protection Officer

1. Equality, Diversity & Inclusion

Does the policy/proposal:
1) Have the potential to discriminate against equality groups or people in inclusion health groups
2) Promote equality of opportunity, or foster good relations between those who share a protected characteristic and those who don't?
3 Where there is potential unlawful discrimination, is this justifiable?

Please tick the relevant box

	Positive impact	Negative impact	No impact	Justification/ evidence
Age			x	
Disability		x		Some MFA methods may not be accessible to individuals with disabilities so alternative methods would need to be looked at or an exception applied which is covered in policy.
Gender reassignment			x	
Pregnancy or maternity			x	
Race			x	
Religion or belief			x	
Sex			x	
Sexual orientation			x	

2. Human Rights

Does the policy/proposal breach the Human Rights of individuals or groups?

	Yes	No	Justification/ evidence
Right to life		x	
Inhumane treatment		x	
Liberty		x	
Privacy/family life, home and correspondence		x	
Thought/conscience		x	
Freedom of expression		x	
Right to a fair trial		x	

3. Health Inequalities

Is there potential that the policy/proposal could have a negative impact on inclusion health groups?

Is the policy/proposal addressing health inequalities? Where there are potential unlawful impacts are they justifiable.

	Positive Impact	Negative Impact	No impact	Justification/ evidence and data source
Deprived Populations			x	
Inclusion health groups			x	

4. Sign off

Name of approving manager	Malcolm Gandy
Job title of approving manager	Eric Phipps
Date approved	19.06.2025

5. EIA Action Plan

Recommendations	Actions Required	Resources required /costs	Timeframe	Lead officer responsible

Please forward an electronic copy of this action plan with the completed assessment to , Cheryl.farmer@sthk.nhs.uk for patient related assessments or equality&diversity@sthk.nhs.uk for workforce related assessments for monitoring purposes.

12. Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		x		
Will the procedural document lead to the collection of new information about individuals?	x			Potential personal / biometric data depending on the MFA method used.
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		x		
Will the implementation of the procedural document require you to contact individuals in ways which they may find intrusive?		x		
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		x		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition	x			Potential personal / biometric data depending on the MFA method used.
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		x		
Will the implementation of the procedural document compel individuals to provide information about themselves?	x			Potential personal / biometric data depending on the MFA method used.

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author **Date**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	**30 July 2025**
Agenda Item	**TB25/062 (14.2)**				
Report Title	Information Governance Annual Report 2024/25 (including Freedom of Information Annual Report)				
Executive Lead	Malcolm Gandy, Director of Informatics				
Presenting Officer	Malcolm Gandy, Director of Informatics				
Action Required		**To Approve**	X	**To Note**	

Purpose

To provide the Trust Board with assurance that Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has an effective Information Governance Agenda and Framework in place.

Executive Summary

This report is designed to inform and give assurance to Trust Board of progress made against the Information Governance (IG) work programme for 2024/25. This report also provides the Board with the necessary assurances that MWL was compliant with the Freedom of Information (FOI) Act and summarises the key points of FOI compliance for 2024/25.

Information Governance (IG)

IG is a framework that not only provides a consistent way for staff to deal with the many different information handling requirements but brings together all of the requirements, standards and best practice that apply to the handling of information, specifically information that contains personal confidential information, now referred to as personal data.

IG has four fundamental aims:

- To support the provision of high-quality care by promoting the effective and appropriate use of information in a secure manner.
- To encourage staff to work closely together, preventing duplication of effort and enabling more efficient use of resources.
- To develop an information management structure to provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards.
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

MWL has a duty to ensure that it complies with its legal and regulatory obligations, for IG this is data protection legislation, specifically the UK GDPR and Data Protection Act 2018. MWL is committed to conducting frequent reviews and improvements of its services including IG.

This report details the progress that has been made against the IG work programme for 2024-25 and provides a 'year ahead' programme of work on areas that are necessary to achieve IG compliance and to further embed IG within MWL.

Freedom of Information (FOI)

From April 2024 until the end of March 2025 822 requests were received, the previous year's totalled 824, a very similar number. 99.2% of the requests received were completed, of those completed requests, 63.6% were completed within the 20-working daytime frame.

	April 2024 / March 2025
Requests received	822
Number of Questions contained within the total FOIs received	5,665
Requests completed	816 (99.2%)
20 working day compliance	523 (63.6%)

Financial Implications

None directly from this report.

Quality and/or Equality Impact

Not applicable.

Recommendations

The Board is asked to note the Information Governance Annual Report 2024/25 (including Freedom of Information Annual Report.

Strategic Objectives

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

Report

Introduction

The NHS Information Governance (IG) Framework is the means by which the NHS handles information about patients and employees, specifically personal identifiable information. This Framework allows MWL to ensure that all personal, sensitive and confidential data is being handled legally, securely, efficiently and effectively. IG is an ongoing process which covers many different areas including records management, data quality, legislative compliance, risk management and information security.

MWL has a duty to comply with data protection legislation such as the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA 2018), the Freedom of Information Act 2000 (FOIA 2000), and to meet IG / Information Security / NHS specifications and requirements to support the assurance standards of the Data Security and Protection Toolkit (DSPT).

MWL has its own IG Strategy which sets out the approach it takes in developing and implementing a robust IG Framework for future management, setting out the arrangements, policies, standards and best practice to support the effective management and protection of personal information. A range of policies and procedures further support the IG work including: the Records Management Policy and Procedure; Confidentiality Code of Conduct Policy; Data Security & Protection Breaches / Incident Reporting Policy and Procedure; Freedom of Information Policy; Data Protection Impact Procedure; and Data Quality Policy. These have been approved since the formation of MWL and have all been made available to staff via the MWL intranet.

MWL completes and submits the Data Security and Protection Toolkit (DSPT) on an annual basis. The DSPT enables organisations to measure their performance against Data Security and IG requirements set out in legislation and Department of Health policy. In September 2024 NHS England published a new DSPT which has moved away from assessing organisations against the National Data Guardian's 10 Data Security Standards and is now aligned with the National Cyber Security Centre's Cyber Assessment Framework. MWL have completed the DSPT for 2024-25 and to provide assurance that the evidence provided was of a good standard it was audited by Mersey Internal Audit Agency. For 2024-25 MWL received the rating of Moderate Assurance.

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the IG work programme for 2024-25.

This section will provide assurance, from the SIRO, that MWL:

- Has a sufficient framework in place to ensure compliance with all elements of the IG Agenda.
- Has an active and effective IG Steering Group forum, meeting regularly.
- Manages and investigates any IG / Confidentiality incidents and issues.

Roles and Responsibilities

The Role of the SIRO

Malcolm Gandy, Director of Informatics, is MWL's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

A SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to a Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk.
- Review and agree action in respect of identified information risks.
- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.
- Provide a focal point for the resolution and / or discussion of information risk issues.
- Ensure the Board is adequately briefed on information risk issues.
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the organisation's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); acts as a champion for information risk on the Board and provides written advice to the Accountable Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS IG risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the Trust**.**

The SIRO has a responsibility for ensuring there are robust IG systems and processes in place to help protect patient and corporate information. The focus of the DSPT is on setting standards and providing tools to achieve them. The SIRO authorises the DSPT Self-Assessment annual submissions once the relevant assurances have been provided by the IG and IT Security Teams. The new Cyber Assessment Framework aligned DSPT provides assurance across 5 areas:

A – Managing Risk

B - Protecting against cyber-attack and data breaches

C - Detecting cyber security events

D - Minimising the impact of incidents

E - Using and sharing information appropriately

The Role of the Caldicott Guardian

Mr Alex Benson is MWL's registered Caldicott Guardian. Mr Benson is tasked with ensuring that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. Mr Benson provides leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader IG agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that all NHS

organisations achieve the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance to the Trust Board that the Caldicott Guardian function within MWL operates at a satisfactory level and that it is appropriately supported within the existing IG structure.

MWL's Caldicott Guardian is supported by MWL's Director of Informatics in his role as Senior Information Risk Owner (SIRO) and MWL's Head of Information Governance & Data Protection Officer and her team.

Data Protection Officer

Camilla Bhondoo is MWL's Data Protection Officer. Data Protection Officers (DPOs) are part of data protection legislation, UK General Data Protection Regulation 2018 (UK GDPR) and Data Protection Act 2018.

DPOs are therefore at the heart of this legal framework for many organisations, facilitating compliance with the provisions of the UK GDPR. It is therefore mandatory for certain Data Controllers and Processors to designate a DPO (Article 37, UK GDPR).

This will be the case for all public authorities and bodies (irrespective of what data they process). MWL is therefore required to appoint a DPO.

The named DPO must be:

- Independent
- An expert in data protection
- Adequately resourced
- Report to the highest management level

As per Article 39 of the UK GDPR the DPO tasks are to:

- Inform and advise you and your employees about your obligations to comply with the UK GDPR and other data protection laws.
- Monitor compliance with the UK GDPR and other data protection laws, and with your data protection polices, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits.
- Advise on, and to monitor, Data Protection Impact Assessments.
- Cooperate with the supervisory authority and
- Be the first point of contact for supervisory authorities and for individuals whose data is processed (employees, customers etc).

Camilla Bhondoo reports into the Director of Informatics/SIRO.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing governance group which is accountable to MWL's IM&T Council and ultimately MWL's Board. The Group oversees the implementation of the IG Agenda throughout the organisation.

Its main purpose is to support and drive the broader IG Agenda and provide MWL's Board with the assurance that effective IG best practice mechanisms are in place within MWL.

The IGSG is chaired by MWL's SIRO Mr Malcolm Gandy, with MWL's Deputy SIRO, Rob Howorth as Deputy Chair. Core membership includes MWL's Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG saw the Group address the following topics –

- Implementation and completion of an IG work plan for 2024-25 that detailed the IG tasks / actions that were required for the year, this IG work plan was even more imperative to have in place with the new DSPT focussing on cyber security. The aim was to provide assurance to the Group (including the SIRO, Caldicott Guardian and DPO) that all areas of data protection laws were being addressed and therefore MWL were complying with these laws. For this IG work plan 22 workstreams were listed and there were 78 individual tasks / actions – all requiring completing before DSPT submission (end of June).
- Review of the Terms of Reference and membership for the IG Steering Group to be more inclusive and representative of the departments across the Trust. Enabling key IG messages to be filtered to the right places. Ensuring that the purpose of the group and the responsibilities of the Group is detailed and being adhered to, which ultimately monitors the Trust's Information Governance agenda. This has been reflected in an updated and approved Terms of Reference for the group.
- Approval of the following IG policies / key documents:
    - Information Governance Strategy – a key document that sets out the approach MWL takes to develop and implement a robust Information Governance Framework for the future management and protection of organisational and personal information.
    - IG Training Needs Analysis – this outlines the key roles within the Trust and the Information Governance training they are required to undertaken to support the Trust's Information Governance Framework and compliance with the Data Security and Protection Toolkit.
    - Patient / Public Privacy Notice – a document required by law (UK GDPR, specifically UK GDPR Principle (a): Lawfulness, fairness and transparency and under the 'right to be informed') where MWL must inform individuals (in our case the public and patients and staff) when we collect personal data from them and how we intend to use it. This has been made accessible to the public via the Trust website. Privacy Notices must be reviewed annually as a minimum. This year:

        - The CCTV and Bodycam section has been expanded to include that where the use is expanded the Trust is obliged to assess, consider and approve any privacy risks before implementation.
        - New Artificial Intellgence section added to advise of inclusion, expansion and the checks that will be involved before implementation
        - How we keep your personal data confidential and secure? section added to, to explain the DSPT, the importance of completing it and the due diligence checks we carry out on Data Processors when the Trust employs organisations to process data on their behalf.
    - Staff Privacy Notice – As above, a must for MWL to have in place. This Staff Privacy Notice is not only useful for staff who work within the Trust but as a Lead Employer and a Payroll provider often organisations the Trust is linked to will ask for a Staff Privacy Notice to see how we are protecting their staff's data. This is made available on the Trusts website and intranet. This year:
        - Introduction of Verifile Limited – the Trust are now using to carrying out ID and DBS checks virtually to try and make the recruitment stage easier for successful candidates.
        - New paragraph confirming what steps the Trust has in place to verify the legitimacy of Data Processors / Suppliers.
    - A Young Person's Privacy Notice created and approved for MWL. This notice is new never having a privacy notice for MWL's young patients. Patients of all ages need to be able to understand how the Trust looks after and protects their data. The Public / Patient Privacy Notice is extremely detailed and maybe seen as difficult to understand for all of our patients, particularly the younger ones, hence the need for a more simplified version.
- Streamlined processes for the Subject Access Request (SAR) Team (when an individual wants a copy of the personal data MWL may hold about them they contact the Subject Access Request Team). This team moved under the management of Information Governance in January 2024 and continues to evolve and improve the process for requestors. Improvements include:
    - Each SAR Officer being allocated with their own caseload, meaning that there is consistency and the requestor is aware that they have an 'assigned' member of staff should they have any questions. Where there is leave handovers are in place. This enables the SAR Lead to have better oversight of the SARs and their movement through the system, allowing focus on the SARs that require more time.
    - The team handling HR and Lead Employers SARs (taking pressure off teams that are not trained in the SAR arena and ensuring they follow the same process as the other SARs). Pockets of HR and Lead Employer were either not aware of the SAR team or presumed they would handle these SARs.
    - Ensuring HR and Lead Employer are informed of all SARs that were being received directly by the SAR team, enabling the teams to work together to ensure no legal privileged information or Trust sensitive information is incorrectly or inappropriately disclosed to the requestor.

- Information Governance team providing support for the more detailed requests that require further review and expert redaction before disclosure.

- Review and update the Individual Rights Policy (this was new to the Trust last year) to include a section on 'The Right to Complain to Trust regarding how an Individual Right has been processed.' Following feedback from a SAR requestor that it was not clear that if a request required a 'fresh' review after a complaint, as there is evidenced to suggest information was missing or has been redacted wrongly, that it would be classed as a new request and this could take up to one calendar month. This was approved.

- A clear process established for 'Right to Rectification' requests. Required for when an individual requests a correction or update to inaccurate, incomplete, or outdated information the Trust may hold about them. The Trust has established a formal process to review and manage these requests, with a target response time of one calendar month. Patient records are approved by the Caldicot Guardian and for staff data these would need to be reviewed by HR and the Information Asset Owner where the employee works / worked to approve these type of requests. These are reported to the IG Steering Group.

