Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 24 September 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 (August and September 2025)** *Purpose: To **note** the Employee of the Month presentations for August and September 2025*	Film	Chair *(15 mins)*
10.15	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.30	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB25/065 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 30 July 2025*	Report	
	6.	**TB25/066 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.	**TB25/067 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	S O'Brien L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Reports				
11.10	8.	**TB25/068 Committee Assurance Reports** 8.1. Executive Committee 8.2. Audit Committee 8.3. Quality Committee 8.4. Strategic People Committee 8.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper S Connor N Fletcher obo C Elliott L Knight S Connor obo C Spencer *(40 mins)*
Other Board Reports				
11.50	9.	**TB25/069 Medical Revalidation Annual Declaration 2024/25** *Purpose: To **approve** the* Medical Revalidation Annual Declaration	Report	K Clark *(10 mins)*
12.00	10.	**TB25/070 Emergency Planning Response and Resilience (EPRR) 2025/26 Compliance with the National Core Standards.** *Purpose: To **approve** the EPPR Statement of Compliance with National Core Standards for 2025/26*	Report	L Neary *(10 mins)*
12.10	11.	**TB25/071 Learning from Deaths Annual Report 2024/25** *Purpose: To **note** the Learning from Deaths Annual Report for 2024/25*	Report	S O'Brien obo Ash Bassi *(10 mins)*
12.20	12.	**TB25/072 Statutory Pay Gap Annual Declaration 2024/25** *Purpose: To **approve** the* Statutory Pay Gap Annual Declaration 2024/25	Report	M Szpakowska *(15 mins)*
12.35	13.	**TB25/073 2025/26 Winter Plan** *Purpose: To **approve** the 2025/26 Winter Plan and the winter plan Board Assurance Statements*	Report	L Neary *(15 mins)*
Concluding Business				
12.50	14.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*

12.55	15.	**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 29 October at 09:30		**13.00 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.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	24 September 2025
Agenda Item	**TB25/000b**			
Report Title	Patient Story - Cardiac Rehabilitation Service, Southport Hospital			
Executive Lead	Sarah O'Brien; Chief Nursing Officer			
Presenting Officer	Michelle Kitson, Matron Patient Experience			
Action Required		**To Approve**	X	**To Note**

Purpose

To share with the Trust Board the patient story regarding the care delivered by the Cardiac Rehabilitation Service at Southport Hospital.

Executive Summary

The patient story is shared by Bernard who experienced a heart attack in January 2025. Prior to this, Bernard was a highly active and healthy person, so this came as a complete shock to him and affected him both physically and emotionally. Bernard contacted the Patient Advice and Liaison Team PALS) at Southport Hospital to offer his feedback and praise about the care he received.

Bernard was initially cared for on Ward 9B at Southport Hospital and then transferred to Liverpool Heart and Chest Hospital for treatment. On discharge he was then referred to the Cardiac Rehabilitation team at Southport Hospital.

Cardiac rehabilitation is a nationally recognised multiprofessional programme that aims to support patients back to a normal lifestyle and hopefully prevents any other cardiac events and admission to hospital.

Bernard found this service invaluable as he initially struggled with a lot of anxiety, which impacted on his confidence to start the programme. However, he felt safe as he was being regularly monitored through the sessions and began to feel more reassured. At the end of the six-week programme his level of fitness had improved which he described as a 'confidence builder'.

By empowering Bernard to manage his own health and risk factors his anxiety has lessened and he has been able to continue to build up his level of fitness, getting back to the things he enjoys.

The story reflects the importance of patient education, rehabilitation and the ability to empower patients to feel confident in managing their own medical conditions.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Patient Story.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care

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

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 30 July 2025
(Approved at Trust Board on Wednesday 24 September 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
Nicola Bunce	NB	Director of Corporate Services
Steve Connor	SC	Non-Executive Director
Claudette Elliott	CE	Non-Executive Director
Neil Fletcher	NF	Associate Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Gareth Lawrence	GL	Chief Finance Officer
Lesley Neary	LN	Chief Operating Officer
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer
Peter Williams	PW	Chief Medical Officer

In Attendance

Name	Initials	Title
Yvonne Mahambrey,	YM	Quality Matron, Patient Experience (Agenda Item 2 via MS Teams)
John Quarmby,	JQ	Business Development Manager – North, Vanguard Health Care Solutions (Observer via MS Teams)
Sue Redfern	SRe	Deputy Director of Infection, Prevention and Control (Agenda Item 13 via MS Teams)
Anuj Sharma,	AS	Account Director, Transformation Services, Ergéa Group (Observer via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager
Claire Wesselingh,	CW	Professional Lead for Dietetics and Therapy Operational Manager (Agenda Item 2 via MS Teams)
Marie Wright	MW	Halton Council Representative (Stakeholder Representative) (via MS Teams)

Apologies

Name	Initials	Title
Lisa Knight	LK	Non-Executive Director
Sarah O'Brien	SOB	Chief Nursing Officer
Hazel Scott	HS	Non-Executive Director
Rani Thind	RT	Associate Non-Executive Director

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for July 2025 was Wendy Askew, Senior Occupational Therapist, Southport Hospital and the Board watched the film of Lynne Barnes (Deputy Chief Nursing Officer) reading the citation and presenting the award to Wendy. **RESOLVED:** The Board **noted** the Employee of the Month for July 2025 and congratulated the winner
2.	**Patient Story**
	2.1. SR welcomed YM and CW to the meeting. 2.2. YM introduced the Patient Story video in which a patient shared her experience of admission at Newton Hospital for rehabilitation following treatment at Whiston Hospital. On admission the patient, who was normally very sociable, had been withdrawn and had been encouraged by the Activities Co-ordinator to join the group activities and one-to-one sessions. The care that the patient received had focused on improving her wellbeing, increasing her social interaction and cognitive stimulation. The patient commented that the group activities gave her 'something to look forward to' and had helped to alleviate the "boredom" of being in hospital in-between rehabilitation sessions. 2.3. The Activities Co-ordinator explained that she worked with the patients to tailor the one-to-one sessions according to their individual interests and hobbies. It was noted that adjustments made to the group activities ensured that patients who had hearing and/or visual impairments were able to participate. 2.4. YM advised that the Activities Co-ordinator role had also been introduced on the Duffy Suite at St Helens Hospital. 2.5. SR thanked YM and CW for sharing the patient's story and asked that they convey the Board's thanks to the patient for her openness in sharing her story as well as to the Activities Co-ordinator for the difference she made for patients, who had long hospital stays for rehabilitation. **RESOLVED:** The Board **noted** the Patient Story

	(YM and CW left the meeting)
3.	**Chair's Welcome and Note of Apologies**
	3.1. SR welcomed all to the meeting and in particular AS and JQ who were attending the meeting as observers 3.2. SR reported that the Board had been made aware that one of the points presented at the meeting held in April as part of the Clinical Strategy update was incorrect and that the Ophthalmology services had not yet opened to referrals for age-related macular degeneration (AMD) patients. PW advised that, once the estates work at Ormskirk Hospital had been completed, the service would re-open to referrals. 3.3. SR reported that this would be PW's last Board meeting in his role as Chief Medical Officer and thanked him for his hard work and focus on clinical service improvements and patient experience over his three year tenure. 3.4. SR acknowledged the following awards and recognition for Trust staff and services: 3.4.1. Frailty Virtual Ward took top honours at the HSJ Digital Awards held on 26 June 2025 in the category of Improving Out of Hospital Care through Digital. The Employment Services Automation Team had been runners up in the category of Driving Change through AI and Automation. 3.4.2. The Trust has been shortlisted in two categories for the Nursing Times Awards: 3.4.3. Carol Fowler, Deputy Director of Governance - Quality and Patient Experience had been nominated in the Nurse Leader of the Year category for being an excellent role model, putting the needs of patients and their families first, and for always demonstrating compassion in her work. 3.4.4. The Palliative Care Team at Whiston and St Helens hospitals had been nominated in the Critical and Emergency Care Nursing category for their nurse-led palliative care initiative in the Emergency Department (ED) at Whiston Hospital. 3.4.5. The Occupational Therapy (OT) Team at Seddon Suite, St Helens Hospital, as part of the Cheshire and Merseyside Rehabilitation Network, won in the 'Excellence in Rehab and Reablement' category at the Occupational Therapy Excellence Awards. 3.4.6. Mr Gurpreet Singh MBE, who had worked at Southport Hospital for over 20 years before retiring, had been awarded the British Association of Urological Surgeons (BAUS) Gold Medal which recognised outstanding contributions to British urology. 3.4.7. The Trust's lead for Same Day Emergency Care and Acute Kidney Injuries (AKI), Dr Ragit Varia, had been appointed as President Elect of the Society for Acute Medicine (SAM). 3.4.8. An adventurous group of staff (including the Chief Executive) undertook the Anfield Abseil challenge to support MWL NHS Charity.

	3.5. The Annual Staff Awards took place on Friday 04 July and SR thanked the Communications and Media Team for organising the event and congratulated all the award winners. SR also thanked the members of the Board who had attended and looked after the guests and sponsors. Apologies for absence were **noted** as detailed above
4.	**Declaration of Interests**
	4.1. There were no new declarations of interests made in relation to the agenda items.
5.	**TB25/053 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 25 June 2025 and approved them as a correct and accurate record of proceedings / subject to the following amendments: 5.1.1. 6.2.4. to be amended to read '*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 <u>divert</u> the workload between neighbouring trusts.*' 5.1.2. 7.4.2. to be amended to read *'The <u>Invasive Procedures Development Group</u> had been created to review the never events in this area'.'* **RESOLVED:** The Board **approved** the minutes from the meeting held on 25 June 2025 subject to the amendments detailed above
6.	**TB25/054 Matters Arising and Action Logs**
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following actions were closed: 6.2.1. Action Log number 13 (TB25/051 Fit and Proper Person Chair's Annual Declaration) – the report had been amended to clarify that AMS had retired solely from her position as Director of Human Resources. **Action closed** 6.2.2. Action Log number 14 (TB25/052 2024/25 Safeguarding Annual Report (Adults and Children) – the information was included in agenda item TB25/060 Learning from Death Report (Q3 2024/25). **Action closed** **RESOLVED:** The Board **approved** the action log
Performance Reports	
7.	**TB25/055 Integrated Performance Report**

	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for June 2025 was presented.
7.1.	**Quality Indicators**
	7.1.1. PW presented the Quality Indicators and highlighted the following: • The latest reported Hospital Standardised Mortality Ratio (HSMR) was now up to March 2025 and for the full 2024/25 year was 90.4, which meant there had been 9.6 less deaths than expected when adjusted for age, diagnosis, co-morbidities and deprivation status of patients. The breakdown of the individual diagnostic groups was regularly reviewed and any groups with higher than expected mortality were reviewed by Mortality Surveillance and Mortality Outcome Groups. • The Summary Hospital-level Mortality Indicator (SHMI) (deaths associated with hospitalisation) data up to February 2025 was 1.03. PW noted that the most recent SHMI, which would be reported in the next IPR, was 1.0. • There had been eight cases of hospital onset hospital acquired (HOHA) and two cases of community onset hospital acquired (COHA) Clostridioides difficile (C.Diff) reported in June 2025. There had been 30 cases reported year to date (YTD) which was three cases above the NHS England (NHSE) threshold and a review was being undertaken to ensure each case was attributed correctly. Work was ongoing on the C.Diff Improvement Plan which would incorporate environmental cleanliness, improved use of antibiotics, staff awareness, and training. Additionally, work was taking place at a system level with Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) and MWL was one of the first trusts to roll out a new toolkit to try and improve staff knowledge and promote the standardised approach to the management of diarrhoea. • There had been 11 cases of healthcare associated Escherichia coli (three HOHA and eight COHA) in June 2025. There had been 39 healthcare associated cases reported YTD which was one case above the NHSE threshold. Actions to support a reduction in E coli infections included an organisational focus on hydration for all patients and timely specimen collection. • There had been a reduction in the number of patient falls (0.11 per 1,000 bed days) in the latest data (April 2025). The Trust Falls Strategy was under review and would be informed by an external review of the Trust's falls processes and procedures, and the newly published National Institute for Health and Care Excellence (NICE) guidance. • There had been one never event reported in June 2025 which had involved the administration of an incorrect dose of insulin. PW reported that there had been no harm to the patient and that immediate actions had been implemented across all wards. The incident had undergone a Patient Safety Incident Investigation (PSII) and PW noted he had recently reviewed the draft report and had been assured by the number of initial actions that had taken place to reduce the likelihood of similar incidents happening in the future.

	• No still births or neonatal deaths had been reported in June 2025.
7.2.	**Operational Indicators**
	7.2.1. LN presented the operational indicators. 7.2.2. LN highlighted the following: <u>Urgent and Emergency Activity</u> 7.2.3. The 4-hour mapped performance for MWL in June 2025 was 78.9% against the national target of 78%. This compared to 75% nationally and 73% for Cheshire and Merseyside (C&M). This performance had been sustained over the preceding six months. The number of 12-hour waits in the Emergency Department (ED) had been 16.7% in June (16.4% in May) against a target of 10%. 7.2.4. Bed occupancy across all MWL sites was 103.3% in June 2025 which equated to 62 additional patients each day and LN advised that this was the lowest occupancy reported since August 2023. There had been a reduction in the non-elective length of stay, although this remained high, and an increase in the percentage of discharges by midday. These improvements were contributing to the improved patient flow. 7.2.5. LN reminded the Board that the national 45 minute rescue and release scheme for ambulance handovers came into effect 01 August. A pilot had been in place at both Whiston and Southport EDs and in July 91.5% of ambulance handovers were within the 45 minute target. This compared to 57% in November 2024 and 87% in June 2025. LN advised that the teams have been working on escalation plans which were being tested ahead of the August implementation. 7.2.6. The percentage of patients with no criteria to reside (NCTR) had deteriorated slightly to 21.1% in June 2025 (19.1% in May) against the 10% target. At Southport Hospital patients with NCTR had increased to 24.7% and this was attributed to a reduction in community bed capacity in Sefton due to the unexpected closure of some beds. At Whiston Hospital the NCTR improvement trajectories had been achieved by all Place partners in June. RC asked whether the increase in NCTR at Southport was having an impact on the number of patients waiting 12 hours or longer in the ED and on overall bed occupancy. LN agreed that there was a direct correlation between an increase in NCTR and patient flow. There had been an increase from circa 30 patients on the bed list to 75. <u>Elective Activity</u> 7.2.7. LN reported that the Trust was delivering higher levels of elective and outpatient activity compared to 2024/25 but remained below the 2025/26 plan. Recovery plans were being implemented in the two most challenged specialities (orthopaedics and general surgery) to improve performance. 7.2.8. The 18 week Referral to Treatment (RTT) performance was 64.8% in June 2025 (2025/26 recovery target 63.7%). 7.2.9. In June 2.6% of patients on the waiting list were waiting longer than 52 weeks to be treated, against the target of less than 1% to be achieved by the end of 2025/26 (May 2.8%).

	7.2.10. In June the Trust still had 198 patients who had waited over 65 weeks. Three specialities were particularly challenged: Plastics, Vascular, and Ear, Nose and Throat (ENT). The Vascular and ENT services were delivered through service level agreements (SLA) with the University Hospitals of Liverpool Group (UHLG) and depended on their capacity. Plastics was an area of concern for the Trust to resolve internally. The target was to eliminate all 65+ week waiters by August. 7.2.11. Diagnostic performance was 86.9% in June against the 95% target and had improved compared to 85.3% in May, due to the increase in capacity for Non-Obstetric Ultrasound. 7.2.12. Performance against the 62 day cancer standard had decreased from 81% in April to 79.9% in May (target 85%). National performance was 67.8% and C&M performance was 67.8%. 7.2.13. Performance against the 28-day cancer standard had deteriorated to 65.6% from 68.2% in April (target 77%) and this was driven by two specific tumour sites (skin and lower gastrointestinal (GI) at Southport Hospital). 7.2.14. A MWL Cancer Summit was held in July 2025 and LN thanked RT for attending. Recovery action plans were being updated following the summit. 7.2.15. SR asked if the impact of the recent industrial action by resident doctors would be presented to Board once it had been assessed. LN responded that an initial analysis of the impact on workforce numbers and cancellation of activities had already been undertaken, but a full de-brief would follow. Resident Doctors (40% of the workforce group) had taken part in the industrial action. Challenges had been experienced in some services and routine activity, including elective clinics, had been stood down. However, no cancer activity had been cancelled and scheduled cancer MDT meetings had taken place. The impact on elective recovery including the 52-week and 65-week activity had been requested by NHSE. PW commented that urgent and emergency care had also continued throughout the period, but the disruption had increased the wait times to be seen and times to be admitted, which would feed through into July performance.
7.3.	**Workforce Indicators**
	7.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for mandatory training was 89.8% (target of 85%). A paper, recommending a single training needs analysis (TNA) for MWL, had been presented to the Executive Committee. This had been approved in principle pending final review by the Chief Medical Officer and Chief Nursing Officer. The plan was to phase in the new TNA but a temporary decrease in compliance was anticipated due to changes in the numbers of staff required to complete each subject. • The compliance rate for appraisals was 73.8% (target of 85%) and this was slightly below trajectory for month 2 of the annual appraisal window. There were a significant number of appraisals booked which provided assurance that managers were undertaking the appraisals and performance was expected to improve. There was a focus on good

	quality appraisal conversations and there had been good engagement with the training sessions and other resources provided . • Staff turnover was 0.6% and remained below the target of 1.1%. • Sickness absence had increased to 6.13% in June from 5.9% in May (target 5%). MWL remained comparable to other acute providers in the C&M. The increase had been across most of the staff groups and areas. The top three reasons for sickness remained anxiety, stress and depression (including non-work related causes), which accounted for 36% of all absences, gastrointestinal issues, and musculoskeletal health (MSK).
7.4.	**Financial Indicators**
	7.4.1. GL presented the financial indicators and reminded the Board that the Trust had set a deficit plan of £10.7m for 2025/26, however, this would have been a £41m deficit plan excluding £31m deficit support funding. The plan was underpinned by £35m of system led and strategic cost reduction opportunities as well as a Cost Improvement Programme (CIP) of 5%. 7.4.2. GL reported that the current plan would break the Trust's statutory breakeven duty and MWL would be expected to recovery this position within three years. New guidance on developing three-year recovery plans was expected from NHSE and once received, this would support the development of an MWL plan to recover the statutory breakeven duty. 7.4.3. At month 3, an adjusted deficit position of £14.6m had been reported and this was £1.6m ahead of plan. GL noted that if deficit support was excluded, the deficit position would be £22.1m. 7.4.4. GL highlighted the following: • The Trust had successfully delivered £12.5m of CIP YTD against a plan of £48.2m. The recurrent full year effect of delivered schemes was £12m (25% of the £48.2m recurrent target). • Cash balances at M3 was £9.4m mainly due to early payments received for the Lead Employer (LE) element of the organisation. The Trust was currently supporting the cash flow by delaying the capital programme payments and GL noted that this was a risk as it pushed capital expenditure towards the end of the financial year. • The financial forecast remained challenging and the Trust continued to work with system partners to achieve the forecast outturn. However this remained difficult as only £3.7m of the system led efficiency savings had been identified to date. • There had been a 35% reduction in agency costs as well as a reduction of 10% in bank costs compared to the same period in 2024/25. Additionally, there had been a 31% reduction in overtime since the start of the year.

	7.4.5. GL highlighted the risk that the Trust's contract with the Integrated Care Board (ICB) remained outstanding. Three escalation meetings with the ICB and NHSE had taken place, however, there had been no resolution. 7.4.6. SR emphasised the need to maintain focus on the Trust's cash position, particularly in light of NHSE's suggestion to delay payments to suppliers and noted that MWL was itself a supplier to other trusts. GL agreed with SR's comment and noted that the Trust was making every effort to reduce its aged debt to help the cash position. GL noted that cash management would be even more challenging in quarter 2 and the ICB had been informed that deficit support funding (worth £7.5m to MWL) has been withheld, due to performance in quarter 1. 7.4.7. AMS asked whether MWL was the only Trust with no signed contract. GL responded that, to his knowledge, one other Trust was in the same position in C&M. The dispute for MWL related to revenue funding for the activity at the Community Diagnostic Centre (CDC) at Southport Hospital and this was the reason for including the regional team in the discussions. 7.4.8. NB asked if the deficit funding had been withdrawn completely or if it would it be possible to earn it back by improving performance. GL responded that this was possible and advised that work was ongoing to agree the metrics for improvement with NHSE. GL noted that C&M had been on-plan at the end of Q1, while some other ICBs had not achieved their plans, but did not have deficit support funding withdrawn. NHSE had stated that there was a lack of confidence in the C&M plan. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB25/056 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. RC presented the Executive Committee Assurance report for the meetings held in June 2025. Bank or agency staff requests that breached the NHSE cost thresholds were reviewed at each meeting, and the Chief Executive's authorisation recorded. Additionally, reports from the weekly vacancy control panel were presented at every meeting. 8.1.2. RC highlighted the following items from the report: • The Committee had approved a proposal to establish a Senior Leadership Group (SLG) comprising of senior operational managers and Deputy Directors. The group would serve as a sounding board to the Executive team and would provide a forum to share views and develop proposals.

	• The Committee had received the quarterly update on the Maternity Patient Survey Action Plan and the work undertaken in response to the National Maternity Survey. • The Committee had received updates from the Finance Improvement Group (FIG) meetings. The FIG also now included a focus on workforce and variable pay. Other aspects of performance were being overseen by the Divisional Performance Reviews with the Executive Committee. • The Committee had approved the proposal to increase car parking charges for 2025/26, with implementation scheduled for September 2025 following payment of the 2025/26 pay award to staff. It was agreed that staff car parking charges would continue to be reviewed annually. The changes to the patient and visitor charges completed the alignment of charges across the MWL hospital sites. The remainder of the report was **noted.**
8.2.	**Quality Committee**
	8.2.1. GB presented the Quality Committee Assurance Report for the meeting held on 22 July 2025 and noted that several items were to be discussed in reports later in the Board agenda and would therefore not be covered in this report. GB advised that that the Committee had approved the minutes of the meetings held in May and June 2025. 8.2.2. Other items to highlight were: <u>Committee Performance Report (CPR)</u> 8.2.3. Compliance with the Malnutrition Universal Screening Tool (MUST) had improved to 88.1%. Although there had been a dip in other nutrition metrics in month, overall performance continued to improve. It was noted that nutrition remained a key area of focus as one of the Trust's Quality improvement objectives for 2025/26. 8.2.4. There had been improved compliance with the National Early Warning Score (NEWS) observations as well as a reduction in triage times following the improvement work undertaken at Whiston Hospital ED. 8.2.5. The Committee had discussed the new Ambulance 45 minutes rescue and release target which would come into effect on 01 August and expressed a concern about the risk for patients being left in the ED by North West Ambulance Service NHS Trust (NWAS), without staff to care for them. 8.2.6. There had been an improvement in the complaints response compliance rate, however compliance remained below the 80% target. 8.2.7. Work had been ongoing to enhance the information presented in the CPR regarding sepsis metrics. GB observed that when fewer data points were available, deviations appeared more significant. The proportion of patients receiving intravenous (IV) antibiotics within one hour or three hours for suspected sepsis had increased to 71.9%. <u>Clinical Effectiveness Committee (CEC)</u>

	8.2.8. The Do Not attempt Cardiopulmonary Resuscitation (DNACPR) training video was now available via Moodle and Electronic Staff Record (ESR). 8.2.9. Work was ongoing with the divisions to increase the number of Department of Medicine for Older People (DMOP) reviews of patients over 65 years of age. 8.2.10. There had been an improvement in histopathology turnaround times and 70% of cases on the cancer pathway were now reported within seven days. This improvement was attributed to the recent recruitment of three consultant histopathologists. GB noted that, from a Non-Executive Director (NED) perspective, the support provided by both the department and the Trust to staff progressing towards consultant roles was evident. 8.2.11. Strategic external funding had been secured for a Band 6 Research Nurse for Marshalls Cross GP Practice. 8.2.12. There had been continued improvement in the Venous Thromboembolism (VTE) risk assessments in Q1 and Q2, however performance remained below target. Work was ongoing to rollout the VTE risk assessment via the Electronic Prescribing and Medicines Administration (EPMA) system and further improvement was anticipated. 8.2.13. The Council had been assured by the on-going efforts to recruit to vacancies in anaesthetists, noting that this remained a national shortage speciality. 8.2.14. The replacement of the pharmacy robot at Southport Hospital remained a risk and approval for replacement as part of the 2025/26 capital programme proposals awaited review by the Capital Council. <u>Care Quality Commission (CQC) Quarterly Report</u> 8.2.15. Two planned inspections had taken place in Q1 and overall feedback was positive, however, the final reports were outstanding for: • the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) at Whiston Hospital took place on 30 April 2025 • the St Helens Urgent Treatment Centre (UTC) was inspected on 08 May 2025. 8.2.16. A CQC Engagement meeting took place on 23 June and included a Southport Hospital site visit. The meeting provided an opportunity to brief the CQC on quality improvements and the Shaping Care Together (SCT) Programme. 8.2.17. The MIAA Ward Quality Spot Checks received substantial assurance and GB reflected on this achievement and acknowledged the Deputy Chief Nursing Officer and her team for their hard work. 8.2.18. The Ward Accreditation programme remained focused on improving Infection Prevention & Control (IPC), Safeguarding and Safety Culture. 8.2.19. The Quality Ward Rounds and the Ward Accreditation process was being rolled out to specialist areas. GB reflected on a recent Quality Ward Round that she had attended at Southport Hospital and the positive feedback from patients. <u>Patient Safety Report</u>

	8.2.20. One never event had been reported in June involving the administration of an incorrect dose of insulin. 8.2.21. There had been no other alerts raised with the Committee. <u>Infection, Prevention and Control (IPC) Annual Report</u> 8.2.22. The 2024/25 IPC Annual Report was presented at Committee and several minor amendments had been requested. 8.2.23. GB noted that the Committee approved the Terms of Reference (ToR) for the Patient Engagement Council. 8.2.24. GB noted that the Quality Committee had recorded their thanks to PW for his service to the Committee during his tenure as Medical Director. 8.2.25. GB advised that she would be stepping down as Chair of the Quality Committee and CE would assume the role going forward. The remainder of the report was **noted**.
8.3.	**Strategic People Committee**
	8.3.1. CS, on behalf of LK, presented the Strategic People Committee (SPC) Assurance report for the meeting held on 23 July 2025 and noted that some key issues had already been discussed in earlier reports to the Board and would not be repeated. 8.3.2. CS highlighted the following: • Time to Hire was currently 58 days against a target of 40 days and this has been an area of focus over the preceding six months. Following the introduction of the new management system there had been an improvement in this metric, however, there had been a slight decrease in performance in month. It was noted that the additional scrutiny required around new appointments via the vacancy control process, had an impact on the time to hire. • The did not attend (DNA) rate for Health Work and Well Being (HWWB) was reported at 11%, exceeding the target of 10%. CS noted that this represented an improvement and a significant amount of work had been undertaken to understand the underlying reasons for the high DNA rate and to identify potential improvements. It was noted that management referrals resulted in the highest rate of DNAs, which may be influenced by factors relating to cooperation and communication. • The Committee had received the standard work programme reports and had discussed adding quantitative improvement trajectories, to allow progress to be tracked in each of the quarterly reports. • The Committee received the MWL values and culture update. CS reflected on the qualitative nature of the report, which encompassed both the soft aspects and the hard, measurable elements. Positive feedback had been received regarding the refreshed corporate induction

	programme. New staff particularly valued the involvement of the Directors and senior leaders in the induction. The Committee had suggested introducing a follow-up or check-in a few months after the induction, to determine whether the initial positive messages persisted and continued to be reflected in their experiences of working at MWL. • The Committee had received a Staff Story presented as a video interview with a resident doctor who had experienced an extended period as a Resident Doctor and had required flexibility and support from the Lead Employer and Deanery. The story included both positive feedback and suggestions for improvement. CS reflected on the challenges associated with inviting staff to share personal experiences with the Committee, acknowledging that such stories can be deeply personal in nature. The remainder of the report was **noted**.
8.4.	**Finance and Performance Committee**
	8.4.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 24 July 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. 8.4.2. Other points to highlight from the report were: • The Committee had received an update on the newly published draft NHS National Oversight Framework (NOF) and CS noted that the Finance and Performance Committee would continue to receive updates at future meetings, as details emerged about how the NOF would be applied. • The Committee had received and noted the PricewaterhouseCoopers International Limited (PWC) rapid finance diagnosis and the C&M ICB CIP Risk Review reports. In particular, the Committee had noted again that lack of progress in delivering the high risk and system CIPs. • The Committee had received an update on the M3 forecast outturn position. It was noted that the Trust was working on local mitigations to reduce the risk of non-delivery in the event that the Q2 deficit funding was not earned back. The Committee had noted that the Trust and ICB had achieved the Q1 plans, but NHSE has still chosen to withdraw the Q2 deficit support funding, because of the risk to delivering the system wide CIPs. 8.4.3. The Committee had received the Medicine and Urgent Care CIP update which outlined the current progress in delivery of the 2025/26 target, including speciality CIP meetings with clinical leads to drive delivery. CS highlighted the effort to bring forward the CIP pipeline earlier in the year for 2026/27 to support timely implementation and ensure achievement of the in-year target.

