Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09:30 on Wednesday 29 October 2025
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month (October 2025)** *Purpose: To **note** the Employee of the Month presentations for October 2025*	Film	Chair *(10 mins)*
09.40	2.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	4.	**TB25/074 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 24 September 2025*	Report	
	5.	**TB24/075 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
09.50	6.	**TB25/076 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	A Bassi G Lawrence obo L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Report				
10.20	7.	**TB25/077 Committee Assurance Reports** 7.1. Executive Committee 7.2. Quality Committee 7.3. Strategic People Committee 7.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*	Report	R Cooper C Elliott C Spencer obo L Knight C Spencer *(40 mins)*
Other Board Reports				
11.00	8.	**TB25/078 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register*	Report	N Bunce *(10 mins)*
11.10	9.	**TB25/079 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
11.20	10.	**TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2)** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for Q2*	Report	A Bassi obo S O'Brien *(15 mins)*
11.35	11.	**TB25/081 Learning from Deaths Quarterly Report Q4 2024/25 and Q1 2025/26** *Purpose: To **note** the Learning from Deaths Quarterly Report*	Report	Ash Bassi *(10 mins)*
11.45	12.	**TB25/082 Workforce Reports** 12.1. Workforce Race Equality Standard Report (WRES) (including action plan) 12.2. Workforce Disability Equality Standard Report (WDES) (including action plan) *Purpose: To **note** the Workforce Reports for assurance and to **approve** the action plans*	Report	M Szpakowska *(15 mins)*
12.00	13.	**TB25/083 MWL Green Plan 2025-28** *Purpose: To **approve** the MWL Green Plan 2025-28*	Report	N Bunce *(10 mins)*

12.10	14.	**TB25/084 Freedom to Speak Up Annual Report 2024/25** *Purpose: To **note** the Freedom to Speak Up Annual Report 2024/25*	Report	AM Stretch *(10 mins)*
Concluding Business				
12.20	15.	**Effectiveness of Meeting**	Report	Chair *(5 mins)*
12.25	16.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 26 November 2025 at 09:30		**12.30 close**
15 minutes break				

Chair: Steve Rumbelow

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

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 24 September 2025
(Approved at Trust Board on Wednesday 29 October 2025)

Name	Initials	Title
Steve Rumbelow	SR	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
Neil Fletcher	NF	Associate Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Lisa Knight	LK	Non-Executive Director (via MS Teams)
Gareth Lawrence	GL	Chief Finance Officer
Lesley Neary	LN	Chief Operating Officer
Sarah O'Brien	SO	Chief Nursing Officer
Hazel Scott	HS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer
Rani Thind	RT	Associate Non-Executive Director

In Attendance

Name	Initials	Title
Rachael Birmingham		Cardiac Rehabilitation Lead Specialist Nurse Agenda Item 2 via MS Teams)
Kate Clark	KC	Director of Strategy (Agenda Item 9 via MS Teams)
Simon Dowson	SD	Designate Chief Medical Officer (Observer via MS Teams)
Greg Hewitt	GH	Managing Director, Rock Oil (Observer via MS Teams)
Katie Hurst	KH	Head of Strategic Relationships, HBSUK (Observer via MS Teams)
Michelle Kitson	MK	Matron Patient Experience (Agenda Item 2 via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Ash Bassi	AB	Acting Chief Medical Officer
Gill Brown	GB	Non-Executive Director and Deputy Chair
Claudette Elliott	CE	Non-Executive Director
Marie Wright	MW	Halton Council Representative (Stakeholder Representative) (via MS Teams)
Carole Spencer	CS	Non-Executive Director

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for August 2025 was Perry Woodburn, Operating Department Practitioner, Whiston Hospital and the Board watched the film of SO reading the citation and presenting the award to Perry. 1.2. The Employee of the Month for September 2025 was Tony Carson, Associate Nurse Practitioner, Ormskirk Hospital and the Board watched the film of LN reading the citation and presenting the award to Tony. **RESOLVED:** The Board **noted** Employees of the Month for August and September 2025 and congratulated the winners.
2.	**Patient Story**
	(MK and RB joined the meeting) 2.1. SR welcomed MK and RB to the meeting. 2.2. MK introduced the Patient Story video in which a patient shared his feedback and praise about the care he received following a heart attack. The patient had initially been cared for on Ward 9B and had been transferred to Liverpool Heart and Chest Hospital for treatment. On discharge, the patient had been referred to the Cardiac Rehabilitation team at Southport Hospital. 2.3. Cardiac rehabilitation is a nationally recognised multiprofessional programme that aimed to support patients back to a normal lifestyle and help to prevent any further cardiac events and admissions to hospital. The patient reported that he had found the service invaluable as he had initially struggled with anxiety and this had impacted on his confidence to start the programme. However, he had felt safe as there was regular monitoring through the exercise sessions and he had started to feel reassured. The patient commented that at the end of the six-week programme his level of fitness had improved, and this was a 'confidence builder' to resume is normal life. 2.4. The story reflected on the importance of patient education, rehabilitation and the ability to empower patients to feel confident in managing their own medical conditions. 2.5. SR reflected on the positive message that the patient story had conveyed about the importance of not just fixing the problem but about working with the patient to ensure their recovery. SR noted that it had also been enlightening to hear about the philosophy of the service from one of the nurses in the team.

	2.6. SR thanked MK and RB for sharing the patient's story. **RESOLVED:** The Board **noted** the Patient Story *(MK and RB left the meeting)*
3.	**Chair's Welcome and Note of Apologies**
	3.1. SR welcomed all to the meeting and in particular SD, GH and KH who were attending the meeting as observers. Additionally, SR welcomed SO to her first meeting since being appointed as Chief Nursing Officer and KC who would be attending the meeting to present the Medical Revalidation Annual Declaration 2024/25. 3.2. SR noted that this would be RT's last Board meeting as her term of office would conclude on 30 September and HS's last Board meeting prior to her retirement from Liverpool University. 3.3. SR acknowledged the following awards and recognition for Trust staff and services: 3.3.1. MWL's Employment Services Automation Team were shortlisted for the Healthcare People Management Association (HPMA) Awards in the category 'Capsticks Award for Innovation' for their achievements in the automation of HR, OD, Recruitment and Employment Services. 3.3.2. Dr Muhammad Rahmdil, won the 'Speciality and Associated Specialist doctors (SAS) Undergraduate Educator' award at the Northwest SAS Annual Conference. A special mention also goes to Dr Vera Barnabe who received a 'highly commended' in the 'SAS Clinical Excellence' category. 3.3.3. St Helens Urgent Treatment Centre (UTC) had been rated as 'Good' by the Care Quality Commission (CQC), following a planned inspection. 3.3.4. Laura Sumner, Preceptorship Lead, was shortlisted in the 'Preceptor of the Year' category at the Nursing Times Workforce Awards. 3.3.5. The IT Service Desk Team has retained 4-Star Business-Led accreditation by the Service Desk Institute for the fourth year in a row 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.	**TB25/065 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 30 July 2025 and approved them as a correct and accurate record of proceedings. **RESOLVED:**

	The Board **approved** the minutes from the meeting held on 30 July 2025
6.	**TB25/066 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 10 (TB25/039 Integrated Performance Report / 7.2 Operational Indicators) - SO advised that, following a review of the data, there had not been a reduction in the number of complaints received about the Emergency Department (ED) waiting times, however, there has been a reduction in reported incidents. **Action closed** 6.2.2. Action Log number 11 (TB25/050 Committee Assurance Reports /8.1 Executive Committee) – an update on the neonatal cot reconfiguration had been presented as part of the Maternity and Neonatal Assurance Report to Quality Committee in September. **Action closed.** 6.2.3. Action Log number 12 (TB25/050 Committee Assurance Reports /7.1 Executive Committee) - an update on the Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA) deep dive had been included in the quarterly Infection Prevention Control (IPC) report to the Quality Committee. **Action closed.** 6.2.4. Action Log number 15 (TB25/059 Aggregated Incidents, Complains and Claims Report Q1) – the corrected report was presented at Executive Committee for approval, and the Trust website has been updated to include the revised report. **Action closed** 6.2.5. Action Log number 16 (TB25/062 Informatics Reports / 13.1 Data Security and Protection Toolkit (DSPT)) – an update and resulting management actions were presented to Audit Committee in September. **Action closed.** 6.2.6. Action Log number 17 (TB25/062 Informatics Reports /13.2 Information Governance Annual Report 2024/25) – MG had confirmed that a process was now in place for reviewing personal identifiable information in reports prior to submitting to Committees or Board. **Action closed.** **RESOLVED:** The Board **approved** the action log
Performance Reports	
7.	**TB25/067 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for August 2025 was presented.
7.1.	**Quality Indicators**
	7.1.1. SO presented the Quality Indicators and highlighted the following: • The final Hospital Standardised Mortality Ratio (HSMR) for the full year 2024/25 for MWL was 90.4, which meant the Trust had 9.6% less deaths

	than expected when adjusted for age, diagnosis, co-morbidities and the deprivation status of patients. • The overall nurse staffing fill rate was 99% (target 90%). • The inpatient Family and Friends Test (FFT) recommendation rate was 94.4% (target 90%). • There was a continued focus on infection rates and pressure ulcers with improvement work ongoing. • Complaints response within 60 days performance was 51.5 % (target 80%) and work was ongoing with the divisional leads to reduce the number of outstanding complaints. There had been a reduction in new stage 1 complaints received in August.
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 August 2025 was 78% (target 78%). This compared to 75.9% nationally and 72.8% for Cheshire and Merseyside (C&M). The proportion of 12-hour waits in the Emergency Department (ED) in August was 18.9% (21% for C&M). 7.2.4. The national 45 minutes rescue and release scheme for ambulance handovers had come into effect on 01 August. In August 90.4% of all ambulances were handed over within 45 minutes. At Southport Hospital the average handover time was 17 minutes in August 2025 compared to 53 minutes in November 2024. It was noted that the Southport Hospital site was the best performing site across C&M. At Whiston Hospital the average handover time in August was 33 minutes compared to 69 minutes in November 2024. LN assured the Board that the North West Ambulance Service NHS Trust (NWAS) had not left any patients in the departments without handover and work was ongoing to ensure that this did not happen. LN noted that ambulance handovers times had also improved across C&M. 7.2.5. The percentage of patients with no criteria to reside (NCTR) was 20.5% in August, however this had increased to 23% in September. There remained a focus on reducing the number of NCTR patients by improving discharge (workstream in the System Urgent and Emergency Care Improvement Programme). Work was also on-going with each PLACE to reduce Length of Stay (LoS). The winter planning exercise had identified variations in approach across the different PLACEs, in the time taken for patients who were medically fit for discharge to be discharged with a package of care. A review was being undertaken to understand the causes and how these differences could be eliminated. 7.2.6. As a result of the improvements in Urgent and Emergency Care (UEC) performance, the Trust had been withdrawn from NHSE intervention and the Emergency Care Improvement Support Team (ECIST) had been withdrawn. <u>Elective Activity</u>

	7.2.7. The 18 week Referral to Treatment (RTT) performance was 63.6% in August 2025 and the Trust was in the top quartile nationally. 7.2.8. The Trust had not met its 65-week waiting time target, with 135 patients having waited over 65 weeks; LN and RC had been called to a meeting with national and regional colleagues to discuss the 65-week waiters performance because the Trust was now an outlier for this metric. At the meeting the mitigation and recovery trajectory had been presented. 7.2.9. LN noted that a key part of addressing the long waits would be to improve productivity and deliver the planned activity across all specialities. An activity recovery plan for the second half of the financial year was in development. 7.2.10. There were three specialities (trauma and orthopaedic, general surgery and ophthalmology) where there was the greatest opportunity for improvement. <u>Cancer Services</u> 7.2.11. Performance against the 62 day cancer standard had declined to 78.8% in July (target 85%). National performance was 69.2% and C&M performance was 75.4%. 7.2.12. Performance against the 28 day cancer standard had declined to 63.4% in July (target 77%). National performance was 76.6% and C&M performance was 71.7%. The decline in performance was attributed to two tumour sites; skin and lower gastrointestinal (GI), where performance was more challenged at Southport Hospital. The high volume of cases on the skin cancer pathway impacted the overall Trust performance. 7.2.13. The Trust had been identified as an outlier both regionally and nationally and recovery plans, which included weekly activity trajectories, were in place with the aim of achieving 80% for skin and 65% for lower GI by the end of October. Weekly meetings were taking place with the Cancer Alliance to monitor progress. 7.2.14. RT asked if the non-elective LoS of 8.5 days included NCTR patients awaiting discharge. LN confirmed that this was the case and summarised the work being undertaken with system partners to improve discharge and reduce the percentage of NCTR patients. RT suggested reported LoS including and excluding NCTR patients to provide a better understanding of the Trust performance and impact of delayed discharges, which would contribute to patients becoming deconditioned by long hospital stays. LN agreed to ask the Business Intelligence team if the LoS performance could be differentiated. LN noted that there had been an average 0.8 day reduction in LoS on the three wards that had taken part in the ECIST Board round programme. RT commented that it was important to understand the reasons for LoS to ensure that best practice was delivered. SR agreed that an in depth analysis was required and commented that whilst, there were numerous discussions around unwarranted variance in hospital, it was also important to have a view of the impact of unwarranted variances for out of hospital services and discharges as this would be crucial to the success of neighbourhood health. **ACTION**