- 95% departments within the Trust have been audited by the IG team over the last 12 months. A total of 136 departments. The IG team assess whether staff are acting in accordance with Information Governance principles when on-site. This includes ensuring identification badges are worn, clear desk policies are adhered to, secure areas are kept locked when unoccupied, etc. Key concerns have been discussed at the Group and actions assigned.

- Establishing Information Asset Registers for each department. The IG team are able to understand what key information assets each department has especially where they contained personal data i.e. personnel files, check that they legally can have them and ensure that whether they are held electronically or in paper format that they are held securely, with appropriate limited access. 92 departments have been identified and 44 registers have been completed to date. Identified risks, such as paper files being stored in a broken filing cabinet, are escalated to the IG Steering Group for action.

- Oversight of the Data Protection Impact Assessments (DPIAs) and Due Diligence Questionnaires (DDQs). These documents are important to ensure any initiative / system involving personal data are properly risk assessed and privacy rules are checked. Where suppliers are contracted to work on behalf of the Trust, that they are 'checked' out to ensure they have the right securities in place. Additionally, this past year the IG team have started to review DPIAs and DDQs which are over a year old. This is to see whether they are still in use or if any there have been any changes to how the initiative / system is being used. 41 DPIAs were reviewed by the Project Lead. The IG team also identified where contracts were missing.

- Monitoring of the IG incidents that are reported on the Trust's Incident Reporting System, InPhase. Each data breach has followed the IG Incident Reporting process and been investigated by the IG Team. Where data breaches have been classed as near miss data breaches or where key actions have been required the IG Officers have completed an IG Incident Proforma which details the data breach, score, findings and an action plan. These are reviewed by the Directorate Manager and sent to the DPO for approval. Where data breaches are classed as serious there is a process in place to escalate to the SIRO and Caldicott Guardian (if patient data involved) via the DPO. A report is presented to the Group which also provides assurance that the Trust has a robust data breach procedure and policy in place. During the

financial year 2024-25 1022 incidents were reported to IG – any incident causing alarm was discussed at the IG Steering Group.

Reportable Incidents

MWL has a duty to report any incidents regarding breaches of the Data Protection Act that score highly to the Information Commissioner's Office (ICO) and for the financial year 2024/25 there was one incident. The Trust is yet to hear from the ICO.

A breakdown of the reported incident to the ICO is below:

April 2024	At 20:00 on the 16/04/2024 the Radiology department at Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) received a telephone call from an individual stating to be the husband of a patient who had recently undergone an obstetric scan. The call was taken by the Radiographer. The caller stated that their partner had asked them to call regarding the results. The Radiographer then informed the caller of the results of the scan over the telephone. An hour later the patient came to the Radiology department to report that the caller was her ex-partner and that safeguarding measures where currently in place. It was also reported that the man purporting to be the patient's husband had covertly recorded the telephone conversation with the Radiographer and posted this on his social media channels.
Outcome	ICO advised of action plan, at the time of writing this report no comments have been received by the ICO. Action Plan included: Immediate Actions Taken The Radiology Manager has spoken to and apologised to the patient. Established that the patient was safe and police notified. The MWL Safeguarding Team also informed as were Human Resources and Information Governance. The incident was recorded on the Datix incident Management System at 16:08 on 17/04/2024. Further Actions: • Initial incident grading matrix completed. • IG incident investigation report started. • IG Training compliance checked (department is compliant). • IG contacted senior department lead to establish the process they have in place for releasing information. • Audit of department arranged, with particular attention to how telephone calls are managed. • IG to attend team meeting to discuss how these calls should be handled.

	• Lessons learnt to be circulated to the Trust via internal comms. • Upcoming face to face training delivered by IG will include a stronger emphasis on the importance of confirming the right to access information and confirming ID over the telephone. • IG to review Radiology Staff Handbook to see if content is appropriate and there are no gaps in the content. • Radiology teams are working with HR around the staff disciplinary process.

There have been no fines issued by the ICO to MWL in 2024-25.

Reporting & Monitoring

Progress against MWL's DSPT and compliance with relevant legislation is monitored by the Head of Risk Assurance & Data Protection Officer (DPO) and the IG Steering Group.

Progress reports are presented to the IG Steering Group and subsequently to the IM&T Council, then ultimately to the MWL's Board by the Senior Information Risk Owner (SIRO).

Any standards or areas of compliance not being met require action plans to be prepared, which will be monitored to ensure improvement and compliance.

The Year Ahead

The next 12 months will see MWL continue to build upon it's IG Strategy and will ensure it remains compliant with its annual IG work plan, data protection legislation and its own IG Framework. Maintaining compliance will occur through planning and day to day activities, which will need to be balanced against the needs of the organisation.

This year the following areas will be of primary focus:

- **To create and implement an MWL IG work plan for 2025-26** – A new IG work plan for 2025-26 for MWL will be in place as of July. The IG work plan details what work the Trust will need to carry out during the course of this next year to ensure it remains on track with its compliancy. This will keep the Trust in line with the any components of the new DSPT (now aligned to the Cyber Assessment Framework) and key data protection legislation. The former IG work plan contained 22 workstreams, the new IG work plan will contain 23 as it will include the implementation of the Data Use and Access Act 2025 (DUAA). The IG team will ensure there is a continuous review of the IG work plan throughout the year and provide assurance via the IG Steering Group.

- **To create a Data Use and Access Act 2025 (DUAA) action plan** – This act is new and received Royal Assent on the 19th June 2025; introducing a series of updates to the UK GDPR, the Data Protection Act 2018 and the Privacy and Electronic Communications Regulations. These changes are seen as evolutionary rather than revolutionary – a supplementary law, not a

replacement. The core principles and obligations for data protection remain unchanged, and the practical impact of the updates will vary depending on our Trust and how its specific data processing activities. Although this will be included in the IG work plan it is important that a specific action plan is developed to make sure the Trust remains data protection compliant. The Information Commissioner's Office (ICO) will interpret the new provisions and issue forthcoming guidance. Organisations have been asked to be ready however until clarity is provided to monitor developments, review current practices, and avoid making any hasty policy changes. Once a DUAA action plan is created this will be monitored by the IG Steering Group.

- **Support Artificial Intelligence (AI) and Robotic Processing Automation (RPA)** – As technology evolves across the Trust and proposals are being presented on the advantages on use of the AI and RPA the IG team will need to assess both the privacy and security risks of this type of processing. The IG team will ensure they are kept abreast of how data protection will factor in these new areas and continue, not only to follow the current Data Protection Impact Assessment process but also incorporate any risk assessment questions / areas that need to be part of this new area. The aim is to continue to provide Data Protection assurance on whatever system / initiative / process needs to be embedded to support the Trust in embracing new technologies and reducing repetitive burden. Any AI / RPA processing will be reported to the IG Steering Group.

- **Complete the DSPT IG recommendations** – There are recommendations that have been produced by the Internal Auditors after their assessment of the MWL's DSPT. An action plan will be produced identifying action owners. This action plan, focusing on any IG recommendations will be monitored under MWL's IG Steering Group.

- **Continue to support Due Diligence Checks** – Last year the IG team started to review mandatory IG documentation; Data Protection Impact Assessments, Due Diligence Questionnaires, Data Sharing Agreements and Contracts. With the heightened cyber threat, where the risk of compromising personal data is at the focus, the continued efforts of the IG team to carry on reviewing what systems, initiatives and suppliers the Trust has is critical. Crucially where the Trust has outsourced (suppliers) processing of its personal data, that the suppliers are contacted at least every 2 years to enable the supplier to update and refresh their information if they still hold a contract with the Trust. Progress will be reported to the IG Steering Group.

- **To support the Subject Access Request Team** – The team who process Subject Access Requests (SARs) moved into the IG Team in January 2024. Although vast improvements have been made since January 2024 (as previously mentioned in this report) there is a need to streamline the service further. Due to IT / technical difficulties it has been difficult to bring the team together as one i.e. former STHK SAR Officers have been working on STHK requests and S&O SAR Officers on S&O requests. The SAR Lead has been tasked to ensure by the 1st September this team will operate as one, using one email address, one contact phone number. This will ensure that requests are received centrally and equally distributed across the team (currently the STHK SAR Officer process 3 times as many as the S&O SAR Officers due to the requests that are received in). There is also a focus to 'upskill' the SAR Officers on complex

redaction as more complicated SAR are being received and processed. Progress will be reported to the IG Steering Group.

- **To continue with Face-to-Face IG Mandatory Training Sessions** – Last year the IG team saw the benefit in introducing 'face to face' IG training sessions. Engagement increased dramatically and the team reported that staff members felt able to ask specific questions regarding their area of work. From April 2024 – March 2025, 587 staff members received this type of training. Feedback has been extremely positive.

  Comments received from a delegate:
  '*Very informative, previously attended always informative and engaging. Good information is and well delivered by Kev. Good to know about information sharing and information provided on records management too'*

  This year the team will promote face to face IG Mandatory Training and increase on the areas they visited in the past year.

- **Continue to implement Information Asset Registers (IARs) across the Trust** – In the last year the team have worked hard to engage with as many departments to produce Information Asset Registers for their area. There is a need to understand where in MWL personal data is processed and to ensure this data can be processed legally, is being held as securely as possible (be it paper or electronic) and to identify any risks. Additionally, where personal data is being held for longer than necessary that it is reviewed before potential destruction. The completion of IARs will continue and any high risks will be highlighted to the SIRO. This work will sit alongside Data Flow Mapping which ensures that any outflows of data are done via a secure manner, i.e., secure email. This continues to be a requirement of the new DSPT and will be monitored by the IG Steering Group.

- **Increase presence onsite through walk around audits** – Through visiting the majority of the Trust's departments in the past year, which are in most cases ad-hoc, presents a true picture and the team were able to identify areas of improvement and work with service leads to have discussions around how new processes could be implemented. It is not only important that these audits are carried out on a regular basis to ensure any changes have been made and to identify any new areas of improvement, but to raise the presence of IG and data protection, bringing to life what staff members hear in the training. Reports will be provided to the IG Steering Group.

- **Supporting the Data Breach Investigation Process** – This is the second year of having MWL's data breach policy in place which has seen all IG related incidents investigated. The team will continue to adhere to this policy and see the completion of IG incident proformas when required. The proformas not only provide all management that a serious / near miss data breach is being managed through a managed action plan but also provides the individual affected with assurance that is has been investigated thoroughly. These proformas have fed into wider complaints received by the Trust. The team support staff members in ensuring all actions are achievable and are achieved. The IG Steering Group are able to monitor incidents that are investigated by the team.

Conclusion

This report confirms that the Trust has an excellent IG awareness, focus and culture. Its staff are honest and work hard to understand their IG role and responsibilities.

With the completion of the tasks listed in the IG work plan for 2024-25 and completing the areas that are for IG within the DSPT, the IG team can confirm that the Trust has not only implemented the key IG foundations which are required to ensure the Trust is meeting its data protection obligations and IG Framework and Strategy, but are actively monitoring and consistently looking at ways to improve.

This has been demonstrated by the completion of MWL's Data Security and Protection Toolkit (DSPT). The Trust able to provide evidence on all IG areas and this evidence was verified by the Trust's external auditor who have confirmed that we met these areas, and that 'high confidence' was received in the quality of the evidence provided. The DSPT looks at the robustness of the processes that have been put in place such as; the reporting and investigation of data breaches, the completion of Data Protection Impact Assessments (DPIAs), data sharing agreements, data processor agreements, the delivery and monitoring of IG training and awareness, information asset registers, providing advice and guidance on a range of data protection queries to name a few areas.

This past year is the first time the IG team has been fully resourced and the movement and progress of IG work areas that were previously stagnant have flourished, such as walkaround audits, completion of Information Asset Registers, annual reviews of key IG documentation and additional checking support for the SAR team. The IG team have worked hard to produce these results and in turn the Trust is able to reap the benefits knowing its staff are in safe hands when they require IG support and the Trust is IG / data protection compliant due to their efforts.

This year, the team will continue to build on the achievements from the past year, working to raise awareness of IG and reiterate its importance especially through training and audits. This will also include picking up on DSPT recommendations made by the auditor which will further strengthen what we have in place.

There will also be close attention on what the new Data Use and Access Act 2025 may bring, and the IG team will ensure that they have a full understanding of any implications it may bring to the Trust and to specific teams / departments, where changes may be required in order to adhere to this new Act.

It must also be recognised the IG team also enable essential cross organisational and collaborative working with our partner organisations by supporting information sharing and processing of personal data for commissioned services.

The established IG Steering Group, which is fortunate to have excellent attendance from all key areas, will continue to monitor the progress of MWL's IG Agenda and will be proactive to escalate any matters arising to the IM&T Council.

Freedom of Information Act Annual Report 2024/25

From April 2024 till the end of March 2025 822 requests were received, the previous years totalled 824, a very similar number. 99.2% of the requests received were completed, of those completed requests, 63.6% were completed within the 20-working daytime frame.

	April 2024 / March 2025
Requests received	822
Number of Questions contained within the total FOIs received	5665
Requests completed	816 (99.2%)
20 working day compliance	523 (63.6%)

Introduction

As a public authority MWL is required to action and respond to Freedom of Information (FOI) Requests under the legislation 'the Freedom of Information Act 2000.' The public are able to request non personal information about MWL and its activities.

Anyone can make an FOI request, and the organisation must respond to the request within 20 working days. Failure to do so could result in a fine or warning from the Information Commissioners Office.

The Chief Executive who has overall responsibility in MWL for the FOI Act delegates the responsibility for the implementation and monitoring of the Act to Anne-Marie Stretch, who is the Deputy Chief Executive (also known as the Executive FOI lead) at MWL. The Executive FOI Lead ensures that MWL complies with the legislation and takes overall ownership of MWL's FOI Policy, making sure systems and procedures that are established are reviewed to support the FOI process.

The Information Governance (IG) team through dedicated resources, process, coordinate, monitor and report all FOI requests. This includes following all administration procedures and record keeping in line with MWL's FOI policy and the FOI Act.

This report is designed to provide the Trust Board with assurance that MWL is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for April 2024 – March 2025 will be shown here.

Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

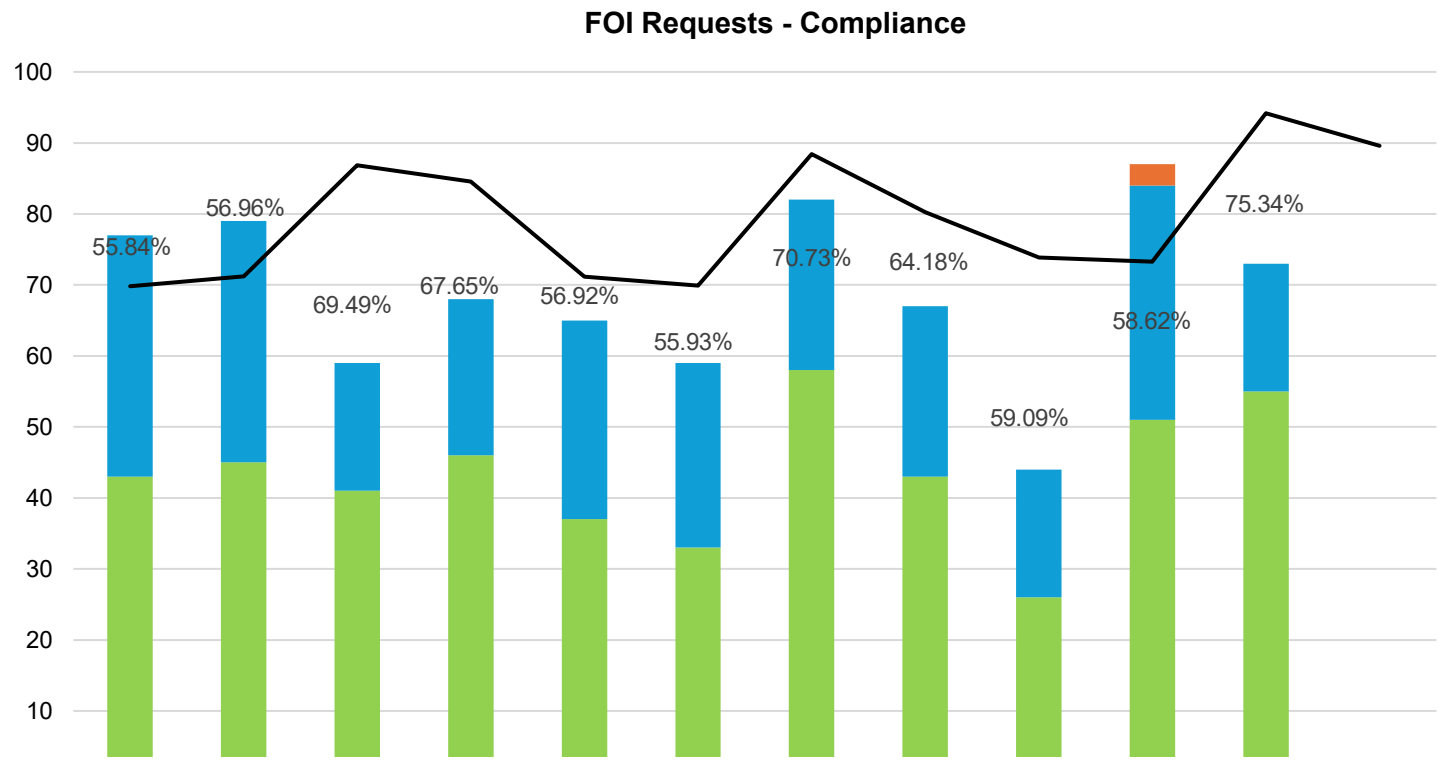
Performance

The overall compliance figure shows a slight decrease on the previous year's compliance levels in terms of completing the requests.

- The breakdown of FOIs handled by executive areas are: Human Resources (151), Finance (215), Chief Operations Officer (230), Nursing (96), Informatics (73), Corporate Services (52), and Chief Medical Officer (5).
- 63.6% of requests were answered within the 20-working day timescale.
- February 2025 saw the highest rate of compliance with 75.34% of requests responded to within 20 working days.
- 99.2% of all requests received in the financial year have been responded to, the remaining 0.6% of requests are still open.
- Requests sources can be broken down into the following group: Commercial (434) 52.7%, Member of the Public (123) 14.9%, Press (94) 11.4%, Research (74) 9.0%, Not Given (45) 5.4%, Other (35) 4.2%, Staff (15) 1.8%, and MPs (5) 0.6%.
- The categories of requests that were received were: “About the Trust” (232), “Decision Making” (11), “Lists & Registers” (273), “Our Services” (129), “Policies and Procedures” (66), Priorities and Progress (4), and “What and How we Spend” (107).

Table 1 below shows the requests completed throughout the year and the monthly compliance with the 20-working daytime scale.

Table 1 – Update (April 2024 – March 2025)



ICO Notification

Disappointingly the Trust received a Decision Notice in May 2025 regarding the answers it had provided to an FOI earlier in the year, applying an exemption with reason time and the time it had taken the Trust to respond to a request. The ICO upheld the Trusts response however have informed the Trust that

response times to FOIs must be looked into and the Trust needs to be responding within the 20-day timeframe.

Areas to Note

- The nature of the requests that are being received have become more complex which often results in 1 FOI request having multiple questions for different departments. The majority of FOIs contain at least 1 finance question which increases the number of FOIs receive, far more than any other department. This means that the approval process is taking longer.

- Due to staff movement at a senior level which has now stabilized it had been difficult to nominate a second 'approver' (a reminder that each Executive Lead is approves FOIs that require a response from their area). A second approver is necessary for when the Executive Lead / main approver is not available.

- The IG team have a dedicated FOI Officer who ensures all FOIs are logged and supports teams in providing updates and information when needed. The extended IG team are trained to 'step into' the role when the FOI Officer is unavailable due to leave. This ensures that the FOIs are constantly monitored when they are in the system.

Areas of Improvement in 2024-25

- During 2024–25, the Information Governance (IG) team focused on strengthening the FOI process across MWL. The IG team began working with individual departments to identify key contacts who can support FOI responses. To ensure consistency and confidence in handling requests, FOI training and clear guidance were provided, helping staff understand the end-to-end process, including the necessary approvals before information is released. HR and Finance, who receive the majority of requests have worked hard to ensure they have internal resources available to process the FOIs they receive.

- The IG team have worked closely with departments such as HR, Finance, and IT to develop and implement publication schemes. These schemes aim to proactively publish frequently requested information, enabling the IG team to signpost requestors and reduce the burden on operational teams. Continually work is needed in this area to ensure that the Trust is proactively publishing more material that would be release under FOI.

- The FOI publication section was migrated to the main MWL website under the 'About the Trust' section. This change improves accessibility and allows the IG Team to redirect requestors more efficiently.

Suggested Areas of Focus for 2025-26

- The Executive Leads to inform their teams of the importance of responding to FOIs in a timely manner and advise of the recent ICO Decision Notice on responding within the legally set timeframe of 20 days.

- Introduction of Departmental FOI Champions - Establish a network of FOI champions across departments to act as first points of contact. This will streamline communication, improve response quality, and embed FOI awareness more deeply across the organisation.

- Advanced FOI Analytics and Reporting - With support from business intelligence the Trust should introduce analytics tools to track trends in FOI requests, identify recurring themes, and inform future publication schemes. This data-driven approach can help anticipate public interest and reduce repetitive requests.

- Resource Planning and Resilience - Each executive area to conduct a workforce planning review to ensure that their departments have the capacity and resilience to provide the requested information to the Information Governance team so that they can respond to the FOI in a timely manner. This is particularly important during periods of key staff absence.

Conclusion

The 2024/25 reporting period has reaffirmed MWL's commitment to transparency and accountability through its management of FOI requests. Despite the increasing complexity and volume of requests, the Trust achieved a high completion rate of 99.2% and made notable progress in streamlining internal processes. However, this was offset by only 63.6% of FOI requests being answered within the 20 working days compliance period.

The introduction of Executive Lead oversight for FOI approvals has strengthened governance and improved visibility of the information being released. Additionally, the IG team has enhanced accessibility by updating the FOI section on the Trust website and working towards developing publication schemes to proactively share commonly requested information.

Looking ahead to 2025/26, the Trust is well positioned to build on these improvements. However, continued progress depends on timely collaboration from departments that hold the requested information. Delays in providing responses or securing Executive sign-off risk undermining the Trust's ability to meet the statutory 20 working day deadline. Without appropriate prioritisation and resourcing at the departmental level, compliance rates are unlikely to improve. The Trust should appreciate the issuance of an ICO Decision Notice and commit to working towards being compliant.

The IG team remains fully committed to supporting the Trust's FOI obligations. It will continue to monitor performance, escalate risks where necessary, and drive improvements through the IG Steering Group and IM&T Council

MWL's FOI process has seen each Executive Lead reviewing and approving FOIs for their respective areas which certainly has resulted in the process becoming more streamlined by making each Executive Lead aware of what information was being requested and released. This approval process will continue.

The FOI requests being received by the Trust are considered not 'straight forward' and result in multiple departments having to contribute to just one, combine this with legacy STHK & S&Os departments

coming together and in a lot of cases still having to go to two sources to pull the information as the information is yet to be merged has meant that the Trust's overall compliance is a fair representation.

As MWL, the IG team will continue to implement the FOI process and work with the departments to see where information can be published. All members of the IG team have been trained in the FOI process and there is daily cover.

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	30 July 2025
Agenda Item	**TB25/062 (14.2)**				
Report Title	Information Governance Annual Report 2024/25 (including Freedom of Information Annual Report)				
Executive Lead	Malcolm Gandy, Director of Informatics				
Presenting Officer	Malcolm Gandy, Director of Informatics				
Action Required		**To Approve**	X	**To Note**	

Purpose

To provide the Trust Board with assurance that Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has an effective Information Governance Agenda and Framework in place.

Executive Summary

This report is designed to inform and give assurance to Trust Board of progress made against the Information Governance (IG) work programme for 2024/25. This report also provides the Board with the necessary assurances that MWL was compliant with the Freedom of Information (FOI) Act and summarises the key points of FOI compliance for 2024/25.

Information Governance (IG)

IG is a framework that not only provides a consistent way for staff to deal with the many different information handling requirements but brings together all of the requirements, standards and best practice that apply to the handling of information, specifically information that contains personal confidential information, now referred to as personal data.

IG has four fundamental aims:

- To support the provision of high-quality care by promoting the effective and appropriate use of information in a secure manner.
- To encourage staff to work closely together, preventing duplication of effort and enabling more efficient use of resources.
- To develop an information management structure to provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards.
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

MWL has a duty to ensure that it complies with its legal and regulatory obligations, for IG this is data protection legislation, specifically the UK GDPR and Data Protection Act 2018. MWL is committed to conducting frequent reviews and improvements of its services including IG.

This report details the progress that has been made against the IG work programme for 2024-25 and provides a 'year ahead' programme of work on areas that are necessary to achieve IG compliance and to further embed IG within MWL.

Freedom of Information (FOI)

From April 2024 until the end of March 2025 822 requests were received, the previous year's totalled 824, a very similar number. 99.2% of the requests received were completed, of those completed requests, 63.6% were completed within the 20-working daytime frame.

	April 2024 / March 2025
Requests received	822
Number of Questions contained within the total FOIs received	5,665
Requests completed	816 (99.2%)
20 working day compliance	523 (63.6%)

Financial Implications

None directly from this report.

Quality and/or Equality Impact

Not applicable.

Recommendations

The Board is asked to note the Information Governance Annual Report 2024/25 (including Freedom of Information Annual Report.

Strategic Objectives

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

Report

Introduction

The NHS Information Governance (IG) Framework is the means by which the NHS handles information about patients and employees, specifically personal identifiable information. This Framework allows MWL to ensure that all personal, sensitive and confidential data is being handled legally, securely, efficiently and effectively. IG is an ongoing process which covers many different areas including records management, data quality, legislative compliance, risk management and information security.

MWL has a duty to comply with data protection legislation such as the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA 2018), the Freedom of Information Act 2000 (FOIA 2000), and to meet IG / Information Security / NHS specifications and requirements to support the assurance standards of the Data Security and Protection Toolkit (DSPT).

MWL has its own IG Strategy which sets out the approach it takes in developing and implementing a robust IG Framework for future management, setting out the arrangements, policies, standards and best practice to support the effective management and protection of personal information. A range of policies and procedures further support the IG work including: the Records Management Policy and Procedure; Confidentiality Code of Conduct Policy; Data Security & Protection Breaches / Incident Reporting Policy and Procedure; Freedom of Information Policy; Data Protection Impact Procedure; and Data Quality Policy. These have been approved since the formation of MWL and have all been made available to staff via the MWL intranet.

MWL completes and submits the Data Security and Protection Toolkit (DSPT) on an annual basis. The DSPT enables organisations to measure their performance against Data Security and IG requirements set out in legislation and Department of Health policy. In September 2024 NHS England published a new DSPT which has moved away from assessing organisations against the National Data Guardian's 10 Data Security Standards and is now aligned with the National Cyber Security Centre's Cyber Assessment Framework. MWL have completed the DSPT for 2024-25 and to provide assurance that the evidence provided was of a good standard it was audited by Mersey Internal Audit Agency. For 2024-25 MWL received the rating of Moderate Assurance.

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the IG work programme for 2024-25.

This section will provide assurance, from the SIRO, that MWL:

- Has a sufficient framework in place to ensure compliance with all elements of the IG Agenda.
- Has an active and effective IG Steering Group forum, meeting regularly.
- Manages and investigates any IG / Confidentiality incidents and issues.

Roles and Responsibilities

The Role of the SIRO

Malcolm Gandy, Director of Informatics, is MWL's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

A SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to a Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk.
- Review and agree action in respect of identified information risks.
- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.
- Provide a focal point for the resolution and / or discussion of information risk issues.
- Ensure the Board is adequately briefed on information risk issues.
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the organisation's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); acts as a champion for information risk on the Board and provides written advice to the Accountable Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS IG risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the Trust**.**

The SIRO has a responsibility for ensuring there are robust IG systems and processes in place to help protect patient and corporate information. The focus of the DSPT is on setting standards and providing tools to achieve them. The SIRO authorises the DSPT Self-Assessment annual submissions once the relevant assurances have been provided by the IG and IT Security Teams. The new Cyber Assessment Framework aligned DSPT provides assurance across 5 areas:

A – Managing Risk

B - Protecting against cyber-attack and data breaches

C - Detecting cyber security events

D - Minimising the impact of incidents

E - Using and sharing information appropriately

The Role of the Caldicott Guardian

Mr Alex Benson is MWL's registered Caldicott Guardian. Mr Benson is tasked with ensuring that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. Mr Benson provides leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader IG agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that all NHS

organisations achieve the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance to the Trust Board that the Caldicott Guardian function within MWL operates at a satisfactory level and that it is appropriately supported within the existing IG structure.