	8.4.4. 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. 8.4.5. The Committee again alerted the Board to the financial challenge and risks to delivery of the forecast outrun if the system opportunities/high risk CIPs were not delivered and that the impact would need to be mitigated. The remainder of the report was **noted**. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**TB25/057 Corporate Risk Register**
	9.1. NB presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the MWL CRR via the Trust's risk management systems. 9.2. NB reminded the Board that the CRR report for Q4 of 2024/25 had not been presented due to the implementation of InPhase, which was the Trust's new risk and incident management system that would also be used for clinical governance management and monitoring. 9.3. The current report was drawn from InPhase on 01 July and reflected a snapshot of the position as at 30 June 2025. 9.4. NB reported that the total number of risks on the MWL risk register at the end of June 2025 was 992 compared to 1,076 in January 2025 (the last report to Board). Additionally, there were 42 risks that had been transferred into InPhase but had not been scored, which were still outstanding from the transition. NB noted the change in numbers reflected both the closure of 2024/25 CIP risks at the end of the financial year and the removal of duplicate risks from the legacy trust systems. 9.5. NB reported that 24 risks were escalated to the CRR compared to 17 in January and two risks have been closed or de-escalated from the CRR. 9.6. NB noted that a summary was included in Appendix 1 and included the turnover of risks, the risk profile and categories as well as a breakdown per division including the unscored risks. This information was taken from the new reporting system in InPhase and NB asked for feedback from Board members on the new format. 9.7. NB highlighted the following:

	9.7.1. The number of risks awaiting review (42) appeared high, however this was part of the transition process, and it was expected this would decrease, as risk owners got used to the new process. 9.7.2. The risk profile was slightly skewed to the higher scored risks, but this was normal for the Trust. The biggest category of risks was patient care (516 risks). 9.8. NB reported that further work was being undertaken to ensure new high/extreme risks could not be added to the CRR without a review by the lead Director. 9.9. NB highlighted that the Board would recognise a number of the new CRR risks as they reflected discussions held at the Board over the last few months. 9.10. NF asked whether there were any concerns regarding the number of outstanding risks, noting that the figures had remained largely unchanged between January and July. NB responded that the number of outstanding risks was consistently higher in January due to staff being on annual leave. Reports were generated on the first working day of the month and when this fell over the weekend or early in the week the risks not yet reviewed tended to be higher. NB provided assurance that the Risk Management Council monitored risks that missed two reporting cycles, and these were discussed with the divisional leads and escalated to the Executive Committee via the Council Assurance Report if necessary. 9.11. GB asked about the risk profile graphs, and NB clarified that these showed the number of risks for each score, for each Division, the Corporate Departments and the Trust overall. In previous reports to Board this had been presented as a table, rather than a graph, but it was hoped the graphs would give a better insight into the risk profile of the different parts of the organisation. 9.12. CS asked whether the grading of risks was consistent across the organisation and whether InPhase would assist with understanding how to quantify a risk. NB responded that there had always been some variation depending on individual perceptions of risk; however, clear guidance and a standard risk rating matrix was part of the Trust risk management framework. The reviews by risk managers and at Divisional meetings, as well as the requirement for scrutiny of proposed high/extreme risks by Directors were all designed to support consistency. However, the implementation of InPhase had highlighted the need for additional training on risk management and risk scoring, and this had been put in place. Additionally, the process of bringing the risk management process together had highlighted slightly different approaches between the former trusts , and therefore work was ongoing to improve consistency. 9.13. AMS reflected on the InPhase demonstration to the Executive and the improvements in reporting functionality and asked whether the report would

	develop over time as the system became more widely understood. NB responded that the divisions and departments were finding it easier to generate standard reports which they can 'interrogate' where previously much of this work had been carried out manually. Additionally, a suite of standard reports had been created. NB reminded the meeting that the purpose of this report was to provide assurance to the Board that there was a risk management process operating within the organisation, and as such would remain high level. 9.14. SR asked how the Board was assured that risks were being effectively addressed. NB responded that the turnover of risks was a good indicator that risks were being identified, reported then managed and reduced in score. This was captured in the first table in Appendix 1. Additionally, the report detailed the new risks escalated to the CRR in the period and those closed or de-escalated. The active management of risks via InPhase with regular review and revisions of risks scores was the work being undertaken by the divisions with their managers and this could more easily be tracked via the InPhase BI modules. **RESOLVED:** The Board **noted** the Corporate Risk Register
10.	**TB25/058 Board Assurance Framework**
	10.1. NB presented the Board Assurance Framework (BAF) and noted that each BAF risk has been reviewed by the lead Executive and updates provided in relation to closed and new actions. 10.2. NB noted that several of the BAF risks had been updated to reflect the completion of associated actions. Additionally, revised completion dates had been included for any actions that remained overdue. 10.3. NB reported that it was recommended that the risk score for BAF 4 (Failure to maintain patient, partner and stakeholder confidence in the Trust) be increased to 16 for approximately three months during the SCT public consultation period. This adjustment would reflect the critical stage of the SCT Programme and the importance of maintaining public /stakeholder confidence during this time. 10.4. NF reflected on the additional assurance required on BAF 1 (Systematic failures in the quality of care) and asked what JOST stood for. PW responded that this was the Joint Oversight Scrutiny Group and NB agreed to update the BAF to reflect this amendment. **Action** BAF 1 additional assurance to be amended to read 'Response to NW Clinical Senate Report and JOSG **RESOLVED:**

	The Board **approved** the increased risk score and changes to the Board Assurance Framework.
11.	**TB25/059 Aggregated Incidents, Complaints and Claims Report (Q1)**
	11.1. PW, on behalf of SOB, presented the Aggregated Incidents, Complaints and Claims Report for Q1 of 2025/26. It was noted that in March of quarter 4, the Trust transitioned to the new InPhase and this change had consolidated reporting across all sites into a single system. This was the first integrated report to the Bard from InPhase 11.2. PW highlighted the following: 11.2.1. There had been 7,269 incidents reported in Q1 across MWL. 11.2.2. There had been 5,590 patient safety incidents reported in Q1 of which 85 were graded as moderate harm or above. 11.2.3. The highest number of incidents reported related to: • Accidents including slips, trips, falls, and collisions (995) • Pressure Ulcers including non-Trust acquired wounds (915) 11.2.4. The Trust had received 135 first stage complaints and delays in clinical treatment was the main reason for complaints. The ED remained the main area to receive complaints. 11.2.5. The Trust received 1,131 Patient Advise and Liaison Service (PALS) queries in Q1. 11.2.6. There had been 18 new clinical negligence claims lodged in Q1 of which seven were new claims and 11 related to previous requests for records. Additionally, 44 new requests for records had been received. 11.2.7. The Trust had received 20 new inquest notifications and 20 inquests had been closed. 11.2.8. No Prevention of Future Deaths (PFDs) had been issued during the period. 11.3. PW reported that there had been a small decrease in the number of incidents reported from Q3 to Q4, and again in Q1, with 7,269 incidents recorded in Q1 compared to 7,898 in Q4. This reduction may have been linked with the transition to the new InPhase system which resulted in lower reporting during the implementation. A higher proportion of incidents were classified as moderate or severe, including those resulting in death, indicating staff continued to report the most serious incidents. PW reported the number of incidents reported had increased in Q2 indicating staff were becoming more familiar with the new process. 11.4. There had been two new PSII's commissioned during Q1 including one relating to the Never Event (administration of an incorrect dose of insulin). 11.5. PW reported that the number of complaints received had continued to increase. However, there had been a reduction in the number of second-stage complaints, which suggested that initial complaints were being appropriately addressed. Work remained ongoing to improve performance against the 60-day response target, with particular focus on addressing breaches of this timeframe in order to reduce the existing backlog.

	11.6. There had been an increase in the number of PALS contacts primarily related to delays in treatment and difficulties experienced by patients in speaking to someone regarding their appointments. 11.7. PW reported that 44 requests for records had been received during Q1, representing a reduction from the 87 requests received in Q4 of 2024/25. This decrease was attributed to a significant change in the way claims were funded in 2023/24, which had previously led to a notable increase in the number of requests for records. General Surgery had the highest number of claims in Q4 and again in Q1 and, following the recent Getting It Right First Time (GIRFT) report, Hill Dickinson has been commissioned to provide an analysis of these claims to understand any themes or organisational learning. 11.8. The Senior Coroner for Liverpool has been appointed to also cover for Sefton, St Helens and Knowsley, following the retirement of the current postholder. 11.9. GB suggested that the Duty of Candour statement be amended to read 'Duty of Candour has been completed for all incidents where harm was identified as moderate or above or for incidents identified for PSIIs'. NF agreed with GB's comment and added that there needed to be positive assurance that Duty of Candour had been completed. 11.10. GB noted that the Top 10 Locations table included in the report did not reflect all areas and asked if this could be amended for future reports. 11.11. GB noted that the Inquests broken down by Department table had included an inquest for the Human Resources Department and asked if this was correct. PW responded that this was likely a recording issue. GB also noted that there had been two inquests included on the 'by site' chart for St Helens Hospital and asked if this was correct. PW responded that he was not aware of any deaths at St Helen's Hospital and that it might be a recording error. 11.12. GB questioned the value of the Responses by Area and Reponses by Coroner tables that had been included in the report and commented that, in her opinion, these had not provided any meaningful benchmarking information, as the Trust had not received any Prevention of Future Deaths (PFD) orders in Q1. 11.13. CS asked about feedback about the complaints process from patients and families, to provide qualitative feedback. GB commented that a survey was sent after the complaints process had been completed, but historically the uptake had been low, and correlated with the complaint outcome. 11.14. MS asked when the review of general surgery claims that was being undertaken by Hill Dickinson would be concluded. PW responded that he did

	not have this information and suggested that SOB would be able to provide further information. **Action:** SOB to advise expected end date of the Surgery Claims review in the next report. 11.15. CE reflected on the second highest category for incidents (pressure ulcers) and asked whether this was unusual. PW responded that not all pressure ulcers were hospital acquired and if a patient presented with a pressure ulcer this had to be logged on InPhase at the time of admission as an incident, and this would contribute significantly to the number of recorded pressure ulcers. PW noted that the CPR presented at Quality Committee showed the split between hospital acquired and community acquired pressure ulcers. RC added that the grading of pressure ulcers was also included in that report. 11.16. NB referred to the New Claims by Speciality table and commented that she was not aware of any clinical negligence claims against Estates and Facilities. PW responded that this also appeared to be an error and agreed to follow up with the Head of Legal Services. 11.17. RC reflected on the number of errors in the report and suggested that it be withdrawn and a corrected version re-issued to Board members. The issues to be corrected were: • The Duty of Candour statement. • The Top 10 Locations table to be legible. • A response to the queries around the inquest recorded against Human Resources, the two inquests noted for St Helens Hospital as well as the clinical negligence claims recorded against Estates and Facilities. 11.18. SR agreed that the report be withdrawn from the Board and re-issued once updated. It was agreed that the Executive Committee would review and approve the amended report as there was no Board meeting in August. **Action** The Aggregated Incidents, Complaints and Claims Report (Q1) to be refreshed and the updated version to be presented at Executive Committee for approval. **RESOLVED:** The Board **noted** the Aggregated Incidents, Complaints and Claims Report (Q1) and agreed that the revised and corrected report would be presented at Executive Committee for approval
12.	**TB25/060 Learning from Deaths Quarterly Report (Q3 2024/25)**
	12.1. PW presented the Learning from Deaths Quarterly Report for Q3 of 2024/25 which provided an overview of the mortality reviews which had taken place to provide assurance that deaths occurring in hospital undergo a robust review to identify lessons which could be learnt.

	12.2. PW highlighted the following: 12.2.1. There had been 657 deaths that met the criteria for a Structured Judgement Review (SJR) across all MWL sites. None of the cases reviewed had been graded red. 12.2.2. There were currently 21 outstanding SJR for Q2 and 50 for Q3 at Whiston and St Helens Hospitals. A rapid review of all cases had been undertaken and presented to the Learning from Deaths Team and any cases identified as potential red or ambers prioritised for an SJR. PW noted that work was ongoing to recruit additional SJR reviewers to reduce the backlog. 12.2.3. At the Southport and Ormskirk Hospital sites 221 deaths had been reviewed by the Medical Examiner, of which 37 were graded as green with positive feedback and one as amber. The case graded as amber predominately related to a family's concerns regarding ward nursing care but this had not impacted on the patient's death. PW noted that the eight cases now graded as green with learning had been downgraded from amber following review. 12.2.4. There had been one case, graded as green, for a patient with learning difficulties reviewed in this period and no concerns had been raised. 12.3. GB reflected that there were still two slightly different processes for learning from Deaths across the legacy organisations and asked about the time table to move to a single MWL process. PW responded that the medical lead jobs were now ready to be recruited to and it was anticipated that the interview process would take place in the first two weeks of September. The successful candidate would then lead on developing a single MWL approach. **RESOLVED:** The Board **noted** the Learning from Deaths Quarterly Report for Q3 of 2024/25
13.	**TB25/061 Infection Prevention and Control Annual Report 2024/25**
	(SRe joined the meeting) 13.1. SRe presented the Infection Prevention and Control (IPC) Annual Report 2024/25 , on behalf of SOB, which provided assurance that the Trust was taking the necessary action to monitor, manage and prevent hospital acquired infections. The report had been reviewed by the Quality Committee which also received quarterly IPC reports as part of the annual workplan. 13.2. The IPC Annual Report was a two-part document; Part 1 outlined the developments and performance related to Infection Prevention (IP) activities during 2024/25 and Part 2 (Appendix 2) was the IPC team annual work plan for 2025/26 which aimed to reduce the risk of healthcare associated infections (HCAIs). The report identified the achievements and challenges faced in-year and the Trust's approach to reducing the risk of HCAI for patients.

	13.3. SRe, in her role as Director of Infection Prevention and Control (DIPC), noted the following: 13.3.1. IPC is a statutory duty of the Trust Board, and an annual report approved by the Board is mandated. 13.3.2. HCAIs were reported monthly via the Committee Performance Report (CPR) to the Quality Committee, which also gained assurance via regular in-depth reports of the actions taken and lessons learnt. 13.3.3. The Trust continued to have appropriate arrangements in place for the prevention and control of infections in accordance with Health and Social Care Act 2008. 13.3.4. The Infection Prevention Team (IPT) was led by SRe as the DIPC. Following her retirement from the Director of Nursing, Midwifery and Governance role in December 2024, SRe has continued as the designated DIPC and was supported by a Consultant Nurse and a Consultant Microbiologist/ Infection Control Doctor at the Whiston, St Helens and Newton sites and a locum Consultant Microbiologist and antimicrobial pharmacist for the Southport and Ormskirk sites. 13.3.5. The DIPC must ensure that 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 IPC Code of Practice. 13.4. SRe highlighted the following: 13.4.1. The Trust maintains a zero tolerance approach to all avoidable healthcare infections. 13.4.2. The Trust had maintained compliance during 2024/25 with the criteria set out in the Health and Social Care Act as well as the key CQC fundamental standards. 13.4.3. There were IPC risks on the Trust Risk Register including the lack of side room capacity, mainly at Southport Hospital and the limitations of the historic building design for the Southport and Ormskirk sites. 13.4.4. During 2024/25 MWL sites had exceeded the thresholds as set out in the NHS Standard Contract for Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridioides difficile (C.diff). This reflected the national picture across acute trusts, with all adult acute trusts in the region exceeding the thresholds for C.Diff. 13.4.5. MWL were below the thresholds set for Escherichia coli (E. coli), Klebsiella and Pseudomonas bacteraemia. 13.4.6. MWL was an outlier for rates of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemi and six MRSA cases had been reported. 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. Reducing or eliminating MRSA bacteraemia and avoidable health care associated infections remained a quality priority for 2025/26 in the Quality Account.

	13.4.7. There was no national objective set for Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia, however, the Trust participated in the national mandatory surveillance scheme. During 2024/25 the Trust had reported 90 healthcare associated MSSA bacteraemia cases which was an increase of 31 (35%) cases compared to the previous financial year. Surveillance was undertaken on all healthcare-associated cases, and the main source of infection was from skin and soft tissue e.g. leg ulcers. A deep dive review of all cases had been undertaken to inform organisational learning and the themes identified 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. 13.4.8. In May 2024, the Whiston site had experienced an increased incidence Carbapenemase Producing Enterobacterales (CPE) including two CPE colonisation outbreaks. These outbreaks had been terminated following enhanced infection prevention actions, including temporary enhanced cleaning and screening measures, and this would continue to be closely monitored. 13.4.9. The IPT had continued to undertake surveillance and contact tracing activities for Mpox, chickenpox, measles and Tuberculosis. 13.4.10. There had been several outbreaks, mainly caused by norovirus, Covid-19 and influenza, throughout 2024/25 and this had been challenging for the IPT. It was noted that Southport Hospital had been disproportionately affected by norovirus and the lack of single rooms and numbers of beds in a bay was a contributory factor. The IPT had worked with the clinical and patient flow teams to reduce the risk of infection. 13.4.11. Hand hygiene continued to be strongly promoted throughout the Trust. Monthly audits of hand hygiene, including covert observations of hand hygiene had been undertaken on all wards throughout the year. 13.4.12. Orthopaedic Surgical site infections - there had been nine surgical site infections: • five hip infections out of 600 procedures and Whiston Hospital was an outlier for hip infection rate (0.83%) and actions had been taken to address this. • four knee infections out of 693 procedures which equated to 0.57% rate of infection, which was below the national expected rate of 1%. 13.4.13. The IPC annual work programme for 2025/26 was included in the meeting pack as Appendix 2. **RESOLVED:** The Board **approved** the Infection Prevention and Control Annual Report 2024/25 *(SRe left the meeting)*
14.	**TB25/062 Informatics Reports**
14.1.	**Data Security and Protection Toolkit (DSPT)**

	14.1.1. MG presented the Data Security and Protection Toolkit (DSPT) 2024/25 which provided assurance that MWL operated within the parameters defined in the DSPT and had completed the annual submission to demonstrate this compliance. MG reminded the Board that all organisations that had access to and processed patient or personal data or systems had to use the DSPT toolkit to provide assurance that they practiced good data security, and that personal information was handled correctly and in line with data protection legislation. 14.1.2. MG highlighted the following: • The DSPT had adopted the Cyber Assessment Framework (CAF) in September 2024 as the basis for cyber security information governance assurance. • MWL had submitted the 2024/25 DSPT assessment, which was fully aligned to the CAF, at the end of June 2025. Evidence had been provided against the 47 contributing sections, supported by indicators of good practice grouped by levels of achievement: Not Achieved', 'Partially Achieved' or 'Achieved'. It was noted that, in order to achieve the 'Standards Met' rating across the 47 contributing sections, all outcomes and standards had to be met. • The Trust had submitted a 'Standards Not Met'. The Trust had provided substantial evidence for all outcomes except the Multi Factor Authentication (MFA) standalone policy, which meant that it had not achieved all the outcomes and could not assess as "Standards Met". MG noted that MFA had been embedded within several other policies, but at the time of submission the Trust did not have a standalone MFA policy in place. • It was noted that NHSE had anticipated that most trusts would not meet the standards in year 1, due to the significant changes following the introduction of the CAF. • The Trust had submitted an improvement plan to NHSE as part of the requirement for not meeting the standard which included the development of a standalone MFA policy. MG noted that this had already been drafted and approved. 14.1.3. MG reported that, following the MIAA audit of the Trust's DSPT submission to assess compliance against the newly CAF aligned DSPT, the Trust had received a high confidence rating but moderate assurance as the Trust could not declare "standards met". 14.1.4. GL noted that the MIAA audit would need to be reported to the next Audit Committee with any assurance of completion of the management actions. **Action:** The MIAA audit of the 2024/25 DSPT submission and resulting management actions to be reported to the next meeting of the Audit Committee.

	14.1.5. GB commented that no progress had been noted against two of the actions included in the Access Review and User Management section on the Improvement Plan (appendix 1). MG noted that these had now been completed and this would be reflected in the report to the Audit Committee. **RESOLVED:** The Board **noted** the Data Security and Protection Toolkit (DSPT
14.2.	**Information Governance Annual Report 2024/25**
	14.2.1. MG presented the Information Governance Annual Report 2024/25 which provided assurance that the Trust has an effective Information Governance Framework. The report detailed the progress made against the Information Governance (IG) work programme for 2024/25 as well as assurances that MWL remained compliant with the Freedom of Information (FOI) Act. 14.2.2. The IG framework was essential for ensuring that all personal, sensitive and confidential data was handled legally, securely and efficiently throughout the Trust. The framework covered various areas including records management, data quality, legislative compliance, risk management and information security. MWL had a duty to ensure that it complied with its legal and regulatory obligations and for IG this was the data protection legislation, specifically the UK GDPR and Data Protection Act 2018. 14.2.3. The Trust continued to have the statutory roles in place: Senior Information Risk Owner (SIRO), Caldicott Guardian, and Data Protection Officer. In addition, an Information Governance Steering Group (IGSG) was in place and met regularly and the report provided an overview of the work undertaken by the Group during 2024/25. 14.2.4. A new area of focus for 2025/26 would be IG support for Artificial Intelligence (AI) and Robotic Processing Automation (RPA) developments, as well as the continued support of the subject access request team. 14.2.5. 822 FOI requests had been received in 2024/25 compared to 824 in 2023/24. 99.2% of the requests received had been completed, of which 63.6% had been completed within the target 20-working day time frame. Work was ongoing to improve the performance. 14.2.6. SC asked how FOI performance would be improved. MG responded that the number and complexity of the FOI requests continued to increase and impacted many departments. Regular reports were made to the Executive Committee which included a breakdown of outstanding requests by the Director who was responsible for authorising the final response. 14.2.7. AMS suggested MG review the level of detail included in the report regarding the incident that had been reported to the Information Commissioner's Office (ICO), to ensure it was appropriate.