	LN to explore if the LoS performance could be reported to both exclude and include patients classified as NCTR and ready for discharge. 7.2.15. RC noted that all PLACEs had targets for reducing the time to discharge, and this had been the subject of discussion at the recent system Winter Planning Workshop, including how PLACEs could work together to offer mutual aid, to maintain effective patient flow during winter. 7.2.16. NF asked whether any concerns or complaints had been received from patients on the cancer pathways. SO responded that she was not aware of any concerns or complaints linked to the cancer pathways or waits but would check and report back. SO noted that cancer services generally did not receive a high number of complaints. **ACTION** SO to confirm if any complaints had been received about cancer waiting times.
7.3.	**Workforce Indicators**
	7.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for appraisals was 74% in August and the annual appraisal window was due to close on 30 September. There were actions in place to achieve the target of 85% and discussions were ongoing as part of the Divisional Performance Reviews (DPR) to ensure appraisal conversations were valued by staff. • The compliance rate for mandatory training remained consistent at 89% (target 85%) and any areas of concern were discussed at Quality Committee and Strategic People Committee. The Executive Committee had approved a consolidated training needs analysis (TNA) for core training across MWL. Work had also started on aligning compulsory training across the Trust and progress would be monitored by the Executive Committee. • Sickness absence had increased to 6.7% in August from 6.5% in July (target 5%) and this was comparable to the performance across C&M. There had been a reduction in the Allied Health Professionals (AHP) and medical workforce sickness, however, registered nurse (RN) sickness absence had increased to 6.9%. Health Care Assistant (HCA) absence remained high but was stable at 7%. The top three reasons for sickness remained anxiety, stress and depression (including non-work related causes) and accounted for 39% of all absences, gastrointestinal issues, and musculoskeletal health (MSK). MS noted that the increase in anxiety, stress and depression sickness absence was comparable across C&M and other public sector organisations. • MS reported that an ICB wide target for a 1% reduction in sickness absence had been proposed and an action plan to achieve this was in development. • In-month staff turnover had increased to 1.7% in August (target 1.1%) but this increase was primarily due to the conclusion of fixed term contracts

	for clinical fellows and resident doctors. The 12-month rolling staff turnover had reduced to 9.8% (target 13.2%) and MS noted that this was consistent with regional and wider NHS trends and reflected the financial constraints in the NHS and wider economy which impacted the job market. It had been discussed at the Strategic People Committee that the Trust was not achieving the workforce plan, due to lower than expected staff turnover. 7.3.2. SR asked if the system target for a 1% reduction in sickness absence had been discussed or if it was being imposed. MS responded that sickness absence was often perceived as straightforward to address, however, this was often not the case. The aspiration to meet sickness absence targets had been an area of continued focus for MWL. MS reported that the savings assumed would come from not backfilling rota gaps caused by sickness absence, however, this did not take into account patient safety considerations. Work was already underway within the system to reduce or discontinue the use of bank and agency staff, and there was a possibility that these savings could be counted twice. SR expressed concern that it appeared that a figure had been linked to the target for a 1% reduction by the ICB without consideration of other ongoing workstreams or the impact for patients.
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 of deficit support funding. The plan was underpinned by £35m of system led and strategic cost reduction opportunities as well as a recurrent internal Cost Improvement Programme (CIP) of £48.2m. 7.4.2. At month 5, the Trust was reporting an adjusted position of £33.4m deficit excluding deficit support funding and was £2m ahead of plan. 7.4.3. GL highlighted the following: • The Trust had successfully delivered £20.4m of CIP YTD against a plan of £48.2m (£1.8m above plan). • The Trust capital plan £23.4m underspent at month 5 but remained on track to deliver by the end of the year. GL noted that this underspend was currently supporting a cash position, which would become significantly more challenging in the second half of the financial year. • The Trust had received cash support in September 2025 of £10.7m. • The Better Payment Practice Code (BPPC) performance was 96%. 7.4.4. GL reported that a 0.9% of turnover risk remained in the forecast outturn position and the Trust had taken into consideration the various reviews of the forecast position by NHSE and had mitigated more of the risk between M4 and M5.

	RESOLVED: The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB25/068 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. RC presented the Executive Committee Assurance report for the meetings held in July and August 2025. Bank or agency staff requests that breached the NHSE cost thresholds were reviewed at each meeting, and the Chief Executive's authorisation recorded. 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 reviewed a number of benchmarking exercises to gain an understanding of the organisation's position, particularly from a corporate perspective following the instruction to reduce workforce growth since 2018/19. • The Committee had received regular finance, including CIP delivery and actions agreed at the Financial and Workforce Improvement Group meetings. The Committee had received and reviewed the PricewaterhouseCoopers International Limited (PwC) reports and recommendations and RC noted that the next meeting with PwC (on behalf of NHSE) was scheduled to take place the following day. • The Committee had reviewed the results of the MWL National Inpatient Survey results for 2024 and, whilst there had been several areas of improvement, there were still some areas of concern that required additional work and action plans were being progressed. • The Committee had received an update on the EPR system improvement plan. RC reflected on the benefits of digital solutions in improving productivity and efficiency of the services as well as improving patient access. • The Committee had received updates on the planned Resident Doctor's industrial action which took place in July. These included the action plan to maintain patient safety as well as the resultant financial impact. RC reflected that there had been an impact for the Trust financially, however, services had been maintained and there had been no patient harm. • The Committee had been briefed on the cash management implications of NHSE withholding deficit support funding to the C&M ICB. • The Committee had reviewed the new NHS National Oversight Framework (NOF) and performance ratings. The metrics being used by NHSE were mostly already included in the Trust IPR, and the remainder would be added.

	• The Committee had received the East Pathology Hub Full Business Case (FBC) and RC noted that this had been approved at the Board meeting in July. • The Committee had received an update on fragile services at Southport and Ormskirk Hospitals, which was one of the fundamental reasons for the amalgamation of the two legacy trusts to create MWL. • The Committee had received the Outpatient Transformation Project Progress report. The importance of this piece of work and the support needed for the divisional team had been discussed. • The Committee had received the Never Events action plan which detailed the themes, learning and actions from the five never events that had occurred in 2024/25. • The Committee had received a progress report on the UEC Improvement Plan. • The Committee had discussed the approach to the development of the MWL Strategy in particular predicting population health needs. It was anticipated that the draft strategy would be presented at the Strategy Board in October. • The Committee had reviewed the 2025/26 Flu Vaccination Campaign for healthcare workers and an action plan was approved to achieve the target of 47% uptake. • The Committee had approved the proposal from Queens Court Hospital for the hosting arrangements for the community Palliative Care Consultants for Sefton and West Lancashire to move from Mersey Care NHS Foundation Trust to MWL. RC reflected on the importance of palliative care as well as hospice capacity and utilisation and bringing these together across the organisation. This supported the national focus on end of life care. • The Committee had received a progress report on the HCA Banding Resolution Framework. Benchmarking had shown that the Trust would remain comparable to other acute trusts across the Band 2 to Band 3 staffing ratios for general inpatient and specialist areas. As a result the next nurse staffing establishment review would reflect these changes. • The Committee had received an update on the 2025/26 Capital Plan. • The Committee had approved the MWL Anti-Racism statement and as part of the launch, events had been held at Whiston and Southport Hospitals and further events would be taking place in October. • The Committee had received an update on the National Uniform project and there was continued support for MWL to adopt the national uniform as this was important from a patient's perspective. • The Committee had received an update on the NetCall Patient Engagement Portal (PEP) which had been implemented for all specialities (except Paediatrics) at Southport and Ormskirk Hospitals. The PEP would improve patient access and ensure that timely reminders were sent to patients. The National Inpatient Survey results had highlighted that communication around waiting times was not optimum and it was anticipated that digital solutions would help improve this.

- The Committee had received the model NHSE Sexual Misconduct Policy and approved adoption of the policy by MWL.
- The Committee had received a report on the appropriate care for mental health in patients who no longer had physical health needs. The report had highlighted the importance of working with Mersey Care NHS Foundation Trust and the Cheshire and Wirral Partnership (CWP) NHSFT, to ensure patients' needs were met.

8.1.3. RC advised that the following investments had been approved during July and August:

- The extension of the Bevan Court lease which remained essential to the delivery of clinical services at Whiston (which had been approved by the Trust Board in July).
- £44k was approved to support the winter staff flu vaccination programme.

8.1.4. RT reflected on the proposal to transfer responsibility and associated funding for hyper acute stroke care to Aintree Hospital, due to service fragility and asked if consideration had been given to linking with the Mid-Mersey Stroke Network. RC responded that there were established relationships and patient flow with Aintree Hospital as part of the North Mersey Stroke Network and that the stroke rehabilitation service would continue to be delivered at Southport Hospital. However, employing consultants as part of a bigger rota had been shown to improve both recruitment and service resilience. RT commented on the historic challenges in collaborating with tertiary centres. RC accepted that there had been challenges for some services, and a robust SLA would be developed to ensure the service for the local population of Southport and Ormskirk would be protected.

8.1.5. RT noted that only 68.5% of eligible HCAs had applied for consideration under the Banding Resolution Framework and asked if there was an optimal skill mix between band 2 and 3 HCAs. RC responded that there were many reasons why staff might choose not to apply, but all had been made aware of the process. SO explained that the ratio of band 2 to 3 HCA might be different in different clinical areas depending on the HCA competencies required. Progression to a band 3 would be subject to training to be able to deliver a range of the band 3 competencies. The desired skill mix was to be determined as part of the next nurse establishment review.

8.1.6. RT asked if there were any concerns about patient harm for wards with a nurse staffing fill rate below 90%. SO responded that, whilst instances of consistently low fill rates were rare, there was no correlation between a low fill rate and occasions of harm. The purpose of the Safer Staffing reports was to monitor that this was the case and provide on-going assurance that staffing levels were safe. AMS reflected on the historical challenges in recruiting registered nurses and that only a few years previously there had been much lower nurse staffing fill rates.

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

8.2.	**Audit Committee**
	8.2.1. SC presented the Audit Committee Assurance report for the meeting held on 10 September 2025 and highlighted the following: • The Committee had received the External Auditors Progress report. • MIAA had issued five internal audit reports since April 2025. Three reports (Quality Spot Checks, Fit and Proper Persons Test (FPPT) and IT Service Continuity) had received substantial assurance. One report (IT Third Party Providers) had received moderate assurance. The Digital Security and Protection Toolkit (DSPT) report had received an overall moderate risk/high confidence. • The Committee had received the MWL Audit Log which highlighted progress in delivering internal and external audit recommendations. • MIAA had presented the Anti-Fraud Progress report and it was noted that 11 of the 12 elements were rated as green and Conflict of Interest (COI) percentage completion rate, remained amber. • The Committee had received the annual review of the Corporate Governance Manual (CGM). The proposed amendments included updates for changes in legislation, amendments to job titles and updates to delegated financial limits. It was noted that the final version of the CGM would be circulated to the Audit Committee members for final approval. • The Committee had received and noted an updated Audit Committee workplan. • The Committee had received the Losses and Special Payments, the Aged Debt and the Tenders and Quotation Waivers Reports. 8.2.2. SC alerted to the Board that Aged Debt continued to be an area closely scrutinised by the Audit Committee, as this linked to cash management. The remainder of the report was **noted.**
8.3.	**Quality Committee**
	8.3.1. NF, on behalf of CE, presented the Quality Committee Assurance Report for the meeting held on 16 September 2025, noting the quality performance indicators had already been reported. 8.3.2. NF highlighted the following: <u>Infection Prevention and Control (IPC) Q1 Report</u> 8.3.3. The increase in the number of Covid-19 cases had been noted and assurance had been provided on outbreak management. 8.3.4. The Committee had noted the plans in place for the 2025/26 staff flu vaccination programme 2025/26. The decision by the National Joint Committee to exclude Covid-19 vaccinations for frontline NHS staff in the programmes for 2025/26 had been noted. <u>Maternity and Neonatal Services Report for Q1</u> 8.3.5. The Year 7 Maternity Incentive Scheme (MIS) had been published in April 2025 and the service was collating the Trust evidence.

	8.3.6. It had been reported that the Trust may not be able to meet the requirements of Safety Action 7 - Maternity and Neonatal Voices Partnership (MNVP) representation as quorate members of the Perinatal Mortality Review Tool (PMRT) and key governance meetings. This was because the MNVP members did not have the capacity (time) or experience to attend all hearings and mortality review meetings. This was a challenge nationally as there was no training in place, which was necessary for members to gain the required experience to be able to attend and participate in the PMRT meetings. However the criteria could be achieved if there was evidence that this gap had been escalated to the Trust Board. 8.3.7. The maternity service reported compliance with Safety Action 1, Standards A, B and D, however, only two of the three elements for Standard C had not yet been met. The third element was non-compliant as the Trust required 20 PMRT cases but anticipated an insufficient number of eligible patients. NF noted that a box had been missed during the completion of one perinatal review, which affected the denominators and could prevent the service from achieving compliance. Consequently, all further cases would need to undergo a review to achieve the standard. It had been noted that this issue was being reviewed by the national team. 8.3.8. RC asked if action had been taken to prevent such an error occurring again and SO responded that the reporting system had been reviewed and additional checks added to the process. RC suggested digitizing the submissions and making the field mandatory and SO agreed to explore this. <u>Adult Palliative and End of Life Care Strategy 2025-2028</u> 8.3.9. The Committee had approved the Strategy and commended the detailed and ambitious strategy for supporting patients and their families requiring palliative and end of life support. 8.3.10. RT asked whether the Chair of the MNVP had now returned from maternity leave. SO confirmed this was the case and had attended the recent Maternity Safety Champions meeting. 8.3.11. SR reflected on the exclusion of Covid-19 vaccinations for NHS staff as part of the national vaccination programme and asked whether staff sickness related to Covid-19 was still recorded. MS confirmed that the Trust completed a daily report to NHSE of sickness related to Covid-19 and noted that this was based on the reported reasons for absence as there was no longer a requirement for Covid-19 testing. The remainder of the report was **noted**.
8.4.	**Strategic People Committee**
	8.4.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 17 September 2025 and noted that some key issues had already been discussed in earlier reports to the Board and would not be repeated.