MWL's Caldicott Guardian is supported by MWL's Director of Informatics in his role as Senior Information Risk Owner (SIRO) and MWL's Head of Information Governance & Data Protection Officer and her team.

Data Protection Officer

Camilla Bhondoo is MWL's Data Protection Officer. Data Protection Officers (DPOs) are part of data protection legislation, UK General Data Protection Regulation 2018 (UK GDPR) and Data Protection Act 2018.

DPOs are therefore at the heart of this legal framework for many organisations, facilitating compliance with the provisions of the UK GDPR. It is therefore mandatory for certain Data Controllers and Processors to designate a DPO (Article 37, UK GDPR).

This will be the case for all public authorities and bodies (irrespective of what data they process). MWL is therefore required to appoint a DPO.

The named DPO must be:

- Independent
- An expert in data protection
- Adequately resourced
- Report to the highest management level

As per Article 39 of the UK GDPR the DPO tasks are to:

- Inform and advise you and your employees about your obligations to comply with the UK GDPR and other data protection laws.
- Monitor compliance with the UK GDPR and other data protection laws, and with your data protection polices, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits.
- Advise on, and to monitor, Data Protection Impact Assessments.
- Cooperate with the supervisory authority and
- Be the first point of contact for supervisory authorities and for individuals whose data is processed (employees, customers etc).

Camilla Bhondoo reports into the Director of Informatics/SIRO.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing governance group which is accountable to MWL's IM&T Council and ultimately MWL's Board. The Group oversees the implementation of the IG Agenda throughout the organisation.

Its main purpose is to support and drive the broader IG Agenda and provide MWL's Board with the assurance that effective IG best practice mechanisms are in place within MWL.

The IGSG is chaired by MWL's SIRO Mr Malcolm Gandy, with MWL's Deputy SIRO, Rob Howorth as Deputy Chair. Core membership includes MWL's Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG saw the Group address the following topics –

- Implementation and completion of an IG work plan for 2024-25 that detailed the IG tasks / actions that were required for the year, this IG work plan was even more imperative to have in place with the new DSPT focussing on cyber security. The aim was to provide assurance to the Group (including the SIRO, Caldicott Guardian and DPO) that all areas of data protection laws were being addressed and therefore MWL were complying with these laws. For this IG work plan 22 workstreams were listed and there were 78 individual tasks / actions – all requiring completing before DSPT submission (end of June).
- Review of the Terms of Reference and membership for the IG Steering Group to be more inclusive and representative of the departments across the Trust. Enabling key IG messages to be filtered to the right places. Ensuring that the purpose of the group and the responsibilities of the Group is detailed and being adhered to, which ultimately monitors the Trust's Information Governance agenda. This has been reflected in an updated and approved Terms of Reference for the group.
- Approval of the following IG policies / key documents:
    - Information Governance Strategy – a key document that sets out the approach MWL takes to develop and implement a robust Information Governance Framework for the future management and protection of organisational and personal information.
    - IG Training Needs Analysis – this outlines the key roles within the Trust and the Information Governance training they are required to undertaken to support the Trust's Information Governance Framework and compliance with the Data Security and Protection Toolkit.
    - Patient / Public Privacy Notice – a document required by law (UK GDPR, specifically UK GDPR Principle (a): Lawfulness, fairness and transparency and under the 'right to be informed') where MWL must inform individuals (in our case the public and patients and staff) when we collect personal data from them and how we intend to use it. This has been made accessible to the public via the Trust website. Privacy Notices must be reviewed annually as a minimum. This year:

        - The CCTV and Bodycam section has been expanded to include that where the use is expanded the Trust is obliged to assess, consider and approve any privacy risks before implementation.
        - New Artificial Intellgence section added to advise of inclusion, expansion and the checks that will be involved before implementation
        - How we keep your personal data confidential and secure? section added to, to explain the DSPT, the importance of completing it and the due diligence checks we carry out on Data Processors when the Trust employs organisations to process data on their behalf.
    - Staff Privacy Notice – As above, a must for MWL to have in place. This Staff Privacy Notice is not only useful for staff who work within the Trust but as a Lead Employer and a Payroll provider often organisations the Trust is linked to will ask for a Staff Privacy Notice to see how we are protecting their staff's data. This is made available on the Trusts website and intranet. This year:
        - Introduction of Verifile Limited – the Trust are now using to carrying out ID and DBS checks virtually to try and make the recruitment stage easier for successful candidates.
        - New paragraph confirming what steps the Trust has in place to verify the legitimacy of Data Processors / Suppliers.
    - A Young Person's Privacy Notice created and approved for MWL. This notice is new never having a privacy notice for MWL's young patients. Patients of all ages need to be able to understand how the Trust looks after and protects their data. The Public / Patient Privacy Notice is extremely detailed and maybe seen as difficult to understand for all of our patients, particularly the younger ones, hence the need for a more simplified version.
- Streamlined processes for the Subject Access Request (SAR) Team (when an individual wants a copy of the personal data MWL may hold about them they contact the Subject Access Request Team). This team moved under the management of Information Governance in January 2024 and continues to evolve and improve the process for requestors. Improvements include:
    - Each SAR Officer being allocated with their own caseload, meaning that there is consistency and the requestor is aware that they have an 'assigned' member of staff should they have any questions. Where there is leave handovers are in place. This enables the SAR Lead to have better oversight of the SARs and their movement through the system, allowing focus on the SARs that require more time.
    - The team handling HR and Lead Employers SARs (taking pressure off teams that are not trained in the SAR arena and ensuring they follow the same process as the other SARs). Pockets of HR and Lead Employer were either not aware of the SAR team or presumed they would handle these SARs.
    - Ensuring HR and Lead Employer are informed of all SARs that were being received directly by the SAR team, enabling the teams to work together to ensure no legal privileged information or Trust sensitive information is incorrectly or inappropriately disclosed to the requestor.

- Information Governance team providing support for the more detailed requests that require further review and expert redaction before disclosure.

- Review and update the Individual Rights Policy (this was new to the Trust last year) to include a section on 'The Right to Complain to Trust regarding how an Individual Right has been processed.' Following feedback from a SAR requestor that it was not clear that if a request required a 'fresh' review after a complaint, as there is evidenced to suggest information was missing or has been redacted wrongly, that it would be classed as a new request and this could take up to one calendar month. This was approved.

- A clear process established for 'Right to Rectification' requests. Required for when an individual requests a correction or update to inaccurate, incomplete, or outdated information the Trust may hold about them. The Trust has established a formal process to review and manage these requests, with a target response time of one calendar month. Patient records are approved by the Caldicot Guardian and for staff data these would need to be reviewed by HR and the Information Asset Owner where the employee works / worked to approve these type of requests. These are reported to the IG Steering Group.

- 95% departments within the Trust have been audited by the IG team over the last 12 months. A total of 136 departments. The IG team assess whether staff are acting in accordance with Information Governance principles when on-site. This includes ensuring identification badges are worn, clear desk policies are adhered to, secure areas are kept locked when unoccupied, etc. Key concerns have been discussed at the Group and actions assigned.

- Establishing Information Asset Registers for each department. The IG team are able to understand what key information assets each department has especially where they contained personal data i.e. personnel files, check that they legally can have them and ensure that whether they are held electronically or in paper format that they are held securely, with appropriate limited access. 92 departments have been identified and 44 registers have been completed to date. Identified risks, such as paper files being stored in a broken filing cabinet, are escalated to the IG Steering Group for action.

- Oversight of the Data Protection Impact Assessments (DPIAs) and Due Diligence Questionnaires (DDQs). These documents are important to ensure any initiative / system involving personal data are properly risk assessed and privacy rules are checked. Where suppliers are contracted to work on behalf of the Trust, that they are 'checked' out to ensure they have the right securities in place. Additionally, this past year the IG team have started to review DPIAs and DDQs which are over a year old. This is to see whether they are still in use or if any there have been any changes to how the initiative / system is being used. 41 DPIAs were reviewed by the Project Lead. The IG team also identified where contracts were missing.

- Monitoring of the IG incidents that are reported on the Trust's Incident Reporting System, InPhase. Each data breach has followed the IG Incident Reporting process and been investigated by the IG Team. Where data breaches have been classed as near miss data breaches or where key actions have been required the IG Officers have completed an IG Incident Proforma which details the data breach, score, findings and an action plan. These are reviewed by the Directorate Manager and sent to the DPO for approval. Where data breaches are classed as serious there is a process in place to escalate to the SIRO and Caldicott Guardian (if patient data involved) via the DPO. A report is presented to the Group which also provides assurance that the Trust has a robust data breach procedure and policy in place. During the

financial year 2024-25 1022 incidents were reported to IG – any incident causing alarm was discussed at the IG Steering Group.

Reportable Incidents

MWL has a duty to report any incidents regarding breaches of the Data Protection Act that score highly to the Information Commissioner's Office (ICO) and for the financial year 2024/25 there was one incident. The Trust is yet to hear from the ICO.

A breakdown of the reported incident to the ICO is below:

April 2024	At 20:00 on the 16/04/2024 the Radiology department at Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) received a telephone call from an individual stating to be the husband of a patient who had recently undergone an obstetric scan. The call was taken by the Radiographer. The caller stated that their partner had asked them to call regarding the results. The Radiographer then informed the caller of the results of the scan over the telephone. An hour later the patient came to the Radiology department to report that the caller was her ex-partner and that safeguarding measures where currently in place. It was also reported that the man purporting to be the patient's husband had covertly recorded the telephone conversation with the Radiographer and posted this on his social media channels.
Outcome	ICO advised of action plan, at the time of writing this report no comments have been received by the ICO. Action Plan included: Immediate Actions Taken The Radiology Manager has spoken to and apologised to the patient. Established that the patient was safe and police notified. The MWL Safeguarding Team also informed as were Human Resources and Information Governance. The incident was recorded on the Datix incident Management System at 16:08 on 17/04/2024. Further Actions: • Initial incident grading matrix completed. • IG incident investigation report started. • IG Training compliance checked (department is compliant). • IG contacted senior department lead to establish the process they have in place for releasing information. • Audit of department arranged, with particular attention to how telephone calls are managed. • IG to attend team meeting to discuss how these calls should be handled.

	• Lessons learnt to be circulated to the Trust via internal comms. • Upcoming face to face training delivered by IG will include a stronger emphasis on the importance of confirming the right to access information and confirming ID over the telephone. • IG to review Radiology Staff Handbook to see if content is appropriate and there are no gaps in the content. • Radiology teams are working with HR around the staff disciplinary process.

There have been no fines issued by the ICO to MWL in 2024-25.

Reporting & Monitoring

Progress against MWL's DSPT and compliance with relevant legislation is monitored by the Head of Risk Assurance & Data Protection Officer (DPO) and the IG Steering Group.

Progress reports are presented to the IG Steering Group and subsequently to the IM&T Council, then ultimately to the MWL's Board by the Senior Information Risk Owner (SIRO).

Any standards or areas of compliance not being met require action plans to be prepared, which will be monitored to ensure improvement and compliance.

The Year Ahead

The next 12 months will see MWL continue to build upon it's IG Strategy and will ensure it remains compliant with its annual IG work plan, data protection legislation and its own IG Framework. Maintaining compliance will occur through planning and day to day activities, which will need to be balanced against the needs of the organisation.

This year the following areas will be of primary focus:

- **To create and implement an MWL IG work plan for 2025-26** – A new IG work plan for 2025-26 for MWL will be in place as of July. The IG work plan details what work the Trust will need to carry out during the course of this next year to ensure it remains on track with its compliancy. This will keep the Trust in line with the any components of the new DSPT (now aligned to the Cyber Assessment Framework) and key data protection legislation. The former IG work plan contained 22 workstreams, the new IG work plan will contain 23 as it will include the implementation of the Data Use and Access Act 2025 (DUAA). The IG team will ensure there is a continuous review of the IG work plan throughout the year and provide assurance via the IG Steering Group.

- **To create a Data Use and Access Act 2025 (DUAA) action plan** – This act is new and received Royal Assent on the 19th June 2025; introducing a series of updates to the UK GDPR, the Data Protection Act 2018 and the Privacy and Electronic Communications Regulations. These changes are seen as evolutionary rather than revolutionary – a supplementary law, not a

replacement. The core principles and obligations for data protection remain unchanged, and the practical impact of the updates will vary depending on our Trust and how its specific data processing activities. Although this will be included in the IG work plan it is important that a specific action plan is developed to make sure the Trust remains data protection compliant. The Information Commissioner's Office (ICO) will interpret the new provisions and issue forthcoming guidance. Organisations have been asked to be ready however until clarity is provided to monitor developments, review current practices, and avoid making any hasty policy changes. Once a DUAA action plan is created this will be monitored by the IG Steering Group.

- **Support Artificial Intelligence (AI) and Robotic Processing Automation (RPA)** – As technology evolves across the Trust and proposals are being presented on the advantages on use of the AI and RPA the IG team will need to assess both the privacy and security risks of this type of processing. The IG team will ensure they are kept abreast of how data protection will factor in these new areas and continue, not only to follow the current Data Protection Impact Assessment process but also incorporate any risk assessment questions / areas that need to be part of this new area. The aim is to continue to provide Data Protection assurance on whatever system / initiative / process needs to be embedded to support the Trust in embracing new technologies and reducing repetitive burden. Any AI / RPA processing will be reported to the IG Steering Group.

- **Complete the DSPT IG recommendations** – There are recommendations that have been produced by the Internal Auditors after their assessment of the MWL's DSPT. An action plan will be produced identifying action owners. This action plan, focusing on any IG recommendations will be monitored under MWL's IG Steering Group.