	Action: MG agreed to review the level of detail reported about ICO reportable incidents. 14.2.8. NF asked whether the Trust had received any penalties for failing to meet the FOI 20-working day response time frame. MG responded that, while failure to meet this time frame could result in financial penalties, the Trust had not been subject to any penalties in 2024/25. MG noted that the ICO was aware of the measures the Trust had in place to improve compliance and recognised the complexity of the FOI requests being handled. There had been one complaint to the ICO about a FOI response, but this had not been upheld. 14.2.9. SR commented that FOI requests were often used by organisations to gather information and asked what information the Trust published on its website. MG responded that there had been a focus on providing direct answers to FOI enquiries and, where relevant, redirecting individuals to information already available on the website via the standard NHS publication scheme. The appropriate sections of the FOI Act were applied where it was believed that the request was not in the public interest, could pose security implications for the Trust or was already publicly available. **RESOLVED:** The Board **noted** the Information Governance Annual Report 2024/25
15.	**TB25/063 Emergency Planning Response and Resilience (EPRR) Annual Report 2024/25**
	15.1. LN presented the Emergency Planning Response and Resilience (EPRR) Annual Report 2024/25 and noted that 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. 15.2. LN advised that once the annual report had been approved it would form part of the Trust's annual core standards compliance which would be presented to Board in September 2025. 15.3. LN highlighted the following: 15.3.1. The Head of EPRR and LN had attended local health resilience strategic and tactical meetings and relevant subgroups as part of the cooperation with others requirement. Additionally, the Trust had hosted a multi-agency exercise and had participated in multi-agency run exercises involving partners from NHSE, ICB, Provider Trusts, Police, Fire and Rescue and North West Ambulance Service NHS Trust (NWAS). 15.3.2. The Trust was responsible for developing and maintaining a suite of emergency plans, for example the Incident Response Plan and the Mass Casualty Plan, and to ensure the effectiveness of all plans for the Trust. The EPRR team had undertaken annual reviews and shared the plans with

	external partners. Additionally, the plans had been tested through a series of exercises. In 2024/25 five exercises had been undertaken, including two internal communications cascade exercises and one external communication exercise. Additionally, the adverse weather plan had been tested. The Trust had taken part in a system wide mass casualty exercise. Lessons learnt from these exercises had been incorporated into the emergency plans. 15.3.3. The Trust had an overall Business Continuity Policy (BCP) in place which was reviewed every three years. This was underpinned by business continuity plans at department and ward level. The BCPs were tested on a regular basis, either as part of planned or unplanned exercises. Examples of planned exercises included downtime as part of the generator test or industrial action. After each incident a debrief exercise was undertaken and the lessons learnt informed action plans. 15.4. LN reported that, as a Category 1 responder, the Trust was required to provide assurance that it met the core standards. This was delivered through an annual self-assessment exercise in which the Trust had to demonstrate compliance with 62 core standards. Supporting evidence for the self-assessment had to be uploaded to a designated portal for review by NHSE. LN noted that the Trust had requested MIAA to review the evidence submitted and substantial assurance had been received. In 2023/24 the Trust had been compliant with 50 of the 62 core standards (81%) and had been recognised as one of the best-performing acute trusts within C&M. Compliance for 2024/25 against the core standards would be presented to Board in September 2025 and work was underway to collect the supporting evidence for this year's assessment. 15.5. LN reported that the Trust response to incidents, had been strengthened by the introduction of an integrated MWL on-call processes and structure, in December 2024. This was now in line with the EPRR guidance and included strategic, tactical and operational on-call levels. There had been a focus on strategic and tactical on-call training in 2024/25, with both internal and external training, and this would continue in 2025/26. 15.6. As part of governance and oversight there was an annual EPRR workplan in place which was overseen by the EPRR Group. The Group, chaired by LN, met bi-monthly and reported into the Risk Management Council (RMC) and, via the RMC Assurance Report to the Executive Committee and Board. 15.7. AMS reflected on recent external incidents which highlighted the importance of training and asked if the Board could support any additional training especially for strategic commanders. LN responded that currently the only mandated training for strategic command was the Principles of Health Management and this was an annual training requirement, however, agreed more training was required due to the complexities of this role. LN commented that, whilst testing plans in a group setting was important, there

	was no substitute for being in a situation that required the individual to act as the Strategic Commander during an incident. 15.8. RC reflected on a discussion that had taken place at national level regarding the use of the EPRR framework to test the resilience of the winter plans and asked whether LN had received any information concerning this. LN responded that the guidance for the 2025/26 winter planning had been received, which included reference to testing plans in Autum using the EPRR principles, and believed that the exercise was being planned for early September. LN reflected that the critical incident in January 2025, had been managed using the EPRR framework. 15.9. GB noted that one of the reasons for partial compliance in the 2023/24 assessment had been the level of resources and asked how this had been addressed. LN noted that the MWL resources had been supplemented with administrative support for the EPRR team, and recognition of the responsibilities of the EPRR managers, however benchmarking with other organisations had not indicated that MWL had a smaller team than other trusts. In addition MWL had now recruited a number of EPRR champions across the Trust, who supported the work of the central team. Much of the initial push for additional resources had been in the immediate post transaction period when all the policies and processes had needed to be harmonised but this work was now mostly completed. The situation was being kept under review. 15.10. GB reflected that she had not realised how many times the plans had been put into place during the previous year and had found the information in Appendix 1 very informative. GB queried if there should have been more reported incidents in relation to Resident Doctors Industrial Action, but LN clarified that there had only been one period of Industrial action during 2024/25, as a settlement had been reached by the labour government when they came into office. **RESOLVED:** The Board **approved** the Emergency Planning Response and Resilience (EPRR) Annual Report 2024/25
16.	**TB25/064 Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common Updates**
	16.1. NB presented Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common Updates and noted that the Board was asked to approve the formalisation for the creation of a single provider collaborate across C&M called the Cheshire and Merseyside Provider Collaborative (CMPC). 16.2. NB highlighted the following:

	16.2.1. The Joint Working Agreement (JWA) and the Committee in Common (CiC) Terms of Reference (ToR) had been modelled on the former Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) that the Board had previously approved. 16.2.2. The Company Secretaries across C&M had been involved in the process and Hill Dickinson had provided legal input to the documents. 16.3. NB reported that at the point of presentation the changes related to membership only and that MWL would be the first Trust to approve this. 16.4. SR commented that the primary driver for the refresh had been the expansion of the collaborative to include community services providers. 16.5. RC reflected on the key work programmes included in the ToR and noted that several core programmes agreed by C&M CEOs were not currently listed and felt this point should be clarified. NB noted her understanding was that the current changes reflected the work to create the single Provider Collaborative and any subsequent changes to the role or scope of work streams would be subject to further consultation. 16.6. GL commented that in future if Provider Collaboratives were not members of ICB Board meetings, it was unclear how the Provider Collaboratives would work with the ICBs. NB agreed that, if the ICB role was to move to that of strategic commissioner, the relationship with the Provider Collaborative would change, and in the current proposals performance management of providers became the responsibility of NHSE, however these agreements reflected the current arrangements that would remain in place until a new statutory framework was put in place. RC acknowledged the concern but felt that at the moment CMPC was being expected to deliver a number of strategic work streams for provider organisations on behalf of the ICB. 16.7. It was noted that the Trust was supportive of the principle of the Provider Collaborative, but clarity was needed on the scope of the CMPC responsibilities. 16.8. SR suggested that further discussion regarding the scope of the ToR be delegated to the Executive Committee, with an updated position to be approved by the Board via correspondence. 16.9. Please note - following the meeting, RC held discussions with the CMPC and clarified the position via email to Board members who all confirmed their support for approving the CMPC Joint Working Agreement and Committee in Common documents. **RESOLVED:**

	The Board **approved** the Revised Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) Partnership Agreement.
Concluding Business	
17.	**Effectiveness of Meeting**
	17.1. This was not discussed.
18.	**Any Other Business**
	18.1. LN referred to the stress testing of the winter plans that had been discussed as part of the Emergency Planning Response and Resilience (EPRR) Annual Report 2024/25 and advised that she had received an email during the meeting advising that this would be taking place on Monday 08 September. 18.2. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 13.04 The next Board meeting would be held on **Wednesday 24 September 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	✓	✓	✓	A								
Gareth Lawrence	✓	✓	✓	✓								
Lesley Neary	✓	✓	✓	✓								
Sarah O'Brien				A								
Hazel Scott	✓	✓	✓	A								
Carole Spencer	✓	✓	✓	✓								
Malise Szpakowska	✓	A	✓	✓								
Rani Thind	✓	✓	✓	A								
Peter Williams	✓	✓	✓	✓								
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball	✓											
Richard Weeks	✓	✓	✓	✓								
Marie Wright			✓	✓								
✓ = In attendance A = Apologies												

Trust Board

Matters Arising Action Log

Action Log updated 19 September 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 Update (19/09/2025) SOB advised that, following a review of the data, that there has not been a reduction in the number of complaints received about the Emergency Department (ED) waiting time, however, there has been a reduction in reported incidents.	~~LB~~ SoB	~~July-25~~ Sept-25		**Completed**
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 (19/09/2025) 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 **Completed**
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. Update (19/09/2025) Included in the quarterly report to Quality Committee in September.	SoB	Sep-25		Delegated to Quality Committee (September 2025) **Completed**

13	30/07/2025	**TB25 /058 Board Assurance Framework**	BAF 1 additional assurance to be amended to read 'Response to NW Clinical Senate Report and *JOSG'*	NB	Oct-25		
14	30/07/2025	**TB25/059 Aggregated Incidents, Complaints and Claims Report (Q1)**	MS asked when the review of general surgery claims that was being undertaken by Hill Dickinson would be concluded. PW responded that he did not have this inforamtion. The expected end date of the Surgery Claims review would be included in the next report.	SOB	Oct-25		
15	30/07/2025	**TB25/059 Aggregated Incidents, Complaints and Claims Report (Q1)**	Board members had raised several queries and concerns regarding the report that was presented and requested that the paper was withdrawn from the meeting pack and replaced with the correct version. It was agreed that the updated paper would be presented at Executive Committee for approval before the Trust's website was updated. Update (19/09/2025) The revised report was presented at Executive Committee for approval and the Trust website has been updated to include the revised report.	SoB	Sep-25		Delegated to Executive Committee **Completed**
16	30/07/2025	**TB25/062 Informatics Reports** 13.1 Data Security and Protection Toolkit (DSPT)	The MIAA audit of the 2024/25 DSPT submission and resulting management actions to be reported to the next meeting of the Audit Committee Update (19/09/2025) Update and actions presented to Audit Committee.	MG	Sep-25		Delegated to Audit Committee **Completed**
17	30/07/2025	**TB25/062 Informatics Reports** 13.2 Information Governance Annual Report 2024/25	MG to review the level of detail reported about the ICO reportable incidents for the 2026/27 IG Annual Report. Update (19/09/2025) Process now in place for reviewing details in reports prior to submitting to relevant Committee/ meeting.	MG	Sep-25		**Completed**

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
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	RW	Jul-25	**25/07/2025** - The report has been updated. **Action closed**	**Closed**
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	PW	Jul-25	**25/07/2025** - The information was included in agenda item TB25/060 Learning from Death Report (Q3 2024/25). **Action closed**	**Closed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	24 September 2025
Agenda Item	**TB25/067**			
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 24/25 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	Aug-25	94.4%	90.0%	94.2%	Worst 40%
Nurse Fill Rates	Jul-25	99.0%	90.0%	99.0%	
C.difficile	Jul-25	11		38	
E.coli	Jul-25	20		59	
Hospital Acq Pressure Ulcers per 1000 bed days	May-25	0.13	0.00	0.12	
Falls ≥ moderate harm per 1000 bed days	Aug-25	0.05	0.00	0.10	
Stillbirths (intrapartum)	Aug-25	0	0	0	
Neonatal Deaths	Aug-25	0	0	0	
Never Events	Aug-25	0	0	1	
Complaints Responded In 60 Days	Aug-25	51.5%	80.0%	49.1%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-25	63.4%	77.0%	66.2%	Worst 10%
Cancer 62 Days	Jul-25	78.8%	85.0%	78.8%	Best 20%
Ambulance Arrival to Vehicle Handover: % <45 mins	Aug-25	90.4%	100.0%	87.7%	
A&E Standard (Mapped)	Aug-25	78.0%	78.0%	78.9%	Best 30%
Average NEL LoS (excl Well Babies)	Aug-25	3.8	4.0	3.9	Best 30%
% of Patients With No Criteria to Reside	Aug-25	20.5%	10.0%	20.5%	
Discharges Before Noon	Data under Validation				
G&A Bed Occupancy	Aug-25	97.7%	92.0%	98.1%	Worst 30%
Patients Whose Operation Was Cancelled	Aug-25	0.9%	0.8%	1.0%	
RTT % less than 18 weeks	Aug-25	63.6%	92.0%	63.6%	Best 40%
18 weeks: % 52+ RTT waits	Aug-25	2.5%	1.0%	2.5%	Worst 50%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-25	74.0%	85.0%	74.0%	
Mandatory Training	Aug-25	89.0%	85.0%	89.0%	
Sickness: All Staff Sickness Rate	Aug-25	6.7%	5.0%	6.3%	
Staffing: Turnover rate	Aug-25	1.6%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Aug-25		28,297	4,847	
Cash Balances - Days to Cover Operating Expenses	Aug-25	1.3	10		
Reported Surplus/Deficit (000's)	Aug-25		-22,809	-25,849	

Board Summary - Quality

Quality

Mortality Data covers deaths in Trust until March 2024. The final HSMR for the full year is 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 final 24-25 SHMI is 1.00.

FFT: Positive results for the month of August. All areas have met or are above target for the month. With acknowledgement of the positive results for all 4 maternity touchpoints – will all areas above target.

Pressure Ulcers: 3 cases remain unvalidated for June. 2 of the 3 HAPU reviews have been presented at Harm Free Care Panel and authors have been requested to provide further detail to the reviews and they will be presented back to Harm Free Care Panel in September. 1 review remains outstanding.

Complaints: August has shown a decrease in the number of stage 1 complaints received. It is to be noted that majority of complaints were received for the Whiston site during August in comparison to July when the complaints received was 50 / 50 across sites.

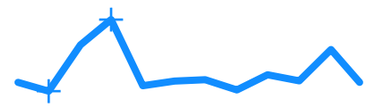
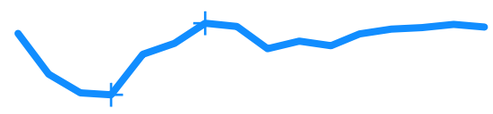
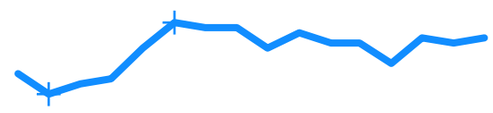
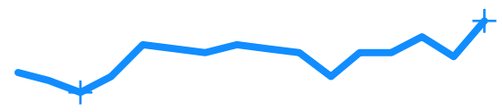
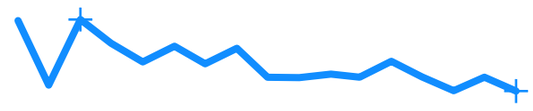
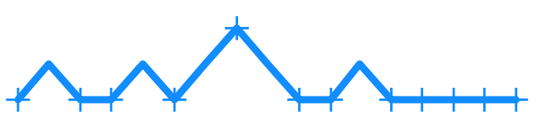
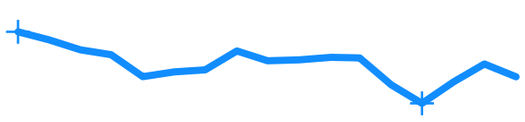
With regards to the number of complaints closed within the agreed Trust 60 working day target August compliance is recorded at 51.5%

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Mar-25	86.8	100	90.4	Best 30%	
FFT - Inpatients % Recommended	Aug-25	94.4%	90.0%	94.2%	Worst 40%	
Nurse Fill Rates	Jul-25	99.0%	90.0%	99.0%		
C.difficile	Jul-25	11		38		
E.coli	Jul-25	20		59		
Hospital Acq Pressure Ulcers per 1000 bed days	May-25	0.13	0.00	0.12		
Falls ≥ moderate harm per 1000 bed days	Aug-25	0.05	0.00	0.10		
Stillbirths (intrapartum)	Aug-25	0	0	0		
Neonatal Deaths	Aug-25	0	0	0		
Never Events	Aug-25	0	0	1		
Complaints Responded In 60 Days	Aug-25	51.5%	80.0%	49.1%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E
4-Hour performance decreased in August, achieving 72.9% (all types). Trust performance is below National (75.9%), and ahead of C&M (72.8%). The Trusts mapped 4-Hour performance achieved 78%.
Patient Flow

Bed occupancy across MWL averaged 104.2% in August equating to 77.1 patients - an ongoing trend of high occupancy. There was a peak of 107 patients (43 at S&O, 75 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 8% higher than last August, driven by a 16% increase in 0 LOS activity, 1+ day LOS activity was the same as last year. Southport had a 76.7% increase in 0 LOS from August 24 to August 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 8.5 at S&O and 7.7 at StHK, with an overall average of 7.9 days, the impact of non CTR patients being 20.5% at Organisation level, 0.8% higher than July but 1.6% lower than August 2024 (21.5% S&O and 20% StHK).

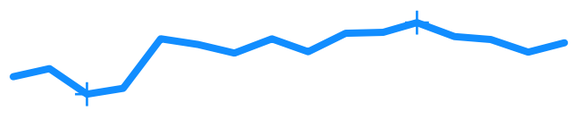
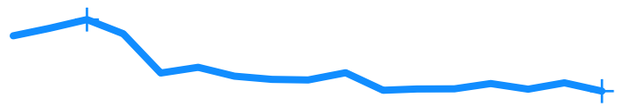
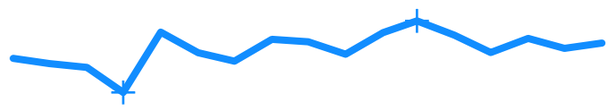
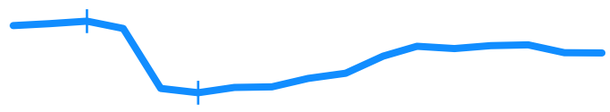
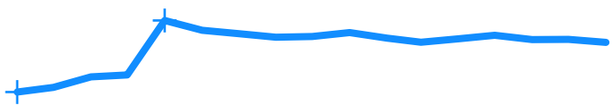
Elective Activity

The Trust had 1,922 52-week waiters at the end of August, (504 S&O and 1418 StHK), 135 65-week waiters and 16 78-week waiters.
The 52-week position is a decrease of 71 from July and the 65-week waiters have decreased by 97 from July to August.
18-Week performance in August for MWL was 63.6%, S&O 63.9% and StHK 63.5%. This was ahead of national performance (latest month Julu) of 61.3% and C&M regional performance of 58.7%.

Cancer
Cancer performance for MWL in July declined slightly, at 63.4% for the 28 day standard (target 77%), with Southport achieving 49.3% and St Helens performance being 72.6%. Latest published data (July) shows national performance of 76.6% and C&M regional performance of 71.7%. Performance for 62-day decreased, achieving 78.8% (target 85%), with Southport achieving 62.8% and St Helens 85.9%. C&M performance was 75.4% and National 69.2%. 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 July was 85.1% for MWL, failing to achieve the 95% target, with S&O achieving 89.9% and StHK 82.9%. MWL performance is ahead of national performance (latest month July) of 78.1% and C&M regional performance of 88.8%.

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Jul-25	63.4%	77.0%	66.2%	Worst 10%	
Cancer 62 Days	Jul-25	78.8%	85.0%	78.8%	Best 20%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Aug-25	90.4%	100.0%	87.7%		
A&E Standard (Mapped)	Aug-25	78.0%	78.0%	78.9%	Best 30%	
Average NEL LoS (excl Well Babies)	Aug-25	3.8	4.0	3.9	Best 30%	
% of Patients With No Criteria to Reside	Aug-25	20.5%	10.0%	20.5%		
Discharges Before Noon	Data Under Validation					
G&A Bed Occupancy	Aug-25	97.7%	92.0%	98.1%	Worst 30%	
Patients Whose Operation Was Cancelled	Aug-25	0.9%	0.8%	1.0%		
RTT % less than 18 weeks	Aug-25	63.6%	92.0%	63.6%	Best 40%	
18 weeks: % 52+ RTT waits	Aug-25	2.5%	1.0%	2.5%	Worst 50%	

Board Summary - Workforce

Workforce

Mandatory Training
The Trust continues to exceed its mandatory training target, maintaining performance at 89% against a target of 85%.

Targeted support remains in place to enable front-line clinical staff to access training, ensuring continued compliance and improvement.

Appraisals
Appraisal compliance has remained static at 74% in August, reflecting the ongoing 2025/2026 appraisal window which opened on 1st May. While this is below the Trust's target of 85%, support, training, and guidance continue to be available to promote high-quality appraisals. Regular compliance updates are being shared with Divisions to support improvement.

Sickness Absence
Sickness absence has increased in August to 6.7%, remaining above the Trust target of 5%. This appears to be a common trend comparing to August 24 and Trusts across the Cheshire and Merseyside area are seeing similar trends.

The top three reasons for absence continue to be:
1. Stress, Anxiety & Depression
2. Gastrointestinal issues
3. Musculoskeletal (MSK) conditions

A comprehensive sickness absence improvement plan is in place, with progress monitored through the People Performance Council and Strategic People Committee. Targeted initiatives under the Looking After Our People pillar of the Trust People Plan are being implemented, and the Absence Support Team continues to provide focused support to teams with the highest levels of absence.

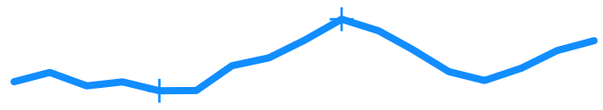
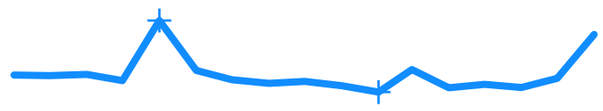
Turnover
In-month turnover has increased in August to 1.7% against a target of 1.1% - there is continued stability in the substantive workforce – the increase in month is due to the ending of fixed term contracts for foundation year 2 medics.

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	Aug-25	74.0%	85.0%	74.0%		
Mandatory Training	Aug-25	89.0%	85.0%	89.0%		
Sickness: All Staff Sickness Rate	Aug-25	6.7%	5.0%	6.3%		
Staffing: Turnover rate	Aug-25	1.6%	1.1%	0.8%		

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 5, the Trust is reporting an adjusted position of £25.8m deficit. Excluding deficit support funding the adjusted position is £33.4m deficit, £2.0m better than plan. This includes the impact of the revised pay award and industrial action costs which are offset against cost reductions delivered ahead of 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 5, the Trust has successfully transacted CIP of £20.4m year to date, £1.8m above plan. 100% of the £48.2m recurrent target is covered by fully developed schemes.

Cash - At the end of M5, the Trust's cash balance was £3.2m. As part of the original plan submitted to NHSE, the Trust assumed the receipt of £30m deficit support funding by the end of the financial year. As at M5, only Q1 2025/26 has been received, the Trust continues to monitor cash closely and see mitigations to the removal of deficit support funding.

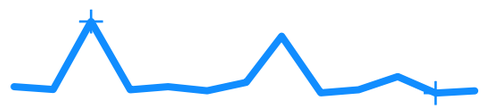
Capital - The capital plan for the year is £64.6m (including PFI lifecycle and lease remeasurements). Capital expenditure for the year to date [including PFI lifecycle maintenance and lease remeasurements] totals £4.8m, which is £23.4m below plan. At M5, the plan assumes expenditure of £14.0m for several system/PDC funded schemes (incl. ePR £6.0m) which is yet to materialise. As a result, PDC funding is yet to be drawn down for these schemes. The Trust anticipates that the programme will be

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Aug-25		28,297	4,847		
Cash Balances - Days to Cover Operating Expenses	Aug-25	1.3	10			
Reported Surplus/Deficit (000's)	Aug-25		-22,8...	-25,8...		

How to Interpret - Summary Table

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	May-22	81.6	100	88.2	Top 20%
Friends and Family Test: % Recommended	Sep-22	93.9%	90.0%	94.8%	Bottom 50%
Nurse Fill Rates	Sep-22	93.7%		93.7%	
C.difficile	Sep-22	2	6	33	Bottom 50%
E.coli	Sep-22	10		38	Top 40%
Pressure Ulcers (Avoidable level 2+)	Aug-22	6		21	
Falls With Harm	Aug-22	4		23	
Stillbirths	Sep-22	0	0	0	
Hospital Associated Thrombosis (HAT)					
Complaints Responded In Agreed Timescale %	Sep-22	66.7%		71.6%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-22	70.4%	75.0%	73.7%	Top 50%
Cancer 62 Days	Aug-22	76.0%	85.0%	82.4%	Top 10%
30 Minute Ambulance Breaches	Sep-22	418	0	2,200	
A&E Standard	Sep-22	47.3%	95.0%	47.3%	Top 30%
Average NEL LoS (excl Well Babies)	Sep-22	3.6		3.6	Top 20%
Average Number of Super Stranded Patients	Sep-22	155		135	
Discharges Before Noon	Sep-22	22.9%	33.0%	21.9%	
G&A Bed Occupancy	Sep-22	97.3%		97.3%	Bottom 10%
Patients Whose Operation Was Cancelled	Sep-22	1.1%	0.8%	1.0%	
RTT 18+	Sep-22	14,455	0	14,455	Top 50%
RTT 52+	Sep-22	2,424	0	2,424	Bottom 40%
% of E-discharge Summaries Sent Within 24 Hours	Sep-22	63.4%	90.0%	62.4%	
OP Letters to GP Within 7 Days	Sep-22	19.7%		19.6%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-22	83.5%	85.0%	64.7%	
Mandatory Training	Sep-22	78.7%	85.0%	77.8%	
Sickness: All Staff Sickness Rate	Sep-22	5.9%	4.3%	6.4%	Top 10%
Staffing: Turnover rate	Sep-22	0.8%		1.1%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ m YTD	Sep-22	500	26,100	4,300	
Cash Balances - Days to Cover Operating Expenses	Sep-22	28	10	28	
Reported Surplus/Deficit (000's)	Sep-22	-2,188	-4,949	-2,188	

The IPR is broken into four sections: **Quality**, **Operations**, **Workforce** and **Finance**.

Each section has a number of metrics underpinning it. In addition to the metric name, the summary table has the following columns:

- **Period** – this is the latest complete months data available for that metric
- **Score** – this is the performance for the month as defined by the 'Period'
- **Target** – this is the target, where applicable
- **YTD** – this is the performance for the Financial Year to Date (Apr to latest month as defined by the 'Period')
- **Benchmark** – where available this makes use of national YTD data to benchmark against other Trusts. For some metrics a low value is good (eg C.Difficile) and for others a high value is good (e.g. 62 day cancer %). Regardless of whether a low metric value is good or bad, the Top 10% represents where STHK are in the top 10% best performing Trusts for a given metric. The bottom 10% represents where STHK are in the 10% worst performing Trusts.

Metric Category Description - Quality

Quality Metrics

Mortality – HSMR (low score is good)
Hospital Standardised Mortality Ratio (HSMR) is a ratio of observed deaths to expected deaths. HSMR uses a basket of 56 diagnosis groups that nationally account for circa 80% of in-hospital deaths. A score of 100 means that the Trust has the same number of deaths as expected. A score of less than 100 means the Trust has less deaths than expected and a score of greater than 100 means STHK had more deaths than expected. Where the HSMR is greater than 100 but RAG rated amber – this means that although there were more deaths than expected it is not statistically. If HSMR is RAG rated red, this means that there is a statically significant higher number of deaths compared to expected levels.

Friends & Family Test: % Recommended (high score is good)
The inpatient Friends and Family test

Nurse Fill Rates (high score is good)
The Registered Nurse/Midwife Overall (combined day and night) Fill Rate

C.Difficile (low is good)
The number of hospital onset and community onset Clostridium Difficile cases.

E.Coli (low is good)
The number of Escherichia coli cases.

Pressure Ulcers (Avoidable level 2+) (low is good)
The number of avoidable hospital acquire pressure ulcers of grade 2 or higher

Falls with harm (low is good)
Number of falls in hospital resulting in either moderate harm, severe harm or death

Stillbirths (low is good)
Number of Stillbirths (death occurring during labour - intrapartum)

Never Events (low is good)
The number of never events

Complaints Responded in Agreed Timescales (high is good)
The percentage of new (Stage 1) complaints resolved in month within the agreed timescales

Metric Category Description - Operations

Operational Metrics

Cancer Faster Diagnosis Standard (high is good)
Percentage of patients having either cancer ruled out or diagnosis informed within 28 days of being referred urgently by their GP for suspected cancer.

Cancer 62 days (high is good)
Percentage of patients that have first treatment within 62 days of being referred urgently by their GP for suspected cancer.

30 Minute Ambulance Breaches (low is good)
Number of ambulance patients waiting over 30 minutes from arrival to handover

A&E Standard (high is good)
Mapped Footprint A&E attendances: The percentage of attendances whose total time in ED was under 4 hours.

Average NEL LOS (excluding well babies) (low is good)
Average Non-Elective length of stay (excluding well babies)

Average Number of Super Stranded Patients (low is good)
The average number of patients in hospital whose length of stay is 21 days or more.

Discharges Before Noon (high is good)
The percentage of patients either discharged from the ward or transferred to the discharge lounge between 7am and noon. Please note this is only for patients with a length of stay of 1 day or more

G&A Bed Occupancy (low is good)
The percentage of General and Acute beds occupied

Patients Whose Operation Was Cancelled (low is good)
Percentage of operations cancelled at the last minute for non-clinical reasons. Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery

RTT 18+ (low is good)
The number of patients waiting 18 weeks or more for treatment to commence from referral.

RTT 52+ (low is good)
The number of patients waiting 52 weeks or more for treatment to commence from referral.