	8.4.2. LK highlighted the following: • The Committee had received the HR Directorate Technology and Transformation Update and the Employment Services Annual Report 2024/25. Several long standing developments had accelerated, presenting opportunities for productivity improvements, such as the use of 'bots' and artificial intelligence (AI) for back office functions. • Employment Services continued to develop and expand and had been successful with their accreditation with the Chartered Institute of Payroll Professionals. The service had also received high assurance from MIAA internal audit for the third consecutive year. LK noted that the payroll service was now processing circa 145,000 payslips per month. • The Lead Employer (LE) was implementing a transformation programme to improve the experience for doctors in training and to reduce unnecessary duplication across the NHS by streamlining transactional interactions and the use of Robotic Process Automation (RPA) was being accelerated to support this. 8.4.3. NF reflected on the reported AHP vacancy rate of 9.4% and asked whether this was attributable to particular professions within the AHPs or whether it was consistent across all areas. MS responded that she would need to investigate and provide further information. SO commented that regionally dietetics and speech and language therapists (SLT) were very challenging to recruit. **Action** MS to investigate whether the reported AHP vacancy rate was attributable to particular professions within the AHPS or whether it was consistent across all areas and to provide further information The remainder of the report was **noted**.
8.5.	**Finance and Performance Committee**
	8.5.1. SC, on behalf of CS, presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 18 September 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. 8.5.2. SC reflected that whilst, the Trust was used to challenge and external scrutiny and regarded it positively; the papers submitted to the recent F&P Committee had demonstrated the substantial volume of additional work the current levels of external challenge were creating and its organisational impact. 8.5.3. Other points to highlight from the report were: • The Committee had received an update on the PwC turnaround work that included the development of a risk stratification framework to monitor and oversee financial performance. As a result of this the Trust had been rated as high risk (for not delivering the financial plan) and

representatives from the Trust would be required to attend additional monthly meetings with PwC.

- A review of MWL's forecast, and mitigation plans to deliver the 2025/26 financial position had been undertaken by Simon Worthington (SW). The review had highlighted that all representatives from the Trust demonstrated a clear understanding of the financial challenge and had effectively communicated both the current forecast and the actions being taken. SC reported that SW had identified a £9.8m optimism bias in the Trust plans but the Committee had received assurance that this had been mitigated in the Trust's updated forecast.
- NHSE had set expectations for all trusts for in-year financial management and interventions and a toolkit to support delivery of the required financial savings. Part of this included a well-led Finance Self-Assessment and peer review and this would be presented at F&P Committee in October 2025.
- NHSE had issued a planning document to support the NHS 10-Year Plan and it was noted that a five year financial plan had to be developed and approved by the Board before the end of December 2025.
- The key risk to cash remained the deficit support funding that had been withdrawn from the C&M ICB, as well as the delivery of the Trust's income and expense forecast. A Provider Revenue Support cash application had been approved by NHSE for £10.9m and a further application had been submitted for another £11m to cover the October cash requirements.
- The Committee had received the Surgery Division CIP update which outlined progress in delivery of the 2025/26 CIP target of £10m and it was noted that £6.9m had been delivered YTD and a further £1.9m of schemes were categorised as low risk. The focus remained on reducing premium pay and work was underway to review further potential non pay schemes. The Committee was assured of the progress made at month 5.
- The Committee had received the CIP Strategy, which provided assurance on the Trust's approach to meeting the CIP challenge, emphasising both financial savings and improvements in clinical outcomes, care quality, and the Trust's long-term sustainability.

8.5.4. The Committee had received Council Assurance Reports from the Procurement Steering Council, CIP Council, Capital Planning Council, Estates & Facilities Management Council, and IM&T Council, with no issues escalated.

8.5.5. RC reflected on the extent of financial intervention from various sources and noted that recent efforts from a Provider Collaborator perspective had been focused on streamlining this to remove duplication. It was anticipated that NHSE would takeover the performance function from PwC in April 2026, and this was expected to alter the level of intervention at a system-wide level.

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

	RESOLVED: The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**TB25/069 Medical Revalidation Annual Declaration 2024/25**
	(KC joined meeting) 9.1. KC, in her role as Responsible Officer, presented the Medical Revalidation Annual Declaration 2024/25 to demonstrate that the medical revalidation process at MWL was operating effectively. 9.2. KC highlighted the following: • The Appraisals Validation team had been consolidated into a single MWL team during 2024/25, and all medical staff had been transitioned to a single appraisal platform. • The initial peer reviews were conducted in partnership with Warrington and Halton Hospitals NHS Foundation Trust (WHH) and NHS University Hospitals of Liverpool Group (UHLG) and a considerable amount of learning had been obtained. Planning was underway for the next peer review with Liverpool at the end of October. 9.3. KC noted that the report highlighted there had been issues regarding appraiser capacity. Work had been undertaken with the Chief Medical Officer (CMO), the clinical leadership team and Divisional Medical Directors (DMDs) to agree expectations for the number of appraisals per appraiser, in order to maintain adequate capacity and consistency. 9.4. Revalidation deferrals, related mainly to maternity leave or long-term sickness, had been granted and returning doctors were given additional time to submit their evidence. KC noted that doctors had been engaged with the process to avoid a deferral wherever possible. 9.5. The report detailed the governance arrangements which supported the fair management of concerns. Additional forums were in place to support and oversee issues relating to capability, conduct, or remediation. 9.6. The report provided assurance that 854 (of 906) appraisals had been completed with 52 not completed (35 recorded as approved missed and 17 as unapproved missed). 132 revalidation recommendations had been submitted to the GMC. 9.7. RT asked if there had been any difficulties in recruiting new appraisers to increase capacity. KC responded that several individuals had expressed interest in taking on the appraiser role, including some who had previously served and wished to return. The recommended allocation was

	approximately four hours per appraisal, with an expectation for appraisers to complete five appraisals each year (amounting to 20 hours annually). Historically, some appraisers had agreed to undertake only one or two appraisals, while others had managed more. This inconsistency had resulted in some appraisers not meeting the five-appraisal benchmark required to maintain their skills. Additionally, work had been carried out with the DMDs to address areas where there were few appraisers and a larger number of consultants, with initial responses from these specialties being positive. 9.8. RC reflected on the need to link medical appraisal with capacity and activity planning, and suggested the Executive undertake a review. 9.9. MS noted that the Revalidation Policy was due for review at the same time as the Capability Policy for the clinical workforce and suggested they be looked at together. Currently there remained two different approaches to the adoption of the national terms and conditions for job planning from the legacy trusts, and this also needed to be addressed to ensure a consistent and effective process. 9.10. RT commented that the national medical appraisal process had traditionally focused on quality and outcomes, rather than productivity. SR commented that there was always a relationship between the two and it should be possible to have a single discussion that addressed both aspects simultaneously. 9.11. HS reflected on the history of medical revalidation which originally focused on safety of clinical practice. 9.12. KC assured the Board that all aspects of performance were regularly reviewed through medical case review meetings, where any issues were escalated via Clinical Directors and DMDs. This forum was recognised as a valuable resource for staff seeking guidance on concerns about medical performance. **RESOLVED:** The Board **approved** the Medical Revalidation Annual Declaration 2024/25 *(KC left meeting)*
10.	**TB25/070 Emergency Planning Response and Resilience (EPRR) 2025/26 Compliance with the National Core Standards**
	10.1. LN presented the Emergency Planning Response and Resilience (EPRR) 2025/26 Compliance Declaration against the National Core Standards and advised that as a Category 1 responder, the Trust was required to meet the NHSE Core Standards for EPRR. 10.2. LN noted that this year the ICB would not be “dip testing” Trust returns as they had done in previous years.

	10.3. The Trust had assessed itself as fully compliant with 60 of the 62 core standards applicable to acute trusts which gave a compliance level of 97%. This was a substantial increase from 44% compliance reported in 2023/24 and 81% in 2024/25. LN advised that it was a requirement to review plans and processes annually and the cycle restarted each year. 10.4. Since 2023/24 learning from incidents (for example the Manchester bombings) nationwide had increased and EPRR requirements for NHS organisations had become more stringent, with additional requirements being introduced. 10.5. The domain were the Trust could not declare full compliance was business continuity and Appendix 2 outlined the action plan to achieve full compliance. LN assured the Board that there were business continuity plans in place, but these were not yet all in the new NHSE specified format. The Trust undertook ongoing retesting and review of departmental and service business continuity plans, that incorporated lessons learnt from exercises and incidents. The 2024/25 EPRR annual report that was presented at Board in July had demonstrated the significant number of tests, incident responses and exercises that had taken place during the previous year. All services will carry out desktop testing of their business continuity plans again in 2025/26, supported by the EPRR team 10.6. RC asked if there was any benchmarking information about the compliance levels across providers and LN explained that this would become available once all the declarations had been submitted. In 2024/25 MWL had been among the top acute trusts in C&M having achieved the highest compliance rate of 44%. **RESOLVED:** The Board **approved** the Emergency Planning Response and Resilience (EPRR) 2025/26 Compliance Declaration with the National Core Standards
11.	**TB25/071 Learning from Deaths Annual Report 2024/25**
	11.1. SO, on behalf of AB, presented the Learning from Deaths Annual Report 2024/25 which provided an overview of the work carried out by the Learning from Deaths Team at MWL during 2024/25 as well as the learning points and themes. 11.2. SO highlighted three key elements: 11.2.1. There were robust processes in place, however, these were historically different at the legacy trusts and an objective for 2025/26 was to fully integrate with a single MWL process. This would be a task for the new Associate Medical Director (AMD) Learning from Deaths Lead, as part of the medical leadership structure, and interviews for these appointments where scheduled.

	11.2.2. Of the deaths reviewed across all the prescribed categories there had been none graded as red during 2024/25, however not all the Structured Judgement Reviews had been completed, due to a shortage of trained reviewers, as several had stepped down. 11.2.3. The report also provided a summary of the key learning during the year, and actions undertaken to share and promote these learning points across the Trust. 11.2.4. RT asked why there were fewer reviewers and whether this was linked to the role of medical examiner. SO clarified that the learning from deaths processes needed to be separate from the role of medical examiner, and the new MWL Learning from Deaths lead would need to be supported to engage and train more reviewers. SO also reflected that there was sometimes overlap with the Patient Safety Incident Investigation Process so the new Associate Medical Director would work closely with the patient safety team. 11.3. RT noted that one of her roles as an Associate NED had been to attend the Mortality Review Group meetings. RT felt this role would be challenging for anyone without a clinical background. SR confirmed that the Trust was working with NHSE to appoint new NEDs and were asking for someone with a clinical background, as the important contribution to the Board was recognised. **RESOLVED:** The Board **noted** the Learning from Deaths Annual Report 2024/25
12.	**TB25/072 2024/25 Statutory Pay Gap Annual Declaration**
	12.1. MS presented the 2024/25 Statutory Pay Gap Annual Declaration and noted that this was previously called the Gender Pay Gap. The report included the Trust pay gaps based on ethnicity, disability, gender and sexuality in line with the Equality Act 2010 and NHS Equality, Diversity, and Inclusion (EDI) High Impact Actions. 12.2. MS highlighted the following: 12.2.1. The gender pay gap has reduced from 30% in 2023/24 to 24.5% in 2024/25 and the median pay gap was now 8.11% (9.56% in 2023/24). 12.2.2. The bonus pay gap in 2023/24 had been in favour of men by 9.17%, however, in 2024/25 there had been a shift in favour of women. 12.2.3. The ethnicity pay gap remained in favour of ethnic minorities and this was mainly due to large representation in medical roles. MS noted that this reduced significantly when medical staff were removed. 12.2.4. The disability pay gap and sexuality pay gap remained fairly stable. MS noted that there had been an improvement in disability disclosure rates which has been an area of focus for several years, which meant the pay gap information was becoming more meaningful. The mean gap for disability was 12.71%. Disclosure of sexuality information remained low, but from the

available information the sexuality pay gap was 5.46%. The bonus gap had widened favouring heterosexual staff.

12.3. MS reported that, overall, there had only been minor change since the 2023/24 pay gap declarations but the general trend was towards a levelling out of gender equality pay disparities. This suggested the interventions and actions previously taken and planned had begun to have an impact.

12.4. It was noted that the shift in the bonus pay gap was driven by national changes to the Clinical Excellence Awards (CEA) scheme for consultants, which had contributed to narrowing the gap.

12.5. MS reported that, in terms of benchmarking, the Trust was ranked 17 out of 17 for mean pay gap in C&M, fourth for the bonus mean pay gap and joint first for the median bonus pay gap.

12.6. The actions for 2025/26 included:

12.6.1. The embedding of the Equality, Diversity, and Inclusion (ED&I) objectives in appraisals for the 2025/26 appraisal window.

12.6.2. The expansion of career progression programmes for people from ethnic minority backgrounds, disabled, and female staff.

12.6.3. Continuing to encourage and remove concerns about disability and sexuality disclosure and to review the reasonable adjustment processes.

12.7. SR reflected that, whilst this was a statutory return, it was also significant for the organisation and commented that there was a possibility that staff may not be aware of why disclosure was important to help the organisation address these disparities, so communicating the outcome would be important.

12.8. RC suggested that this might be an opportunity to engage the staff networks in promoting understanding of why making disclosures was important. MS agreed that the staff networks and on-going work with staff side representatives to illustrate how data was used to support positive actions, would be part of the on-going work in this area.

12.9. MS noted that disclosures about disability had increased when the Trust had introduced a Reasonable Adjustments Policy and staff felt more confident that they would be supported.

12.10. NF asked how staff updated their personal data and made disclosures. MS confirmed that all staff were reminded to review and update their personal data on ESR periodically throughout the year, however, there was some apprehension about data sharing due to privacy considerations. MS recognised that on-going staff engagement and clear communication about the purpose and use of collected data were essential to improving disclosure rates and the data quality.