- **Continue to support Due Diligence Checks** – Last year the IG team started to review mandatory IG documentation; Data Protection Impact Assessments, Due Diligence Questionnaires, Data Sharing Agreements and Contracts. With the heightened cyber threat, where the risk of compromising personal data is at the focus, the continued efforts of the IG team to carry on reviewing what systems, initiatives and suppliers the Trust has is critical. Crucially where the Trust has outsourced (suppliers) processing of its personal data, that the suppliers are contacted at least every 2 years to enable the supplier to update and refresh their information if they still hold a contract with the Trust. Progress will be reported to the IG Steering Group.

- **To support the Subject Access Request Team** – The team who process Subject Access Requests (SARs) moved into the IG Team in January 2024. Although vast improvements have been made since January 2024 (as previously mentioned in this report) there is a need to streamline the service further. Due to IT / technical difficulties it has been difficult to bring the team together as one i.e. former STHK SAR Officers have been working on STHK requests and S&O SAR Officers on S&O requests. The SAR Lead has been tasked to ensure by the 1st September this team will operate as one, using one email address, one contact phone number. This will ensure that requests are received centrally and equally distributed across the team (currently the STHK SAR Officer process 3 times as many as the S&O SAR Officers due to the requests that are received in). There is also a focus to 'upskill' the SAR Officers on complex

redaction as more complicated SAR are being received and processed. Progress will be reported to the IG Steering Group.

- **To continue with Face-to-Face IG Mandatory Training Sessions** – Last year the IG team saw the benefit in introducing 'face to face' IG training sessions. Engagement increased dramatically and the team reported that staff members felt able to ask specific questions regarding their area of work. From April 2024 – March 2025, 587 staff members received this type of training. Feedback has been extremely positive.

  Comments received from a delegate:
  '*Very informative, previously attended always informative and engaging. Good information is and well delivered by Kev. Good to know about information sharing and information provided on records management too'*

  This year the team will promote face to face IG Mandatory Training and increase on the areas they visited in the past year.

- **Continue to implement Information Asset Registers (IARs) across the Trust** – In the last year the team have worked hard to engage with as many departments to produce Information Asset Registers for their area. There is a need to understand where in MWL personal data is processed and to ensure this data can be processed legally, is being held as securely as possible (be it paper or electronic) and to identify any risks. Additionally, where personal data is being held for longer than necessary that it is reviewed before potential destruction. The completion of IARs will continue and any high risks will be highlighted to the SIRO. This work will sit alongside Data Flow Mapping which ensures that any outflows of data are done via a secure manner, i.e., secure email. This continues to be a requirement of the new DSPT and will be monitored by the IG Steering Group.

- **Increase presence onsite through walk around audits** – Through visiting the majority of the Trust's departments in the past year, which are in most cases ad-hoc, presents a true picture and the team were able to identify areas of improvement and work with service leads to have discussions around how new processes could be implemented. It is not only important that these audits are carried out on a regular basis to ensure any changes have been made and to identify any new areas of improvement, but to raise the presence of IG and data protection, bringing to life what staff members hear in the training. Reports will be provided to the IG Steering Group.

- **Supporting the Data Breach Investigation Process** – This is the second year of having MWL's data breach policy in place which has seen all IG related incidents investigated. The team will continue to adhere to this policy and see the completion of IG incident proformas when required. The proformas not only provide all management that a serious / near miss data breach is being managed through a managed action plan but also provides the individual affected with assurance that is has been investigated thoroughly. These proformas have fed into wider complaints received by the Trust. The team support staff members in ensuring all actions are achievable and are achieved. The IG Steering Group are able to monitor incidents that are investigated by the team.

Conclusion

This report confirms that the Trust has an excellent IG awareness, focus and culture. Its staff are honest and work hard to understand their IG role and responsibilities.

With the completion of the tasks listed in the IG work plan for 2024-25 and completing the areas that are for IG within the DSPT, the IG team can confirm that the Trust has not only implemented the key IG foundations which are required to ensure the Trust is meeting its data protection obligations and IG Framework and Strategy, but are actively monitoring and consistently looking at ways to improve.

This has been demonstrated by the completion of MWL's Data Security and Protection Toolkit (DSPT). The Trust able to provide evidence on all IG areas and this evidence was verified by the Trust's external auditor who have confirmed that we met these areas, and that 'high confidence' was received in the quality of the evidence provided. The DSPT looks at the robustness of the processes that have been put in place such as; the reporting and investigation of data breaches, the completion of Data Protection Impact Assessments (DPIAs), data sharing agreements, data processor agreements, the delivery and monitoring of IG training and awareness, information asset registers, providing advice and guidance on a range of data protection queries to name a few areas.

This past year is the first time the IG team has been fully resourced and the movement and progress of IG work areas that were previously stagnant have flourished, such as walkaround audits, completion of Information Asset Registers, annual reviews of key IG documentation and additional checking support for the SAR team. The IG team have worked hard to produce these results and in turn the Trust is able to reap the benefits knowing its staff are in safe hands when they require IG support and the Trust is IG / data protection compliant due to their efforts.

This year, the team will continue to build on the achievements from the past year, working to raise awareness of IG and reiterate its importance especially through training and audits. This will also include picking up on DSPT recommendations made by the auditor which will further strengthen what we have in place.

There will also be close attention on what the new Data Use and Access Act 2025 may bring, and the IG team will ensure that they have a full understanding of any implications it may bring to the Trust and to specific teams / departments, where changes may be required in order to adhere to this new Act.

It must also be recognised the IG team also enable essential cross organisational and collaborative working with our partner organisations by supporting information sharing and processing of personal data for commissioned services.

The established IG Steering Group, which is fortunate to have excellent attendance from all key areas, will continue to monitor the progress of MWL's IG Agenda and will be proactive to escalate any matters arising to the IM&T Council.

Freedom of Information Act Annual Report 2024/25

From April 2024 till the end of March 2025 822 requests were received, the previous years totalled 824, a very similar number. 99.2% of the requests received were completed, of those completed requests, 63.6% were completed within the 20-working daytime frame.

	April 2024 / March 2025
Requests received	822
Number of Questions contained within the total FOIs received	5665
Requests completed	816 (99.2%)
20 working day compliance	523 (63.6%)

Introduction

As a public authority MWL is required to action and respond to Freedom of Information (FOI) Requests under the legislation 'the Freedom of Information Act 2000.' The public are able to request non personal information about MWL and its activities.

Anyone can make an FOI request, and the organisation must respond to the request within 20 working days. Failure to do so could result in a fine or warning from the Information Commissioners Office.

The Chief Executive who has overall responsibility in MWL for the FOI Act delegates the responsibility for the implementation and monitoring of the Act to Anne-Marie Stretch, who is the Deputy Chief Executive (also known as the Executive FOI lead) at MWL. The Executive FOI Lead ensures that MWL complies with the legislation and takes overall ownership of MWL's FOI Policy, making sure systems and procedures that are established are reviewed to support the FOI process.

The Information Governance (IG) team through dedicated resources, process, coordinate, monitor and report all FOI requests. This includes following all administration procedures and record keeping in line with MWL's FOI policy and the FOI Act.

This report is designed to provide the Trust Board with assurance that MWL is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for April 2024 – March 2025 will be shown here.

Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

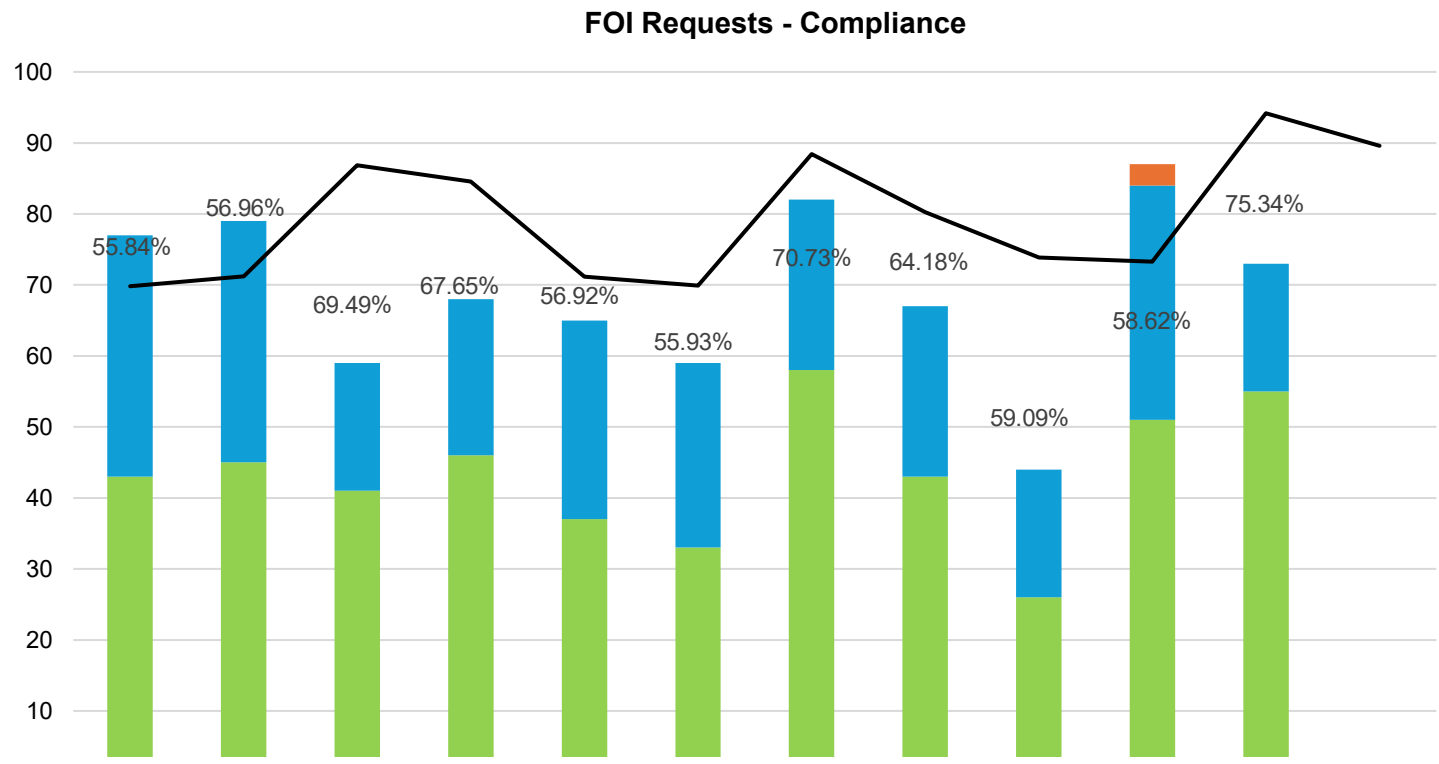
Performance

The overall compliance figure shows a slight decrease on the previous year's compliance levels in terms of completing the requests.

- The breakdown of FOIs handled by executive areas are: Human Resources (151), Finance (215), Chief Operations Officer (230), Nursing (96), Informatics (73), Corporate Services (52), and Chief Medical Officer (5).
- 63.6% of requests were answered within the 20-working day timescale.
- February 2025 saw the highest rate of compliance with 75.34% of requests responded to within 20 working days.
- 99.2% of all requests received in the financial year have been responded to, the remaining 0.6% of requests are still open.
- Requests sources can be broken down into the following group: Commercial (434) 52.7%, Member of the Public (123) 14.9%, Press (94) 11.4%, Research (74) 9.0%, Not Given (45) 5.4%, Other (35) 4.2%, Staff (15) 1.8%, and MPs (5) 0.6%.
- The categories of requests that were received were: “About the Trust” (232), “Decision Making” (11), “Lists & Registers” (273), “Our Services” (129), “Policies and Procedures” (66), Priorities and Progress (4), and “What and How we Spend” (107).

Table 1 below shows the requests completed throughout the year and the monthly compliance with the 20-working daytime scale.

Table 1 – Update (April 2024 – March 2025)



ICO Notification

Disappointingly the Trust received a Decision Notice in May 2025 regarding the answers it had provided to an FOI earlier in the year, applying an exemption with reason time and the time it had taken the Trust to respond to a request. The ICO upheld the Trusts response however have informed the Trust that

response times to FOIs must be looked into and the Trust needs to be responding within the 20-day timeframe.

Areas to Note

- The nature of the requests that are being received have become more complex which often results in 1 FOI request having multiple questions for different departments. The majority of FOIs contain at least 1 finance question which increases the number of FOIs receive, far more than any other department. This means that the approval process is taking longer.

- Due to staff movement at a senior level which has now stabilized it had been difficult to nominate a second 'approver' (a reminder that each Executive Lead is approves FOIs that require a response from their area). A second approver is necessary for when the Executive Lead / main approver is not available.

- The IG team have a dedicated FOI Officer who ensures all FOIs are logged and supports teams in providing updates and information when needed. The extended IG team are trained to 'step into' the role when the FOI Officer is unavailable due to leave. This ensures that the FOIs are constantly monitored when they are in the system.

Areas of Improvement in 2024-25

- During 2024–25, the Information Governance (IG) team focused on strengthening the FOI process across MWL. The IG team began working with individual departments to identify key contacts who can support FOI responses. To ensure consistency and confidence in handling requests, FOI training and clear guidance were provided, helping staff understand the end-to-end process, including the necessary approvals before information is released. HR and Finance, who receive the majority of requests have worked hard to ensure they have internal resources available to process the FOIs they receive.

- The IG team have worked closely with departments such as HR, Finance, and IT to develop and implement publication schemes. These schemes aim to proactively publish frequently requested information, enabling the IG team to signpost requestors and reduce the burden on operational teams. Continually work is needed in this area to ensure that the Trust is proactively publishing more material that would be release under FOI.

- The FOI publication section was migrated to the main MWL website under the 'About the Trust' section. This change improves accessibility and allows the IG Team to redirect requestors more efficiently.

Suggested Areas of Focus for 2025-26

- The Executive Leads to inform their teams of the importance of responding to FOIs in a timely manner and advise of the recent ICO Decision Notice on responding within the legally set timeframe of 20 days.

- Introduction of Departmental FOI Champions - Establish a network of FOI champions across departments to act as first points of contact. This will streamline communication, improve response quality, and embed FOI awareness more deeply across the organisation.

- Advanced FOI Analytics and Reporting - With support from business intelligence the Trust should introduce analytics tools to track trends in FOI requests, identify recurring themes, and inform future publication schemes. This data-driven approach can help anticipate public interest and reduce repetitive requests.