% E Discharge Summaries Sent Within 24 Hours (high is good)
Percentage of inpatient E-Discharge summaries sent within 24 hours

OP Letters to GP Within 7 Days (high is good)
Percentage of outpatient E-attendance letters sent within 14 days

Metric Category Description - Workforce

Workforce Metrics

Appraisals (high is good)
Percentage of staff that have a valid appraisal

Mandatory Training (high is good)
Percentage of staff that are compliant with mandatory training

Sickness: All Staff Sickness Rate (low is good)
Percentage of WTE calendar days lost due to sickness

Staffing: Turnover Rate (low is good)
The in-month staff turnover rate

Metric Category Description - Finance

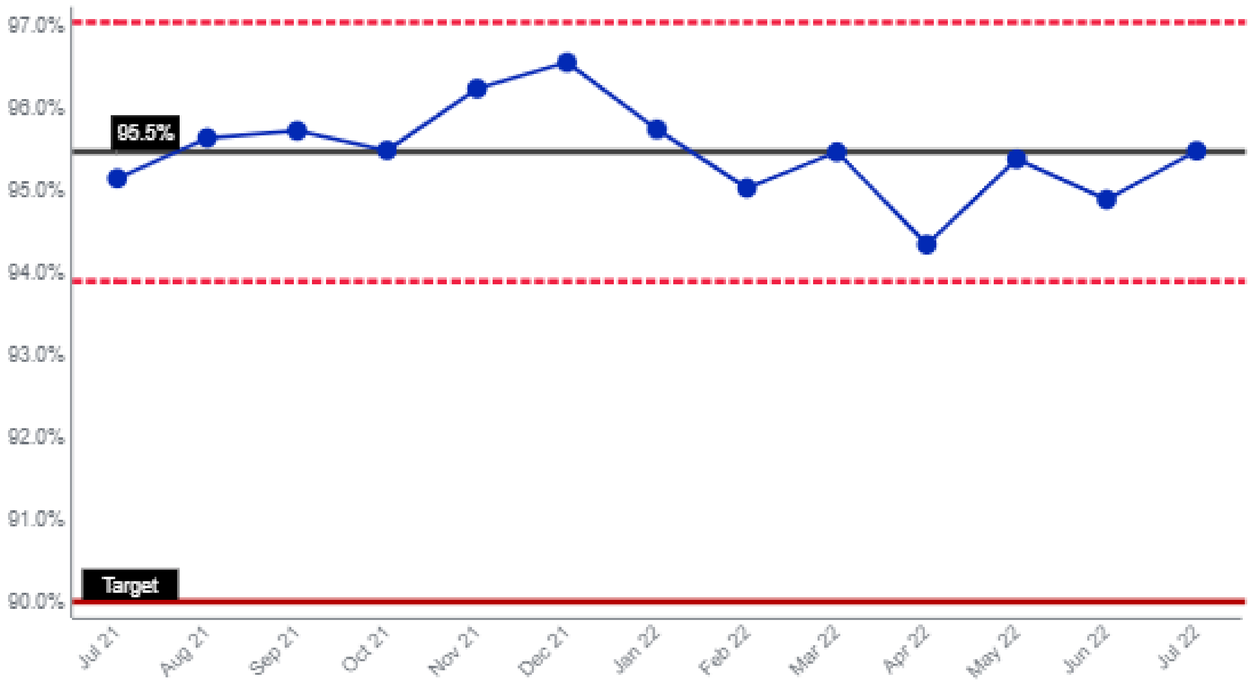
Finance Metrics

Capital Spend £M
Capital Spend £M

Cash Balances – Days to Cover Operating Expenses
Cash Balances – Days to Cover Operating Expenses

Reported Surplus/Deficit (000's)
Reported Surplus/Deficit (000's)

How to Interpret - SPCs



The IPR uses Statistical Process Control (SPC) charts. These charts plot metrics over time. The chart below is an example SPC chart.

The measurements (metric data points) are plotted as **blue** dots and the points joined together with a **solid blue** line.

The **central line** (black line) on a control chart is the *mean* of the measurements. The *mean* is calculated by adding up all the measurement points and then dividing by the total number of measurement points.

The dotted **red** lines represent the *upper* and *lower control limits*. These *control limits* are calculated using the individual measurements and represent the variation within the metric. You can expect approximately 99% of data points to fall within the control limits.

The target line (if applicable) is represented as a solid dark **red** line. In the example, the target line is below the lower control limit. This means that (assuming a high % is good for this metric) you would always expect the target to be achieved. The converse also applies, so if a lower % is good, then within the current process you would not expect to achieve the target i.e. a change in process is required to achieve the target. If the target line falls between the upper and lower control limits this means that, with the current process, you would not expect to achieve every month i.e there would be no reason to investigate a failed month if it was still within the control limits (expected variation – also referred to as common cause variation).

There are a number of rules regrading SPC charts to determine whether something unusual has happened (usually referred to as special cause variation). If there is a need to understand this in more detail a session can be arranged.

Legacy STHK

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	79.2	100	89.3	
FFT - Inpatients % Recommended	Aug-25	94.2%	94.0%	93.8%	
Nurse Fill Rates	Jul-25	97.8%	90.0%	97.5%	
C.difficile	Jul-25	5		23	
E.coli	Jul-25	10		36	
Hospital Acq Pressure Ulcers per 1000 bed days	May-25	0.12	0.00	0.12	
Falls ≥ moderate harm per 1000 bed days	Aug-25	0.08	0.00	0.11	
Stillbirths (intrapartum)	Aug-25	0	0	0	
Neonatal Deaths	Aug-25	0	0	0	
Never Events	Aug-25	0	0	0	
Complaints Responded In 60 Days	Aug-25	52.4%	80.0%	49.2%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-25	72.6%	77.0%	77.2%	
Cancer 62 Days	Jul-25	85.9%	85.0%	85.0%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Aug-25	86.0%	100.0%	82.5%	
A&E Standard (Mapped)	Aug-25				
Average NEL LoS (excl Well Babies)	Aug-25	3.9	4.0	3.9	
% of Patients With No Criteria to Reside	Aug-25	20.0%	10.0%	19.8%	
Discharges Before Noon	Data Under Validation				
G&A Bed Occupancy	Aug-25	98.0%	92.0%	98.4%	
Patients Whose Operation Was Cancelled	Aug-25	0.9%	0.8%	1.1%	
RTT % less than 18 weeks	Aug-25	63.5%	92.0%	63.5%	
18 weeks: % 52+ RTT waits	Aug-25	2.7%	1.0%	2.7%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-25	74.8%	85.0%	74.8%	
Mandatory Training	Aug-25	88.5%	85.0%	88.5%	
Sickness: All Staff Sickness Rate	Aug-25	6.9%	5.0%	6.4%	
Staffing: Turnover rate	Aug-25	1.7%	1.1%	0.9%	

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

Board Summary

Jce_aw Q$M

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	Aug-25	94.7%	90.0%	95.2%	
Nurse Fill Rates	Jul-25	100.0%	90.0%	100.4%	
C.difficile	Jul-25	6		15	
E.coli	Jul-25	10		23	
Hospital Acq Pressure Ulcers per 1000 bed days	May-25	0.16	0.00	0.12	
Falls ≥ moderate harm per 1000 bed days	Aug-25	0.00	0.00	0.06	
Stillbirths (intrapartum)	Aug-25	0	0	0	
Neonatal Deaths	Aug-25	0	0	0	
Never Events	Aug-25	0	0	1	
Complaints Responded In 60 Days	Aug-25	50.0%	80.0%	49.1%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Jul-25	49.3%	77.0%	48.2%	
Cancer 62 Days	Jul-25	62.8%	85.0%	64.0%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Aug-25	98.4%	100.0%	96.8%	
A&E Standard (Mapped)	Aug-25				
Average NEL LoS (excl Well Babies)	Aug-25	3.6	4.0	3.9	
% of Patients With No Criteria to Reside	Aug-25	21.5%	10.0%	21.7%	
Discharges Before Noon	Data Under Validation				
G&A Bed Occupancy	Aug-25	97.3%	92.0%	97.5%	
Patients Whose Operation Was Cancelled	Aug-25	0.8%	0.8%	0.9%	
RTT % less than 18 weeks	Aug-25	63.9%	92.0%	63.9%	
18 weeks: % 52+ RTT waits	Aug-25	2.2%	1.0%	2.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Aug-25	72.2%	85.0%	72.2%	
Mandatory Training	Aug-25	89.8%	85.0%	89.8%	
Sickness: All Staff Sickness Rate	Aug-25	6.3%	5.0%	6.0%	
Staffing: Turnover rate	Aug-25	1.4%	1.1%	0.7%	

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	24 September 2025
Agenda Item	**TB25/068 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the nine Executive Committee meetings held in July and August 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were nine Executive Committee meetings held during July and August 2025. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The weekly vacancy control panel decisions were also reported, at each committee meeting.		
03 July 2025		
2024/25 Corporate Benchmarking Data Submission	• Committee reviewed the data collected for the 2024/25 Corporate Benchmarking submission to NHSE. • Subject to final clarifications, review and confirmation by lead directors the data would be submitted by the deadline on 11 July 2025.	Assurance
MWL Temporary Workforce Provision Options	• The Chief People Officer presented a paper detailing the options for a single MWL temporary workforce delivery model. • The national discussions about the use of NHS Professionals were acknowledged, as were the historic benefits to the former St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) of developing an inhouse temporary workforce bank. • It was agreed that a business case should be developed with a full optional appraisal of both financial and qualitative benefits to allow an informed decision on the best way forward for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).	Assurance
PriceWaterHouse-Copper (PWC) Report	• Committee discussed the PWC report on the 2025/26 financial plans at ICB and Trust level. • A meeting with PWC to discuss the MWL report was scheduled for 04 July 2025, and the CEO and Chief Finance Officer would then prepare	Assurance

	briefings for the Board and Finance and Performance Committee.	
Bevan Court Lease	• The Director of Corporate Services presented the options for the extension of the lease for Bevan Court. • Committee agreed that the accommodation remained essential to the delivery of clinical services at the Whiston site. • Committee supported the lease extensions on the commercial terms agreed, acknowledging the IFRS16 impact. • Due to the whole life value of the lease a recommendation would be made to the July Trust Board for approval of the preferred option.	Approval
10 July 2025		
Medical Photography Service for the Southport and Ormskirk Hospital Sites	• The Chief Operating Officer introduced the report, noting the former Southport and Ormskirk Hospital NHS Trust (S&O Trust) had not provided a medical photography service and this had been identified as a risk, particularly in relation to the recording and management of pressure ulcers. • Proposals to expand the former STHK medical photography service to cover the whole of MWL had been developed, which would require additional investment. • Committee supported the expansion of the service in principle but sought greater clarity on the impact for the Ophthalmology and Burns services if the current staffing resource was not supplemented. • It was agreed a revised business case including this additional information would be developed for the Committee to consider.	Assurance
NHS 10 Year Plan	• The Committee considered the new NHS 10-year plan and the role MWL could play in supporting the local Places develop bids to become Neighbourhood Health hubs by 01 August 2025.	Assurance
MWL National Inpatient Survey Results 2024	• The Chief Nursing Officer presented the Trust results from the national inpatient survey. • This allowed comparisons with the MWL 2023 data. • The national results were expected to be published in August 2025. • The MWL results demonstrated improvements in some of the areas that had been identified for action the previous year. There were also positive	Assurance

	scores for new questions introduced for this survey round. • Areas performing less well included ward moves at night and waiting for admission to a ward bed, and actions were being developed in response. • A full analysis including benchmarking would be presented to the Executive and Quality Committee, with an action plan once the national results had been published.	
MWL single Training Needs Analysis (TNA) for Mandatory Training	• The Chief People Officer presented the report on the impact of aligning the MWL mandatory training with the national mandatory training subject's guidance. • This national guidance had been used to calculate the numbers of staff that would be required to complete each subject, to create a standardised TNA across MWL. • Committee noted that for some subjects this resulted in a change to the categories of staff who were required to undertake the training, resulting in either more or fewer staff being covered by the TNA, which would impact compliance scores during the transitional period. • There were a few outstanding queries in relation to some of the clinical skills subjects and it was agreed that the Learning and Development team would meet with the Chief Medical Officer and Chief Nursing Officer to resolve these before the new TNA was implemented.	Assurance
Federated Data Platform Roll Out	• The Director of Informatics presented the options to introduce the NHSE mandated system across all MWL sites. • Committee agreed that there was a need to better understand the cost/benefits of moving away from the current processes, and to engage the relevant staff in product demonstrations to understand any additional functionality and staff feedback.	Assurance
System C System Improvement Action Plan	• The Director of Informatics presented the outcome of the work undertaken by System C to assess where the functionality of the current Electronic Patient Record (EPR) systems could be improved for the remaining contract periods. • Committee agreed the focus should be on those actions with the greatest impact and that there should be regular progress reports to monitor delivery against the agreed timescales.	Assurance

Finance Improvement Group (FIG)	• Committee reviewed the FIG action logs and assurance report. • It was agreed that the format of the report should be reviewed to enable the committee to monitor actual against expected delivery of the agreed actions.	Assurance
Resident Doctors Industrial Action.	• The Chief People Officer reported that the British Medical Association (BMA) had confirmed resident doctors would be taking industrial action between 25 and 30 July. • Planning had commenced to maintain services wherever it was safe to do so.	Assurance
17 July 2025		
Cash Implications Following Deficit Support Funding Withdrawal for Cheshire and Merseyside Integrated Care Bard (ICB)	• The Chief Finance Officer briefed the committee on the NHSE decision to withdraw deficit support funding from the C&M ICB for quarter 2 of the financial year and the implications for cash management at MWL. • The deficit support funding in the agreed MWL financial plan was £30.2m and the loss of the funding in quarter 2 would create a £7.56m pressure. • The greatest risk was in respect of the Lead Employer payroll if host trusts did not pay MWL and representations were being made to NHSE both regionally and nationally. • NHSE had indicated that cash advances to manage cash flow would not be granted and systems would need to work together to manage cash. • The Finance and Performance Committee members would be briefed at the July meeting.	Assurance
NHS National Oversight Framework (NOF)	• The Chief Finance Officer outlined the new NOF, designed to enable NHSE to assess the performance of ICBs and Provider Trusts. • The information would be refreshed as new data became available which meant a NOF segmentation rating could change during the year, and poor or worsening performance would trigger intervention. • Committee reviewed the NOF metrics and noted that the majority were already reported via the Trust Integrated Performance Report (IPR) and would need to be incorporated where they were not. • How the segmentation ratings were calculated, and the weighting of each metric had not yet been	Assurance

	published, but Committee agreed further discussion would be required when this was known, and then all Board members and senior teams would need to familiarise themselves with the process.	
PWC Rapid Financial Diagnostic Reports	• The Chief Finance Officer shared the ICB and Trust reports. • The Committee noted the five recommendations for the Trust. A formal response was being developed. • Both reports would be presented to the Finance and Performance Committee.	Assurance
Month 3 Financial Forecast	• The Chief Finance Officer presented the proposed Month 3 forecast position that was to be submitted to the ICB by 18 July. • The month 3 YTD position was £1.6m ahead of plan, which indicated the additional financial controls that had been put in place were starting to reduce pay spend. • To date, the system and high risk schemes in the plan had not delivered savings, but Trust Cost Improvement Programme (CIP) was on track. • Mitigation plans were reviewed and the impact assessed. • A three year financial recovery plan would be discussed with PWC at a scheduled meeting the following week.	Assurance
Cheshire and Merseyside ICB Cost Improvement Programme (CIP) Risk Review	• The Chief Finance Officer presented the review undertaken on behalf of the ICB on the risk to delivery of each provider trust's CIP. • The Trust had been rated as an "Amber" risk and the report included recommendations on how to improve the financial grip and control.	Assurance
Workforce Plan 2025/26	• The Chief People Officer presented the position against the agreed workforce plan at the end of quarter 1. • Overall, the workforce position was ahead of plan with variances between different staff groups. • Further work was required to understand the variances from plan for Medical and Dental staff and Health Care Assistants.	Assurance
Legacy Trust Staff Different Working Arrangements	• The Chief People Officer reported that the working group, which included staff side representatives had now agreed an approach to moving back to the Agenda for Change working patterns. • This would apply to new staff and those not covered by TUPE protection.	Assurance

	• Guidance and roster templates had been developed to support managers to implement this change.	
East Pathology Hub Full Business Case (FBC)	• The Director of Strategy presented the FBC, which would be considered for approval by the MWL and Warrington and Halton Hospitals NHSFT Boards on 30 July and 06 August respectively. • This was subject to the outcome of the procurement process, with the intent to award notice issued and the stand still period ending on 29 July. • Committee endorsed the FBC for presentation to the Trust Board, subject to the procurement stand still period.	Approval
Fragile Services Update	• The Director of Strategy provided an overview of progress against the pre transaction S&O fragile services. • Committee noted the progress made for ENT, Vascular and Ophthalmology. • Committee agreed this should continue to be monitored and regularly reported via the Strategy and Transformation Council so that change from the baseline position on each of these services was tracked.	Assurance
Outpatient Transformation Project Progress Report	• The Director of Strategy presented the June progress report. • The full project plan and workstreams were still in the development phase. • Committee discussed the importance of this piece of work and how the divisional team could be further supported. • Committee would continue to oversee progress monthly.	Assurance
Winter Planning and Board Assurance Statements	• The Chief Operating Officer briefed the committee on the Winter Plan submission requirements and Board Assurance Statements that would need to be submitted with the plan on 30 September. • It was agreed the Trust Board would be briefed in July, to prepare for the September approval deadline.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services presented the quarterly review of the BAF. • Committee agreed the changes that would be recommended to the Board.	Assurance
24 July 2025		

Resident Doctors Planned Industrial Action	• The Chief Operating Officer and Chief Medical Officer provided assurance in relation to the planning process for the period of industrial action to maintain patient safety. • Committee discussed the derogations process and the need to submit derogation applications where it was felt these were needed to maintain access to essential services.	Assurance
Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25	• The Chief Operating officer presented the draft EPRR Annual Report for review which demonstrated how the Trust had fulfilled its statutory duties during 2024/25. • The report also detailed the Trust response to both planned and unplanned incidents during the year and learning that would be used to improve future responses. • In September 2024 the Trust had been assessed as Partially Compliant against the 2024 EPRR core standards. • The annual report would be presented to Board for approval and the 2025 core standards assessment would then be presented in September ahead of the 2025/26 submission deadline.	Assurance
Data Security and Protection Toolkit (DSPT) Annual Submission	• The Director of Informatics presented the DSPT assessment for 2024/25, which had been submitted on 30 June. • This was the first year the DSPT had been aligned to the National Cyber Security Centre's Cyber Assessment Framework (CAF), which was the first substantial change to the DSPT since 2018. • NHSE had anticipated that most trusts would not achieve all the standards in the first year. • MWL could evidence all the standards except 1, and were therefore categorised as "standards not met" in June • Actions had been put in place to address this standard, which had all been delivered. • MIAA had audited the evidence for several of the standards for additional assurance and due to not meeting one standard had given an outcome of Moderate Assurance.	Assurance
Never Events Action Plan	• The Chief Medical Officer introduced the report which detailed the themes, learning and actions from the five never events that had occurred in 2024/25.	Assurance

	• Each never event had been subject to a Patient Safety Incident Investigation (PSII). • A new method of developing and monitoring the action plans had been used, which allowed actions to be weighted for impact. • Committee also discussed how the common themes from the never events had been identified and shared across the Trust. • Committee supported the new approach to action planning, which would focus resources on the most impactful actions, and agreed it remained crucial to understand the root cause of an incident and any system or process failures that needed to be addressed across the organisation.	
Urgent and Emergency Care (UEC) Improvement Plan	• The Chief Operating Officer and ICB UEC Programme Lead presented progress report. • The Admission Avoidance workstream was focussed on creating a single point of access for the MWL footprint, with the first phase for Knowsley due to go live in August. Further phases were to be proposed to the ICB Executive for approval as there were contractual implications. • The discharge workstream was focused in creating a single integrated discharge team for the whole MWL footprint. Monitoring of the non-criteria to reside patient numbers continued against the agreed improvement trajectories, with the average numbers reducing from 147 to 114. • To date these workstreams had not delivered the expected benefits to enable escalation beds and corridor care to be stood down. • Work was also being undertaken by the ICB to standardise the Urgent Treatment Centre offer, so that all could offer diagnostics, to provide a consistent alternative to Emergency Department (ED) conveyances for North West Ambulance Service NHS Trust (NWAS). • The Reduced Length of Stay workstream was being led by the Trust. This was focused on reducing unnecessary admissions and improving same day emergency care, particularly at the Southport site. • The proposed Care Coordination Hub would support better patient flow by optimising the use of community resources and Rapid Access Clinics.	Assurance

	• Committee welcomed the progress to date but noted this was not yet of the scale or pace to enable Trust escalation bed capacity to be closed.	
North Mersey Stroke Network	• The Chief Medical Officer introduced a paper setting out proposals to address the fragility of the stroke rehabilitation service at Southport Hospital which were dependant on a single-handed locum consultant. This was despite several attempts at substantive recruitment • The proposal was to transfer responsibility (and local funding) to the Hyper Acute Stroke Unit to provide an outreach stroke service, which aligned with national stroke services guidance. • This would safeguard the service and improve the likelihood of recruitment into a larger clinical team. • This model reflected best practice and would safeguard high quality stroke care for patients repatriated after the acute phase and for transient ischaemic attack (TIA) clinics. • The Committee agreed with the option appraisal and the recommendation to deliver safe effective stroke care for the population of the North Mersey Stroke Network. Work would be taken forward to agree a robust service level agreement (SLA) with the Stroke Network.	Assurance
Single EPR)	• The Director of Informatics presented the full EPR procurement and implementation programme, including the communication and stakeholder engagement plans to ensure clinical and operational staff co-designed the new standardised processes. • Committee would receive a further update following the end of the pre-market engagement process.	Assurance
Information Governance (IG) Annual Report 2024/25	• The Director of Informatics presented the draft IG annual report ahead of reporting to the Trust Board. The report demonstrated that the Trust remains compliant with the legal requirements. • There had been one reportable incident to the Information Commissioners Office, the action plan had been accepted and no fines imposed.	Assurance
MWL Strategy Development – Population Health Needs	• The Director of Strategy presented a discussion paper to explore how MWL could assess its catchment population predicted health needs to support the development of the Trust's 5 – 10 year strategy.	Assurance

	• Committee agreed that much of this information existed and was produced by system partners, such as commissions and Public Health, so there was a need to work in collaboration rather than duplicate effort.	
2025/26 Flu Vaccination Campaign	• The Chief People Officer detailed the annual Flu vaccination campaign for healthcare workers who had patient contact which was being condensed into a nine week "sprint" during October and November. The target for MWL was to achieve a 47% uptake. • There was no NHS staff Covid-19 vaccination campaign planned for 2025/26 • Unlike previous years, additional national funding had not been allocated to support the Flu vaccination campaign • A national publicity campaign to promote the value of vaccinations was being planned by the Department of Health and Social Care to try and counter vaccine hesitancy. • The proposals to deliver the vaccines was approved and a small additional internal resource (£44k) allocated to ensure that other health, work and wellbeing functions could continue during this period.	Approval
31 July 2025		
Inter-speciality Referrals	• The Director of Informatics provided an update on the implementation of the in-house inter-speciality referral system for the Whiston ED. • This had been "soft" launched on 29 July to allow for testing in the live environment and the full launch planned for 06 August to coincide with the Resident Doctor rotation to enable all new staff would be inducted to the new process. • There had been no impacts on ED activity reporting detected but this would continue to be monitored and mapped. • Committee suggested the opportunity to better monitor 12 hour breaches also be explored.	Assurance
Freedom of Information (FOI) Performance Report	• The Director of Informatics presented the FOI response time compliance report for June. • In quarter 1 294 FOI requests had been submitted, which included 2,504 questions, many requiring responses from more than one department/service. 218 of the requests had been responded to and 76 remained open.	Assurance

	• Compliance with the 20-working day response standard was 69.44%, which was a 4% improvement from May. • Committee discussed again if the common requests could be addressed via regular updates to the Trust publication scheme, and it was agreed this would be explored with each Director.	
Southport Community Palliative Care Consultants	• The Chief Medical Officer outlined a proposal from Queens Court Hospice for the hosting arrangements of the community Palliative Care Consultants for Sefton and West Lancashire to move from Mersey Care NHS Foundation Trust to MWL. • A formal TUPE would need to take place, but the Committee supported the proposal in principle and requested the Chief People Officer to start the process, on the basis that it would be cost neutral. • Committee also agreed to explore a more standardised hosting model for all the community Palliative Care consultants with other hospices in the Trust catchment.	Approval
Mandatory Training and Appraisal Compliance Report - June	• The Chief People Officer presented the report. • Mandatory training compliance was 89.8% • Compulsory skills training was 86.2% • Detailed monthly reports including non-compliant staff per subject were sent to each division and service to maintain performance above the target of 85%. • Appraisal compliance was 73.8% at month 2 of the appraisal window, and this was behind trajectory, but it was noted that many appraisals had been booked but not yet taken place and recorded on the Electronic Staff Records (ESR), so the position was expected to improve.	Assurance
September Trust Board Agenda	• The Director of Corporate Services presented the draft September Trust Board agenda for review, noting the meeting fell early in the month. • The Committee selected the Employee of the Month (EOTM) for August from the nominations received in July.	Assurance
Finance Improvement Group Assurance Report	• The Committee received updates on the agreed FIG actions for each Clinical Division. The focus of the meetings had been on actions to reduce premium pay spend on locum and agency staffing.	Assurance
07 August 2025		

Knowsley Urgent Community Response (UCR) Service	• Committee reviewed the proposals to transfer the UCR service for Knowsley to MWL, as part of the UEC improvement programme. • The paper detailed the proposed operating model and the aspiration to achieve the transfer of the service by November 2025. • Work was required to engage the current team and resolve contractual funding levels. • Committee approved the direction of travel, subject to a final business case being developed.	Approval
Health Care Assistant (HCA) Banding Resolution Framework	• The Chief Nursing Officer and Chief People Officer presented a progress report on the implementation of the resolution framework working with staff side colleagues. • The number of new applications being received had now fallen away and it was recommended the application phase of the process be closed. • The national job profile changes for HCAs meant that a higher proportion of band 3s would be required to maintain the appropriate skill mix and undertake some clinical competencies, although this varied between different wards and departments. • Where these duties had been undertaken historically, a process was in place to review the evidence of this and apply for retrospective back-pay and re-banding, for which funding had been accrued. • 68.5% of eligible staff had applied. • 823 applications had been reviewed and approved, 118 were still going through the process, three had been formally rejected and 114 were pending submission of the required evidence or documentation. • Benchmarking had shown that based on the outcome MWL would remain comparable to other acute trusts for band 2 to 3 staffing ratios for general in patient and specialist clinical areas. • As a result, the next nurse staffing establishment review would reflect these changes, and the committee confirmed that this would need to be accompanied by a business case to demonstrate changes to care needs and overall value for money	Assurance
All Together Smoke Free	• The Chief Nursing Officer briefed the committee on a letter from C&M ICB asking providers to re-confirm their commitment to a smoke free NHS.	Assurance