	12.11. HS noted that some consultant staff had reported reluctance to make disclosures to support CEA applications and suggested a role to support staff might increase representation. MS agreed with HS's suggestion and commented that previously training had been provided on applying for the local awards that had now been abolished, however, there was scope to enhance support for individuals aiming for national awards. 12.12. SO commented that, despite 79% of the workforce being female, there remained a low proportion of women in senior medical roles and asked if there was more the Trust could do to support female progression in the medical workforce. MS commented that there was a women's network, which was chaired by the Director of Strategy. The Executive had discussed how to make medical leadership roles attractive to female consultants. Over time the increase in the number of female medical students was also expected to result in more senior female medics. MS suggested undertaking a review of the current medical leadership structure to investigate if the roles were more attractive to male gendered staff. **Action** MS and the CMO to review the current medical leadership structure to better understand if roles were more attractive to male gendered staff. 12.13. HS reflected that the reasons why staff of certain genders chose to put themselves forward for senior roles or external awards was currently being explored in higher education institutions and the evidence had shown that female staff were more reluctant to put themselves forward. If this was the case at the Trust the first step might be to encourage and support female staff to make these choices. 12.14. RT queried whether there was an understanding about the level of full and part time working among female staff compared to male staff as this often influenced the desire to work in leadership roles. MS responded that since the introduction of the Flexible Working Policy there had been an increase in flexible working requests predominantly from female staff. MS reflected, that historically, there had been a 'glass ceiling' in certain professions in the NHS and work was ongoing to review and de-risk this. **RESOLVED:** The Board **approved** the Statutory Pay Gap Annual Declaration 2024/25
13.	**TB25/073 2025/26 Winter Plan**
	13.1. LN presented the 2025/26 Winter Plan which detailed the process that each system had undertaken against key timescales and the planning checklist. The report also included the completed planning checklist incorporating feedback from the ICB Check and Challenge sessions and exercise Aegis and the proposed responses to the Board assurance statements. 13.2. LN highlighted the following:

	13.2.1. The 2025/26 planning for winter had commenced much earlier than in previous years, with whole-system involvement including acute trusts, ICBs, community providers, and local authorities. 13.2.2. A winter plan checklist was submitted to the ICB in July and feedback had been positive. The checklist had been updated and re-submitted in August. 13.2.3. The Trust had attended Exercise Aegis, an NHS England regional stress test, on 08 September and a check and challenge session with the ICB on 19 September to test the winter plans 13.2.4. A Winter Plan Workshop with system partners had also been held on 22 September. 13.3. The ICB had been assured by the local system plan and commended it as a model of collaborative working. LN thanked the Senior Responsible Officer (SRO) for the UEC Improvement. 13.4. No additional national funding had been allocated to support the winter planning this year, which meant all the actions had to be achieved with existing resources and capacity. 13.5. A set of system escalation cards, based on Opal levels, had been developed to support a coordinated system-wide response. This work had been supported by the Advancing Quality Alliance (AQUA). The cards outlined the specific actions required at each Opal level, detailing the expected responses from community providers, local authorities, and organisations such as NWAS. The escalation cards had been tested on several occasions, including during Exercise Aegis, where three distinct scenarios had been used to assess effectiveness. The outcomes of these exercises had been positive and provided assurance regarding preparedness. 13.6. LN acknowledged that different action may be needed if the escalation parameters where exceeded or responses were not adequate, but the stress testing had been designed to give assurance that the system could cope if effectively coordinated and managed. 13.7. Each Board was required to approve the Winter Plan Board Assurance Statements and the Board was assured the winter plan would be effective. 13.8. SR asked whether the Vaccination Programme was part of the winter plan and LN confirmed that the flu vaccination campaign was part of the plan and internal resources had been allocated to ensure this achieved the target frontline staff vaccination rate. 13.9. AMS noted that the Quality and Equality Impact Assessment (QEIA) was outstanding and asked when this would be completed and when the Board would be informed of the outcome. LN confirmed that the QIEA would be available by 26 September and then incorporated in to the on-going assurance processes. The Board agreed that, unless any significant issues

	were identified in the QEIA, the Winter Plan could be approved, with the QEIA review being delegated to the Executive Committee. **Action** LN to confirm that Quality and Equity Impact Assessment had been received and was reviewed by the Executive Committee and that the Winter Plan was approved. 13.10. GL reflected on the financial Board Assurance statements that had been required to support the financial plan submission earlier in the year and asked if there were any consequences or sanctions if the plan was not successful. RC agreed that the statements could only be made based on the planning parameters and therefore needed to be caveated, as unforeseen or extreme events, such as industrial action or higher than planned for flu numbers, may mean the plan would not be sufficient. RC recommended that a caveat should be included as part of the additional comments, stating that the confidence in the plans' ability to mitigate identified risks was dependent on circumstances remaining within the planning parameters. 13.11. The Board approved the Winter Board Assurance Statement, with the caveats discussed and noting that the approval for the QEIA was delegated to the Executive Committee. **RESOLVED:** The Board **approved** the 2025/26 Winter Plan and the Winter Board Assurance Statement.
Concluding Business	
14.	**Effectiveness of Meeting**
	14.1. Board members agreed that meeting had been effective.
15.	**Any Other Business**
	15.1. GL reported that, the Trust's external auditors, Grant Thornton (GT), had been audited by the National Audit Office (NAO) and, whilst the process had been concluded, GT was waiting on clearance to issue the final Trust audit letter. GL noted that, if the audit certificate was not released prior to the Annual General Meeting on 26 September 2025, GT would provide a statement. SR asked if this was a normal process. GL responded that the Trust's external auditors had been audited previously by the Financial Reporting Council (FRC). However, the audit undertaken by the NAO was on behalf of NHSE as MWL was now a big organisation and any issues with the audit could impact the national position. It was noted that the NAO randomly selected the auditors of large organisations to audit every year. 15.2. LN commented that it should be noted under TB25/070 (Emergency Planning Response and Resilience (EPRR) 2025/26 Compliance with the National Core Standards) the Trust evidence had been audited by MIAA as part of the

	internal audit programme to provide independent assurance of the declaration and substantial assurance had been received. 15.3. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.47 The next Board meeting would be held on **Wednesday 29 October 2025 at 09:30**

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

Trust Board (Public)
Matters Arising Action Log
Action Log updated 24 October 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
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'*. Update 24/09/2025 BAF 1 updated to read 'Response to NW Clinical Senate Report and JOSG'	NB	Oct-25		**Completed**
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 information. The expected end date of the Surgery Claims review would be included in the next report. Update (24/10/2025) An update will be provided in Agenda Item 10 (TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2).	SO	Oct-25		**Included on Agenda**
18	24/09/2025	**TB25/067 Integrated Performance Report** 7.2 Operational Indicators	LN to explore if the LoS performance could be reported to both exclude and include patients classified as NCTR and ready for discharge. Update (24/10/2025) An update will be provided in Agenda Item 6 (TB25/076 / 6.2 Operational Indicators) .	LN	Oct-25		**Included on Agenda**

19	24/09/2025	**TB25/067 Integrated Performance Report** 7.2 Operational Indicators	SO to confirm the number of complaints received about waiting times from patients on cancer pathways. Update (24/09/2025) SO advised that there had been no complaints received regarding cancer wait times in the preceding 12 months.	SO	Oct-25		**Completed**
20	24/09/2025	**TB25/068 Committee Assurance Reports** 8.4 Strategic People Committee	MS to investigate whether the reported AHP vacancy rate was attributable to particular professions within the AHPs or whether it was consistent across all areas and to provide further information. Update (24/10/2025) The AHP vacancy rate, which had previously risen, has now fallen back below target as of September. The most significant gaps were identified in Occupational Therapists (OTs), Operating Department Practitioners (ODPs), Physiotherapists, and Radiographers. Pipelines are in place to address the gaps, with the following expected by December: • OTs: 7.12 WTE •ODPs: 12.8 WTE + 2 WTE apprentices •Physiotherapists: 16.35 WTE •Radiographers: 4 WTE Further monitoring will continue to ensure progress is sustained.	MS	Oct-25		**Completed**
21	24/09/2025	**TB25/072 Statutory Pay Gap Annual Declaration 2024/25**	MS and the CMO to review the current medical leadership structure to better understand if roles were more attractive to male gendered staff	MS / CMO	Jan-26		
22	24/09/2025	**TB25/073 2025/26 Winter Plan**	LN to confirm that Quality and Equity Impact Assessment had been received and was reviewed by the Executive Committee and that the Winter Plan was approved. Update (24/10/2025) QIA undertaken and received Executive approval. The Winter Plan has been submitted as per agreed timescales.	LN	Oct-25		**Completed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	29 October 2025
Agenda Item	**TB25/076**				
Report Title	**Integrated Performance Report**				
Executive Lead	Gareth Lawrence, Chief Finance Officer				
Presenting Officer	Gareth Lawrence, Chief Finance Officer				
Action Required		**To Approve**	X	**To Note**	

Purpose

The Integrated Performance Report provides an overview of performance for MWL across four key areas:

1. Quality
2. Operations
3. Workforce
4. Finance

Executive Summary

Performance for MWL is summarised across 29 key metrics. Quality has 11 metrics, Operations 11 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

The forecast for 2024/25 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

The 11 metrics for Quality provide an overview for summary across MWL

Recommendations

The Trust Board is asked to note the Integrated Performance Report.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
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	Sep-25	93.6%	90.0%	94.1%	Worst 40%
Nurse Fill Rates	Sep-25	97.0%	90.0%	98.2%	
C.difficile	Sep-25	8		58	
E.coli	Sep-25	10		83	
Hospital Acq Pressure Ulcers per 1000 bed days	Jul-25	0.03	0.00	0.10	
Falls ≥ moderate harm per 1000 bed days	Sep-25	0.19	0.00	0.12	
Stillbirths (intrapartum)	Sep-25	0	0	0	
Neonatal Deaths	Sep-25	0	0	0	
Never Events	Sep-25	1	0	2	
Complaints Responded In 60 Days	Sep-25	68.4%	80.0%	53.6%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-25	64.2%	77.0%	65.9%	Worst 10%
Cancer 62 Days	Aug-25	81.7%	85.0%	79.4%	Best 20%
Ambulance Arrival to Vehicle Handover: % <45 mins	Sep-25	90.6%	100.0%	88.2%	
A&E Standard (Mapped)	Sep-25	78.4%	78.0%	78.9%	Best 30%
Average NEL LoS (excl Well Babies)	Sep-25	3.9	4.0	3.9	Best 30%
% of Patients With No Criteria to Reside	Sep-25	23.4%	10.0%	20.9%	
Discharges Before Noon	Sep-25	17.4%	20.0%	18.7%	
G&A Bed Occupancy	Sep-25	97.7%	92.0%	98.0%	Worst 30%
Patients Whose Operation Was Cancelled	Sep-25	1.1%	0.8%	1.0%	
RTT % less than 18 weeks	Sep-25	64.2%	92.0%	64.2%	Best 30%
18 weeks: % 52+ RTT waits	Sep-25	2.3%	1.0%	2.3%	Worst 50%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-25	87.5%	85.0%	87.5%	
Mandatory Training	Sep-25	89.4%	85.0%	89.4%	
Sickness: All Staff Sickness Rate	Sep-25	6.9%	5.0%	6.4%	
Staffing: Turnover rate	Sep-25	0.9%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Sep-25		33,489	11,749	
Cash Balances - Days to Cover Operating Expenses	Sep-25	0.7	10		
Reported Surplus/Deficit (000's)	Sep-25		-25,663	-29,532	

Board Summary - Quality

Quality

Mortality Data: The Trust was expecting to report on HSMR up to and including May-25, however there appears to be an issue with the data that we are investigating with our supplier. The latest SHMI for the period Jun-24 to May-25 is 0.99.

FFT: September positive score and below internal target of 94% (National average score August -2025 is 95%). 2024 National Inpatient Survey results have been received and supporting action plan now implemented.

Clostridium difficile infection: There were 6 HOHA and 2 COHA cases at MWL in September, a reduction compared to August. There were 58 healthcare-associated cases YTD, and the Trust is above NHSE threshold by 10 cases. In the most recent comparative regional UKHSA data available, Q1 benchmarking data indicates that MWL is the only acute Trust in C&M below the C&M rate.

E coli: There were 12 healthcare-associated cases in September, 4 HOHA and 8 COHA. YTD there has been 82 healthcare-associated cases which is 7 cases above NHSE threshold, but 3 cases below the same period last year.

Pressure Ulcers: Only 1 Category 2 HAPU with lapse in care validated at Harm Free Care Panel for July 2025. All cases have been validated till July .

Falls: The Trust has recruited 2 additional Band 5 falls nurses who will cover all 5 hospital sites. This will ensure increased training provision and service improvement. A new Falls Strategy is in development and will be launched in October 2025.

Never Events: 1 never event reported in September 2025. PSII has been commissioned in accordance with Trust PSIRF Plan. Early learning identified and actions taken.

Complaints: September has shown an increase in the number of stage 1 complaints received. It is to be noted that the majority of complaints were once again received for the Whiston site during September in comparison to August.
With regards to the number of complaints closed within the agreed Trust 60 working day target September compliance is recorded at 68%. It should be noted that there now remains no outstanding Legacy (Datix) complaints.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
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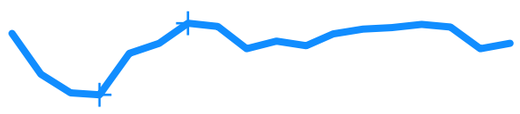
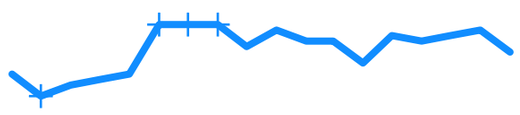
Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Mar-25	86.8	100	90.4	Best 30%	
FFT - Inpatients % Recommended	Sep-25	93.6%	90.0%	94.1%	Worst 40%	
Nurse Fill Rates	Sep-25	97.0%	90.0%	98.2%		
C.difficile	Sep-25	8		58		
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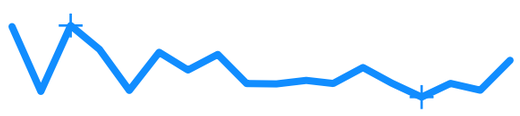
Falls ≥ moderate harm per 1000 bed days	Sep-25	0.19	0.00	0.12		
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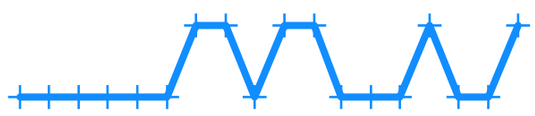
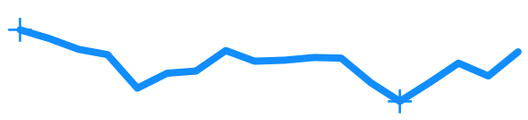
Never Events	Sep-25	1	0	2		
Complaints Responded In 60 Days	Sep-25	68.4%	80.0%	53.6%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E
4-Hour performance improved in September, achieving 73.3% (all types). Trust performance is below National (75%), and ahead of C&M (72.5%). The Trusts mapped 4-Hour performance achieved 78.4%.