- Resource Planning and Resilience - Each executive area to conduct a workforce planning review to ensure that their departments have the capacity and resilience to provide the requested information to the Information Governance team so that they can respond to the FOI in a timely manner. This is particularly important during periods of key staff absence.

Conclusion

The 2024/25 reporting period has reaffirmed MWL's commitment to transparency and accountability through its management of FOI requests. Despite the increasing complexity and volume of requests, the Trust achieved a high completion rate of 99.2% and made notable progress in streamlining internal processes. However, this was offset by only 63.6% of FOI requests being answered within the 20 working days compliance period.

The introduction of Executive Lead oversight for FOI approvals has strengthened governance and improved visibility of the information being released. Additionally, the IG team has enhanced accessibility by updating the FOI section on the Trust website and working towards developing publication schemes to proactively share commonly requested information.

Looking ahead to 2025/26, the Trust is well positioned to build on these improvements. However, continued progress depends on timely collaboration from departments that hold the requested information. Delays in providing responses or securing Executive sign-off risk undermining the Trust's ability to meet the statutory 20 working day deadline. Without appropriate prioritisation and resourcing at the departmental level, compliance rates are unlikely to improve. The Trust should appreciate the issuance of an ICO Decision Notice and commit to working towards being compliant.

The IG team remains fully committed to supporting the Trust's FOI obligations. It will continue to monitor performance, escalate risks where necessary, and drive improvements through the IG Steering Group and IM&T Council

MWL's FOI process has seen each Executive Lead reviewing and approving FOIs for their respective areas which certainly has resulted in the process becoming more streamlined by making each Executive Lead aware of what information was being requested and released. This approval process will continue.

The FOI requests being received by the Trust are considered not 'straight forward' and result in multiple departments having to contribute to just one, combine this with legacy STHK & S&Os departments

coming together and in a lot of cases still having to go to two sources to pull the information as the information is yet to be merged has meant that the Trust's overall compliance is a fair representation.

As MWL, the IG team will continue to implement the FOI process and work with the departments to see where information can be published. All members of the IG team have been trained in the FOI process and there is daily cover.

ENDS

Title of Meeting	**Trust Board**			**Date**	30 July 2025
Agenda Item	**TB25/063**				
Report Title	Emergency Planning Response and Resilience (EPRR) Annual Report 2024/25				
Executive Lead	Lesley Neary, Chief Operating Officer				
Presenting Officer	Lesley Neary, Chief Operating Officer				
Action Required	X	**To Approve**		**To Note**	

Purpose

To approve MWL Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/2025

Executive Summary

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be presented to the governing committee which will ultimately report to Trust Board.

Once approved, the EPRR Annual Report will be retained as evidence for the Core Standards Self-assessment process.

Financial Implications

No new financial implications as a direct result of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the EPRR Annual Report 2024/25 for submission as part of the core standards.

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

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) MWL ANNUAL REPORT 2024/2025

1. EXECUTIVE SUMMARY

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be produced for the Trust Board to assure them that the organisation is meeting its obligations.

This report will cover the period 1 April 2024 to 31 March 2025.

Responsibility for Resilience within the UK sits with the Civil Secretariat. Failure to meet the set-out obligations can lead to prosecution via relevant Government agency. NHS England oversees the arrangements within NHS England organisations and provides assurance to the Local Resilience Forum via the Local Health Resilience Partnership. This body of work is known as Emergency Preparedness, Resilience and Response (EPRR).

The role of NHS England relates to potentially disruptive threats and the need to take command of the NHS, as required, during emergency situations. These are wide ranging and may be anything from extreme weather conditions to outbreak of an infectious disease, a major transport accident or a terrorist incident. There continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing risk and hazard landscape. Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the trust must be prepared for. It is essential that there is a continued focus on the Trust's EPRR and business continuity arrangements and that the Trust maintains and continues to contribute towards the region's preparedness.

The Trust must be able to continue to deliver key services during times of disruption as part of the wider health economy. In doing so it must ensure patient and staff safety and consider stakeholder considerations.

This report aims to update the Board on progress in this matter and sets out how the Trust meets its obligations. The Trust is required to have an up-to-date Major Incident Plan and Business Continuity Plan. These must be updated following a major incident, exercises and/or other learning**.**

The Trust has a suite of plans to deal with major incidents and business continuity issues. These conform to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with stakeholders to ensure cohesion with the plans.

Throughout the year the plans have been reviewed, any changes to plans must be tested/exercised to ensure they are fit for purpose.

The responsibility for EPRR sits within the portfolio of the Chief Operating Officer. The work is managed on a daily basis by the Head of Emergency Preparedness and supported by a designated Consultant within the Whiston and Southport Emergency Departments. The work programme is managed through the EPRR Group, which is chaired by the Chief Operating Officer. The group meets quarterly with representatives from across the organisation and reports directly into Risk Management Council, then to Executive Committee and Board.

2. LEGAL OBLIGATIONS

As a Category 1 responder, the Trust has the following legal obligations:

a) Co-operation with other responders
b) Risk Assessment
c) Emergency Planning
d) Communicating with the public
e) Sharing information
f) Business Continuity Management

Ways that the Trust is meeting these obligations are listed below:

a) Co-operation with other responders

The Trust is represented by the Chief Operating Officer and Head of Emergency Preparedness at the Local Health Resilience Partnership Strategic and Tactical meetings and relevant subgroups.

The Trust has hosted a multi-agency exercise and has participated in meetings with multi agency partners, including NHS England Cheshire and Merseyside Integrated Care Board (ICB), provider Trusts, commissioners and other partners including the Police, Mersey Fire and Rescue Service and Northwest Ambulance Service.

b) Risk Assessment

Under the Civil Contingencies Act (2004), the Trust, as a Category 1 responder, is required to assess risks associated with emergencies. This includes evaluating potential impacts on patients, staff, and facilities.

EPRR risk assessments are conducted based on the National Risk Register and Community Risk Registers. These assessments help identify and mitigate risks to the Trust's operations. Currently, the top national risks include pandemics, cyber-attacks, loss of critical infrastructure, terrorism, large scale CBRN attack, attack on UK ally or partner outside NATO and climate change effects such as flooding, heatwaves, and space weather. The Local Resilience Forum Community Risk Registers reflects similar priorities.

Any identified concerns or risks are reviewed at EPRR meetings and may be added to the Trust Risk Register if necessary. These risks are then discussed at Risk Management Council to ensure appropriate oversight and action.

EPRR considerations are integrated into the Trust's Board Assurance Framework to provide oversight and ensure that preparedness measures align with the organisation's overall risk management strategy.

c) Emergency Planning

EPRR are responsible for the development and maintenance of a suite of emergency plans including (but not limited to):

- Incident Response Plan
- Major Incident Action Cards
- Mass Casualty Plan
- CBRN Plan
- Adverse Weather and Health Plan
- Evacuation and Shelter Plan
- Trust Communications (Crisis Communications) Plan
- New and Emerging Pandemic Plan
- Business Continuity Policy
- EPRR Policy

All of these plans and policies are essential documents that require formal approval from the Board.

To ensure their continued effectiveness and relevance, these emergency plans undergo a comprehensive review at least annually and are shared with multi-agency partners. Following development or updates, the plans are rigorously tested through exercises to assess their practicality and effectiveness.

Lessons learned from these exercises, as well as from real-life incidents, are carefully documented during debrief sessions. These lessons are subsequently monitored by the EPRR Group and Risk Management Council until all action items are addressed and the situation returns to a new business as usual state.

Capturing and acting on these lessons is crucial for continuous improvement in our emergency planning arrangements, ensuring that our strategies adapt effectively to emerging challenges and opportunities.

d) Communicating with the public

The Trust continues to explore ways of communicating with the public. Social media has enormous potential to help the NHS reach patients and service users who do not use traditional communications and engagement channels. During the year, the Trust has used a range of methods to communicate with the public, including local radio, local TV, local press, Facebook, Twitter, and a public facing Trust website.

e) Sharing information

Under the Civil Contingencies Act (2004), responders have a statutory duty to share information with partner organisations. This obligation is a fundamental aspect of civil protection work, facilitating cooperation and coordination across various entities.

The Trust actively engages in this information-sharing mandate through the use of Resilience Direct, an online private network managed by the Cabinet Office. This platform enables civil protection practitioners to collaborate effectively across geographical and organisational boundaries during the preparation, response, and recovery phases of an event or emergency.

Resilience Direct supports organisations in meeting their responsibilities under the Civil Contingencies Act (2004) by ensuring that information is shared seamlessly and actions are coordinated. This collaborative approach is essential for effective emergency management and response.

f) Business Continuity Management

The Trust's Business Continuity Policy is reviewed and updated at least every three years and at the time of reporting, had been fully reviewed and implemented on the 24th August 2023. This policy outlines the framework for responding to disruptions in accordance with legal obligations and EPRR guidance. It is the responsibility of each ward and department to develop and maintain their own continuity plans, which must be updated annually and immediately following an incident or service change. Support for these plans is available from the EPRR Team as needed.

Throughout the year, the Trust has responded to a range of disruptions, including industrial action, local incidents, public disorder, significant operational pressures, and IT downtime. In an ongoing effort to enhance resilience, the Trust conducts debriefs following each incident to capture key learnings and inform action plans for improvement. These incidents and the corresponding actions are reviewed and documented through the EPRR Group meetings and Risk Management Council, then to Executive Committee and Board.

The Trust has activated its Business Continuity Plans on multiple occasions during 2024-2025 in response to both planned and unplanned outages. Planned downtimes were managed in coordination with the EPRR Group or Senior Operational meetings, while unplanned outages across hospital sites necessitated the activation of Business Continuity Plans by affected wards and departments as set out in Appendix 1.

3. ASSURANCE

In line with the EPRR 2024-2025 Assurance Process requirements, compliance is assessed based on the percentage of Core Standards fully met against established rating thresholds. The Trust was compliant with 50 out of 62 Core Standards, 81%, an overall EPRR assurance rating of 'partial-compliance' for 2024/2025, as set out in Appendix 2. This was an increase of 37% from the previous year.

Summary position for Cheshire and Merseyside ICB

	Compliance Percentage from 2023/2024	Compliance Level 2023/2024	Compliance percentage from 2024/2025	Compliance Level 2024/2025	Overall Compliance Percentage Increase
Acute Trust					
Liverpool University	18%	Non-Compliance	89%	Substantial	71%
Wirral University	2%	Non-Compliance	84%	Partial Compliance	82%
Countess of Chester	8%	Non-Compliance	81%	Partial Compliance	73%
East Cheshire	29%	Non-Compliance	81%	Partial Compliance	52%
Mersey and West Lancashire	44%	Non-Compliance	81%	Partial Compliance	37%
Mid Cheshire	37%	Non-Compliance	76%	Non-Compliance	39%
Alder Hey	8%	Non-Compliance	68%	Non-Compliance	60%
Warrington and Halton	5%	Non-Compliance	68%	Non-Compliance	63%
Specialist Trusts					
Clatterbridge	17%	Non-Compliance	95%	Substantial	78%
LHCH	15%	Non-Compliance	86%	Partial Compliance	71%
Walton	?	Non-Compliance	78%	Non-Compliance	increase
Liverpool Womens	?	Non-Compliance	73%	Non-Compliance	increase
Community and Mental Health					
Merseycare	33%	Non-Compliance	97%	Substantial	64%
Wirral Community	?	Non-Compliance	86%	Partial Compliance	increase
CWP	?	Non-Compliance	84%	Partial Compliance	increase
Bridgewater	0%	Non-Compliance	81%	Partial Compliance	81%
ICB					
NHS C&M	19%	Non-Compliance	87%	Partial Compliance	68%

The Trust's 'partial compliance' rating has led to the development and implementation of targeted action plans to address identified gaps. These actions have been incorporated into the 2024/2025 EPRR Workplan.

The primary factors contributing to the partial compliance rating were:

- **Duty to Maintain Plans**: Several legacy plans require harmonisation across the Trust to ensure consistency and alignment.
- **Training and Exercising**: There is a need to enhance the training and exercising of staff across all healthcare services.
- **Business Continuity Management**: Greater focus is needed on developing and governing ward and service-level business continuity plans to ensure organisational resilience and preparedness.
- **EPRR Resourcing**: A business case was developed to increase EPRR resources and support the Trust in fulfilling its emergency preparedness responsibilities. However, recent changes announced by the Health Secretary have halted the progression of this proposal.

4. TRAINING

The EPRR Team has organised a range of training and awareness sessions for staff, including those responsible for on-call duties at Strategic and Tactical levels. The training programs offered include:

- **Strategic Commander PHC Training**
- **Tactical Commander PHC Training**
- **Legal Awareness for EPRR Training**
- **Media Awareness Training**

To further support senior managers on call, additional training courses are being sourced and will be implemented over the next 12 months.

Compliance with training requirements for senior managers is monitored and reported through the EPRR Group and RMC, in alignment with the Minimum Occupational Standards and the EPRR Training Needs Analysis.

In addition to senior manager training, EPRR Awareness eLearning is in the process of being developed and distributed across the Trust. Compliance with this awareness training will be monitored and reported through the governance groups mentioned above.

5. EXERCISES

In accordance with NHS England's EPRR Core Standards, Acute Trusts are required to engage in planned exercises with external partner organisations.

During this reporting period, the Trust conducted a Mass Casualty exercise (Exercise Jupiter) on 29th February 2024 and a Trust-Wide Adverse Weather and Health exercise (Exercise Dorothy), on 4th September 2024.

This exercise aimed to evaluate the effectiveness of the Mass Casualty and the Adverse Weather and Health Plans across the Trust.

The exercises were attended by representatives from the Strategic, Tactical, and Operational Teams, including key participants from acute care areas. Feedback was positive, and all lessons identified were captured during the debrief sessions.

6. COMMUNICATIONS

Effective communication is crucial in managing adverse incidents. To ensure preparedness, the Trust conducts regular communication exercises designed to test and enhance our incident response capabilities.

A full communications cascade exercise is conducted twice yearly across Whiston, Southport, St Helens and Ormskirk Hospitals. These exercises simulate a major incident communications cascade and are intended to assess and validate the Trust's ability to alert staff and initiate incident response processes effectively.

Internal communication cascade exercises were held in June 2024 (Exercise Babble) at Southport and Ormskirk, August 2024 (Exercise Jabberwocky) and a regional led 'No Notice' exercise (Exercise Calliope) in August 2024. Lessons identified from the exercise cascades were captured in response plans and reported through the governance groups mentioned above.