	• It was agreed that a response would be drafted setting out the Trust position.	
Palliative Care ad End of Life Strategy	• The Chief Nursing Officer presented the draft Palliative Care and End of Life Strategy. • Committee endorsed the strategy and agreed it should be presented to the Quality Committee.	Assurance
Updated Aggregated Incidents, Complaints and Claims Report Quarter 1	• The Chief Nursing Officer presented the revised and corrected report, following the July Board. • The Committee approved the changes and for the revised report to be added to the July Board papers published on the Trust website.	Approval
Finance Improvement Group (FIG) Assurance Report	• The report detailed progress against the agreed actions, and any variances from plan. • Issues discussed included recharges for 1 to 1 care for Children and Adolescent Mental Health Services (CAMHS) patients awaiting a discharge package. • Additional controls put in place for the approval of Waiting list Initiatives (WLI) • Decreases in bank and agency spend in nursing and support roles.	Assurance
Nurse Safer Staffing Report - June	• The Chief Nursing Officer presented the report. • The overall Registered Nurse fill rate was 97.62% and the HCA fill rate 113.32% • Committee reviewed the reported incidents, harms, sickness absence levels for wards with a fill rate below 90%	Assurance
Procedural Documents Update	• The Chief Nursing Officer presented the report. • MWL had 857 live policies and procedural documents (861 in June) • 200 of these are currently overdue for review • 520 procedural documents are still awaiting harmonisation (557 in June) • Each Director had an action plan to address the overdue policies within their areas of responsibility, and it was noted that many policy reviews were in progress.	Assurance
14 August 2025		
2025/26 Capital Plan	• The Committee received the final 2025/26 capital plan for the estate, IT and equipment. • The Capital Planning Council had prioritised the schemes from the discretionary capital available • Other sources of capital, i.e. from national bids were designated for specific purposes • It was recognised that the Capital Departmental Expenditure Limit (CDEL) available to the Trust	Assurance

	this year had meant some difficult decisions had to be made, which created risk for the items that could not be funded, unless further national capital became available. • Committee recognised the challenges and the need for early agreement of the capital plans for 2026/27 to allow the maximum time for the schemes to be delivered and especially where these were enablers for the activity plans or service developments.	
Month 4 Forecast	• At the end of month 4 the Trust had reported a £27m deficit (excluding deficit support funding) which was £1m better than plan, which included the impact of the Resident Doctors Industrial Action. • This included 5% internal CIP and a further 3% of high risk/system developments • Committee reviewed the actions being taken to deliver the agreed financial plan, including the additional system opportunities identified by the ICB and the risks to delivery	Assurance
MWL Anti-Racism Statement	• The Chief People Officer presented the proposed MWL Anti-Racism statement for approval. • The statement set out the Trust's commitment to actively tackling racism in all its forms – individual, structural and systemic – across our workforce, services and communities, and had been developed through staff engagement events and e-surveys • The statement was to be launched at a series of events across the different Trust sites in August and September followed by other initiatives to promote anti racist behaviours. • Committee approved the Anti-Racism statement.	Approval
National Uniform Project	• The Chief Nursing Officer presented an update on the National Unform project. • Committee continued to support the move for MWL to adopt the national uniform but were cognisant of the upfront investment needed and time to achieve a return on this investment. • There were also implications for the current linen room services and for groups of staff not covered by the national uniform (Medical and Dental Staff, Porters, Domestics etc.) to ensure patients could easily identify different types of staff. • It was agreed that a business case including a detailed implementation plan was required.	Assurance

Inter-speciality Referral System	• The Director of Informatics reported that the new system had been successfully implemented but not yet fully adopted by all clinicians. • There had been no adverse impacts on external reporting of 12-hour breaches, although this continued to be closely monitored with Business Intelligence.	Assurance
NetCall Patient Engagement Portal (PEP) Update	• The Director of Informatics introduced the report. • PEP was fully implemented for all specialities (except Paediatrics) at the Southport and Ormskirk Sites. • The PEP systems linked to the NHS App and had been used to communicate 104,000 appointments and over 4,395 cancellations or re-bookings. There was also a reduction in letters being posted each month of circa 4,000. • Checks with patients via PEP had resulted in 9% confirming their referrals was no longer required, which supported effective waiting list management. • The implementation of PEP for the Whiston, St Helens and Newton sites remained dependant on resolving the outpatient clinic configuration issues which were a legacy of the previous EPR implementation. It was agreed that the adoption of PEP needed to be a key part of the outpatient booking process redesign. • Opportunities for expanding and optimising the PEP functionality were detailed and included tools for predicting Did Not Attend (DNA) rates and keeping in touch, including wellbeing information. • Committee discussed how the clinic configuration project could be brought forward as an enabler for PEP and the new single EPR.	Assurance
21 August 2025		
Whiston Site Cold Decontamination	• The Director of Corporate Services introduced the report, which detailed the risk in relation to the end of life decontamination equipment and potential mitigations. • The current unit did not meet the required JAG accreditation standards and for several years it had been acknowledged that an alternative provision would be needed. Although a new site had been identified the capital to deliver this had not been identified, and if approved the scheme was complex and would take several years to deliver.	Assurance

	• Mitigation options had been developed to replace the end of life equipment in the existing unit, to maintain the on site capacity for cold decontamination. This equipment could then be transferred to the new unit when it was completed. • The Committee reviewed the options and supported the preferred option to move forward to the capital prioritisation process for 2026/27. • Committee also agreed that a similar exercise was needed for the decontamination unit at Southport Hospital, noting the units at St Helens and Ormskirk had been replaced in recent years.	
Sexual Misconduct Policy	• The Chief People Officer presented the model NHSE Sexual Misconduct Policy and recommended this be adopted by MWL. This would set the expected standards of behaviour and provide a direct route for staff to raise concerns if they had experienced sexual misconduct. • The Committee approved the adoption of the policy	Approval
Inter-speciality Referral System Implementation	• The Director of Informatics reported the system was working as expected but was not yet being used by all clinicians, so support and education were continuing. • There had been no issues identified for 12 hour breach reporting to date, but this would continue to be monitored. • Committee acknowledged this was an interim and partial solution pending the new EPR but did enable better tracking of patients and recording of the time of a decision to admit.	Assurance
Appraisal and Mandatory Training Reports - July	• The Chief People Officer reported that 42.8% of expected appraisal had been completed, which was an improvement on this point in the appraisal window in 2024. • Mandatory training compliance was 89.9% and compulsory training 87.3%, so both were exceeding the 85% target. • Committee reviewed the subjects and teams that were below target and the actions being undertaken.	Assurance
28 August 2025		
Estates and Facilities Management Cost Improvement Schemes	• The Director of Corporate Services updated the Committee on proposed cost improvement plans and potential risks to delivery in 2025/26.	Assurance

	• Committee considered the proposals and agreed those to be pursued or explored further.	
Communications and Media Activity Report – Q1	• The Deputy CEO introduced the report, which summarised the activity during Q1. • The report detailed the activity on social media, press releases and media interest, the MWL campaigns and activities in the period and support for the Shaping Care Together consultation.	Assurance
Mental Health Patients	• The Chief Nursing Officer reported on the complexity in respect of providing the appropriate care for mental health patients who no longer had physical health needs. A Mental Health crisis response service was being discussed by the ICB. • Committee also considered if dual trained nursing staff could be recruited.	Assurance
Review of System Workforce Efficiency Schemes	• The Chief Finance Officer introduced an update on the ICB system wide workforce schemes which included reducing Nursing overtime payments, waiting list initiative reductions and standardising medical and dental locum rates. • Proposals for a C&M staff bank were also under consideration.	Assurance
Employee of the Month (EOTM) - September	• Committee reviewed the nominations received during August and selected the EOTM for September	Approval
Financial Improvement Group (FIG) - August	• The Chief Finance Officer presented the updated FIG action log • Medical and Dental vacancy review and plans for substantive recruitment had been reviewed. • Updates on consultant job planning were received with a timetable for completion. • Divisional recovery plans were being developed where activity was below plan. • Non-pay controls had been reviewed and were working well • The digital catalogue had been reviewed to restrict/standardise options and streamline the approval process	Assurance
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during July and August 2025 were:</u> • £44k to support the winter staff flu vaccination programme		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee/ Assurance Report			
Title of Meeting	**Trust Board**	**Date**	24 September 2025
Agenda Item	**TB25/068 (8.2)**		
Committee being reported	Audit Committee		
Date of Meeting	10 September 2025		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
External Audit Progress Report	No one from Grant Thornton (GT) was in attendance to present the External Audit progress report. The report was received for noting. It was noted that audit was subject to National Audit Office (NAO) review and therefore the final audit letter had not been received.	Assurance
Internal Audit Report	MIAA summarised the internal audit progress reports key messages section. MIAA confirmed five reports had been finalised. one report received moderate assurance and three reports received substantial assurance. The Digital Security and Protection Toolkit (DSPT) report received an overall moderate risk/high confidence. MIAA also confirmed four reviews are currently in various stages of progress.	Assurance
MWL Audit Log	Committee received the audit log report which highlighted key movements on the audit log, both in relation to internal and external audit recommendations.	Assurance
Anti-Fraud Progress Report	MIAA presented the anti-fraud progress report from April to August, which summarised the anti-fraud and investigations activity during the year by referring to specific pages in the report.	Assurance
Corporate Governance Manual (CGM)	The Assistant Director of Finance – Financial Services presented proposed changes and updates	Assurance

	to the CGM which largely consisted of updates for changes in Legislation, updates for changes to job titles, updates to Delegated Financial Limits and any miscellaneous amendments. A final updated version of the CGM will be circulated to Audit Committee members for final approval.	
Review of Annual Objectives aligned to the Audit Committee	The Deputy Director of Finance provided a verbal update and advised that there were no annual objectives explicitly linked to the Audit Committee.	Assurance
Revised Audit Committee Workplan for 2025/26	The Deputy Director of Finance presented the paper which identified some revisions to the annual workplan following its approval in February 2025.	Assurance
Financial Reports	The losses and special payments report was presented. Total losses identified as at 31 July 2025 were approximately £113k. £372k in total was recorded in 2024/25. The aged debt report was presented. Specific attention was paid towards the age and value of aged debt in the >90 day category, and what actions would be needed to help reduce these values down going forward. The tenders and quotation waivers report was presented and its contents noted.	Assurance
Alerts:		
Items for escalation to Board is the aged debt		
Decisions and Recommendation(s):		
None.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	24 September 2025
Agenda Item	**TB25/068 (8.3)**		
Committee being reported	Quality Committee		
Date of Meeting	16 September 2025		
Committee Chair	Claudette Elliott, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Quality Committee Corporate Performance Report (CPR).	• Committee reviewed the Quality Committee Performance Report noting how it was evolving and agreed actions to take forward for next committee meeting. • Pressure Ulcer data reports for May with ongoing oversight of data validation to assure updated future reporting. • One Never event reported - no patient harm. • Venous Thromboembolism (VTE) remain below target. • National Early Warning Score (NEWS) scores remain under target. • Nutrition - no new issues data validation ongoing. • Complaints with main themes aligned to poor communication, waiting times with long waits being a particular concern and mis/delayed diagnosis. • Zero moderate or severe falls at Southport site over last four months. • Sepsis - assurance in the data and the timescales provided. Consideration for additional targets for antibiotics given within the correct timescale. • Discharge targets (seven days) discussed and whilst target not achieved resource issues noted. Potential positive impact on the future introduction of Artificial Intelligence as a key enabler. • Assurance on improved 45 minute ambulance handover with no patients left at 45 minutes across MWL with assurance 15-minute handover remains a target.	Assurance

Monitoring of Annual Trust Objectives aligned to the Quality Committee (Incl. the Quality Account Improvement Priorities)	• Six Trust quality objectives aligned to the Trust Quality Account. The performance report provided the position for quarter 1. • On track with areas of improvement identified. • Assurance given on "waiting well" as part of patient portal exercise. Action plan to executive committee. • Assurance on program of work to support timely discharges and take-home medications (TTO's). Ongoing monitoring through the Divisional Performance Review meetings (DPR).	
Patient Safety Report (Inc. Chair's Assurance Report)	• Three Patient Safety Incident Investigations (PSII's) commissioned within reporting period. • Positive steady increase in incidents reported since implementation of InPhase. • Majority of falls remain low/no harm with similar numbers reported. • Highest category of incident reporting majority nonhospital acquired with themes identified and subsequent actions taken. • Falls themes – around examination and supplementary care needs. • External review completed with report awaited. Initial assurance following site based review. • InPhase training continues moving to development phase for bespoke reporting and triangulation. Assurance on continued training for InPhase and incident reporting. • The Patient Safety Council assurance reports for September was noted. There were no alerts to the committee. • Patient Safety Council Terms of Reference approved.	Assurance
Infection Prevention & Control Quarterly Report	• Q1 2025/26 report was received and the Committee were assured by the reporting an identified key themes and learning. • The NHS Standard Contract for 2025/26 in respect of reportable healthcare associated infections and thresholds received. • One healthcare-associated Methicillin sensitive Staphaureus bacteraemia (MRSA) bacteraemia cases in Q1, with one case year to date (YTD) deemed unavoidable following the Interprofessional Learning Review (IPLR) panel, although organisational lessons were identified.	Assurance

	• Aseptic Non Touch Technique (ANTT) - Increase in level 1 and level 2 compliance in June but below target 85%. • New Getting It Right First Time (GIRFT) guidance in Q1 - Task and Finish Group in place. • MWL MRSA screening compliance for Q1 on target reporting at 95% • Following a 35% increase in Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) bacteraemia cases in 2024/25 a deep dive into MSSA informed the development of the Bloodstream Infection (BSI) Improvement plan for 2025/26. Q1 reports reduction of seven cases compared to last year. • 27 cases of Clostridioides difficile (C-Diff) YTD above NHSE threshold by three cases. Improvement plan continues. • Escherichia coli (E coli) Bacteraemia – 38 cases in Q1, one case above threshold, equal to last year, however the Trust remains below Cheshire and Mersey (C&M) rate. Key action remains on patient hydration. • Klebsiella Bacteraemia – nine cases in Q1. Trust is below threshold. • Pseudomonas aeruginosa – Trust above the Cheshire and Mersey rate for Q1 comparative to below rate for previous three quarters. Incident meetings supporting actions and learning. • 44 cases of Covid-19 in June with noticeable increase of cases on the Southport site from 37 in May to 88 in June. Assurance provided on outbreak management. • Assurance provided to Committee on staff vaccination programme for 2025/26 in line with National Joint Committee on Vaccinations decisions. • Mersey Internal Audit Agency (MIAA) review of outbreak control measures at Whiston, Southport, Ormskirk and St Helens sites commenced in June. Draft report received into the Trust. Assurance on next steps provided. Divisional teams to embed the learning with Infection Prevention and Control (IPC) oversight and support. • Retrospective case note review report in relation to MSSA (April - March) received.	

Maternity & Neonatal Services Quarterly Report (CQSG)	• Q1 summary received. • Maternity Incentive Scheme (MIS) Year 7 scheme released in April 2025 work continues to collate evidence for this submission. • Representation as quorate members to Perinatal Mortality Review Tool (PMRT) and key governance meetings not achievable due to capacity and experience/training a recognised requirement within the broader Maternity Incentive Scheme (MIS) framework. Able to declare compliance to safety action 7 through escalation to Trust board. • Service compliant with safety action 1 standards A, B and D. Standard C – compliant to two elements. Third element non-compliant. Trust requires 20 PMRT cases (19/20 being fully compliant). Eight cases applicable with 7/8 fully completed reporting 87% compliance at end of Q1. • Perinatal Mortality: three reportable deaths in Q1 assurance on full PMRT review. • Maternity and Newborn Safety Investigation (MNSI) -zero new cases. • Saving babies lives: Q4 data advises 99% compliance across MWL sites. Element 5 not reaching 100% - Local Maternity and Neonatal System (LMNS) assured with ongoing monitoring. • Antenatal and Newborn Screening Quality assurance - 39 recommendations with action plan in place. • Three formal complaints received in maternity, zero for Neonatal services in Q1. • One new claim in Q1 for maternity services. Zero claims for Neonatal services. • Maternity workforce-Birthrate + review required for 2025/26. • Both neonatal units meeting British Association of Perinatal Medicine (BAPM) Neonatal Nursing standards. • Zero Maternity suspension of services. • 46 neonatal suspensions in Q1 remaining open for emergency admissions. • Regional Chief Midwife Annual visit – post annual visit letter received. • Maternity Safer Staffing Oversight Reports received.	Assurance

	• Perinatal mortality reports received.	
Adult Palliative and End of Life Care Strategy 2025-2028	• Committee approved the Strategy noting suggested changes. • Strategy assured on MWL's approach structured around six national ambitions. • Strategy addresses current service variations across the five hospital sites and community settings. • Implementation overseen by the End-of-Life Steering group with further reporting through established Trust governance structures.	Assurance
Patient Experience Report (Including Council Chair's report and quarterly incidents, complaints and claims report and regulation 18 complaints annual report (June)	• Report covered data between May and August 2025. • Patient experience Tendable audit June to August report consistently high scores for questions relating to personalisation of care. Improving trajectory against the provision of the Trust discharge booklet. • Friends and Family (FFT): Positive satisfaction rates were met with the exception of Birth (slightly below target), Antenatal and Postnatal ward. These areas were also above target for negative ratings with themes reported to the Committee. • Withdrawal of postcards as method of patient feedback from 01 July 2025 due to FFT provider resources. New methods of collection implemented with ongoing monitoring. • Trust given notice from 31 August 2026 from the survey provider they will no longer provide FFT platform. Procurement supporting review of new platform provision. • Communication themes reported following deep dive. 41 pieces of negative feedback received with update on impact of patient portal provided. • Highlights on patient experience and inclusion strategy provided • Updates to National inpatient surveys reported • Summary on patient experience and inclusion champions provided with reference to the profile being further raised through the recent patient experience conference in September. • New prayer room opened June on the Southport site. • 40 quality ward rounds completed since September 2024 (May to August - 12). Actions and themes noted.	Assurance

	• Committee noted the Patient Experience Council assurance report for July 2025. • Patient Experience Council Terms of Reference approved.	
Any Other Business	• Updated IPC Data noted by the Committee as per action from July meeting. • Rani Thind, NED, thanked for her contributions and commitment to the Committee and support to the Chair.	
Alerts:		
• None		
Decisions and Recommendation(s):		
The Trust Board note the report.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	24 September 2025
Agenda Item	**TB25/068 (8.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	17 September 2025		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Workforce Dashboard - August	Mandatory Training - 89% compliance in August against the target of 85% with trajectory plans in place to address those teams and staff groups where compliance remained below 85%. The Executive Committee had approved a consolidated Training Needs Analysis (TNA) for MWL's core mandatory training, which is being implemented. Work will now commence to review the compulsory training modules. Appraisals – appraisal performance was 74% in August with one month remaining of the 2025/26 appraisal window. Sickness - in-month sickness continues to be above target, at 6.7% (5% target). Allied Health Professionals (AHP) and medical workforce sickness is below target (at 4.7% and 2.4%) however sickness for Qualified Nursing and Midwifery staff and Health Care Assistants (HCAs) remains above target (at 6.9% and 7.7%). Vacancy rate - the Trust's vacancy position is 5.8% which is positively below the target of 8%. All staff groups are within tolerated threshold limits, except AHP's (9.4%). Time to Hire (T2H) - in-month T2H is at 67.4 days against the target of 40 days. Time to hire had improved in July 2025 but continues to be above both Trust and National targets. Time for completion of Identity (ID) and DBS checks had improved but there continued to be delays with occupational health (OH)	Assurance

	clearance. The Recruitment team continue to work with OH colleagues to prioritise candidates who only have OH clearance outstanding and a turnround plan is in place. There had also been an increase in the time taken to obtain references, and the recruitment team were focusing on reducing this. Turnover - in month turnover had increased to 1.6% against the target of 1.1% which was due to seasonal variance attributed to medical workforce fixed term contracts ending to coincide with August rotation. The 12-month rolling turnover had reduced to 9.8% against the 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 13%.	
HR Directorate Technology and Transformation Update	The update provided assurance that the HR Directorate continues progress the automation and technology transformation agenda to support service improvement and the delivery of efficiencies aligned to national and system level workforce solution programmes of work. This update provided an overview the developments over the previous 18 months and the pipeline of future plans to expand the use robotic process automation (RPA) and Artificial Intelligence (AI) opportunities for process transformation. The report included information on the opportunities being developed nationally and in other Trusts which would support the Trust's ambition to expand the range of shared service solutions for the system to support productivity improvements and resilience in the delivery of back office /corporate functions. The next steps noted are: • Draft a Technology & Transformation plan 2025-2028 for the HR Directorate • Develop a consolidated year one Trust HR and HR Commercial Services action plan for Q3/Q4 2025/26 and benefits tracking.	Assurance
Employment Services Annual Report 2025/26	The annual update of Employment Services, Payroll and Pension services delivered to 19 NHS client organisation provided assurance of robust operational management and development of the	Assurance

	service. Key achievements and challenges noted were: <u>Achievements and Recognition</u> Employment Services has received several accolades, including the Payroll Assurance Scheme (PAS) accreditation from the Chartered Institute Payroll Professional (CIPP) the only chartered institute for pensions and payroll professionals in the UK, high assurance from Mersey Internal Audit Agency (MIAA) for the three consecutive years, and being shortlisted as finalists in the HPMA Excellence in People Awards 2025. <u>Challenges and Improvements</u> The team faces ongoing challenges such as complex changes to NHS Terms and Conditions, staff shortages, and increased overpayments. Efforts are being made to improve digital maturity and automation readiness to optimise payroll and pension services. <u>New Business</u> Four new NHS trusts have transferred their payroll service to MWL since April 2025 from C&M and one Trust has moved to MWL from the South East of England. MWL currently processes c.145,000 payslips per month which has increased from c.100,000 in 2024/25. <u>Payroll Improvement Project</u> A national payroll improvement programme has been launched by NHS England (NHSE) with the purpose of reducing payroll errors, for Resident Doctors not managed under Lead Employer arrangements. MWL will support clients on the delivery of this plan for their workforce.	
New Ways of Working and Delivering Care (Lead Employer) 2025/26	The Lead Employer (LE) is implementing a transformation programme to improve the experience for doctors in training and reduce unnecessary duplication across the NHS by streamlining transactional interactions with LE. To support this ambition, LE are accelerating the use of Robotic Process Automation (RPA) and - • Implementing SharePoint across all regions to enable host organisations to access real-time	Assurance

	employment information about the Resident Doctors on rotation from the lead employer. Hosts can also provide information about rosters/work schedules to the LE to enable timely processing of the information required for payroll. • Changes to Exception Reporting to simplify processes and improve responsiveness. • Review of new starter processes to improve candidate experience. • Expansion of automation into how rotas/work schedule are processed, to reduce manual processing and improve flow of data between the LE and Payroll Services. Committee was assured that the LE continues to deliver a high-quality, efficient service that meet the evolving needs of clients and stakeholders.	
Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the People Performance Council and Valuing Our People Council. The following policies were noted as being approved. • Personal Relationships at Work • Secondment Policy	Assurance
Any Other Business	None	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Committee Assurance Report			
Title of Meeting	**Trust Board Meeting**	**Date**	24 September 2025
Agenda Item	**TB25/068 (8.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	18 September 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Chief Finance Officer (CFO) Update	• PwC turnaround work across the system is ongoing, with a risk stratification framework having been developed to monitor and oversee financial performance. • Risk stratification is based on factors including 2025/26 CIP materiality, efficiency programme maturity, 2025/26 planned deficit contribution and forecast risk to 2025/26 plan. • MWL has been rated High Risk.	Assurance
External MWL Financial Forecast Deep Dive	• Simon Worthington had conducted a review into MWL's forecast and mitigation plans to deliver the 2025/26 financial position • Report notes that all from the Trust were clear on the scale of the financial challenge and clearly articulated current forecast and associated actions. • £9.8m optimism bias referred in the report has been mitigated in updated Trust forecast. • Recommendations will continue to inform work in progress on controls and mitigations	Assurance
Strengthening Financial Management and Supporting Delivery in 2025/26	• NHS England (NHSE) have set expectations for in-year financial management and interventions to deliver a more financially sustainable NHS. • Guidance from NHSE includes expectations, intervention options and tools to support delivery. • Well-Led Finance Self-Assessment will be completed and presented at October's Finance and Performance Committee for review	Assurance

	• Surviving and Thriving programme from One NHS Finance includes resources and tools to support financial recovery	
Planning Framework	• NHSE have shared a planning document articulating the approach to planning to support the Ten-Year Health Plan. • Five-year plan (2026/27-2030/31) to be developed and signed off by Board before the end of December.	Assurance
Committee Performance Report Month 5 2025/26	• Bed occupancy averages 104.2% in August equating to 77.1 additional patients. General and Acute (G&A) bed occupancy was 97.7%, significantly higher than the target of 92%. • Average length of stay for emergency admissions remains high at 7.9, with 8.5 at Southport and Ormskirk sites and 7.7 at St Helens, Whiston and Newton sites. • Type 1 4-Hour performance was 72.9% in August, below National performance at 75.9% and ahead of Cheshire and Merseyside (C&M) performance at 72.8%. Mapped performance was 78%. • 18 Week performance in August for MWL was 63.6%. National Performance (latest month July) was 61.3% and C&M performance 58.7%. • The Trust had 1,922 52-week waiters at the end of August, 135 65-week waiters and 16 78-week waiters. • Diagnostic performance for July for MWL was 85.1% which remained ahead of national performance at 78.1% but below C&M performance at 88.8% and the target (95%). • Cancer performance for MWL in July deteriorated to 63.4% for the 28-day standard (target 77%) and to 78.8% for the 62-day standard (target 85%).	Assurance
Finance Report Month 5 2025/26	• The approved MWL financial plan for 2025/26 is a deficit of £10.7m. This is a £41m deficit excluding the deficit support funding. • The plan includes £35m of system led strategic opportunities/cost reductions to be realised or reallocated by C&M during 2025/26. • The Trust is reporting a M5 deficit of £33.4m (excluding deficit support funding) which is £2.0m better than plan.	Assurance

	• 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 Cost Improvement Programme (CIP) target is £48.2m. In M5, the target has been exceeded with £20.4m delivered to date, £1.8m above plan. • At M5 agency costs equate to £6.7m (2.4% of total pay costs). • The Trust had a closing cash balance of £3.2m. The Trust's Provider Revenue Support application for £11m was approved and a further circa £11m is being sought from NHSE. • Aged debt has further reduced (debt greater than 90 days at £12.9m in August compared to £13.2m in July) and work is ongoing to reduce this further. • The capital plan for the year totals £64.6m which includes PFI Lifecycle and IFRS16 Lease Remeasurement.	
M5 Forecast	• The Committee reviewed the current forecast based on normalised run-rate. • The Committee noted the current mitigations that had been identified, and further internal and system opportunities that could further bridge the current gap. • The Committee were assured that Trust were evaluating all options in order to deliver the financial plan.	Assurance
Cash Update	• Key risks to cash remain deficit funding being withdrawn and delivery of Income and Expense (I&E) forecast • Provider Revenue Support cash application was approved at £10.9m • Application has been submitted for a further £11m to cover October cash requirement	Assurance
Month 5 2025/26 CIP Programme Update Surgery CIP update	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, which equates to 5% for all departments. • At M5, 134 schemes have been delivered with a further 172 schemes at finalisation stage. Current delivered/low risk schemes have a	Assurance

	value of £52.9m in year equating to 110% of the target and £50.8m recurrently, 105% of the target. • Surgical division update outlined current progress in delivering 2025/26 target of £10.0m. £6.5m delivered and further £1.9m low risk. Focus remains on premium pay reductions and work is underway with Procurement to review further potential non pay schemes. Nursing and clinical colleagues engaged in process of identifying schemes	
CIP Strategy	• CIP Strategy document sets out approach to delivering CIP challenge, focusing not solely on financial savings but also improving clinical outcomes, enhancing care and supporting the Trust's long-term sustainability, • Enablers utilised include Patient Level Costing Information (PLICS), Service Line Reporting (SLR), Business Intelligence (BI), the Quality Impact Assessment (QIA) and Project Initiation Document (PID) process alongside other improvement methodologies and engagement across the organisation.	Assurance
SLR/PLICs Update	• National Cost Collection (NCC) for 2024/25 has been submitted and was prepared in accordance with the guidance. • The self-assessment quality checklist was completed. • Based on available rolling national averages at the time of submission, MWL's unadjusted NCCI for 2024/25 is approximately 96. • Data is expected to be published in late autumn and will be reported to the Committee.	Assurance
Urgent Care Performance Review	• August's all types mapped performance was at 78% against the 76% target. • Ambulance handovers longer than 45 minutes were at 14% for Whiston and 1.53% for S&O sites. • Workstreams are in place with actions taking place in preparation for winter, feeding into the Winter Board Assurance statement	Assurance
Assurance Reports from Subgroups:	Committee noted the assurance reports from the following councils:	Assurance

	• Procurement Steering Council Update • CIP Council Update • Capital Planning Council • Estates & Facilities Management Council Update • IM&T Council update	
Alerts		
None		
Decisions and Recommendation(s):		
The Board note the report		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	24 September 2025
Agenda Item	**TB25/069**				
Report Title	Medical Revalidation Annual Declaration 2024/25				
Executive Lead	Ash Bassi, Acting Chief Medical Officer				
Presenting Officer	Kate Clark, Director of Strategy and Responsible Officer				
Action Required	X	**To Approve**		**To Note**	

Purpose

To present the Annual submission for Appraisal, Revalidation and Medical Governance.