Patient Flow
Bed occupancy across MWL averaged 104.4% in September equating to 80.4 patients - an ongoing trend of high occupancy. There was a peak of 120 patients (53 at S&O, 71 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 14% higher than last September, driven by a 23% increase in 0 LOS activity, 1+ day LOS activity was 5% higher than last year. Southport had a 88.5% increase in 0 LOS from September 24 to September 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 9.4 at S&O and 7.5 at StHK, with an overall average of 8.1 days, the impact of non CTR patients being 23.4% at Organisation level, 2.9% higher than August and 4.3% higher than September 2024 (27.8% S&O and 20.7% StHK).

Elective Activity
The Trust had 1,767 52-week waiters at the end of September, (543 S&O and 1224 StHK), 55 65-week waiters and 5 78-week waiters.
The 52-week position is a decrease of 155 from August and the 65-week waiters have decreased by 80 from August to September. 18-Week performance in September for MWL was 64.2%, S&O 64.9% and StHK 63.9%. This was ahead of national performance (latest month August) of 61% and C&M regional performance of 58.4%.

Cancer
Cancer performance for MWL in August improved slightly, at 64.2% for the 28 day standard (target 77%), with Southport achieving 54.2% and St Helens performance being 70.7%. Latest published data (August) shows national performance of 74.6% and C&M regional performance of 70.5%. Performance for 62-day improved, achieving 82.2% (target 85%), with Southport achieving 58.5% and St Helens 89.3%. C&M performance was 76.2% and National 69.1%. 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.

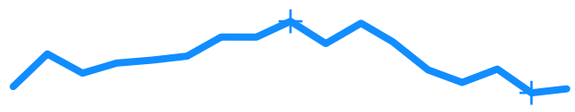
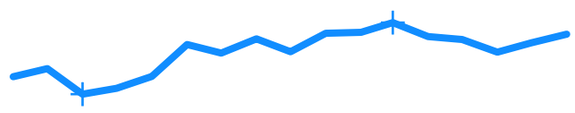
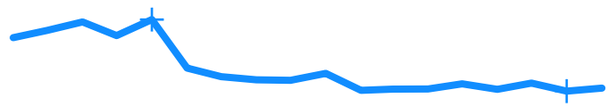
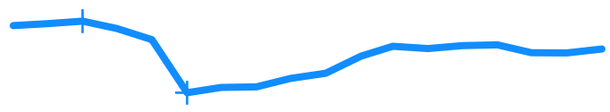
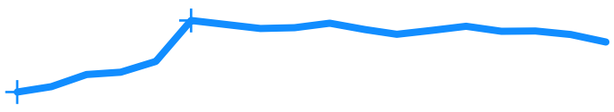
Diagnostics
Diagnostic performance in September was 90.7% for MWL, failing to achieve the 95% target, with S&O achieving 92.3% and StHK 89.8%. MWL performance is ahead of national performance (latest month August) of 76% and C&M regional performance of 85.8%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Aug-25	64.2%	77.0%	65.9%	Worst 10%	
Cancer 62 Days	Aug-25	81.7%	85.0%	79.4%	Best 20%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Sep-25	90.6%	100.0%	88.2%		
A&E Standard (Mapped)	Sep-25	78.4%	78.0%	78.9%	Best 30%	
Average NEL LoS (excl Well Babies)	Sep-25	3.9	4.0	3.9	Best 30%	
% of Patients With No Criteria to Reside	Sep-25	23.4%	10.0%	20.9%		
Discharges Before Noon	Sep-25	17.4%	20.0%	18.7%		
G&A Bed Occupancy	Sep-25	97.7%	92.0%	98.0%	Worst 30%	
Patients Whose Operation Was Cancelled	Sep-25	1.1%	0.8%	1.0%		
RTT % less than 18 weeks	Sep-25	64.2%	92.0%	64.2%	Best 30%	
18 weeks: % 52+ RTT waits	Sep-25	2.3%	1.0%	2.3%	Worst 50%	

Board Summary - Workforce

Workforce

Mandatory Training
The Trust continues to exceed its mandatory training target, maintaining performance at 89.4% 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 is positively exceeding the 85% target (87.5% in September).

Sickness Absence
Sickness absence has increased in September to 6.9%, remaining above the Trust target of 5%.

Top 3 reasons for sickness absence:
Anxiety/stress/depression/other psychiatric illnesses 37.30%
Other musculoskeletal problems 10.08%
Gastrointestinal problems 8.46%

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.

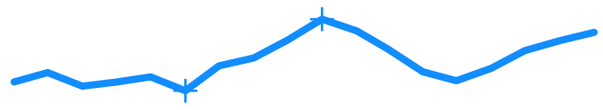
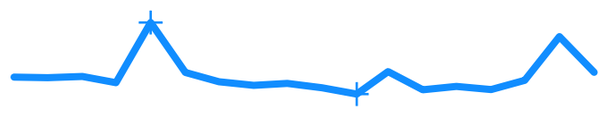
Turnover
In-month turnover has increased in September to 0.9% against a target of 1.1%.

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	Sep-25	87.5%	85.0%	87.5%		
Mandatory Training	Sep-25	89.4%	85.0%	89.4%		
Sickness: All Staff Sickness Rate	Sep-25	6.9%	5.0%	6.4%		
Staffing: Turnover rate	Sep-25	0.9%	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 6, the Trust is reporting an adjusted position of £29.5m deficit. Excluding deficit support funding the adjusted position is £37.1m deficit, £3.7m 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 6, the Trust has successfully transacted CIP of £24.2m year to date, £1.9m above plan. 100% of the £48.2m recurrent target is covered by fully developed schemes.

Cash - At the end of M6, the Trust's cash balance was £1.9m. 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 M6, only Q1 2025/26 has been received, the Trust continues to monitor cash closely and see mitigations to the removal of deficit support funding. Following revenue support requests the September cash balance includes £11m cash support.

Capital - The original 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 £11.7m, which is £21.7m below plan. At M6, the plan assumes expenditure of £16.9m for several system/PDC funded schemes (incl. ePR £7.2m

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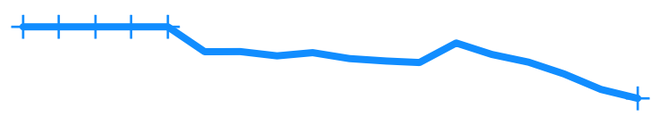
Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Sep-25		33,489	11,749		
Cash Balances - Days to Cover Operating Expenses	Sep-25	0.7	10			
Reported Surplus/Deficit (000's)	Sep-25		-25,6...	-29,5...		

Board Summary

Legacy STHK

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Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-25	79.2	100	89.3	
FFT - Inpatients % Recommended	Sep-25	93.4%	94.0%	93.8%	
Nurse Fill Rates	Sep-25	95.1%	90.0%	96.8%	
C.difficile	Sep-25	5		37	
E.coli	Sep-25	4		48	
Hospital Acq Pressure Ulcers per 1000 bed days	Jul-25	0.04	0.00	0.09	
Falls ≥ moderate harm per 1000 bed days	Sep-25	0.29	0.00	0.14	
Stillbirths (intrapartum)	Sep-25	0	0	0	
Neonatal Deaths	Sep-25	0	0	0	
Never Events	Sep-25	0	0	0	
Complaints Responded In 60 Days	Sep-25	68.0%	80.0%	52.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-25	70.7%	77.0%	76.0%	
Cancer 62 Days	Aug-25	89.3%	85.0%	85.9%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Sep-25	87.1%	100.0%	83.3%	
A&E Standard (Mapped)	Sep-25				
Average NEL LoS (excl Well Babies)	Sep-25	3.8	4.0	3.9	
% of Patients With No Criteria to Reside	Sep-25	20.7%	10.0%	19.9%	
Discharges Before Noon	Sep-25	17.5%	20.0%	19.2%	
G&A Bed Occupancy	Sep-25	98.2%	92.0%	98.3%	
Patients Whose Operation Was Cancelled	Sep-25	1.0%	0.8%	1.1%	
RTT % less than 18 weeks	Sep-25	63.9%	92.0%	63.9%	
18 weeks: % 52+ RTT waits	Sep-25	2.3%	1.0%	2.3%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Sep-25	88.0%	85.0%	88.0%	
Mandatory Training	Sep-25	89.0%	85.0%	89.0%	
Sickness: All Staff Sickness Rate	Sep-25	6.9%	5.0%	6.5%	
Staffing: Turnover rate	Sep-25	1.0%	1.1%	0.9%	

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

Board Summary

Legacy S&O

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Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-25	108.5	100	93.7	
FFT - Inpatients % Recommended	Sep-25	94.0%	90.0%	94.9%	
Nurse Fill Rates	Sep-25	98.8%	90.0%	99.6%	
C.difficile	Sep-25	3		21	
E.coli	Sep-25	6		35	
Hospital Acq Pressure Ulcers per 1000 bed days	Jul-25	0.00	0.00	0.12	
Falls ≥ moderate harm per 1000 bed days	Sep-25	0.00	0.00	0.07	
Stillbirths (intrapartum)	Sep-25	0	0	0	
Neonatal Deaths	Sep-25	0	0	0	
Never Events	Sep-25	1	0	2	
Complaints Responded In 60 Days	Sep-25	69.2%	80.0%	55.2%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Aug-25	54.2%	77.0%	49.4%	
Cancer 62 Days	Aug-25	57.0%	85.0%	62.8%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Sep-25	97.1%	100.0%	96.8%	
A&E Standard (Mapped)	Sep-25				
Average NEL LoS (excl Well Babies)	Sep-25	3.9	4.0	3.9	
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Workforce	Period	Score	Target	YTD	Benchmark
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Mandatory Training	Sep-25	90.3%	85.0%	90.3%	
Sickness: All Staff Sickness Rate	Sep-25	6.8%	5.0%	6.1%	
Staffing: Turnover rate	Sep-25	0.8%	1.1%	0.7%	

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 October 2025
Agenda Item	**TB25/077 (7.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in September 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held during September 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.		
04 September 2025		
Ward Moves and Ward Refurbishment Plan (Southport and Ormskirk sites)	• The Chief Operating Officer introduced the project plan to facilitate ward configurations to optimise beds at Southport Hospital and release a ward to allow for refurbishment. This was supported by an outline estates programme detailing the level of refurbishment required to achieve current Health Technical Memorandum Standards (e.g. bed spaces and bathroom facilities) that were achievable within the allocated funding and timescales. • Committee discussed the options and risk of reducing beds at Southport Hospital. • There was agreement to focus on creating a Surgical Assessment Unit to address surgical outliers and refurbishing ward 10b in 2025/26, with the transfer of some step down/ready for discharge patients to the Ormskirk site.	Assurance
Core Clinical Skills Training Needs Analysis (Update)	• The Chief Nursing Officer and Acting Chief Medical Officer reported that they had reviewed the Training Needs Analysis (TNA) proposal with the Learning and Development team, in relation to the required levels of Safeguarding Training and Resuscitation Training for different staff groups. A modified approach to staff requiring Level 3 resuscitation training had been proposed.	Approval

	• With this change the Committee approved the TNA to move to the implementation phase.	
Cost Improvement Programme (CIP) Strategy 2025 - 2028	• The Chief Finance Officer presented the draft strategy for comment. An updated version would be presented to the Finance and Performance Committee.	Assurance
Medical Photography Service (Southport Hospital)	• The Chief Finance Officer and Chief Operating Officer confirmed that funding had been secured for the Burns and Plastics service that would enable the Medical Photography team to be expanded so a service could be offered at Southport Hospital.	Assurance
NHS England Oversight Framework – Provider Capability Assessment	• The Committee were briefed on the new requirement for every Board to complete a Provider Capability self-assessment that would be reviewed and graded by NHS England. • It was agreed that the Trust Board would be briefed and the initial review and evidence gathering completed by the most appropriate lead director.	Assurance
Nurse Safer Staffing - July	• The Chief Nursing Officer presented the report. • Registered Nurses (RN) overall fill rate had been 97% and the Health Care Assistants (HCA) fill rate 113%. • Average Care Hours Per Patient Day (CHPPD) were 8. • RN and HCA sickness absence rates remained above the Trust target level. • HCA agency spend had continued to reduce. • 106 staffing incidents reported in July, six reported as low harm and 100 as no harm. • There was no reported correlation between lower than planned staffing levels and falls, infection outbreaks, pressure ulcers or medication errors.	Assurance
Freedom of Information (FOI) Compliance Report - July	• The Director of Informatics presented the report. • From April – July the Trust had received 365 FOI requests with a total of 3,061 questions. • Compliance with the 20-day response standard was 58.89% in July. • Actions to improve response time were detailed in the report and would continue to be monitored by the Committee.	Assurance
Procedural Documents Update – August	• The Chief Nursing Officer presented the update. • Of 860 Trust policies and procedural documents 216 were reported as overdue for review. • 509 policies/procedural documents required harmonising, which was a reduction of 11.	Assurance