7. GOVERNANCE AND OVERSIGHT

The EPRR Workplan is overseen by the EPRR Group, which is responsible for managing progress and actions. The EPRR Group reports on its activities and the status of the workplan to Risk Management Council, Executive Committee and to Board, where ongoing actions and progress are reviewed and managed.

As a Category 1 responder, the Trust is required to report on progress and provide assurance regarding emergency planning directly to the Trust Board. This ensures that the Board is informed of the Trust's preparedness and compliance with emergency planning requirements.

8. PARTNERSHIP WORKING

The Trust actively collaborates with a variety of partner agencies through both formal and ad hoc arrangements. This collaboration is facilitated through formal standing meetings, committees and attendance at external exercises. During the reporting period, the Head of Emergency Preparedness attended a Cheshire and Merseyside ICS led Cyber Incident Response Exercise in March 2024, Regional Cyber Groups, Extreme Weather Preparedness webinar, Regional Shelter and Evacuation Group and Regional Energy Resilience Group.

Notably, the Trust is a member of the Local Health Resilience Partnership, among other formal committees, where the Chief Operating Officer represents at a Strategic Level and the Head of Emergency Preparedness represents at Tactical Level. These partnerships are integral to ensuring effective coordination and resilience in our emergency preparedness and response efforts.

9. RECOMMENDATIONS

In accordance with our legal obligations as a Category 1 responder, it is crucial to maintain robust Business Continuity Management and Emergency Preparedness arrangements. The Trust Board is therefore requested to acknowledge and review this Annual Report on EPRR.

The arrangements detailed in this report align with our legal responsibilities under the Civil Contingencies Act (2004) and NHS England EPRR guidance, ensuring that the Trust meets its statutory obligations and maintains effective emergency preparedness.

Appendix 1: EPRR - Unplanned Incidents 2024 – 2025

INCIDENTS	
19/04/2024	Careflow Vitals / Ambulance Screen down in ED Whiston
03/05/2024	Suspected Gas Leak - Lowe House Health Centre (Evacuation)
08/05/2024	Virgin Media Issues impating on IT Systems
03/06/2024	Automatic Door Failure - Ormskirk Site (affecting Neonates / Labour Ward / Maternity)
27/06/2024	IT system failure at Southport (Careflow / VitalPac)
04-05/07/2024	No hot water across Southport Site overnight
19/07/2024	Global IT Outages (CloudStrike) - affecting EMIS (Microsoft Upgrade)
29/07-30/07/2024	NWAS / Merseyside Police Major Incident - Mass Casualty Stabbing in Southport
30/07/ - 04/08/2024	Ongoing Disorder in Southport
10/08/2024	Drop in Wifi Connection affecting Vitalpac at Southport
14/08/2024	NWAS Emergency Red Phone in ED at Southport not working
11/10/2024	CT Scanner out of service for 1 hour.
12/11/2024	Sewage Leak in ED at Southport
17/11/2024	MRI Scanner unplanned downtimes
05/12/2024	Breakdown of MRI Scanner at Whiston
02 - 13/01/2025	Critical Incident - Pressures (Level 2)
20 - 21/01/2025	Chemical Spillage at St Helens Hospital (Level 1)
30/01/2025	Pilkington's Explosion with self-presenters at Whiston ED
12/03/2025	Whiston Fire Alarm System Failure
FULL TO CAPACITY (OPEL 4)	
08/05/2024	MWL escalated to Opel 4
14-16/05/2024	MWL escalated to Opel 4
02/01-13/01/25	MWL escalated to Opel 4
INDUSTRIAL ACTION	
03 - 07/04/24	Biomedical Scientists' Industrial Action
08 - 12/04/24	Biomedical Scientists' Industrial Action
15 - 19/04/24	Biomedical Scientists' Industrial Action
22 - 26/04/24	Biomedical Scientists' Industrial Action
29/04/24 - 03/05/24	Biomedical Scientists' Industrial Action
06 - 10/05/24	Biomedical Scientists' Industrial Action
13 - 17/05/24	Biomedical Scientists' Industrial Action
20 - 24/05/24	Biomedical Scientists' Industrial Action
27/06/24 - 31/06/24	Biomedical Scientists' Industrial Action
27/06/24 - 02/07/24	Junior Doctors' Industrial Action
TRAINING AND EXERCISES	
05/06/2024	Exercise Babble (Comms Cascade) - Southport & Ormskirk Sites
14/08/2024	Exercise Jabber Wocky (Comms Cascade) - Whiston & St Helens Sites
04/09/2024	Exercise Dorothy - MWL
14/02/2025	Exercise Creta
25/02/2025	Exercise Gabriel (no notice comms cascade)
PLANNED UPGRADES / MAINTENANCE WORK (WARDS / DEPARTMENTS REVERT TO BC)	

09/04/2024	PACS Downtime at S&O (for one hour)
17/04/2024	CRIS Downtime S&O (approx. 10 minutes)
25/04/2024	Monthly Patching at S&O
01/05/2024	CRIS Downtime S&O (approx. 10 minutes)
09/05/2024	Phone system switch upgrade (affecting Ward 3F, Whiston)
13/05/2024	Pathology all sites - copier maintenance (10:00-11:00)
21/05/2024	EMIS Migration at S&O (20:30 to 04:00)
30/05/2024	Monthly Patching at S&O
02/06/2024	Electrical Maintenance - Switchboard, Ormskirk
04 - 05/06/24	EMIS Web Downtime
05/06/2024	Phone system switch upgrade (affecting Ward 5C/5D, Whiston)
06/06/2024	PACS Downtime at S&O (for one hour)
06-07/06/24	Water Shutdown (affecting Ward 14A, Southport)
11/06/2024	EMIS Migration at Whiston
12/06/2024	Phone system switch upgrade (affecting Ward 1C/1D/Endoscopy, Whiston)
15/06/2024	EPR Upgrade (Whiston, St Helens and Newton)
17/06/2024	EMIS Web Downtime (1 hour)
19/06/2024	Phone system switch upgrade (affecting Ward 2C/2D, Whiston)
26/06/2024	EPR Upgrade (Southport and Ormskirk) - CANCELLED
26/06/2024	Phone system switch upgrade (affecting Ward 2D/2E, Whiston)
27/06/2024	EPR Upgrade, S&O
27/06/2024	Monthly Patching at S&O
27/06/2024	IT Failure (Careflow / VitalPac)
27/06/2024	PACS Maintenance at S&O
30/06/2024	Water Works at Southport (affecting HSDU - closed, Renal - closed and Salus Centre)
10/07/2024	Water Shutdown (affecting Red / Amber 1 in ED, Southport)
10/07/2024	Phone system switch upgrade (affecting Ward 2F, Whiston)
14/07/2024	ICE Migration across all MWL sites
18/07/2024	Water Shutdown (affecting Ward 14A and Ward 14B, Southport)
07/08/2024	Phone system switch upgrade (affecting Ward 2A/2B and Maternity, Whiston)
08/05/2024	Phone system switch upgrade (affecting Ward 3F, Whiston)
15/05/2024	Phone system switch upgrade (affecting Ward 4F, Whiston)
22/05/2024	Phone system switch upgrade (affecting Ward 5B/5A, Whiston)
29/05/2024	Phone system switch upgrade (affecting Ward 1B/1A, Whiston)
03/07/2024	Phone system switch upgrade (affecting Ward 3A/Holbrook/Medical Photography, Whiston)
10/07/2024	Water shutdown in ED at Southport (affecting Red Majors and ED Amber 1)
10/07/2024	Phone system switch upgrade (affecting Ward 2F)
14/07/2024	ICE Upgrade / maintenance - all sites
17/07/2024	Phone system switch upgrade (affecting Ward 1D/1E/ECG, Whiston)
18/07/2024	Water shutdown at Southport (affecting Wards 14A and 14B)
24/07/2024	Phone system switch upgrade (affectingWomens OPD/Ultrasound, Whiston)
25/07/2024	Monthly Patching at S&O
27/07/2024	CT Scanner Downtime at Southport (07:00-14:30)

PLANNED UPGRADES / MAINTENANCE WORK (WARDS / DEPARTMENTS REVERT TO BC) Cont.

28/07/2024	Essential maintenance on electric power supply at Southport (08:00-16:00)
31/07/2024	Phone system switch upgrade (affecting Ward 3B/Plastics Assessment Unit, Whiston)
07/08/2024	Phone system switch upgrade (affecting Ward 2A/2B/Maternity Offices)
13/08/2024	PACS Maintenance at S&O - routine monthly patching
15-16/08/24	EMIS Web Unavailable - Software Upgrade affecting S&O
21/08/2024	Phone System Switch upgrade (affecting Ward 4B, Whiston)
28/08/2024	Phone System Switch upgrade (affecting Ward 4C/4D, theatres and ITU)
04/08/2024	Phone System Switch upgrade (affecting Ward 4E and Theatres)
05/12/2024	CT Scanner Urgent Maintenance (11:00-14:00)

Appendix 2: EPRR Statement of Compliance

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) Assurance 2024-2025

STATEMENT OF COMPLIANCE

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, MWL will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Partial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial ✖	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

L Neary

10/09/2024

12th September 2024	25th September 2024	
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix 3: Core Standards Self-Assessment

Please select type of organisation: Acute Providers

Click button to format the workbook Format Workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	6	5	0
Command and control	2	2	0	0
Training and exercising	4	3	1	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	9	3	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	50	12	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	9	2	0
Total	11	9	2	0

Overall assessment:	Partially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 6: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 7: In the Action Plan tab, click on the 'Format Action Plan' button.

Title of Meeting	**Trust Board**		**Date**	30 July 2025
Agenda Item	**TB25/064**			
Report Title	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common Updates			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

To secure Board agreement to the CMPC Joint Working Agreement (JWA) and Committee in Common (CiC).

Executive Summary

Cheshire and Merseyside (C&M) providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. CMPC has come about through a process borne from bringing together its two forerunners Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) and Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative (MHLDC) to focus on work of shared provider delivery: acute, specialist and community services. Working together has achieved real and tangible benefits since the pandemic and been consolidated since. All providers consider this next step will provide further opportunities and opportunities for at scale working where this makes sense.

Following a review requested by the system leaders and sponsored by Trust CEOs, Trust Company Secretaries have engaged in a process of seeking to build upon the established and available collaboration mechanisms within C&M that have been shown to work and support a track record of collaboration.

In identifying, promoting and championing the benefits of collaboration NHS England (NHSE) have encouraged all providers to build on local successes through provider collaborative structures where these can be shown to work.

C&M Company Secretaries (CoSecs) have worked together and drawn upon the expertise and advice of Hill Dickinson to support the redrafting and reframing of a CMPC Joint working agreement and Committees in Common terms of reference. This approach continues the chosen route of governing collaborative delivery and ongoing potential within the system.

The CMPC Leadership Board recommends the enclosed documents for adoption by Trust Boards. The updated documentation follows a review and redrafting process to reflect broadened arrangements and scope of the collaboration.

Joint Working Agreement (JWA), further detail, and to be read in conjunction with CiC ToR:

- Covers: vision; function; priorities and headline areas of focus
- Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making
- Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

Committee in Common - Terms of Reference (CiC ToR), further detail, and to be read in conjunction with JWA:

- Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
- Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance
- Sets aims and objectives of CiC
- Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
- Quorum
- Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA
- To note: NWAS is proposed as a participant of the meeting rather than as a Member

Changes and variation from previous documentation (or familiar approaches): further detail, and to be read in conjunction with JWA and draft CiC:

Terms of References:

- Updates of names and terminology – organisations, CMPC etc
- Added definitions – to reflect content of documents at request of company secretaries
- Refer to the full breadth of CMPC responsibilities – including community – but also not seek to restrict nor curtail future Trust Board choices
- Additional words without altering meaning of sentences to support clarity
- Reframing of section 2.1 (ToR) to reorder theme stated aims and objectives.
- Add to ICB reference 'and regulator or those charged with performance management'
- Specifying MS Teams or equivalent as an option for a CiC meeting

Joint working agreement:

- Provide further clarity on the route for determining any costs arising from collaborative arrangements (section 6)
- Provide further clarity on the route for calculating any exist costs or transition arrangements arising from a cessation of collaborative arrangements (section 6)
- Additional parameters on timescales for stages of any dispute resolution (section 10)

A request was also made from one Trust for definition and adoption of an information sharing agreement (something explored on numerous occasions in the past by Leadership Boards). If the will exists for this it is proposed that this is developed by Trust Company Secretaries (with legal support and input) and proposed to Leadership Board for adoption.

The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M's preferred way of operating.

The document delivers both a foundation and framework for CMPC development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMPC develops and the ask of the system, for it, expands, varies or diminishes.

Financial Implications
None. Collaboration is expected to be more efficient and should result in a more pragmatic response to any financial challenges in C&M.

Quality and/or Equality Impact
None

Recommendations
The Board is asked to: 1. Approve the CMPC Joint Working Agreement and Committee in Common as proposed 2. Commit to the use of delegation when required as a means of embedding system decision making

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

Draft No: 2
Date of Draft: June 2025

Dated 2025

CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE (CMPC) JOINT WORKING AGREEMENT

Between

(1) **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**

(2) **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST**

(3) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(4) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(5) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(6) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(7) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(8) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(9) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(10) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(11) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(12) **MERSEY CARE NHS FOUNDATION TRUST**

(13) **EAST CHESHIRE NHS TRUST**

(14) **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

(15) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

(16) **WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST**

and

(17) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 **Introduction**

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMPC CiCs;
CMPC CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMPC CiC**" shall be interpreted accordingly.
CMPC Leadership Board	the CMPC CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMPC CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMPC CiC meetings when they meet in common;
Member	a person nominated as a member of a CMPC CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, , Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey

	Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT, Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMPC as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMPC but is not forming a CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMPC CiC will be different.

1.5 The CMPC Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMPC Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident, clear and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

Key functions

2.2 The key functions of CMPC are to:

2.2.1 Deliver the CMPC vision;

2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.2.3 Align priorities across the member Trusts,

2.2.4 Support delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.2.5 Direct operational resources across Trust members to improve service provision;

2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.3 CMPC's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

2.3.3 Reduce health inequalities;

2.3.4 Improve access to services and health outcomes;

2.3.5 Stabilise fragile services;

2.3.6 Improve pathways;

2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

2.3.8 Achieve financial sustainability.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMPC CiCs acting through the CMPC Leadership Board.