Executive Summary

The report denotes progress against all actions with all doctors connected to MWL undergoing appraisal on a single system supported by a single team. Further work needed to align appraiser capacity to job planned activities and to incorporate learning from peer review into policies.

Financial Implications

Nil

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the Medical Revalidation Annual Declaration 2024/25 for submission to NHS England Northwest.

Strategic Objectives

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

2024-2025 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2025**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Mersey and West Lancashire Teaching Hospitals NHS Trust
What type of services does your organisation provide?	Acute Hospital Care

	Name	**Contact Information**
Responsible Officer	Dr Kathryn Clark	Kate.Clark@merseywestlancs.nhs.uk 0151 430 1134
Medical Director	Dr Peter Williams	Peter.Williams3@merseywestlancs.nhs.uk 0151 430 1134
Medical Appraisal Lead	Dr Stephen Allsup	Stephen.Allsup@merseywestlancs.nhs.uk 0151 430 2419
Appraisal and Revalidation Manager	Kim Harrison	Kim.Harrison@merseywestlancs.nhs.uk
Assistant HR Business Partner	Ann Higgin	Ann.Higgin@merseywestlancs.nhs.uk 01704 704 781
Assistant HR Business Partner	Michelle Langton	Michelle.Langton@merseywestlancs.nhs.uk 0151 430 1650

Service Level Agreement
Do you have a service level agreement for Responsible Officer services?

No.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board of Mersey and West Lancashire Teaching Hospitals NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Comments:	Yes, Dr Kathryn Clark is the Responsible Officer for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes.
Comments:	A review of staffing and systems has taken place, and an appraisal system was introduced across the whole of the MWL medical staff.
Action for next year:	Continue to review resources and processes.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Comments:	The GMC Connect list of doctors is reviewed weekly. A cross check of GMC Connect, all doctors on the electronic staff record system and all doctors listed on the Trusts appraisal system is also completed monthly. Any anomalies are actioned accordingly.

Action for next year:	To ensure the data is reviewed and kept up to date.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	To ensure the successful role out of the revised MWL Medical Appraisal and Revalidation policy for all non-training grade doctors. The policy will be communicated to doctors through various channels including the Trust intranet, emails and medical forums. It will also be included in all emails as part of the escalation process for any doctors who are non-compliant with the appraisal process
Comments:	The Medical Appraisal and Revalidation Policy was further extended until September 2025 following learning identified from peer review (see 1A(v) and is currently under review. Additional policies to support Medical Revalidation are regularly reviewed which include Maintaining High Professional Standards, Handling Medical Concerns, Disciplinary Policy, Remediation Policy, and Grievance Policy.
Action for next year	To ensure the successful role out of the revised MWL Appraisal and Revalidation policies for all non-training grade doctors.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	Incorporate any best practice identified from the initial peer review.
Comments:	MWL took part in a peer review of Warrington and Halton Teaching Hospitals in October 2024. The team found this helpful and informative and have made plans to introduce some best practice, which involves separate Medical Appraisal and Revalidation Policies.
Action for next year:	To support the peer review of Liverpool University Hospitals FT in October 2025 and incorporate further best practice in readiness for the MWL peer review which has been agreed to take place during October 2026.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	To provide consistency across the whole of the organisation in how doctors are provided with governance information to support their appraisal and revalidation.
Comments:	The Trust continues to provide support with appraisal and revalidation for all doctors including those on short term contracts and those working solely on the Trust's medical bank. All of these doctors undergo Trust induction and are provided with relevant information to enable safe working.

	For any doctor with a prescribed connection to another organisation, the Trust will provide information to the doctor and their Responsible Officer to assist their revalidation when requested. Some inconsistency remains between sites regarding how supporting information in relation to any complaints and incidents is provided to doctors to enable reflection. The Trust has recently transitioned to a single incident management system (InPhase) and work is ongoing to standardise this.
Action for next year	To provide consistency across the whole of the organisation in how doctors are provided with governance information to support their appraisal and revalidation.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Comments:	All doctors completing an appraisal whilst working at our Trust are required to declare their whole practice and provide supporting information in their appraisal from any external organisations where they undertake other work. This includes clinical outcome reports where appropriate. Information is provided to the doctor pertaining to work undertaken within the Trust and they are asked to provide information for work undertaken for any other body such as a formal letter of no concerns.
Action for next year:	To continue to improve governance processes to ensure all information relating to the doctor's fitness to practice such as complaints, incidents, and clinical outcome data is provided in a consistent manner

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments:	There is a process in place for any doctors not complying with the GMC/Trust requirements in relation to completion of annual appraisal which includes expected actions.
Action for next year:	Continue review of processes to ensure consistency for all doctors across the trust.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Comments:	We have a policy in place and in date which is currently under review, for all MWL non-training doctors. The revised policy will be presented to the relevant groups for review and ratification i.e. (Local Negotiating Committees (LNC), People Policy Group and People Performance Committee).
Action for next year:	To ensure the successful role out of the revised MWL Medical Appraisal

	and Revalidation policies for all non-training grade doctors, including updating on the trust intranet and referencing in relevant appraisal communications.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	To review the job planning and appraisee allocation process to ensure divisional involvement in confirming appraiser requirements and encouraging appraiser recruitment.
Comments:	As of 31st March 2025, the Trust has a total of 174 trained medical appraisers, both consultants and specialty doctors. They support 906 doctors across the Trust.
Action for next year:	To ensure appraisers are utilised in accordance with their job plan capacity and to ensure divisional involvement in confirming appraiser requirements and to continue to encourage appraiser recruitment.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Comments:	Appraisers are required to participate in relevant continuous professional development to maintain their appraisal skills. The trust provides support to appraisers through the Appraiser Support Groups which are run regularly throughout the year. The doctors are provided with feedback summaries detailing anonymised feedback/commentary from their appraisees. Appraisers have been provided with the facility to undertake online update training from MIAD training.
Action for next year:	To continue to provide appraisers with feedback. To ensure the appraisers are up to date with refresher training.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments:	Appraisal compliance is monitored bi-weekly at the Medical Case Review Meeting and reported to the Strategic People Committee.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	The Annual Submission, Annual Board Report and Statement of Compliance form the basis of reporting to the Strategic People Committee before being presented to the Board and then submitted to NHSE. Appraisal completion rates are published monthly.
Action for next year:	To continue.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Comments:	All doctors are supported and encouraged to ensure they have met the revalidation requirements in a timely manner. Where this does not occur, information is recorded in the appraisal management system.
Action for next year:	To continue.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Comments:	Prior to a recommendation being made to the GMC, the Team will discuss the potential recommendation with the doctor. If any deferral is necessary, this will be discussed with the doctor in advance and an action plan put in place to help facilitate the doctor successfully revalidating in the future. This information will be recorded in the appraisal management system. A Recommendation Assurance Form signed by the RO is also competed and retained on the system. Once any recommendation has been made, the Team will email the doctor to confirm.
Action for next year:	To continue to provide support and assurance to doctors to help them achieve the requirements for a positive revalidation recommendation in the required timescales, avoiding any necessity for deferral where at all possible.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Comments:	There are systems in place for reporting and reviewing incidents, complaints, and clinical performance. Openness and reporting of incidents are encouraged. The trust has implemented the Patient Safety Incident Response Framework (PSIRF). The Medical Director chairs a Clinical Effectiveness Committee and divisions report through this committee as well as through the Quality and Safety Committee. The RO in the organisation is responsible for managing any concerns raised regarding doctors and would involve HR/senior medical management in the organisation as per policy.
Action for next year:	Continue.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Comments:	There are several policies and processes in place that include – • Whistleblowing • Speaking out Safely • PSIRF • Respect and Dignity at Work • Medical Appraisal and Revalidation Policy • Handling Medical Concerns Policy There is a bi-monthly case review meeting to review any concerns or performance issues involving the RO, Head of Medical Workforce, relevant HRBP's and members of the Appraisal and Revalidation Team. Actions are tracked via this forum. This feeds into a Strategic Workforce Review which is chaired by the Director of HR. Quarterly meetings are held between the RO and the GMC's Employer Liaison Advisor to discuss any performance or revalidation issues. The RO meets with the PPA advisor 4-6 times per year and ad hoc as required, to review ongoing concerns and ensure appropriate support is in place. Professional Support and Well-being (PSW) meetings are held monthly. This also includes oversight of international recruits and items would be escalated through medical education or the RO as needed.

Action for next year:	Continue.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Comments:	All non-training grade doctors holding a contract of employment are supported by the Trust and given the resources to undertake an annual appraisal regardless of whether they are employed as a locum or a permanent doctor. Doctors are provided with information in relation to complaints, claims, incidents to enable reflection. This information can be uploaded to the appraisal system.
Action for next year:	To continue to provide doctors with the necessary information to include and reflect upon in appraisal and align processes across sites where necessary.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Comments:	The Strategic Case Review Meeting and Medical Case Review Meetings allows for discussion and reviews of any ongoing cases with senior colleagues across the Trust. Policies to support this would include – • Handling Medical Concerns Policy • Disciplinary Policy • Remediation Policy
Action for next year:	Continue.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Comments:	The RO in the organisation is responsible for managing any concerns raised regarding doctors and would involve HR/senior medical management in the organisation as per policy. There are systems in place for reporting and reviewing significant events, complaints, and clinical performance. Openness and reporting of incidents are encouraged. Numbers, types and outcomes of concerns are discussed at the Employer Relationship Oversight Group (EROG) which feeds into the Trust Board.

	The EROG whose members include a non-executive director, monitor demographics and characteristics of all staff, including doctors involved in performance and practice processes. The Board also receives Workforce Racial Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and gender pay gap reports.
Action for next year:	Continue

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Comments:	When a doctor joins the Trust, a RO Transfer of Information Form is requested. Any concerns received are escalated to the Responsible Officer. Any issues raised in relation to a doctor working at the Trust whether they are directly connected to our trust and working elsewhere or connected to another organisation but working at the Trust would result in RO-to-RO contact being made to transfer any relevant information. Information is transferred electronically via a generic email which is monitored every working day. Should a doctor leave the Trust where concerns had not been resolved and the doctor had not connected to a new designated body, then the GMC ELA would be informed to enable contact to be made with the relevant RO once a new connection had been made. Where appropriate a Health Professionals Alert Notice (HPAN) would be documented on the doctors GMC record.
Action for next year:	Continue.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Comments:	This is monitored through the EROG and reported as described in Section 1D(v). Concerns are also discussed with the PPA.
Action for next year:	Continue.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Comments:	Through trust governance, national reviews, reports, and enquiries are integrated into trust policies and procedures and ultimately reported to the Quality and Safety Committee. Cultural oversight is reported through the Strategic People Committee. The trust has recently undertaken staff engagement to develop new cultural values for MWL. There is a standard agenda item within the Executive Committee to consider any strategic issues that would influence trust governance. From a medical staff perspective, a clinical leadership forum led by the medical director is used as a platform for discussion of any items of relevance.
Action for next year:	Continue.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Comments:	There is a bi-weekly medical case review meeting, in addition to the Professional Standards group (discussing all healthcare professionals) and EROG to ensure consistency and fairness.
Action for next year:	Continue.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Comments:	The system we use in Recruitment is called Trac which is set up to follow the 6 compulsory 6 standard checks for all doctors, including locum and short-term recruits. This includes checks on professional registration, qualifications and fitness to practice; as well as employment history and references to cover the previous 3 years.

Action for next year:	Continue.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Comments:	The Trust has recently engaged with all staff groups to develop and launch MWL values (Kind, open & Inclusive) underpinned by our 5-star patient care framework to deliver Trust Objectives. This promotes continuous improvement, innovation and excellence and all supporting professional activities should be linked to a standard or trust objective. All staff undertake annual appraisals and have opportunities to work towards a personal development plan with objectives that support excellence in clinical care.
Action for next year:	Continue.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Comments:	Trust values and vision continue to promote inclusivity and kindness. The Trust continues to promote equality diversity and inclusion, and a variety of training and education programs are available to managers and staff to improve their knowledge and inclusivity. The Trust is involved in the pilot scheme for Compassionate Conversations which will be incorporated into the clinical director development program.
Action for next year:	Continue.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Comments:	There are several policies and process in place that include – • Whistleblowing • Speaking out Safely • PSIRF • Respect and Dignity at Work Effectiveness of the policies are monitored through the groups previously mentioned reporting through Strategic People Committee. The Trust socialises the information on platforms such as a closed social media page, trust intranet page, weekly Trust Brief Live meetings, posters, daily global emails and weekly MWL newsletters.
Action for next year:	Continue.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Comments:	Where concerns have been raised about a doctor, they are offered support through health and wellbeing as well as the opportunity of a support buddy to enable them to receive any required support. This also acts as a feedback mechanism. Where a doctor has been subject to an investigation, all relevant policies are provided. A named HR contact is also assigned to the doctor. Doctors are asked to provide feedback in relation to their appraisal. For MHPS cases a Non-Executive Director is assigned to oversee and ensure the process is followed in a timely manner.
Action for next year:	Continue.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Comments:	Yes, there is a monthly PSW meeting and a bi-weekly Medical Case Review meeting. Information from both groups is reviewed within the EROG.
Action for next year:	The Trust have recently appointed two new LED leads who will be reviewing and improving the current induction programme and support offered to IMG's. To review all statistics to look for areas of improvements in support.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Comments:	The Responsible Officer and Medical Appraisal and Revalidation Team members attend the Responsible Officer network meetings. The Medical Appraisal and Revalidation Team members also attend local bi-monthly network meetings. The trust took part in a local peer review meeting with two other local trusts in October 2024. The next meetings are scheduled for October 2025 and October 2026.
Action for next year:	Continue.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	906
Total number of appraisals completed	854
Total number of appraisals approved missed	35
Total number of unapproved missed	17
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	132
Total number of late recommendations	1
Total number of positive recommendations	118
Total number of deferrals made	14
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	48
Total number of trained case managers	6
Total number of concerns received by the Responsible Officer[2]	25
Total number of concerns processes completed	31
Longest duration of concerns process of those open on 31 March (working days)	449
Median duration of concerns processes closed (working days)[3]	66.7
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	1
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	131
Total number of new employment checks completed before commencement of employment	131
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Following the creation of MWL, there is now a single appraisal and revalidation team with all doctors on a single appraisal system. Progress has been made against all actions incorporating learning from peer review.
Actions still outstanding
• Agree and implement revised Medical Appraisal and Revalidation Policies. • Ensure consistency of processes incorporating best practice from legacy organisations. • Incorporate best practice from the peer review meeting.
Current issues
- Appraiser capacity
Actions for next year (replicate list of 'Actions for next year' identified in Section 1): • Agree and implement revised Medical Appraisal and Revalidation Policies. • Ensure consistency of processes incorporating best practice from legacy organisations. • Incorporate best practice from the initial peer review meeting. • To review the job planning and appraisee allocation process to ensure divisional involvement in confirming appraiser requirements and encouraging appraiser recruitment. • To provide consistency across the whole of the organisation in how doctors are provided with governance information to support their appraisal and revalidation.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
During the reporting period the Trust has appointed a new Chairman and new Chief Executive Officer. The interim Director of HR was successful in a substantive recruitment process. The Trust is engaging with senior leaders to refresh its strategic direction aligned to the NHS 10 year plan.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of the designated body:	Mersey and West Lancashire Teaching Hospitals NHS Trust

Name:	Malise Szpakowska
Role:	Director of HR
Signed:	
Date:	September 2025

Name of the person completing this form:	Kim Harrison
Email address:	Kim.Harrison@merseywestlancs.nhs.uk

Title of Meeting	**Trust Board**		**Date**	24 September 2025
Agenda Item	**TB25/070**			
Report Title	Statement of Compliance with National Core Standards for Emergency Planning Response & Resilience (EPRR) for 2025/26			
Executive Lead	Lesley Neary, Chief Operating Officer (Accountable Emergency Officer)			
Presenting Officer	Lesley Neary, Chief Operating Officer (Accountable Emergency Officer)			
Action Required	X	**To Approve**		**To Note**

Purpose

The Trust's annual statement of compliance for 2025/26 with EPRR national core standards are required to be approved by the Trust Board prior to submission to the Integrated Care Board (ICB) at the end of September 2025.

This paper seeks approval from the Trust Board for submission.

Executive Summary

NHS England (NHSE) has a statutory requirement to formally assure both itself and the NHS in England of Emergency Preparedness, Resilience and Response (EPRR readiness).

This is provided through the EPRR Core Standards self-assessment annual assurance process.

There is a requirement that this Statement of Compliance is agreed by the organisation's Board/governing body.

Following a Trust self-assessment, and in line with the definitions of compliance, the organisation currently declares that out of 62 areas applicable to acute trusts, the Trust is complaint with 60 areas, giving the Trust a total compliance level of **97%**.

The Trust is therefore able to declare that it is **substantially complaint** against the EPRR Core Standards.

This is an improvement against 81%, partially compliant level reported for MWL the previous year (2024/25) and 44% for 2023/24.

The full statement of compliance, summary of the Trust position against each standard and an action plan to address areas of partial compliance are included in the supporting papers.

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 EPPR Statement of Compliance with National Core Standards for 2025/26 stating substantial compliance and approve the submission noting immediate actions that will be taken to address the remaining areas of partial compliance.

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Emergency Preparedness Resilience and Response (EPRR)

Board Approval Core Standards Self-Assessment 2025-2026

Lesley Neary

Chief Operating Officer (Accountable Emergency Officer)

24th September 2025

Introduction

The EPRR Core Standards self-assessment cover 10 domains:

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and informing
- Cooperation
- Business Continuity
- Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

Each year, alongside the annual assurance process, a ‘deep dive’ is conducted to gain valuable additional insight into a specific area. This year NHS England decided that there is to be no ‘deep dive’.

Number of Applicable Standards

Acute Providers: 62

Specialist Providers: 59

NHS Ambulance Service Providers: 58

Community Service Providers: 58

Patient Transport Services: 42

NHS 111 Service: 43

Mental Health providers: 58

NHS England Region: 47

NHS England National: 45

Integrated Care Boards: 47

Commissioning Support Unit: 39

NHS England Compliance Process

2025/26 EPRR annual assurance process

This year's process largely remains unchanged from 2024/25. The process must promote inclusive, open and transparent dialogue; be supportive and encouraging; and enable the sharing of good practice and continual improvement. The following familiar actions are required as part of this year's assurance process:

- All NHS funded organisations should undertake a self-assessment against the organisation-relevant NHS core standards for EPRR. The compliance level for each standard is defined as:
  - Fully compliant: 100% compliant with the core standards
  - Substantially compliant: 89 - 99% compliant with the core standards
  - Partially compliant: 77 - 88% compliant with the core standards
  - Non-compliant: < 76% compliant with the core standards

The outcome should then be presented and discussed at a public board meeting prior to submission and published in the annual report within the organisation's own regulatory reporting requirements.

Previous EPRR Compliance

With the structural changes in the NHS, particularly the establishment of Integrated Care Boards (ICBs) in July 2022, and the implementation of the updated, more thorough annual assurance process based upon hard evidence to be scrutinised, the Trust has faced challenges in maintaining compliance. Additionally, the merger of St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) with Southport and Ormskirk Hospital NHS Trust (S&O), along with a gap in EPRR service provision, led to a significant decline in compliance levels.

Despite this deterioration, the Trust still achieved the highest compliance percentage in the region for 2023-2024 and, with ongoing efforts from the Head of EPRR, supported by the EPRR Manager, continued to improve compliance for 2024-2025:

- **44% (2023-2024)**: Mersey and West Lancashire Teaching Hospitals NHS Trust was found to be **non-compliant.**
- **81% (2024-2025)**: Mersey and West Lancashire Teaching Hospitals NHS Trust was found to be **partially-compliant.**

Statement of Compliance

Following the Trust's self-assessment and in line with the compliance definitions, the organisation can currently declare compliance and provide hard evidence for 60 out of the 62 areas applicable to acute trusts, resulting in **97% compliance**.

It is important to note, however, that although this represents an increase of **16%** from the previous year's submission, the Core Standards is an annual process, and the EPRR workstream resets to 0% compliance following each submission.

Based on these results, the Trust must declare **substantial compliance** with the EPRR Core Standards for the 2025/2026 period.

This declaration highlights the need for further efforts to address the gaps in compliance and strengthen the Trust's preparedness and resilience in alignment with the Core Standards.

Summary Table 2025/256 vs 2024/25

Domain	Total standards applicable	Fully compliant	2025-2026 Domain %	2024-2025 Domain %
Governance	6	6	100%	83%
Duty to risk assess	2	2	100%	100%
Duty to maintain plans	11	11	100%	55%
Command and control	2	2	100%	100%
Training and exercising	4	4	100%	75%
Response	7	7	100%	100%
Warning and informing	4	4	100%	100%
Cooperation	4	4	100%	100%
Business Continuity	10	8	80%	80%
Hazmat/CBRN	12	12	100%	75%
Total	**62**	**60**	**97%**	**81%**

Appendicies

Appendix 1: Summary of the Trust position against each standard

Domain	Standard name	Standard Detail	Self assessment RAG	Previous Year RAG
Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Fully compliant	Fully compliant
Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Fully compliant	Fully compliant
Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Fully compliant	Fully compliant
Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Fully compliant	Fully compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Fully compliant	Partially compliant
Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Fully compliant	Fully compliant
Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Fully compliant	Fully compliant
Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Fully compliant	Fully compliant
Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Fully compliant	Fully compliant
Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Fully compliant	Fully compliant
Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Fully compliant	Fully compliant
Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Fully compliant	Partially compliant
Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Fully compliant	Partially compliant
Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Fully compliant	Partially compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Fully compliant	Fully compliant
Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Fully compliant	Partially compliant
Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Fully compliant	Fully compliant
Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	Fully compliant	Partially compliant
Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Fully compliant	Partially compliant
Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Fully compliant	Fully compliant
Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Fully compliant	Fully compliant
Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Fully compliant	Fully compliant
Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Fully compliant	Fully compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Fully compliant	Fully compliant
Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Fully compliant	Partially compliant
Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Fully compliant	Fully compliant
Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Fully compliant	Fully compliant
Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Fully compliant	Partially compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Fully compliant	Fully compliant
Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Fully compliant	Fully compliant
Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Fully compliant	Fully compliant
Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Fully compliant	Fully compliant
Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Fully compliant	Partially compliant
Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Fully compliant	Fully compliant
Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Fully compliant	Fully compliant
Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Fully compliant	Fully compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Fully compliant	Fully compliant
Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Fully compliant	Fully compliant
Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Fully compliant	Fully compliant
Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Fully compliant	Fully compliant
Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Fully compliant	Partially compliant
Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Fully compliant	Partially compliant
Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Fully compliant	Partially compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially compliant	Fully compliant
Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Fully compliant	Fully compliant
Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Fully compliant	Fully compliant
Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Fully compliant	Fully compliant
Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Partially compliant	Fully compliant
Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Fully compliant	Fully compliant
Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Fully compliant	Fully compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Fully compliant	Fully compliant
Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Fully compliant	Fully compliant
Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Fully compliant	Fully compliant
Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Fully compliant	Partially compliant
Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Fully compliant	Partially compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Fully compliant	Fully compliant
Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Fully compliant	Fully compliant

Appendix 1: Summary of the Trust position against each standard (cont.)

Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Fully compliant	Fully compliant
Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Fully compliant	Partially compliant
Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Fully compliant	Partially compliant
Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Fully compliant	Fully compliant
Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Fully compliant	Fully compliant

Appendix 2: Action plan to address the areas of partial compliance

Domain	Standard name	Standard Detail	Self assessment RAG	Action to be taken	Lead	Timescale
Business Continuity	Business Continuity Plans (BCP)	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Partially compliant	10 month rolling programme to support areas to complete new BIA and BC Template as per the NHS Toolkit	AM	10 Months
Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Partially compliant	to complete BC audit following roll out of new BIA and BCP Templates	AM	12 months

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	24 September 2025
Agenda Item	**TB25/071**			
Report Title	Learning from Deaths Annual Report 2024/25			
Executive Lead	Ash Bassi, Acting Chief Medical Officer			
Presenting Officer	Sarah O'Brien, Chief Nursing Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

To summarise the work carried out by the Learning from Deaths Team at Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) over the last 12 months and the learning which has been made following the review of deaths which have occurred.

Executive Summary

MWL has well-established processes to review deaths occurring in hospital and identifying areas of learning to ensure continuous improvement of patient care.

The teams involved in review and Learning from Deaths (LFD) work together to ensure that the processes of review are robust and consistent, and that learning is shared to across the Trust. Divisions will create action plans and evidence their completion to address any concerns. Where concerns have been identified these have been escalated as appropriate via the Trust's Patient Safety processes.

LFD process continues to support the ongoing staff education programmes to improve the recognition of patients being sick enough to die, decision making and care at the end of life.

The appointment of an Assistant Medical Director for Patient Safety (Learning from Deaths, Claims and Inquests) will enable the development of a single process across the Trust

Financial Implications

Nil

Quality and/or Equality Impact

The LFD process promotes continuous learning to foster a culture which leads to ongoing improvement of care, pathways and services for all patients.

Recommendations

The Board is asked to note the Learning from Deaths Annual Report 2024/25.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems

	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

Learning from the deaths of people in their care can help healthcare providers improve the quality of the service which they provide to patients and identify where these could be improved.

A CQC review in December 2016, *"Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England*" found some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care.

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. We are now helping trusts to meet the requirements of the new guidance.

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has embraced the Learning from Deaths (LFD) Process to encourage continuous improvement and enable lessons to be learned when patients die in hospital.

2. Approach to Mortality Review across the Trust

Both legacy Trusts at MWL have different process for reviewing and learning from deaths. Although there are differences in the approach, both provide robust, consistent and transparent review of deaths in hospital. Once a new Medical Director and in turn and new lead for Learning from Deaths is in place, work can commence to align the two processes into one across MWL

	Process	**Reporting to**
Southport and Ormskirk Hospitals	All deaths in hospital reviewed by Medical Examiner Team. Outcome recorded on Careflow system. Any concerns around lapses in care are referred for Structured Judgement Review (SJR) and logged on InPhase and reviewed via the NHS Patient Safety Incident Response Framework (PSIRF) Mortality Outcomes Group reviews learning from ME reviews and SJRs.	Clinical Effectiveness Council
Whiston and St Helens Hospitals	ME and LFD processes are separate Deaths in hospital within scope are referred for SJR and reviewed at Mortality Surveillance Group. Any concerns around lapses in care logged on InPhase and reviewed via PSIRF.	Clinical Effectiveness Council

Interviews for the post of Assistant Medical Director for Patient Safety (Learning from Deaths, Claims and Inquests) will be held on 25th September 2025. The newly appointed AMD will, along with the patient safety team, be responsible for the alignment of processes across the Trust to bring them together under one system.