	• Departments and approving Councils receive regular reports on overdue or soon to be out of date policies/procedural documents. • The outstanding policies were being prioritised to ensure resources were directed to make the biggest impact.	
11 September 2025		
Statutory Pay Gap Annual Declaration 2025	• The Chief People Officer introduced the report which was due to be presented at the September Board (and published) and was based on the average hourly rate of earnings between two population groups. • The mean gender pay gap was 24.5% and the median 8.11%. This continued to reflect the underrepresentation of women in senior medical roles. • The report also covered the pay gaps for other protected characteristics including disability, ethnicity and sexuality and proposed actions to address the pay gaps.	Assurance
NHS National Uniform Project update	• The Chief Nursing Officer presented an update on the national uniform project for Nurses and Allied Health Professionals. • The project timetable was for the new uniforms to be introduced from May 2026. • There would be an initial investment required in the new uniform stock, but this would release longer term savings as staff could retain uniforms as they moved between Trusts. • There were also national projects reviewing uniforms for Medics and facilities management staff.	Assurance
Friends and Family Test (FFT)	• The Chief Nursing Officer reported on the national changes to the FFT mandatory reporting fields. • It was also reported that the current Trust FFT provider was withdrawing from the market and would cease to provide the service from September 2026. • The Patient Experience team would be evaluating the options for a replacement, including any opportunities for a single system across Cheshire and Merseyside (C&M) and a business case would be developed. • This also provided an opportunity to adopt a single approach to FFT across MWL.	Assurance

Financial Forecast Month 4 Review	• The Chief Finance Officer presented the report by Simon Worthington, on behalf of the C&M Integrated Care Board (ICB). • The report included several recommendations, and these would be reported to the September Finance and Performance Committee. • Many of the recommendations were already in progress. • The report had highlighted an optimism bias in the forecast which was acknowledged, however mitigations had also been identified and included to offset this.	Assurance
NHSE Guidance – 2025/26 Financial Management expectations, tools, interventions and oversight.	• The Chief Finance Officer briefed the committee on NHSE's expectations for financial management for the remainder of 2025/26. • This included a self-assessment and peer review of the Finance Well Led Toolkit. • The MWL self-assessment would be developed and presented to the Finance and Performance Committee and Trust Board in October to provide assurance the Trust was following best practice financial controls.	Assurance
Discretionary Spend Controls	• The Chief Finance Officer presented the paper which detailed areas of discretionary spend within the total revenue budget, and the existing controls in place to oversee and manage this discretionary spend. • Further controls were proposed for identified areas of non-pay discretionary spend. • The paper also detailed the proposals from NHS England (NHSE) to assist cash management. It was noted that the Trust had successfully applied for cash support in September to be able to manage the cash flow position, following the non-payment of deficit support funding to C&M. • Committee discussed the balance between central control and disempowering budgets holders and frontline staff, reflecting on the importance of supporting leaders and sharing best practice.	Assurance
Optimising the legacy Electronic Patients Record (EPR) systems	• The Director of Informatics provided a progress report on the work with the current legacy EPR provider to optimise the impact of the systems. • A summary of each workstream and the progress to date against the agreed timescales was provided. All active projects were scheduled for completion during 2025/26.	Assurance

Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the RMC assurance report for September. • The new InPhase risk management module was now fully embedded and being used for all reporting. • There were 1,022 live risks on the MWL risk register with 19 escalated to the Corporate Risk Register (CRR). • Two of the 17 policies/procedural documents aligned to the RMC were overdue for review, with one on the agenda for approval. • The RMC approved eight Emergency Preparedness, Resilience and Response (EPRR) policies and supporting plans.	Assurance
Urgent and Emergency Care (UEC) Improvement Plan Update	• The Chief Operating Officer introduced the report which detailed the progress with the three UEC improvement workstreams; Admission avoidance, In-Hospital and Discharge. The In-Hospital workstream was led by MWL, with four improvement metrics: improving ambulance handover times, increasing Same Day Emergency Care (SDEC) attendances, reducing length of stay in the Emergency (ED) and reducing length of stay for medical inpatients. • Committee noted the improvements against each of the In-Hospital metrics. • Committee also reflected on the limited impact of the other two workstreams. • The UEC improvements were recognised as having a direct impact on the success of the winter plans, that were being stress tested by NHSE.	Assurance
18 September 2025		
Care Quality Commission (CQC) Diagnostic Imaging Inspection Report and Action Plan	• The Chief Nursing Officer presented the update on the action plan developed following the CQC Ionising Radiation Medical Exposure Regulations (IRMER) inspection of Whiston Hospital in August. • The three actions were all in progress and on track to be completed by October.	Assurance
National Inpatient Survey results and action plan	• The Chief Nursing Officer presented the results of the 2024 national inpatient survey, which had recently been published. • MWL had improved in eight of the nine sections compared to 2023. • The areas of least satisfaction remained waiting times, particularly waiting to be seen in ED, waiting for a bed if admission was required and	Assurance

	waiting times for Take Home Medication (TTO) medicines. • Committee discussed actions to improve communications with patients on elective waiting lists and in real time for non-elective and discharged patients. • Regular updates on the impact of the agreed actions would be presented to the Committee.	
Outpatient Improvement Programme Update	• The Director of Strategy presented the update, which focused on future transformation of outpatient services. • Committee discussed the urgent requirement for improvement in the business-as-usual processes to optimise outpatient capacity and address long waits. • New clinic and patient booking guidelines had been issued to standardise the processes across sites and avoid late changes to clinics wherever possible. This was intended to ensure all planned activity took place and provide sufficient notice is provided for patients. • Committee acknowledged that more work was needed to align the expectations and practices across all divisions and further investigation was required to understand why these changes were reported as having a negative impact. This would be discussed at each Divisional Performance Review (DPR). • The remodelling of the legacy STHK clinic templates was recognised as a key enabler for improving the current outpatient booking processes and for a new EPR, and it was accepted that if funding could be drawn down in the current financial year, this process should commence as soon as possible.	Assurance
Emergency Planning, Resilience and Recovery (EPRR) Annual Statement of Compliance	• The Chief Operating Officer presented the annual EPRR compliance statement that was due to be presented to the September Board meeting for approval. • Committee reviewed the evidence and proposed compliance score.	Assurance
Maternity Patient Experience Survey Action Plan	• The Chief Nursing Officer provided a progress report against the 2024 Maternity Patient Experience Survey results action plan. • Of the 35 agreed actions, 15 had been completed 17 were in progress and on track and three were currently behind plan.	Assurance

	• Committee noted the progress and reviewed how the impact of the actions was being monitored, as it was noted the 2025 national survey would target women who gave birth in February, who would currently be experiencing antenatal care. • It was confirmed that regular local questionnaires were being conducted which gave more real time feedback. • The purchase of recliner chairs to enable partners to stay overnight following the birth had been well received. • It was also confirmed that work remained on track for the implementation of the single Maternity Information System in March 2026.	
Medical Workforce Principles	• The Chief People Officer presented the proposed medical workforce principles to sit alongside the general workforce principles that had been developed earlier in the year. • These were to provide guidance for operational managers charged with managing medical staffing and standardise practice across the Trust. • The principles summarised policy, delegation limits and escalation procedures to maintain safe services. • The Committee approved the medical workforce principles.	Approval
Winter Plan and Board Assurance Statements	• The Chief Operating Officer presented the final winter plan, which had been updated following the NHSE stress testing exercise and proposed Board Assurance Statement responses. • Committee endorsed the plan for presentation to the September Board meeting.	Assurance
Finance Improvement Group (FIG) Assurance Report	• The Chief People Officer and Chief Finance Officer presented the assurance reports from the Workforce and Finance Improvement Group meetings.	Assurance
25 September 2025 (Condensed Executive Committee due to PWC finance meeting with NHSE and ICB)		
Mental Health Framework	• The Chief Nursing Officer presented the revised document, that had been amended to reflect previous comments from the Committee. • The framework would also be presented to the Clinical Effectiveness Council and following ratification a delivery plan and escalation flow chart would be developed.	Assurance

	• Committee welcomed the framework which clarified the responsibilities of the Trust in relation to patients with mental health conditions.	
Enhanced Therapeutic Observation and Care (ETOC) Pilot Outcomes	• The Chief Nursing Officer presented the evaluation of the impact of the national NHSE ETOC collaborative pilot at MWL • Four wards had been selected to participate in the pilot, two at Whiston Hospital and two at Southport Hospital, which had the highest demand for supplementary care. • The assessment used to identify enhanced care needs for MWL patients had been judged as effective. • Of the different care models trialled in the pilot, bay tagging had been assessed as most effective. • Further work was required to evaluate the impact on patient outcomes and staffing levels and then a proposal would be brought to the Committee for the roll out of ETOC across the Trust.	Assurance
Ambient Voice Technology (AVT)	• The Director of Informatics presented a proposal to pilot AVT in selected clinical specialties from November 2025. The pilot would be at no cost to the Trust. • Committee requested a demonstration of the technology and a visit for key staff to Alder Hey Hospital where AVT was already in use for clinical notes and clinic letters. • It was noted that C&M ICB were bidding for funding to introduce standardised AVT across the system. • Following the evaluation of the pilot a business case would be developed. • Committee approved the pilot.	Approval
Alerts:		
None		
Decisions and Recommendations:		
Investment decisions taken by the Committee during September 2025 were: • None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 October 2025
Agenda Item	**TB25/077 (7.2)**		
Committee being reported	Quality Committee		
Date of Meeting	21 October 2025		
Committee Chair	Claudette Elliott, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes and Action Log	• The minutes of the Quality Committee meeting held on 16 September were approved following some minor amendments. • There were 17 actions due for completion in October, and all were approved as completed or updated as part of the agenda. • Progress noted regarding the patient portal including the waiting well initiative, digital waiting list and patient reminder processes. Work continues to standardise processes across MWL sites/services, and assurance will continue to be reported via the Patient Experience Council Assurance Report.	Assurance
Quality Committee Corporate Performance Report (CPR).	• The Committee reviewed the Corporate Performance Report (CPR) for September, and it was acknowledged how the report had evolved. • One never event (wrong site block) reported in month with no harm to the patient. Patient Safety Incident Investigation (PSII) commenced. Committee sought further assurance in relation to organisational learning from similar never events and the Local Safety Standards for Invasive Procedures (LocSSIPS). Human factors had been re-introduced. • One Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia reported to be presented to learning panel on 05 November 2025. • Pressure Ulcer validated data presented for July 2025.	Assurance

	• National Early Warning Score (NEWS) scores remain under target in the Emergency Department (ED) – Committee was assured by the actions being taken to secure a sustained improvement. • Complaints received have increased compared to Q1. There had been a further improvement in response times but remains below target. Patient Advise and Liaison Service (PALs) team involved in the EDs to help resolve complaints informally, wherever possible. Some concerns had been raised regarding new maternity pathways, but no formal complaints to date. • Flu/Covid/Norovirus – cases increasing and having an impact on patient flow. Infection Prevention and Control (IPC) teams supporting EDs and clinical teams to promote correct Personal Protective Equipment (PPE) use, timely samples, FIT testing, appropriate use of side rooms. Flu vaccine available for staff with a stretch target for uptake, to protect staff and patients. • Hospital Standardised Mortality Ratio (HSMR) – remained at 86.8 for March 2025 (latest published data). SHMI score of 0.99 (May 2025). • Sepsis – 75% administration of antibiotics within one hour continued to improve, with more work required to address disparity between sites. Assurance was provided that the Trust is not an outlier for patient outcomes.	
Patient Safety Report (Inc. Chair's Assurance Report)	• No new PSII's commissioned within reporting period. • One Patient Safety Incident Review (PSIR), two Learning Reviews (LR), one Expanded Learning Review (ELR) reported. • Falls – reduction in month and per thousand bed days. Fall with harm reported in September now reviewed and downgraded following medical review, due to conclusion of patient collapse. Updated Falls Strategy being presented at Patient Safety Council in November 2025. Thematic review of falls data to be repeated. • Legal analysis of claims – numbers of new claims remaining stable. Hill Dickinson LLP to	Assurance

	review the NHS resolution Claims Scorecard to identify themes or areas of concern. • Quality and Safety Red Lines audit in ED's – areas of good practice found, and areas identified for improvement. Action plans developed. Audits to be incorporated into tendable programme. • Chief Nursing Officer (CNO) and Chief Operating Officer (COO) reviewing escalation processes as part of preparation for winter. • Committee discussion regarding staff incidents and methods of cascading lessons learned. • The October Patient Safety Council assurance reports was noted. There were no alerts to the Quality Committee.	
Quarterly Safeguarding Report – Q2	• Report included assurances regarding achievement of Key Performance Indicators (KPIs) reported to Commissioners, training, activity, local safeguarding partnerships and sub-group attendance. • Deprivation of Liberty Safeguards (DoLS) – Ferrara case law being discussed nationally. Government reintroduced consultation regarding the introduction of Liberty Protection Safeguards (LPS) to replace DoLS. • Section 42 enquiries – increased in Q2with the usual themes of pressure ulcers and discharge. All are investigated by the Safeguarding Team, and many are not substantiated. • Two child deaths reported (not at the Trust) – learning in respect of the correct processes, when conveyed to the Trust. • Training – good compliance noted apart from level 3 adult training due to change to the training needs analysis (TNA) harmonisation across MWL. Forecast to be compliant by end of Q3. • Children in Care (CIC) – Initial Health Assessments (IHA) noted improvement for St Helens. Data for West Lancashire to be included in future reports – 100% compliance with IHA but delays in report production. Further training to be provided for NEDs in respect of the Trust's statutory duties for Safeguarding.	Assurance

Clinical Effectiveness Report (Inc. Chair's Assurance Report)	• Report presented from Clinical Effectiveness Councils from 08 September and 13 October 2025. • Nine policies approved. • Several updates received including Intensive Care National Audit and Research Centre (ICNARC), National Major Trauma Registry annual report, Future Care Planning in Cancer Care, National Emergency Laparotomy Audit (NELA) and National Institute for Health and Care Excellence (NICE). • AAA reports received from Community and Support Services and Medicine and Urgent Care Divisions. • Venous Thromboembolism (VTE) – introduction of VTE as part of Electronic Prescribing and Medicines Administration (EPMA) had been positive. • Resuscitation and Bedside Emergency Assessment Course (BEACH) training discussion at the Committee. • Additional information on resuscitation training compliance to be provided via the mandatory training report to committee in November 2025.	Assurance
Care Quality Commission (CQC) Quarterly Report	• Trust continues to be rated as outstanding overall. • Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) report from Whiston site published 05 August 2025. No rating for this inspection. Three minor recommendations received. Improvement plan in place. • St Helens Urgent Treatment Centre (UTC) report received 06 August 2025. Rated as good. Action plan in place. • CQC engagement and enquiries – meeting took place at Ormskirk site on 17 September 2025 with tour of paediatric department. No concerns raised. • 5-star accreditation and Quality Ward Rounds (QWR) – processes embedded. Independent evaluation to be commissioned. QWRs attended by Executives and Non-Executive Directors and well received by clinical areas.	Assurance
Alerts:		