2.5 More specifically the CMPC CiCs and the CMPC Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMPC development*:*

2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.5.2 Delivery and co-ordination of the community programme to support alignment with other programmes;

2.5.3 Further development of community based alternatives to hospital admission and standardisation of the community services offer in Cheshire and Merseyside as per the Neighbourhood health guidance;

2.5.4 Cancer Alliance delivery and enablement – subject to requests of the Alliance;

2.5.5 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.5.6 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.5.7 Coordinating and enabling CMPC members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.5.8 Coordinating and enabling CMPC members contribution and response to system wide financial decision making, pressures and financial governance;

2.5.9 Responding to and coordinating CMPC action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

2.5.10 The CMPC Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMPC will provide

both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMPC may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMPC Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMPC workplan.

2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMPC will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMPC CiCs as the **CMPC Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMPC openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Recognising the relationship between acute, mental health, community and specialist providers ensuring that information is shared where this impacts on other sectors;

3.1.8 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.9 Recognising and respecting the collective view and keeping to any agreements made between the CMPC CiC's;

3.1.10 Maintain CMPC collective agreed position on shared decisions in all relevant communications;

3.1.11 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.12 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMPC CiCs shall meet together as the CMPC Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-18).

4.1.1 Meetings of the CMPC Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMPC Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMPC Leadership Board – Decisions to be made under the CMPC CiC delegations - CiC CEOs;

C. CMPC Leadership Board – CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMPC CiCs shall work collaboratively with each other as the CMPC Leadership Board in relation to the committees in common model.

4.3 Each CMPC CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMPC CiC or its duty to act in the best interests of its Trust, each CMPC CiC shall seek to reach agreement with the other CMPC CiCs in the CMPC Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMPC CiCs meet in common, as the CMPC Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2026.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMPC Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution) in the following approach:

Scale of involvement/impact	Approach to decision
Matter under discussion has no involvement or impact on other CMPC Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMPC Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMPC Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMPC CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMPC Leadership Board.
Matter involves or impacts all CMPC Trusts and comes within the delegation under the	Matter to be dealt with through the CMPC CiCs at the CMPC Leadership Board in

[1] Chairs will be invited to CMPC Leadership Board meetings, at least quarterly.

CMPC CiCs (e.g. collaborative approach to non-clinical services or workforce)	accordance with this Agreement and the Terms of Reference.

4.6 Each CMPC Trust will report back to its own Board and the CMPC Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMPC Trust Board meetings. The CMPC Trust chairs may (as well as their quarterly CMPC meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMPC on an informal basis. In addition, the CMPC Leadership Board will seek to ensure that each CMPC programme has the opportunity for a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMPC CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMPC (or if relevant, section of the meeting), may be held in public except where a resolution is agreed by the CMPC Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMPC meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Any exit plan, when required or proposed by a Trust, will be drafted for consideration by the Leadership Board with support by the CMPC DoFs. . it is a necessity that an agreed exit plan deals with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMPC CiC Chairs varying the Agreement under clause 10.6.2.

6.1.4 cost apportionment, where appropriate, will be applied on a proportionate fair shares basis

6.2 An exit plan approach is drafted shall be inserted into this Agreement at Appendix 18 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMPC CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMPC Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 19) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMPC CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMPC Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMPC Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMPC is committed to clear, consistent and transparent communication across the CMPC Trusts and with system partners' where appropriate. It is specifically recognised that CMPC Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMPC and the CMPC Trusts may be asked to represent both their own organisations and CMPC in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMPC Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMPC activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMPC across the Trusts as envisaged if and when required.. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be

inserted into this Agreement at Appendix 19 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMPC CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMPC Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMPC's decision-making processes.

9.2 The CMPC Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMPC website. It is proposed that such policies will either be CMPC developed or CMPC will support the adoption and application of the policy of the CMPC Chair and/or Meeting Lead.

9.3 All CMPC Leadership Board, committee and sub-committee members, and employees acting on behalf of CMPC, will comply with the CMPC policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMPC. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMPC Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMPC Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMPC Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMPC Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMPC CiCs at the CMPC Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMPC Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMPC Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMPC Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMPC Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMPC Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMPC Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMPC Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMPC Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 The above process (10.5) will seek to be addressed within one calendar month and no longer than 6 weeks unless, in such circumstances, as all parties agree to a longer time frame

10.7 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMPC Leadership Board may decide to recommend their Trust's Board of Directors to:

10.7.1 terminate the Agreement;

10.7.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.7.3 agree that the Dispute need not be resolved.

11 **Variation**

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 **Counterparts**

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 **Governing law and jurisdiction**

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **BRIDGEWATER COMMUNITY HEALTHCARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **CHESHIRE AND WIRRAL PARTNERSHIP NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL COMMUNITY HEALTH AND CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1– TERMS OF REFERENCE FOR BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Bridgewater Community Healthcare NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Cheshire and Wirral Partnership NHS Foundation Trust CiC]

APPENDIX 3– TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 5– TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 12– TERMS OF REFERENCE FOR MERSEY CARE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey Care NHS Foundation Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 14 – TERMS OF REFERENCE FOR THE MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 15 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 16– TERMS OF REFERENCE FOR WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral Community Health and Care NHS Foundation Trust CiC]

APPENDIX 17 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 18 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one seventeenth of any professional advisers' fees incurred by and on behalf of CMPC in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMPC Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no joint assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMPC and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMPC CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMPC as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMPC CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 19 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

V 3-refresh June 2025

CMPC LEADERSHIP BOARD
TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMPC TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Provider Collaborative or CMPC	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMPC Agreement	the Joint Working Agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC together with the other CMPC CiCs;
CMPC CiCs	the Trust CIC and the other respective committees established by each of the Trusts to work alongside each other and "**CMPC CiC**" shall be interpreted accordingly;
CMPC Leadership Board	The Leadership Board is a regular meeting of Trust CEOs across C&M which can (when business demands, and responsibility is delegated) be called as a CMPC CiC Leadership Board can also be used as the CMPC CiCs meeting at the same time and place to consider matters of shared interest in line with these Terms of Reference;
CMPC Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMPC Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMPC;
CMPC Programme Support	Administrative infrastructure supporting CMPC;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the CMPC CiC meetings when they meet in common;
Member	a person nominated as a member of an CMPC CiC in accordance with their Trust's Terms of

	Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
NHS Cheshire & Merseyside Integrated Care Board or "C&M ICB"	the Integrated Care Board (ICB) for Cheshire and Merseyside. An NHS organisation established on July 1, 2022, that leads an Integrated Care System (ICS). ICBs are responsible for planning and funding most NHS services in their area, managing the NHS budget, and ensuring services are in place to meet the health needs of the local population.
Mersey and West Lancashire Teaching Hospitals CiC	the committee established by Mersey and West Lancashire Teaching Hospitals NHS Trust, pursuant to these Terms of Reference, to work alongside the other CMPC CiCs in accordance with these Terms of Reference;
Mersey and West Lancashire Teaching Hospitals NHS Trust	Mersey and West Lancashire Teaching Hospitals NHS Trust of Whiston Hospital, Warrington Road, Prescot L35 5DR;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT, Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The Mersey and West Lancashire Teaching Hospitals NHS Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMPC to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMPC but is not forming its own CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each respective individual CMPC CiC will be different.

1.5 Each Trust has entered into the CMPC Agreement on **[DATE]** and agrees to operate its CMPC CiC in accordance with the CMPC Agreement.

2 Aims and Objectives of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC

2.1 The aims and objectives of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC are to work with the other CMPC CiCs on system work or matters of significance as delegated to the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 Leadership

Provide strategic leadership, oversight and delivery of new models of care through the development of CMPC and its workstreams.

Set the strategic goals for CMPC, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.2 Delivery

Consider different employment models for service line specialities including contractual outcomes and governance arrangements;

Review the key deliverables and hold the Trusts to account for progress against agreed decisions;

Ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

Establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

Improve the quality of care, safety and the patient experience delivered by the Trusts;

Deliver equality of access to the Trusts service users; and

Ensure the Trusts deliver services which are clinically and financially sustainable.

2.1.3 Collaborate

Receive and seek advice from the relevant Professional (reference) Groups, including Medical, Nursing, Finance, Strategy, Human Resources, Operational and governance;

Receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board and regulator or those charged with performance management;

Review and approve any proposals for additional Trusts to join the founding Trusts of CMPC;

Ensure compliance and due process with regulating authorities regarding service changes;

Oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.2 Review the CMPC Agreement and Terms of Reference for CMPC CiCs on at least a biennial basis

3 Establishment

3.1 The Mersey and West Lancashire Teaching Hospitals NHS Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC.

3.2 The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall work cooperatively with the other CMPC CiCs and in accordance with the terms of the CMPC Agreement.

3.3 The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC is a committee of Mersey and West Lancashire Teaching Hospitals NHS Trust's board of directors and therefore can only make decisions binding Mersey and West Lancashire Teaching Hospitals NHS Trust. None of the Trusts other than Mersey and West Lancashire Teaching Hospitals NHS Trust can be bound by a decision taken by Mersey and West Lancashire Teaching Hospitals NHS Trust CiC.

3.4 The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Trust to be delegated to a committee of directors of the Trust.

4.2 Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC in paragraph 4 of these Terms of Reference shall be retained by Mersey and West Lancashire Teaching Hospitals NHS Trust's Board. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of Mersey and West Lancashire Teaching Hospitals NHS Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to Mersey and West Lancashire Teaching Hospitals NHS Trust's Board for inclusion on the private agenda of Mersey and West Lancashire Teaching Hospitals NHS Trust's next Board meeting in order that Mersey and West Lancashire Teaching Hospitals NHS Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall send the minutes of Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meetings to Mersey and West Lancashire Teaching Hospitals NHS Trust's Board, on a monthly basis, for inclusion on the agenda of Mersey and West Lancashire Teaching Hospitals NHS Trust's Board meeting.

6.3 Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall provide such reports and communications briefings as requested by Mersey and West Lancashire Teaching Hospitals NHS Trust's Board for inclusion on the agenda of Mersey and West Lancashire Teaching Hospitals NHS Trust's Board meeting.

7 Membership

7.1 The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall be constituted of directors of Mersey and West Lancashire Teaching Hospitals NHS Trust. Namely the Mersey and West Lancashire Teaching Hospitals NHS Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each Mersey and West Lancashire Teaching Hospitals NHS Trust CiC Member shall nominate a deputy to attend Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for Mersey and West Lancashire Teaching Hospitals NHS Trust's Chief Executive shall be an Executive Director of Mersey and West Lancashire Teaching Hospitals NHS Trust.

7.4 In the absence of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend Mersey and West Lancashire Teaching Hospitals NHS Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of Mersey and West Lancashire Teaching Hospitals NHS Trust CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a **Mersey and West Lancashire Teaching Hospitals** NHS Trust CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 The chair of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall be nominated by the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC.

7.6 When the CMPC CiCs meet in common, one person nominated from the Members of the CMPC CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMPC CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of Mersey and West Lancashire Teaching Hospitals NHS Trust CiC. The Mersey and West Lancashire Teaching Hospitals NHS Trust's Chair shall be invited to meetings of the CMPC CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see CMPC JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of Mersey and West Lancashire Teaching Hospitals NHS Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMPC CiCs.

8.3 The CMPC Programme Lead shall have the right to attend the meetings of Mersey and West Lancashire Teaching Hospitals NHS Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMPC CiCs' meetings, but for the avoidance of doubt, any such persons in

attendance at any meeting of the CMPC CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of Mersey and West Lancashire Teaching Hospitals NHS Trust CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meetings shall take place monthly.

9.2 The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall meet with the other CMPC CiCs as the CMPC Leadership Board in accordance with the CMPC Agreement (as set out in clause 4 of the CMPC Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMPC CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMPC Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMPC Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall be confidential to the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of Mersey and West Lancashire Teaching Hospitals NHS Trust Board.

10 Quorum and Voting

10.1 Members of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC have a responsibility for the operation of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall have one vote. The Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall comply with the provisions on conflicts of interest contained in Mersey and West Lancashire Teaching Hospitals NHS Trust's Standing Orders, the CMPC Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Mersey and West Lancashire Teaching Hospitals NHS Trust's Standing Orders also apply to conflicts which may arise in their position as a Member of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC.

11.2 All Members of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC shall declare any new interest at the beginning of any Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meeting and at any point during a Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meeting if relevant.

12 Attendance at meetings

12.1 Mersey and West Lancashire Teaching Hospitals NHS Trust shall ensure that, except for urgent or unavoidable reasons, Mersey and West Lancashire Teaching Hospitals NHS Trust CiC Members (or their Nominated Deputy) shall attend Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meetings (in person) and fully participate in all Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) i.e MS Teams or equivalent to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC will be provided by CMPC Programme Support (or such other route as the Trusts may agree in writing). The CMPC Programme Support will:

13.1.1 draw up an annual schedule of CMPC CiC meeting dates and circulate it to the CMPC CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMPC CiC meetings; and

13.1.3 take minutes of each Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meeting and, following approval by the Meeting Lead, circulate them

to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meeting.

13.2 The agenda for the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meetings shall be determined by the CMPC Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMPC Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST CIC

The Board of each Trust within CMPC remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to Mersey and West Lancashire Teaching Hospitals NHS Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC to decide are set out in the table below.

If it is intended that the CMPC CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meeting with a view to Mersey and West Lancashire Teaching Hospitals NHS Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by Mersey and West Lancashire Teaching Hospitals NHS Trust's Board). Any proposals discussed at the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC meeting outside of these parameters would come back before Mersey and West Lancashire Teaching Hospitals NHS Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMPC Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMPC Agreement and which may be supplemented or further defined by an annual CMPC Work Programme) and may include both back office and clinical services.

	Decisions delegated to Mersey and West Lancashire Teaching Hospitals NHS Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMPC programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Mersey and West Lancashire Teaching Hospitals NHS Trust CiC referred to it by the CMPC Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMPC Programmes and recommending remedial and mitigating actions across the system;

	Decisions delegated to Mersey and West Lancashire Teaching Hospitals NHS Trust CiC
5.	Formulating, agreeing and implementing strategies for delivery of CMPC Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMPC priorities or programmes (including as required by any agreed CMPC annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements;

	Decisions delegated to Mersey and West Lancashire Teaching Hospitals NHS Trust CiC
	d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMPC Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]