3. Annual Review of Deaths across MWL 2024/25

In 2024/25, for deaths occurring in Whiston and St Helens Hospitals, there have been 229 SJRs requested to date. Of these, 86 have been completed. Delays in SJR have been caused by a reduction in the number of SJR reviewers and the introduction of the InPhase system. All deaths are also subject to Medical Examiner scrutiny and any deaths which occur as a result of a patient safety incident will be logged and investigated immediately via PSIRF. The outcomes of the completed reviews are shown below.

	24/25 Q1 (Datix)	24/25 Q2 (Datix)	24/25 Q3 InPhase)	24/25 Q4 (InPhase)	Total
RED	0	0	0	0	
AMBER	2	0	1	0	
GREEN	32	16	0	0	
GREEN - WITH LEARNING	15	3	3	0	
GREEN WITH LEARNING - POSITIVE FEEDBACK	9	4	2	0	
NOT YET REVIEWED	6	23	24	70	
Total	64	46	30	70	

Amber cases have been logged on InPhase and are being reviewed via the Patient Safety Incident Response Framework. Amber cases are discussed at Mortality Surveillance Group and may be downgraded following a more detailed review.

In 2024/25, for deaths occurring at Southport and Ormskirk Hospitals, 610 case record reviews occurred, with 18 proceeding to SJR following Medical Examiner scrutiny. The switch to Inphase initially prevented identification of SJR referrals being tracked from Q3 onwards however a workaround is now in place and a retrospective review is being undertaken. Q4 results are currently under review by the LFD Team at Southport Hospital.

	24/25 Q1 SJR / ME	24/25 Q2 SJR / ME	24/25 Q3 SJR / ME	24/25 Q4 SJR / ME	Total SJR / ME
Red	0/0	0/0	0/0	**	0/0
Amber	2/5	1/1	0/2	**	3/8

Green with learning	2/21	2/10	0/7	**	4/38
Green With Positive Feedback	0/32	0/23	0/37	**	0/92
Green	2/151	9/146	0/175	**	11/472
Total	6/209	12/180	0*/221	**	18/610

4. Lessons learned and action taken following Mortality Reviews in 2024/25

Patients on home ventilation

There is a new protocol on the Trust Electronic Prescribing and Medicines Administration (EPMA) system for patients who receive home ventilation (CPAP or NIV/BiPAP). This is prescribed on admission for patients who have their own home ventilation machine and prompts nursing staff to assist the patient to use their own machine whilst they are a hospital inpatient.

This protocol is used for patients who are stable from their respiratory condition and have pre-existing home ventilation. Patients who usually use home ventilation but have developed a respiratory acidosis are be discussed with the on-call team before using this protocol or if their respiratory condition changes during their inpatient stay.

Thoracic imaging in older patients with suspected chest trauma

All patients with who are admitted with a significant mechanism of injury or penetrating chest injury should undergo a CT chest.

If the patient is >65 years, they should also undergo a CT chest if they meet any of the following criteria:

1. They have a diagnosis of COPD or chronic lung disease
2. They are currently taking anticoagulation
3. They are found to be hypoxic (sats <94% or <88% with chronic lung disease)

The Thoracic Injuries Pathway is available for all clinical staff on the Intranet

PICC (Peripherally inserted central catheter) learning

PICC lines are an alternative to traditional central venous catheters and tunnelled catheters, with the advantage of patient comfort, reduced insertion complications, reduced infection rates and ease of placement. They have the potential to provide continuous venous access for patients throughout the duration of a treatment episode and are especially useful

Once inserted, the PICC must not be used until the position of the catheter has been confirmed by x-ray. The x-ray must be reviewed by a competent staff member to determine correct positioning of device.

The Policy for the placement and care of all indwelling intravenous and subcutaneous catheters is available for clinical staff on the intranet.

Respect of patient's DNACPR

A patient with complex underlying medical conditions and learning difficulties, had previously expressed that he would not wish to receive CPR in the event of a cardiac arrest. Although the patient did not bring his DNACPR form into hospital with him, a new form was completed in accordance with

Trust policy. When he suffered an unexpected cardiac arrest, his wishes were respected, and he was allowed to die peacefully. The death was reviewed and no issues were identified with his care.

DNACPR communications on Transfer

On the patient transfer form which is completed when a patient moves from ED to an inpatient area, there is a specific box to indicate a DNACPR in place which must be ticked and the lilac DNA-CPR form must be placed prominently at the front of the casenotes.

Imaging with contrast

Inpatients who receive imaging with contrast are at a higher risk of renal complications if their hydration is not correctly managed. Patients undergoing contrast enhanced scans should be considered for intravenous pre-hydration if this is appropriate. Guidance for fluid management is available on the Intranet

Observe caution in the use of Lorazepam in the elderly.

Caution must be exercised in the use of sedatives in the elderly who are suffering from agitation. The principle to follow is "***Start low and go slow***". Low dose Haloperidol should be considered as the first line or Lorazepam if haloperidol is contraindicated.

Guidance for clinical staff is given in the Delirium assessment and management proforma of the intranet.

Communication with families / carers

At times of emotion and distress, families and carers may not retain information which has been given to them about their loved ones and may not understand the diagnosis or prognosis. This may be even more challenging over the telephone. Staff must remain aware of verbal and physical cues from families and carers suggesting key messages haven't been fully appreciated, in order to allow these to be reinforced accordingly

Appendix 1: Forums and channels where learning is shared within the Trust

Forum/Communication Channel	Chair	Support
Quality Committee	Gill Brown	Joanne Newton
Finance & Performance	Steve Connor	Laura Hart
Clinical Effectiveness Council	Ash Bassi	Helen Burton
Patient Safety Council	Rajesh Karimbath	Helen Burton
Patient Experience Council	Carol Fowler	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email		Jane Bennett
Medical Division Safety and Governance Meeting	David Snow/Gemma Causer	Joy Woosey
Surgical Division Safety and Governance Meeting	John McCabe/Helen Hurst	Gina Friar
Women and Children's Division Safety and Governance Meeting	Kevin Thomas/Sue Orchard	Julie Rigby
Community and Clinical Support Division Safety and Governance Meeting	Vinod Gowda/Tracy Greenwood	Sam Barr
ED and AMU Teaching	Ragit Varia/Sarah Langston/Michael Aisbitt	Ann Thompson
FY Teaching	Sue Priestly (W&StH)/Paul Stockton(S&O)	

Title of Meeting	**Trust Board**		**Date**	24 September 2025
Agenda Item	**TB25/072**			
Report Title	Statutory Pay Gap Annual Declaration 2024/25			
Executive Lead	Malise Szpakowska, Chief People Officer			
Presenting Officer	Malise Szpakowska, Chief People Officer			
Action Required	X	**To Approve**		**To Note**

Purpose

The report the Trust Gender Pay Gap as per regulations, and the disability, ethnicity and sexuality pay gaps as per the NHS High Impact Actions.

Executive Summary

This report outlines the Trust's statutory pay gaps for Gender, Ethnicity, Disability, and Sexuality as of March 2025, in line with the Equality Act 2010 and NHS Equality, Diversity, and Inclusion (EDI) High Impact Actions.

Key Findings

- **Gender Pay Gap**: Has reduced from 30% to 24.5% in year (Mean 24.52%, Median 8.11%. The bonus gap is mixed, with a small mean gap in favour of women (improvement from 2024)
- **Disability Pay Gap**: Has remained fairly stable however the median has increased (Mean 12.71%, Median 10.46%) suggesting more disabled staff in lower paid roles. Bonus gap favours non-disabled staff.
- **Ethnicity Pay Gap**: Remains in favour of ethnic minorities (Mean -32.52%, Median -19.38%). The bonus gap also favours ethnic minorities.
- **Sexuality Pay Gap**: Mean 5.46%, Median 5.52%. Bonus gap has widened favouring heterosexual staff.

Analysis

- Gender gaps are driven by underrepresentation of women in senior medical roles.
- Ethnic minority staff are more represented in higher-paid medical roles.
- Disability and sexuality gaps are affected by low disclosure rates and uneven distribution across pay bands.
- Bonus gaps are influenced by changes to Clinical Excellence Awards, now favouring national awards.

Action Plan (2025–2026)

- Embedding of ED&I objectives in appraisals for this recent appraisal window.
- Continuation of career progression programmes for people from ethnic minority backgrounds, disabled, and female staff.
- Continue to improve disability disclosure and review our reasonable adjustment processes.
- Expand inclusive learning and development resources.

Financial Implications

Not applicable

Quality and/or Equality Impact

This report is a legal requirement under the specific equality duties of the Equality Act 2010.

Recommendations	
The Board is asked to approve the Statutory Pay Gap Annual Declaration 2024/25.	
Strategic Objectives	
	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
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Statutory Pay Gap Report
2025

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1. Introduction

In accordance with *The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017*, and the NHS EDI Improvement Plan (2023[1]), Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) is pleased to report its annual Statutory Pay Gaps for Gender (Sex), Ethnicity, Disability, and Sexuality, for March 2025, specifically the:

- mean pay gap,
- median pay gap,
- proportion of each comparison group in 4 equal population quartiles,
- mean bonus pay gap,
- median bonus pay gap,
- proportion of each comparison group receiving a bonus payment.

The data reported in relation to the mean and median pay gaps and the population quartiles corresponds to the employee population as of the 31st March 2025; and the mean and median bonus pay gaps correspond to any bonus pay paid in the period of the 1st April 2024 to 31st March 2025 and where the recipients were still employed in March 2025.

1.1. About Mersey and West Lancashire Teaching Hospital NHS Trust

Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) provides acute and community healthcare services at Ormskirk and District General Hospital, Southport and Formby District General Hospital, St Helens Hospital, and Whiston Hospital; Community Intermediate Care services at Newton Community Hospital in Newton-le-Willows, and an Urgent Treatment Centre, operating from the Millennium Centre, in the centre of St Helens.

The Trust is also the "Lead Employer" for over 13,000 doctors in training who are employed by the Trust but are in placement across the country. *Lead Employer data is not included within this report.

1.2. What is the Statutory Pay Gap

The statutory pay gap is defined in the Act as the difference between the average hourly rate of earnings between two population groups, expressed as a percentage.

For the purposes of this report the following comparisons are included:

- Male v Female[2],
- No Known Disability v Known Disability,
- White v Ethnic Minority,
- Heterosexual v Lesbian, Gay, Bisexual & Other sexuality (LGBO).

Where the pay gap is a positive black number, the pay gap is in favour of the baseline population group (men, no known disability, white, heterosexual); and where the pay gap is a negative red number, the pay gap is in favour of the comparator group (women, known disability, ethnic minority, and LGBO).

[1] NHS EDI High Impact Action 3

[2] For the purposes of *The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017*, the term gender is synonymous with the protected characteristic of 'Sex' and as such a Gender Pay Gap is a comparison between Men/Male and Women/Female.

For the pay gap calculation, an employee means all posts/assignments that were paid in March 2025 and who received 100% of their expected hourly rate of pay (without deductions because they were on leave). These are known as the Full Pay Relevant Employees.

The Hourly rate of pay means the total amount of pay received by a post/assignment in March 2025, including enhancements, but excluding overtime. Any salary sacrifice payments are deducted, including pension, car loan scheme etc; and the final amount is divided by the number of hours worked to provide each post/assignment with an hourly rate of pay.

The Bonus Pay Gap is calculated from the total amount of Bonus Payments received in the 12-month period up to the snapshot date with the mean and median bonus pay gap calculated from the total value.

A pay gap of 5% or higher requires the Trust to take action to address the gap. A pay gap of 3-5% should be monitored, and if it persists action should be taken to reduce it. A pay gap of <3% is statistically insignificant and no action is required.

1.3. Bonus Payments

For the purpose of this report, Bonus Pay is a reference to the Local and National Clinical Excellence Awards (CEA) / Clinical Impact Awards (CIA). The CEA/CIA are a bonus scheme that is limited to eligible consultants only, to recognise clinical excellence in delivering services, leadership, education, and research.

An annual Local Clinical Excellence / Impact Awards round ceased[3] from the 1 April 2024 meaning that no new LCEA are included in the 2025 pay data. The value of these awards was redirected into medical pay. Pre-2018 LCEA will still be included were eligible, as well as national level awards.

1.4. Data source for Pay Gap

The data for the Pay Gap is provided by an inbuilt report in the Electronic Staff Record (ESR). Once data categories are selected for inclusion, the report automatically provides the data used for all of the pay gap data categories.

The ESR report only reports data based on employee sex. To enable the pay gap for other characteristics to be completed, the Trust ESR Team merges additional data categories with the ESR report.

The Ethnicity and Sexuality population have high levels of “unknown” and “decline” data records. To complete the calculation these are removed from the population. This is sufficient to complete the mean, median, bonus mean, bonus median and quartile population calculations.

However, the Bonus Pay Population (Pay Relevant Employees) cannot be calculated from the report because it does not include the detailed population list from which the correct population can be identified.

Therefore, when calculating the bonus pay population, the relevant Full Pay Relevant Population is used instead. This is indicated by an asterix (*).

[3] NHS Employers (2025)

2. Summary

The high-level figures for each pay gap are outlined in Table 1.

Table 1: High Level Summary Pay Gap Figures

	Male v Female	White v BME	No Disability v Known Disability	Heterosexual v LGBO
Total Workforce				
Mean	24.52	-32.52	12.71	5.46
Median	8.11	-19.98	10.46	5.52
Bonus Mean	-2.18	-5.54	71.62	81.13
Bonus Median	3.24	-3.24	54.43	69.33
Agenda for Change Only				
Mean	-0.18	-1.46	4.38	4.27
Median	-4.80	-12.32	5.94	3.44
Bonus Mean	n/a	n/a	n/a	n/a
Bonus Median	n/a	n/a	n/a	n/a
Medical & Dental Only				
Mean	9.21	4.00	10.13	20.74
Median	13.21	12.74	3.20	42.62
Bonus Mean	-2.18	-5.54	71.62	81.33
Bonus Median	3.24	-3.24	54.44	69.33

3. Gender Pay Gap

3.1. Population Summary

On the snapshot date of the 31st March 2025, the following number of full pay relevant employees (from now on 'employees') were included in the data analysis:

Table 2: Trust Population by Sex

	# Total	# Female	# Male	% Female	% Male
Total	11,359	8940	2419	78.7%	21.3%
AfC	10,233	8449	1784	82.6%	17.4%
M&D	1126	491	635	43.6%	56.4%

3.2. Mean Gender Pay Gap

The mean gender pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole male population, and the average hourly income of the whole female population expressed as a percentage.

Table 3: Mean Gender Pay Gap

	Trust	AfC	M&D
Female	£19.95	£18.54	£44.21
Male	£26.43	£18.51	£48.69
Difference	£6.48	£0.03	£4.48
% Pay Gap	**24.52%**	**-0.18%**	**9.21%**

3.3. Median Gender Pay Gap

The median gender pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole male population (from smallest to largest), and the middle value hourly income of the whole female population expressed as a percentage

Table 4: Median Gender Pay Gap

	Trust	AfC	M&D
Female	£17.55	£16.97	£42.17
Male	£19.09	£16.20	£48.59
Difference	£1.54	£0.77	£6.42
% Pay Gap	**8.11%**	**-4.80%**	**13.21%**

3.4. Proportion of males and females in each pay quartile

To calculate the population quartiles, and allow comparisons with other organisations, the total population is divided into 4 equal sizes, ranked from the smallest to largest by hourly rate of pay. Quartile 1 represents the lower and 4 the higher. The total number of men and women are counted in each quartile to produce the quartile populations.

Table 5: Quartile Populations (Sex)

	# Female	# Male	% Female	% Male
Quartile 1	2305	535	81.2%	18.8%
Quartile 2	2284	556	80.4%	19.6%
Quartile 3	2378	462	83.7%	16.3%
Quartile 4	1973	866	69.5%	30.5%

3.5. Mean and Median Bonus Gender Pay Gaps

For this report, Bonus Pay is a reference to the Local and National Clinical Excellence Awards (CEA) / Clinical Impact Awards (CIA). The CEA/CIA are a bonus scheme that is limited to eligible consultants only, to recognise clinical excellence in delivering services, leadership, education, and research.

An annual Local Clinical Excellence / Impact Awards round ceased[4] from the 1 April 2024 meaning that no new LCEA are included in the 2025 pay data. The value of these awards was redirected into medical pay. Pre-2018 LCEA will still be included were eligible, as well as national level awards.

Consequently, the number of employees within the Bonus Pay sample has decreased significantly by 66% from 373 (2024) to 128 (2025).

The National CEA / CIA are awarded via a national competitive process and awarded via a regional/national assessment process. However, the payment of these awards is via the Trust payroll and are therefore included in the pay calculations.

The population used to calculate the Bonus Pay Gap is based on the total workforce, whether or not they are classed as Full Pay Relevant in the March 2025 snapshot date. This is to ensure that any person who received a bonus payment from the 1st April 2024 to the following 31st March 2025, and

[4] NHS Employers (2025)

where they are still employed on the 31st March 2025, are included within the data. This group is known as the Pay Relevant Population.

Therefore, the total workforce population (Pay Relevant Employees) was 12,445 posts, of which 128 received a bonus payment. The mean and median bonus gender pay gaps were as follows:

Table 6: Mean Bonus Gender Pay Gap

Sex	Mean	Median
Female	£9125.7	£5653.7
Male	£8931.4	£5842.9
Difference	£194.3	£189.2
% Pay Gap	**-2.18%**	**3.24%**

3.6. Proportion of males and females receiving a bonus payment

Table 7 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were male and female.

Table 7:Number of Bonus Pay recipients.

Sex	MWL
% Female receive Bonus Pay	0.3%
% Male receive Bonus Pay	3.7%
% Bonus Pay recipients Female	23.4%
% Bonus Pay Recipients Male	76.6%

4. Disability Pay Gap

4.1. Introduction

The Disability Pay Gap is a comparison between the No Known Disability population v the Known Disability population. Where an employee is recorded as Unknown, Blank or Decline, these have been counted as No Known Disability.

The following calculations are based only on data held within the Electronic Staff Record (ESR), which is known to hold underreported disability figures.

4.2. Population summary

On the snapshot date of the 31st March 2025, the following number of employees were included in the data analysis:

Table 8: Trust Population by Disability

	# Total	# Dis	# No Dis	% Dis	% No Dis
Total	11,359	710	10,649	6.3%	93.7%
AfC	10,233	681	9552	6.7%	93.3%
M&D	1126	29	1097	2.6%	97.4%

4.3. Mean Disability Pay Gap

The mean disability pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole No Known Disability population, and the average hourly income of the whole Known Disability population expressed as a percentage.

Table 9: Mean Disability Pay Gap

	Trust	AfC	M&D
Disability	£18.77	£17.77	£42.12
No Disability	£21.50	£18.59	£46.86
Difference	£2.73	£0.82	£4.74
% Pay Gap	**12.71%**	**4.38%**	**10.13%**

4.4. Median Disability Pay Gap

The median disability pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole No Known Disability population, (from smallest to largest), and the middle value hourly income of the whole Known Disability population expressed as a percentage.

Table 10: Median Disability Pay Gap

	Trust	AfC	M&D
Disability	£16.15	£15.85	£44.33
No Disability	£18.04	£16.85	£45.80
Difference	£1.89	£1.00	£1.47
% Pay Gap	**10.46%**	**5.94%**	**3.20%**

4.5. Proportion of No Known Disability and Known Disability staff in each pay quartile

To allow the trust to compare the distribution of No Known Disability and Known Disability staff within its pay structure with those from different organisations, the population is ranked in order of pay and divided equally into 4 population quartiles, where quartile 1 is the lowest and 4 the higher.

The total number of No Known Disability and Known Disability staff are counted in each to produce the quartile populations

Table 11: Quartile Populations (Disability)

	# Dis	# No Dis	% Dis	% No Dis
Quartile 1	232	2608	8.2%	91.8%
Quartile 2	185	2665	6.5%	93.5%
Quartile 3	174	2666	6.1%	93.9%
Quartile 4	129	2710	4.5%	95.5%

4.6. Bonus Disability Pay Gap

4.6.1. Mean and Median Bonus Disability Pay Gaps

The mean and median bonus disability pay gaps were as follows:

Table 12: Mean Bonus Disability Pay Gap

	Mean	Median
Disability	£2576.4	£2576.4
No Disability	£9078.5	£5653.7
Difference	£6502.1	£3077.3
% Pay Gap	**71.62%**	**54.43%**

4.6.2. Proportion of No Known Disability and Known Disability staff who received a bonus payment

Table 13 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were Known Disabled and No Known Disability.

Table 13: Number of Bonus Pay recipients.

	MWL
% Dis receive Bonus Pay	0.3%*
% No Dis receive Bonus Pay	1.2%*
% Bonus Pay recipients Dis	1.6%
% Bonus Pay Recipients No Dis	98.4%

5. Ethnicity Pay Gap

5.1. Introduction

The Ethnicity Pay Gap is a comparison between the White population v the combined ethnic minority population.

White includes White British, White Irish, Gypsy/Traveller, and Other White Background.

The ethnic minority population includes Bangladeshi, Chinese, Indian, Pakistani, White & Asian, Other Asian background; African, Caribbean, White & Black African, White & Black Caribbean, Other Black background; Arab, Other Mixed background, and Other Ethnicity.

379 pay records have no known Ethnicity (including 268 AfC, 111 M&D, and 5 Bonus pay records), accounting for 3.3% of the population. For the purposes of the following calculations these records have been omitted.

5.2. Population Summary

On the snapshot date of the 31st March 2025, the following number of employees were included in the data analysis:

Table 14: Trust Population by Ethnicity

	# Total	# EthMin	# White	% EthMin	% White
Total	10980	1966	9014	17.9%	82.1%
AfC	9965	1406	8559	14.1%	85.9%
M&D	1015	560	455	55.2%	44.8%

5.3. Mean Ethnicity Pay Gap

The mean ethnicity pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole White population, and the average hourly income of the whole Ethnic Minority population expressed as a percentage.

Table 15: Mean Ethnicity Pay Gap

	Trust	AfC	M&D
EthMin	26.69	18.78	46.40
White	20.14	18.51	48.33
Difference	£6.55	£0.24	£1.93
% Pay Gap	**-32.52%**	**-1.46%**	**4.00%**

5.4. Median Ethnicity Pay Gap

The median ethnicity pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole White population (from smallest to largest), and the middle value hourly income of the whole Ethnic Minority population expressed as a percentage.

Table 16: Median Ethnicity Pay Gap

	Trust	AfC	M&D
EthMin	£20.26	£18.49	£45.22
White	£16.97	£16.46	£51.82
Difference	£3.29	£2.03	£6.60
% Pay Gap	**-19.38%**	**-12.32%**	**12.74%**

5.5. Proportion of White and Ethnic Minority staff in each pay quartile

To allow the trust to compare the distribution of White and Ethnic Minority staff within its pay structure with those from different organisations, the population is ranked in order of pay and divided equally into 4 population quartiles, where quartile 1 is the lowest and 4 the higher. The total number of White and Ethnic Minority staff are counted in each to produce the quartile populations.

Table 17: Quartile Populations (Ethnicity)

	# EthMin	# White	% EthMin	% White
Quartile 1	191	2554	7.0%	93.0%
Quartile 2	471	2274	17.2%	82.8%
Quartile 3	636	2109	23.2%	76.8%
Quartile 4	668	2077	24.3%	75.7%

5.6. Bonus Ethnicity Pay Gap

5.6.1. Mean and Median Bonus Ethnicity Pay Gap

The mean and median bonus ethnicity pay gaps were as follows:

Table 18: Mean Bonus Ethnicity Pay Gap

Ethnicity	Mean	Median
EthMin	£9568.6	£6032.0
White	£6066.4	£5842.9
Difference	£3502.3	£189.2
% Pay Gap	**-5.54%**	**-3.24%**

5.6.2. Proportion of White and Ethnic Minority staff who received a bonus payment

Table 19 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were White and Ethnic Minority.

Table 19: Number of Ethnicity Bonus Pay recipients.

Ethnicity	MWL
% EthMin receive Bonus Pay	2.6%*
% White receive Bonus Pay	0.8%*
% Bonus Pay recipients EthMin	41.5%
% Bonus Pay Recipients White	58.5%

6. Sexuality Pay Gap

6.1. Introduction

The Sexuality Pay Gap is a comparison between the known Heterosexual population v the combined Lesbian, Gay, Bisexual and Other sexuality population (LGBO).

1295 pay records have no known sexual orientation (of which 1107 AfC, 188 M&D, and 36 Bonus pay records), accounting for 11.4% of the population. For the purposes of the following calculations these records have been omitted.

6.2. Population Summary

On the snapshot date of the 31st March 2025, the following number of employees were included in the data analysis:

Table 20: Trust Population by Sexuality

	# Total	# LGBO	# Hetero	% LGBO	% Hetero
Total	10064	395	9669	3.9%	96.1%
AfC	9126	350	8776	3.8%	96.2%
M&D	938	893	45	4.8%	95.2%

6.3. Mean Sexuality Pay Gap

The mean sexuality pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole Heterosexual population, and the average hourly income of the whole LGBO population expressed as a percentage.

Table 21: Mean Sexuality Pay Gap

	Trust	AfC	M&D
LGBO	£19.92	£17.75	£36.85
Heterosexual	£21.07	£18.54	£46.49
Difference	£1.15	£0.79	£9.64
% Pay Gap	5.46%	4.27%	20.74%

6.4. Median Sexuality Pay Gap

The median sexuality pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole Heterosexual population (from smallest to largest), and the middle value hourly income of the whole LGBO population expressed as a percentage.

Table 22: Median Sexuality Pay Gap

	Trust	AfC	M&D
LGBO	£16.86	£16.18	£26.53
Hetero	£17.85	£16.76	£46.23
Difference	£0.99	£0.58	£19.70
% Pay Gap	**5.52%**	**3.44%**	**42.62%**

6.5. Proportion of Heterosexual and LGBO staff in each pay quartile

To allow the trust to compare the distribution of Heterosexual and LGBO staff within its pay structure with those from different organisations, the population is ranked in order of pay and divided equally into 4 population quartiles, where quartile 1 is the lowest and 4 the higher. The total number of Heterosexual and LGBO staff are counted in each to produce the quartile populations.

Table 23: Quartile Populations (Sexuality)

	# LGBO	# Hetero	% LGBO	% Hetero
Quartile 1	111	2405	4.4%	95.6%
Quartile 2	102	2414	4.1%	95.9%
Quartile 3	98	2418	3.9%	96.1%
Quartile 4	84	2432	3.3%	96.7%

6.6. Bonus Sexuality Pay Gap

6.6.1. Mean and Median Bonus Sexuality Pay Gaps

The mean and median bonus sexuality pay gaps were as follows:

Table 24: Mean Bonus Sexuality Pay Gap

	Mean	Median
LGBO	£1734.2	£1734.2
Heterosexual	£9190.3	£5653.7
Difference	£7456	£3919.5
% Pay Gap	**81.13%**	**69.33%**

6.6.2. Proportion of Heterosexual and LGBO staff who received a bonus payment

Table 25 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were Heterosexual and LGBO.