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 October 2025
Agenda Item	**TB 25/077 (7.3)**		
Committee being reported	Strategic People Committee		
Date of Meeting	22 October 2025		
Committee Chair	Carole Spencer, Non-Executive Director on behalf of Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Workforce Dashboard	Mandatory Training - the Trust continues to exceed its mandatory training target, achieving 89.4% compliance in September, above the 85% threshold. This reflects consistent performance across sites and follows the implementation of the revised Training Needs Analysis (TNA) in August. Those staff groups and teams where Mandatory Training is below the 85% threshold have developed a recovery plan which is being monitored at the Divisional Performance Review monthly meetings. Appraisals - appraisal compliance rose significantly to 87.5% in September, from 74% in August. This improvement coincides with the close of the 2025/2026 appraisal window. Sickness – in-month sickness absence remains above the Trust's target, at 6.9% (5% target). While this reflects regional trends, the Trust continues to experience higher absence rates across Qualified Nursing & Midwifery (7.6%) and Health Care Assistants (HCAs) (10%), with comparatively lower rates in Medical (2.8%) and Allied Health Professionals (AHPs) (4.2%). Vacancy rate - the Trust's vacancy rate remains favourable at 6.5%, below the 8% target. Most staff groups are within thresholds, though HCAs remain high at 14.1%, and targeted recruitment continues. Time to Hire (T2H) - September's average time to hire was 66.7 days, against the 40-day target. Time to hire has improved from August (67.4 days). A	Assurance

	recovery plan has been launched, focusing on: • Proactive follow-up via phone rather than email • Enhanced use of the OPAS system to automate Occupational Health processes • Clear trajectories for backlog clearance in Occupational Health (OH), with progress monitored at People Performance Council (PPC) Turnover - turnover remains stable and below target: • In-month turnover: 0.9% (target: 1.1%) • 12-month rolling turnover: 10.7% (target: 13.2%) Health Work and Wellbeing (HWWB) - pre-employment screening times have improved, reducing from 8 to 6.3 days. The did not attend (DNA) rate for appointments is now at 10%, meeting the Trust target.	
Trust Objectives 2025/26 Q2 Update	The update provided assurance of the progress made towards the 2025–26 Trust objective of "Developing Organisational Culture and Supporting our Workforce". Actions are on track and work is underway to evaluate and demonstrate impact periodically throughout the year in readiness for a full assessment at the end of Q4.	Assurance
HR Commercial Services Objectives 2025/26 Q2 Update	The update provided assurance of the progress made towards the 2025–26 Trust objectives as relating to HR Commercial Service. The Q2 update shows that the 2025/26 HR Commercial Services Objectives are being progressed to plan with service improvement plans being developed to increase onboarding performance in the Lead Employer Service in 2026/27.	Assurance
Belonging in the NHS (Lead Employer) Update 2025/26	The update provided assurance of the initiatives and actions identified as priorities for the "Belonging in the NHS" pillar and supports our ambition of continuing to be the Lead Employer Model of choice. The LE transformation programme is focused on improving the experience of colleagues in training through better communication, inclusive practices,	Assurance

	and streamlined processes. The delivery of the pillar "Belonging in the NHS" is on trajectory for Q1/Q2 and the LE continue to monitor stakeholder engagement by the introduction of pulse surveys in 2025/26. The priorities for Q3/Q4 are to: • Deliver roadshows for East of England and North West in January 2026 • Develop an Anti-Racism plan for the Lead Employer • Develop a communication plan for the roll out of the Sexual Safety Policy. • Develop staff stories and talking heads for Q4 • Establish an Inclusion Matters Network	
New Ways of Working and Delivery Care (Trust) 2025/26	The update provided assurance of the initiatives and actions identified as priorities for year 1 of the "New Ways of Working and Delivering Care" pillar of the 2025-2028 MWL People Plan. The priorities support the delivery of the four commitments identified under this pillar of the strategy and support our aim to have strategic and affordable workforce plans which provide career and development opportunities for our staff.	Assurance
Lead Employer Stakeholder Survey action plan update 2025/26	The paper provided assurance of the delivery of the LE staff survey action plan for Q1/Q2 2025/26. The plan addresses feedback from the LE colleague in training survey in 2024 and also feedback from the recent pulse survey results from 2025/26. A 13-point action plan from addresses the key themes arising from the 2024 survey which is aligned to the NHS People Plan. In advance of launching the 2025 staff satisfaction survey which will be circulated in November 2025 for a period of six weeks, a further Q3 pulse survey has been circulated to gain a further temperature check on current views from stakeholder and colleagues in training to ensure our ongoing actions and commitments continue to align to the LE people plan and the commitment to the Improving Working Lives agenda for Resident Doctors.	Assurance
Trust staff survey action plan update 2025/26	The update provided assurance of the actions delivered following feedback from the 2024 National Staff Survey and provided the timeline and process for the implementation and promotion of the 2025 National Staff Survey.	Assurance

	The 2024 action plan aligned to the pillars of the People Plan and People Promise themes. Activities being undertaken to support the delivery of the plan include those that are Trust wide, led by a relevant Subject Matter Expert (SME) and led by Divisional Directors of Operations and their teams which required a more localised specific response. The 2025 National Staff Survey was launched on the 06 October and will close on the 28 November 2025. The survey is being delivered by IQVIA and has been sent to all members of staff by email, or on paper if no email exists on Electronic Staff Records (ESR). The target response rate is 45% which is an increase from the response rate of 37.8% in 2024. A communications plan has been launched with promotions and incentives and have managers being asked to support staff in the completion of the survey.	
Team MWL - Values/ Culture Update	The paper provided assurance of the Q2 progress made with the Culture and Engagement Plan particularly highlighting two key events; Anti Racism Launch and MWL People Week.	Assurance
Equality Diversity & Inclusion (EDI) Governance	It was recommended that the Trust establishes an Equality, Diversity and Inclusion (EDI) Council to provide assurance to the Strategic People Committees on the achievement of the Trust's strategic and operational objectives in relation to workforce, and patient, equality, diversity and inclusion as set out in the MWL People Plan. The Committee considered the terms of reference of the proposed EDI Council and the three supporting steering groups: • Disability Steering Group • LGBTQIA+ Steering Group • Race Steering Group The Strategic People Committee approved the establishment of an Equality, Diversity & Inclusion Council. It was agreed that membership of the Council and Group should be reviewed and that the terms of reference for the EDI Council should be brought to the November Committee for approval.	Decision

Assurance Reports from Subgroup(s)	It was noted that the following policies have been approved by the People Performance Council • Professional Registration Policy • MWL Under and Overpayments Policy • Neonatal Leave Policy	Assurance
Any Other Business	Committee noted the work being undertaken by the Chief People Officer and Chief Financial Officer to implement the PricewaterhouseCoopers International Limited (PWC) Grip and Control recommendations and maintain a single integrated financial and workforce action and impact tracker.	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
The Strategic People Committee approved the establishment of an Equality, Diversity & Inclusion Council.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 October 2025
Agenda Item	**TB25/077 (7.4)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	23 October 2025		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Chief Finance Officer (CFO) Update	• National CFO meeting to discuss what organisations need to do to stay on track and how NHS England (NHSE) can help Boards deliver. • Contract rebasing trialled across the country, significant amounts of under and over payments across systems, more work needed. • Planning: three year allocations to be agreed, Deficit support funding (DSF) to move into target, Elective Recovery Fund (ERF) recurrent. • Capital to 2029/30 to be agreed. Further allocations for organisations with Public Finance Initiative (PFI) likely, but to be confirmed. £7bn nationally to allocate for infrastructure issues. • Increased focus on productivity going forwards	Assurance
PricewaterhouseCoopers International Limited (PwC) Reviews	• Finance Performance Review Meetings (FPRM) meetings with PwC. Focus on financial improvement. Trust provided clarification on funding for PFI, transaction support and Community Diagnostic Centre (CDC) to both Integrated Care Board (ICB) and PwC. • Grip and Control report was received from PwC - similar to previous reviews we have engaged in. Trust implemented previous recommendations. PwC have suggested further actions given the current financial climate. • Committee reviewed recommendations and discussed the risk and reward of some of the actions. Noted that there are a number of	Assurance

	recommendations already linked to the Trust forecast. • Trust action plan presented, request from Committee for clear timeframes for responses. • Balance sheet review – ongoing	
Committee Performance Report Month 5 2025/26	• Accident and Emergency (A&E) performance was 78.4% in September, above both the national at 75% and Cheshire and Merseyside (C&M) at 72.5%. Best performing Trust within C&M. • Long waits in Emergency Department (ED) a challenge – 18.2% waited over 12 hours in September. • Handover 45 – over 90% of patients arriving by ambulance were handed over within 45 minutes. Southport best across C&M; Whiston site, most improved. • Number of No Criteria to Reside (NCTR) patients is at highest level it's been all year (23.4%). Impacted by reduction in community bed and system-level processes. • 18 Week performance in September was 64.2%. • The Trust had 1,767 52-week waiters at the end of September, 55 65-week waiters and 5 78-week waiters. • Diagnostic 6-week performance for September was 90.7% which remained ahead of both national performance at 76% and C&M performance at 85.8%. The target remains at 95%. • Cancer performance in September improved slightly to 64.2% for the 28-day standard (target 77%) and to 82.2% for the 62-day standard (target 85%). • Bed occupancy averaged 104.4%	Assurance
Finance Report	• The approved MWL financial plan for 25/26 is a deficit of £10.7m. This is a £41m deficit excluding the deficit support funding. • The plan includes £35m of system led strategic opportunities/cost reductions to be realised or reallocated by C&M during 2025/26. • The Trust is reporting a M6 deficit of £37.1m (excluding deficit support funding) which demonstrated an improved run rate and £3.7m better than plan.	Assurance

	• Income assumes variable activity and the Southport CDC being funded by commissioners. Contracts are not yet finalised, and negotiations continue. • The Trust's combined 2025/26 CIP target is £48.2m. In M6, the target has been exceeded with £24.2m delivered to date, £1.9m above plan. • At M6 agency costs equate to £7.8m (2.4% of total pay costs). • The Trust had a closing cash balance of £1.9m. The Trust's Provider Revenue Support application for £11m in October was approved. A further application has been submitted for November for £8m & is awaiting national decision. • Aged debt has increased slightly (debt greater than 90 days at £13.3m in September compared to £12.9m in August). • The capital plan for the year totals £64.6m which includes PFI Lifecycle and IFRS16 Lease Remeasurement. Year to date (YTD) spend is below plan however there are plans in place to ensure no slippage by year end.	
M6 Forecast	• Current plan less deficit support stands at £40.9m deficit • Current run rate would give a £74.9m deficit, therefore improvement required of £34m. • Of this £34m improvement, £33m relates to system supported items and £1m to Trust efficiencies. • Current forecast is a (£6.8m) variance to plan excluding deficit support funding, this includes non-recurrent mitigations. • Committee reviewed the updates following the M5 forecast • Delivery of the forecast depends on significant internal workstreams realising the savings such as bank and agency reductions, plus maintaining the reduction on overtime across the Trust. • Whole Time Equivalent (WTE) currently below planned levels and forecast to reduce in line with efficiencies described above.	Assurance

	• Focus on grip and control forecast to improve the run rate. Working alongside system partners to identify further opportunities. • Discussion regarding the underlying position of the Trust and the impact of significant savings programmes on the ongoing sustainability of the system.	
Cash Update	• Key risks to cash remain deficit funding being withdrawn and delivery of Income and Expense (I&E) forecast • Provider Revenue Support cash applications have so far been approved at £10.9m and £11m. • Application has been submitted for a further £8m to cover November cash requirement • Cash forecast directly linked to I&E forecast in recovery plan. • Cash risk for 2026/27 discussed with acknowledgement that a number of support elements are non-recurrent. • Trust Lead Employer arrangements are not factored in to the current cash regime. This is being picked up with NHSE	Assurance
Month 6 2025/26 Cost Improvement Programme (CIP) Programme Update Clinical Support Services (CSS) & Community Division	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, which equates to 5% for all departments. • At M6, 164 schemes have been delivered with a further 137 schemes at finalisation stage. Current delivered/low risk schemes have a value of £51.5m in year equating to 107% of the target and £40.6m recurrently, 84% of the target. • CSS/Community Division update outlined the focus on recurrent CIP delivery and specialty level supported sessions to deliver run rate reductions.	Assurance
Corporate Benchmarking Update	• Report is submitted on an annual basis • Report compared 2024/25 to prior year returns in line with the national requirements as set out by Chief Executive of NHSE. • We have seen a reduction in costs across years. • Trust costs are at the national lower quartile. • Committee discussed reducing costs of corporate services further presents a risk to the support of the wider organisation.	Assurance

Planning 2026-27 – 2030-31	• Planned approach to the Trust submitting a 5-year plan in December 2025 and the 2026/27 plan in March 2026. • Summarised expected changes to NHS Planning, allocations, business rules and financial oversight arrangements. • NHSE are yet to publish the final technical guidance on the 2026/27 planning cycle – this plan is subject to change and updates will be brought to F&P Committee.	Assurance
Elective Care Performance Review	• Overview of long waiters provided with detail around predictions and anticipated outcome of actions undertaken. • Specialties with long waits – Ears, Nose and Throat (ENT), Trauma and Orthopaedics (T&O), Dermatology, Plastics, Vascular, General Surgery. • Recovery trajectory presented and committee discussed review of historic trajectories and incorporating lessons learnt into future plans.	Assurance
Revised F&P workplan	• Workplan for 2026/27 was approved	Assurance
Assurance Reports from Subgroups:	• Procurement Steering Council Update • CIP Council Update • Capital Planning Council • Estates & Facilities Management Council Update • IM&T Council update	Assurance
Alerts		
None		
Decisions and Recommendation(s):		
The Board is asked to note the report		

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB25/078**			
Report Title	Corporate Risk Register (October 2025)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

1. Risk Management Systems

The MWL Risk Management Framework has been in place since 2023, however a new single electronic system for managing risks, incidents, claims and complaints was implemented in March 2025. This new system (InPhase) replaced the two legacy Trust Datix risk management systems. Following the transition phase normal reporting resumed in July 2025.