Table 25: Number of Sexuality Bonus Pay recipients.

	MWL
% LGBO receive Bonus Pay	0.3%*
% Hetero receive Bonus Pay	0.9%*
% Bonus Pay recipients LGBO	1.1%
% Bonus Pay Recipients Hetero	98.9%

7. Discussion

Our analysis shows that the key cause of the Trust Pay Gaps continues to be the inclusion of the Agenda for Change, and Medical & Dental pay T&C within the single calculation.

This has a significant effect of influencing the data, in particular for the gender and ethnicity pay gaps. When considering the AfC and M&D separately, for the latter, the pay gap as in the 2024 Statutory Pay Report reduces significantly to be in favour of both women and ethnic minority employees, and in some instances, to statistically insignificant levels.

The Trust understand that the reporting requirements of the statutory regulations is based on the whole Trust approach, but in terms of our analysis and subsequent actions, our aim is to understand where the most significant impacts are occurring, and take steps to address these.

Our key observations include:

- Although the Trusts workforce is 79% female, pay gaps continues to exist. This is predominantly impacted by the lower proportion of women in senior medical roles, as well as the smaller proportion of men in Bands 1-4. It will take time for parity to be achieved in the medical senior leadership as women progress in their careers. We are determined to ensure that there are no discriminatory barriers to this progression.
- Although the pay gaps are generally in favour of ethnic minorities, we recognise that we still have work to do to make the Trust inclusive and supportive, and truly Anti-Racist. This activity is not specifically related to reducing the ethnicity pay gaps but linked to the opportunities for ethnic minority staff to progress, and to address any negative day to day experiences because of their ethnicity.
- The disability and sexuality pay gaps are relatively low, but there is a high degree of uncertainly relating to the validity of the data. The official disability disclosure rate of 6-7% is far lower than reporting figures within the staff survey, and 1295 employees have not answered the sexual orientation monitoring question. We welcome the lower reported pay gaps for these groups but recognise that work is needed to ensure the data set is robust, and that this is not a statistical anomaly.

Below we summarise the key causes for each respective protected characteristic.

7.1. Gender Pay Gap

The main cause of the Trusts (MWL) Gender Pay Gap are:

- **Total Gender Pay Gap**: A far larger proportion of male employees are Medical & Dental (26.3%) compared to women (5.5%) which have higher starting salaries, pay scales and enhancements compared to those on Agenda for Change. For examples, the starting salary of a Foundation 1 doctor is the equivalent to the Band 5 on AfC. With 45% of the female employees earning less than a F1, this causes a significant pay disparity for the total workforce.
- **AfC Gender Pay Gap**: The mean pay gap is statistically insignificant whilst slightly favouring women, with a higher Median pay gap also in favour of women. The Median is higher than less than 5% and so requires ongoing monitoring. This reflects the fact that 83% of AfC employees are female and form the majority on all pay bands.
- **M&D Gender Pay Gap**: 56.4% of Doctors are male increasing to 62% for Consultants. A higher proportion of male medics are Consultants (47% v 37%) and a higher proportion of female medics are F1/F2 (29% v 17%). The causes of the male and female ratio of consultants will be impacted by a number of factors including training rates, progression lag times, career breaks, and recruitment/retention trends.
- **Bonus Pay**: Changes to the Local CEA/CIA in 2024 has removed 66% of the previous population. With the overall smaller population of recipients, the average bonus pay value has increased, in particular for women, resulting in a Mean Bonus Pay Gap in favour of women, and a Median in favour of men, both of which are relatively low (<4%).

7.2. Disability Pay Gap

The main cause of the Trusts (MWL) Disability Pay Gap are:

- **Total Disability Pay Gap**: Overall, the total number of disabled employees within the pay record has increased from 593 or 5.4% (2024) to 710 or 6.3% (2025), with the larger increases in disclosure happening in the lower Quartile 1 (6.9% to 8.2%) and Quartile 2 (5% to 6.5%).
- Compared to this, the proportion of known disabled medics decreased from 2.8% to 2.6%; and overall, medics account for 4% of Disabled employees compared to 10.3% of Non-Disabled employees.
- The combination of these factures has caused the Mean to decrease from 13.5% to 12.7%, and the Median to increase from 5.5% to 10.5%.
- **AfC Disability Pay Gap**: Overall the Mean increased slightly from 3.7% to 4.4%, and the Median from 5.3% to 5.9%. This is caused by the larger increases in the disability disclosure rates in Q1 and Q2 as previously mentioned.
- **M&D Disability Pay Gap**: Overall the Mean decreased from 23.7% to 10.1%, and the Median from 40.4% to 3.2%. The proportion of known disabled staff increased by 14% from 25 to 29, with the proportion of known Consultants within the disability population increased to 37.9% (compared to 42.7% for non-disabled medics). In addition, the total number of medics increased (904 to 1126), and changes to the Clinical Excellence / Impact Award payments, have combined to reduce the non-disabled employee hourly pay rate, whilst simultaneously increasing the disabled hourly pay rate; causing the reductions in the pay gaps.
- **Bonus Pay**: Changes to the Clinical Excellence / Impact Awards have significantly impacted on the Disabled Bonus Pay increasing the Mean from -3.7% to 71.6%, and the Median from

-7.9% to 54.4%. However, the number of disabled bonus recipients is ≤10, and has decreased substantially as a result of the eligibility changes. Furthermore the CEA/CIA award values are now based on the larger national pay awards, compared to the previous year where the LCEA/LCIA had a dampening effect on the average pay levels.

7.3. Ethnicity Pay Gap

Note: overall there are 379 (3.3%) employee pay records which do not have a recorded ethnicity. This is lower than 2024 where 393 (3.6%) were unknown.

The main cause of the Trusts (MWL) Ethnicity Pay Gap are:

- **Total Ethnicity Pay Gap**: Overall, the total number of ethnic minority employees within the pay record has increased from 1676 or 15.8% (2024) to 1966 or 17.9% (2025), with the larger increases in disclosures happening in the lower Quartile 2 (13.5% to 17.2%) and Quartile 4 (21.2% to 24.3%).
- A far larger proportion of ethnic minority employees are in Medical & Dental roles (28.5%) compared to White (5.0%) which has higher starting salaries, pay scales and enhancements than Agenda for Change, for example the starting salary of a Foundation 1 doctor is the equivalent to Band 5 AfC.
- Overall, ethnic minority employees are more likely to be in the higher Q3+Q4 with 66.3%, compared to 46.4% of White employees.
- However, the Ethnicity Pay Gap has decreased slightly from -39.2% to -32.5%, and the Median from -21.1% to -19.4% (in favour of ethnic minorities), which is positive.
- **AfC Ethnicity Pay Gap**: Overall the AfC ethnicity pay gap is in favour of ethnic minority staff with a Mean of -1.5% (statistically insignificant) and a Median of -12.3%. These both represent slight decreases from 2024 where the Mean was -1.6% and the Median -14.8%. The likely cause of these improvements, is the increase in the proportion of ethnic minority staff in Quartile 1 (6.2% to 7%) and Quartile 2 (13.5% to 17.2%).
- **M&D Ethnicity Pay Gap**: Overall the Mean decreased from 14.3% to 4.0%, and the Median from 25.1% to 12.7%. This has been caused by the simultaneous drop in the hourly rate of pay for White employees and an increase in the hourly rate of pay for Ethnic Minority employees.
- Overall, the number of ethnic minority medics increased from 452 (53.7%) to 560 (55.2%), and the number of White medics from 389 to 455.
- The proportion of White medics who are F1/F2 increased from 23.6% (2024) to 26.2% (2025), compared to Ethnic Minority medics which increased from 8.9% (2024) to 13.2% (2025). Similarly, the proportion of White medics who are Consultants decreased from 59.8% to 54%, and the proportion of Ethnic Minority consultants decreased from 42% to 38%.
- The combined effects of these changes in the population size, coupled with the CEA/CIA changes, has caused the drop in the M&D pay gap.
- **Bonus Pay**: The Mean Ethnicity Bonus Pay Gap increased from 3.4% to -5.5% in favour of ethnic minority medics, and the Median increased from 0% to -3.2% in favour of ethnic minority medics. The changes made to the CEA/CIA are the principal reasons for this change, with the value of the award based on the national award levels. Previously the LCEA/LCIA had a dampening effect on the mean/median values which is no longer the case.

7.4. Sexuality Pay Gap

Note: overall there are 1295 (11.4%) employee pay records which do not have a recorded sexual orientation. This is lower than 2024 where 1391 (12.7%) were unknown.

The main cause of the Trusts (MWL) Sexuality Pay Gap are:

- **Data Sample**: The 1295 or 11.4% of pay records have no known sexual orientation, including 10.8% of AfC, 16.7% of M&D employees. The omission of this large data set may impact on the accuracy of the overall calculation.
- **Total Sexuality Pay Gap**: The Mean pay gap increased from 4.6% (2024) to 5.5% (2025) with the Median increasing from 4.2% (2024) to 5.5% (2025).
- The overall number and proportion of LGBO employees increased from 342 or 3.6% (2024) to 395 or 3.9% (2025), with similar increases for AfC (3.5% to 3.8%) and for M&D (3.7% to 4.8%).
- However, the distribution of LGBO employees is not equal, with the proportion of Known LGBO employees decreasing from 4.4% in Quartile 1 to 3.3% in Quartile 4.
- The main cause of the pay gaps appear to be the unequal distribution of LGBO staff within the Quartiles.
- **AfC Sexuality Pay Gap**: The pay gap has increased from 2.6% to 4.3% (Mean) and 2.7% to 3.4% (Median). As outlined above, the main cause is the unequal distribution of LGBO staff, but for AfC there proportions are lower, at 3.6% in Quartile 3 and 3.2% in Quartile 4.
- **M&D Sexuality Pay Gap**: With a relatively low LGBO population sample, small distribution changes within the pay bands will have a larger impact. Overall, a far larger proportion of LGBO staff are F1/F2 (55%) compared to Heterosexual employees (17.7%) and 24% of LGBO employees are Consultants, compared to 44.3% of Heterosexual employees. This unequal distribution of LGBO employees within the pay bands is the cause of the mean, and specifically the median pay gaps.
- **Bonus Pay**: The number of LGBO bonus pay recipients is significantly low with the comparison comparing against the national pay award levels. This is the cause of the bonus pay gap.

8. Cheshire & Merseyside ICB Benchmarking 2024

Here MWL in compared against the other 16 Trusts within the Cheshire & Merseyside ICB area for the Gender Mean, Median, Bonus Mean and Bonus Median pay gaps.

When using this data, the following caveats needs to be considered:

- The type of Trusts varies from Acute, Specialist and Community Trusts whose workforce profiles will differ based on the services they offer.
- 10 of the Trusts have workforce profiles of between 1000-4999, and 7 Trusts have workforce profiles in the range of 5000 to 20,000 (as reported in the GPG Portal).
- Local Pay and Workforce Practices are not considered which may impact on the respective calculations and ranking. For example, the provision of salary sacrifice practices such as car loans and electric goods within each Trust is unknown, as well as the specific methodologies used to create their GPG data reports.

The ultimate target is to have a pay gap of 0% for all indicators. The following ranking is therefore based on 1st place being closest to or actually 0% and all trusts ranked in order from lowest to highest, with 17th place having the highest pay gap.

Overall, when compared to the Trusts within the ICB, MWL ranked:

- 17 out of 17 for the Mean Pay Gap
- 10 out of 17 for the Median Pay Gap
- 4 out of 17 for Bonus Mean Pay Gap
- Joint 1st for the Median Bonus Pay Gap

The lower the ranking the better the results when compared to other Trusts.

9. Action Planning

The Trust has developed a new People Strategy within which Equality, Diversity and Inclusion is a golden thread. The 5 key objectives set out in the People Strategy delivery plan include:

- Continue to embed health and wellbeing support and initiatives that champion a safe and healthy environment for all.
- Continue to harness a culture of kindness, openness and inclusivity where everyone is treated with civility and respect.
- Celebrate diversity and promote an environment of openness and inclusion.
- Tackle all forms of discrimination, harassment and bullying.
- Improve the experience of those people with a protected characteristic as identified by the Equality Act 2010.

A summary of our specific actions for 2025-2026 are:

- Deliver Trust High Impact Actions.
- Launch EDI Objective within the appraisal process for all staff.
- Provide of a suite of learning and development options in relation to EDI and wider inclusion that includes courses, reading, listening, watching and volunteering.
- Continue to deliver the people from ethnic minority backgrounds Nurses & Midwives Band 5 Career Progression programme.
- Expand Career Progression programme to other equality groups.
- Develop ‘career planning’ resources for people from ethnic minority backgrounds, Disabled, and Female employees.
- Continue to campaign for staff to disclosing their health conditions and expand knowledge of support and advice available for those that have conditions to disclose.
- Streamline staff disability reasonable adjustment processes, to remove unnecessary processes, speed up the timeliness of adjustments, and increase confidence by staff in requesting support.
- To work with departments/teams with disproportionately low disclosure rates and reasonable adjustment satisfaction levels to identify any barriers to disclosure, and support needs for managers.

10. Conclusion

The analysis of the 2025 data indicates that there remains pay gap differences within the workforce, caused by a combination of factors including the number of staff from each equality group, where those individuals are located within the staff groups (horizontal segregation) and within the pay scale (vertical segregation). In addition, the limited eligibility of the clinical excellence / impact awards and the varying values of those payments and pay practices, continues to cause varying bonus pay gaps.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	24 September 2025
Agenda Item	**TB25/073**				
Report Title	Winter Planning 2025/06				
Executive Lead	Lesley Neary, Chief Operating Officer				
Presenting Officer	Lesley Neary, Chief Operating Officer				
Action Required	X	**To Approve**		**To Note**	

Purpose

To approve the latest iteration of the Mersey and West Lancashire Teaching Hospitals NHS Trust 2025/26 Winter Plan.

Executive Summary

Following on from the update at Board in July 2025, the Board is asked to approve the latest iteration of the winter plan and agree the Board assurance submission.

The paper sets out the winter planning process that each system has undertaken against key timescales and also provides the latest version of the planning checklist incorporating feedback from the Integrated Care Board Check (ICB) check and challenge sessions and exercise Aegis.

Further information will be presented to the Board ahead of winter with any changes.

Financial Implications

None

Quality and/or Equality Impact

Improvement expected

Recommendations

The Board is asked to approve the 2025/26 Winter Plan and the winter plan Board Assurance Statements.

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Winter Planning 2025/26

Lesley Neary, Chief Operating Officer

24th September 2025

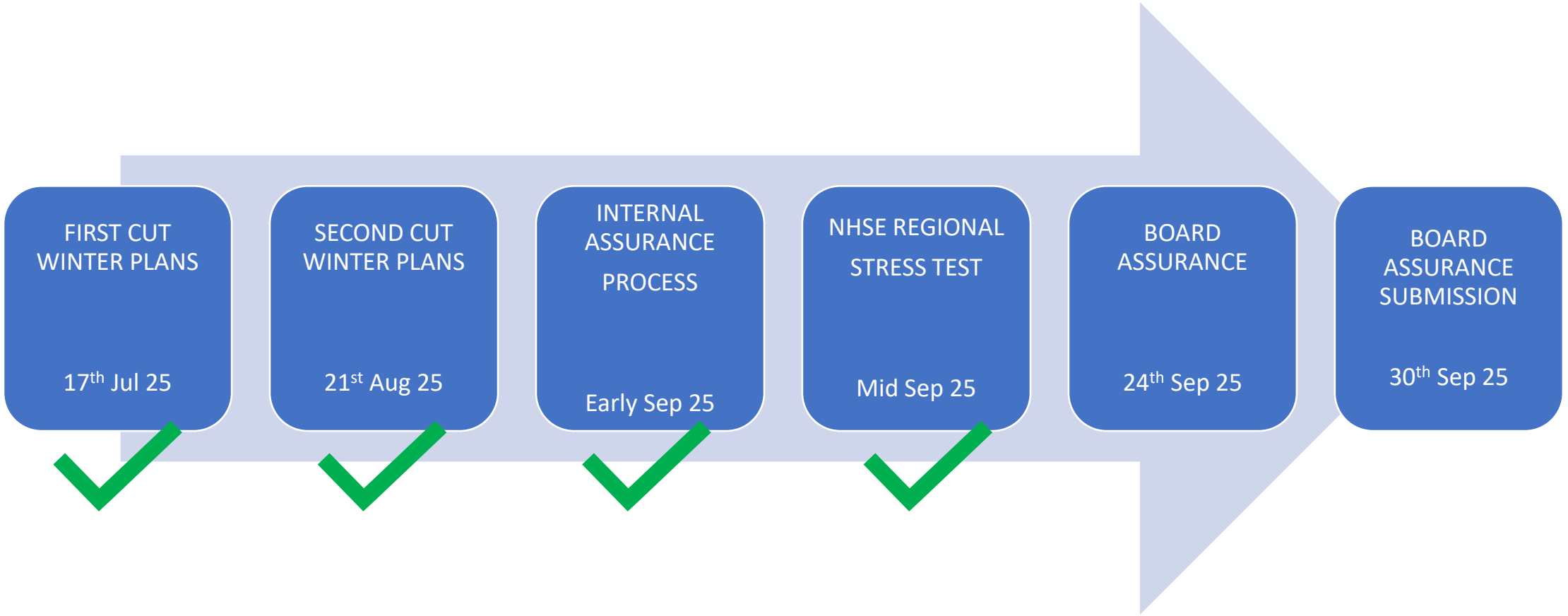
Winter Planning Key Lines of Enquiry

Patient safety & risk	Vaccination & wider prevention	IPC	Primary care & community	Mental health
Bank holiday preparations	EPRR & System resilience	Children & young people	High intensity users	Health inequalities & prevention
Workforce	Discharge & LLOS	UTCs & Streaming	Leadership & Control	System working

15 Key lines of enquiry, 3 templates for completion

- Provider: Acute / Community and Mental Health
- Locality
- System

Winter submission timeline



MWL Winter action plan + Escalation

Workstream	Focus	Action	Expected impact	When
LOS in ED	ECIST 'front door' support	ECIST working with Whiston ED medics on clinical assessment model	Reduction in Time to Clinical Assessment and overall time in ED for Non-Admitted patients	10/09 – 01/10/25
	Data surveillance	Use available data to identify patterns in clinical demand and acuity.	Support for proactive management of resources	01/11/25 - onwards
	Care Coordination Hub	Increase usage of Care Coordination hub by NWAS	Reduced hospital conveyances and increased proportion of direct admissions for Ambulance arrivals	01/10/25 - onwards
Ward level LOS	P0	Establish weekly P0 challenge meetings in line with p1-3 DTL meetings	5% reduction in 'P0' LOS and achievement of 20% discharges before midday	01/10/25 - onwards
	P1-3 LOS	Continue work on ECIST Ward LOS programme; Tranche 3 to focus on DMOP and Intermediate Care and Therapy areas. Escalation DTL's to continue 3 x weekly.	Maintain current LOS through Winter months Whiston – Max 7.7 days Southport – Max 9.3 days	Ongoing
Workforce / IPC	Vaccination programme	Ensure roll out of vaccination programme within time and to minimum of 47% staff	Minimise staff sickness to with accepted levels as per HWWB proposal	01/10 – 30/11/25
	IPC education programme	Rolling programme of ward education sessions	15% reduction in bed / ward closures compared with 2024	01/11/25 – 31/03/26
	Rapid diagnostics	Rapid diagnostic results for suspected cases of Flu / RSV, to support bed management and allocation	Reduction in time spent in ED for admitted patients and improved decision making around patient cohorting	01/11/25 – 31/03/26
Escalation	Trust escalation plans	Revise Trust escalation plan, to include divisional responses i.e 8 - 10 flow plan and RESET and MADE events	Improved awareness and response to increased pressures across sites, and system	01/10/25 - onwards
	Regional escalation plans	Formalise regional response to acute pressure / instances of escalation		01/11/25 – 31/03/26

Winter Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		To be agreed at Board (24/09/25)
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.		To be undertaken by Corporate Nursing prior to Board.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Yes. Plans were initially developed internally, and then with external stakeholder, supported by AQUA
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Yes. Tested 08/09/25. post update winter workshop 22nd September 2025
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Chief Operating Officer supported by Chief Nursing Office and Chief Medical Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	Section B completed – see appendix 1
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Key risks identified and plans seek to address these during base and moderate escalation. Trust and Regional escalation plans have been developed to mitigate risks within escalated pressures.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	Trust plan is to deliver on trajectories agreed as part of annual planning.

Appendix 1: Winter Planning Checklist

Winter Planning Checklist (1) MWL

Key Area		Exec Lead	Narrative

Prevention	Vaccination: 5% improvement on last year's flu vaccination rate for frontline staff.	CPO	• Vaccination plan to be taken to execs for approval – July.
			  • Proposal to include Occ. Health delivery, with funding for additional resource and capacity
			  • Date range: 01/10/2025 – 31/03/2026
			  • To include all Health Care Workers and high risk staff, with priority areas of focus (ED, AMU, ITU)

Capacity	The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	COO	• Activity plan is based on demand predicted on previous years data, which incudes moderate surges in demand. No extreme surges in demand were experienced in 2024/25. • Escalation plans were redesigned following the Critical Incident in Jan 2025, to include revised plans from the Community, W&C and Surgical Divisions • Identified escalation areas 4E, Cath lab and 3D 5ths have been de-escalated due to improved flow and demand management actions and will be available to manage surge demand.
	Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	CPO	• Current medical rotas are designed to mirror peaks in demand, as much as possible, accounting for contract restrictions and working directives. • Post Take Ward rounds in ED are aligned with demand but are reduced from 5 shifts to 2 at weekends.

	Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	COO	• As part of the regional UEC programme, pathway targets were agreed with local authorities as follows:
			  • Pathway 0 – 88%
			  • Pathway 1 - 7%
			  • Pathway 2 - 3%
			  • Pathway 3 - 2%
			• To increase discharge profiles across the 7 days, focus has been on ensuring estimated day of discharge(EDD) recording is improved across all non-assessment areas, to highlight patients initially identified for discharge at a weekend.

Winter Planning Checklist (2) MWL

Key Area		Exec Lead	Narrative
Capacity	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	COO	• Recovery plans for cancer pathways currently non compliant with targets, are being worked on and monitored against trajectories. • Escalation plans protect capacity until extremis, and include the review of TCI's based on priority and position on the day, including Trauma cases.
IPC	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	CNO	• IPC colleagues have been involved in the evolution of previous plans, which form this years response. • IPC lead on the appropriate actions as part of plans; cohorting, restricted access and testing.
	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	DoE	• FIT testing in high risk areas (ED, AMU, ITU) is being managed by Division. • Sufficient PPE stock is in place to manage a surge in demand.
	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	CNO	• Patient cohorting for IPC purposes is managed jointly by IPC and Patient flow teams, with Operational input. • Plans include communications and rapid testing and results, supported by Labs, as well as additional IPC walk-arounds and staff engagement.
Leadership	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	COO	• On-call structures are well embedded, and forums established for shared learning. • On call structures and responsibilities tested during critical incident on Whiston site (January 2025) and Southport site (July 2024)
	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	COO	• In place, and utilised in bed meetings for both sites.

Winter Planning Checklist (1) SYSTEM

Key Area		System Lead	Narrative
Prevention	Enhanced prevention offer as a result of winter pressures	System Providers	• Vaccination – 5% improvement. Vaccination plans with all providers including Trusts, Primary Care, Care Homes and Local Authority staff • IPC Plans in place with providers • C&M Communications pack in development
Leadership	Oversight and control of system response to winter pressure	SRO	• SRO to act as Executive Sponsor for Winter (Jenny Wood) • Clinical support and oversight to be provided by Sefton (Rob Caudwell & Debbie Fagan) alongside the programme Clinical Lead, Kate Clark • C&M No Criteria to Reside meetings to continue during winter, Recovery Director will continue to lead these • SCC will convene daily meetings to provide oversight and report into NHSE and Region
Capacity	Additional capacity available Dec – March to support flow	DASS	• All local authorities have provision to block purchase additional community transitional bed capacity. • St Helens - recruitment for additional Home First capacity to increase in P1 discharges. • Knowsley - additional EMI capacity, 5 beds • BCF discharge monies (split between Halton , St Helens and Knowsley) to recruit a LLAMS (later life and memory service) in Reach Worker to work in ED and support complex discharges to EMI care homes. Recruitment to commence mid – late July • Intermediate Care capacity to be reviewed – external support
Demand	Changes in decision making during times of extreme demand	System Providers	• C&M No Criteria to Reside meetings to continue during winter, Recovery Director will continue to lead these • COO will enact operational oversight meetings as appropriate • Risk based decision making during extreme winter pressures – as during critical incident • Direct challenge to those local authorities who are failing to meet expected trajectories of improvement

Winter Planning Checklist (2) SYSTEM

Key Area		System Lead	Narrative
Primary Care & Community	Additional capacity available Dec – March to support flow	DASS	• Enhanced access plans are live across all places • Intensive contractual oversight for those practices highlighted as a concern • GP oversight into care homes to reduce admission rates • Same day emergency care plans are progressing through the system development funding to ensure additional access during winter including medical leadership into WIC / UTC's • Dedicated protected learning time event scheduled with a focus on options for winter with our Primary Care • Pharmacy first to be maximised including enhanced training and use of triage tools.
Mental Health	Changes in approach during times of extreme demand	System Providers	• Weekly MADE and NCTR meetings • Operate a full Core 24 model on all Acute sites • Employ including the NHS 10 High Impact Actions for MH Discharge, all designed to optimise flow. This is now in the process of being implemented across the system • Capital funding to update and enhance its s136 provision with one site being designated for CYP. • Enhanced Emergency Department access to Crisis Response Team. Primary Care will also have access to early intervention to support admission avoidance, e.g. Talking Therapies. • Crisis offer to be closely monitored to ensure capacity, specifically the crisis line

Winter Planning Checklist (3) SYSTEM

Key Area		System Lead	Narrative
Children & Young People	Working with CYP services to ensure adequate support for our CYP over Winter	System Providers	• Communication with parents around the use of UTC / WIC to avoid attendance at ED – This can be done via schools • Further work with our UTC / WICS to ensure referral to ED criteria is utilised – Pead's nurses on shift • Digital support offers in place through Local Authorities • Focus on CYP MDT's within the places via Neighbourhood Health • Improved access via the Family Hubs / Family First Programmes within Places • High Intensity User focus on CYP
Risks	Financial Turnaround	System Providers	• On-going return on investment reviews within places to identify areas to de-commission – full EIA / QIA processes will be undertaken • Reduction in intermediate care capacity in North Sefton – 10 beds • No other planned service changes
	Workforce	System Providers	• Significant reduction in ICB staff • Ongoing workforce challenges within key providers due to sickness and staff vacancies • Place assurance regarding provider level operational plans to reduce vacancies, retention, recruitment and sickness management. • Place will be sighted on business continuity plans, escalation and mutual aid between providers and places. With the current financial position there is no spend on agency staffing.