Work continues to support the consistent description, scoring and reporting of risks and the systems and processes in each Division/Service to maintain effective risk management. This also includes the review of tolerated risks, and a planned refresh of the Trust Risk Management Framework.

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

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

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

2. Risk Registers and Corporate Risk Registers

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

Risk Register Summary (Appendix 1)

The total number of risks on the MWL risk register was 994 compared to 992 in July 2025.

23 risks are escalated to the CRR compared to 24 in July.

Four new escalated risks are reported on the CRR in October compared to July and five risks have been closed or de-escalated from the CRR.
Financial Implications
None as a direct result of this report
Quality and/or Equality Impact
Not applicable
Recommendations
The Board is asked to note the Corporate Risk Register.

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

October 2025 – MWL Risk Register and Corporate Risk Register Report

1. Risk Register Summary for the Reporting Period

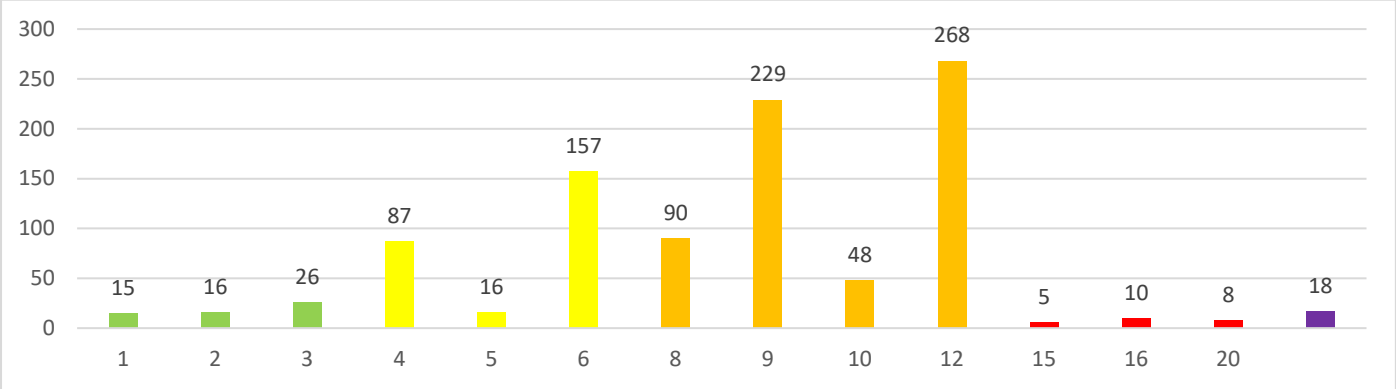
This table provides a high-level overview of the "turnover" in the risk profile of the **MWL** sites compared to previous reporting periods.

RISK REGISTER MWL SITES	Current Reporting Period (October 2025)	Previous Reporting Period (September 2025)	Previous Reporting Period (August 2025)	Previous Reporting Period (July 2025)
Number of new risks reported	28	43	56	65
Number of risks closed or removed	34	39	1	88
Number of risks overdue for review	370	346	318	243
Number of Tolerated Risks	23	24	23	23
Total Number of InPhase risks	**994***	**1022***	**1013***	**992***

**includes new risks not yet scored and tolerated risks*

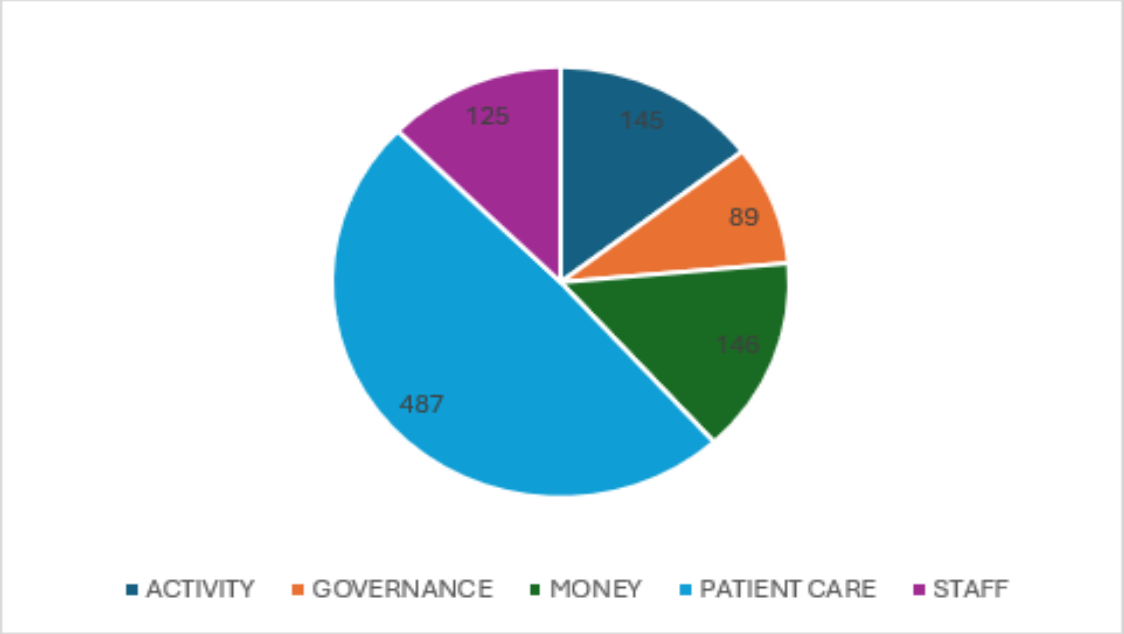
2. Risk Profiles

MWL Organisational Risk Profile
(number of risks by risk score)



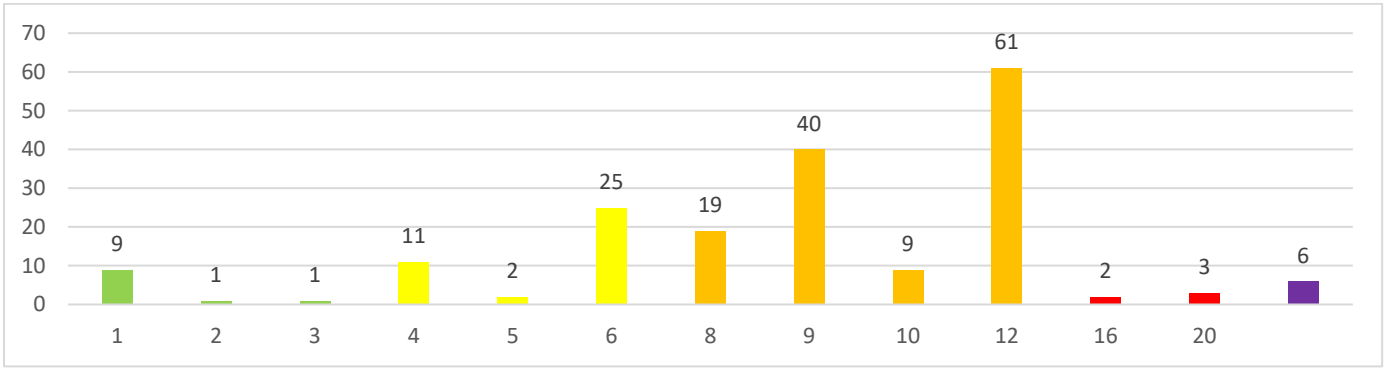
**18 new risks awaiting review and control*

Risk Category overview



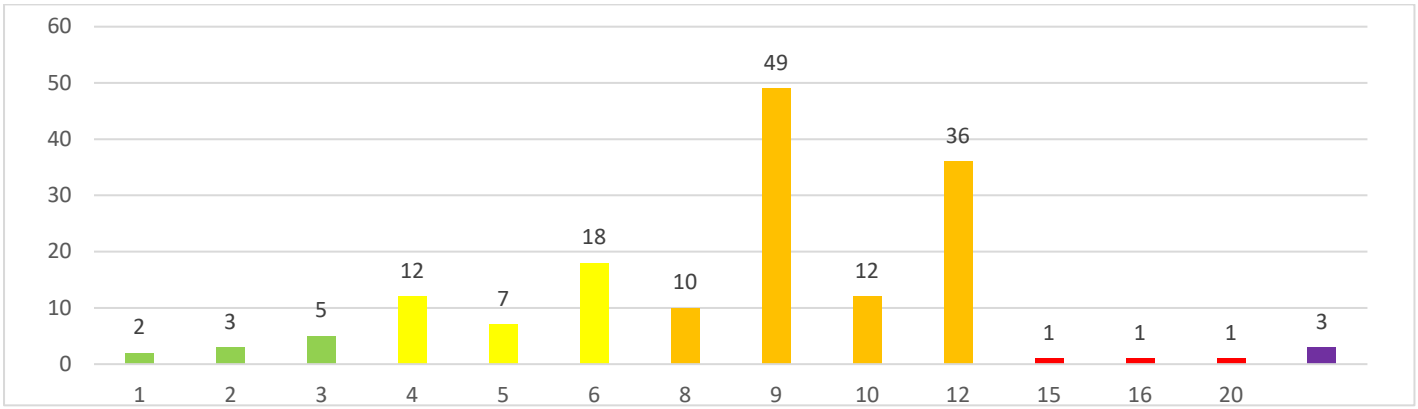
The risk profiles for each of the Trust Care Groups and for the collective Corporate Services are:

Surgical Division (189)



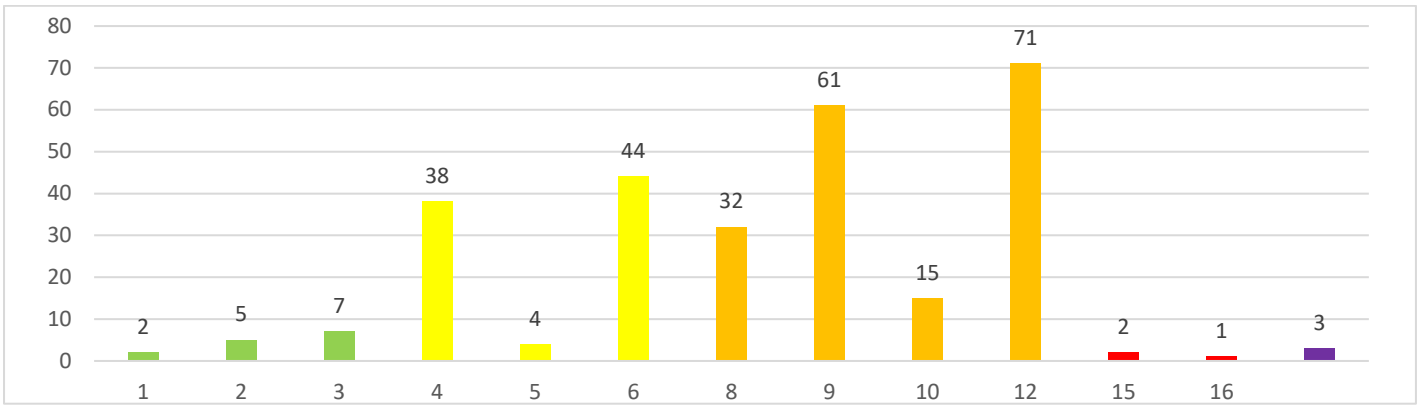
** 6 new risks awaiting review and control*

Medicine & Urgent Care Division (160)



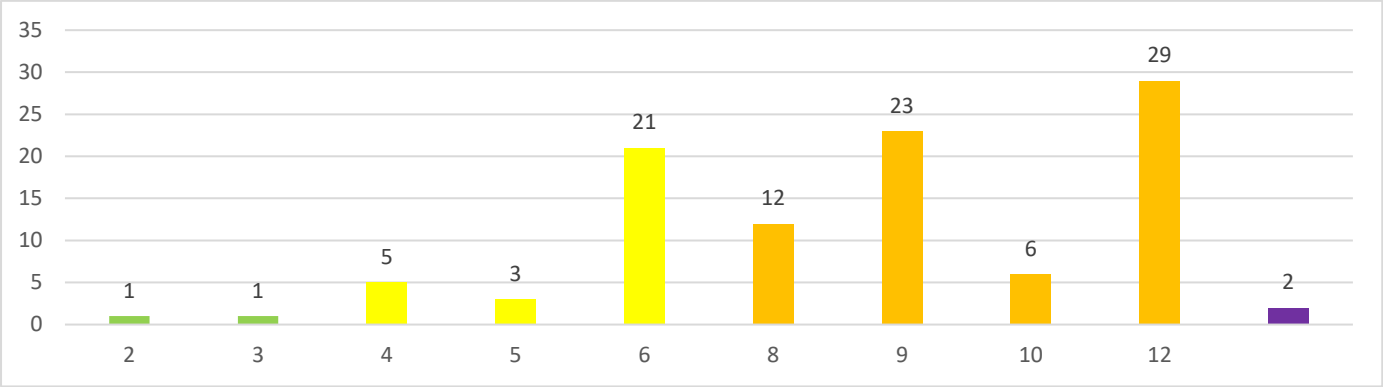
**3 new risks awaiting review and control*

Community & Clinical Support Services Division (285)



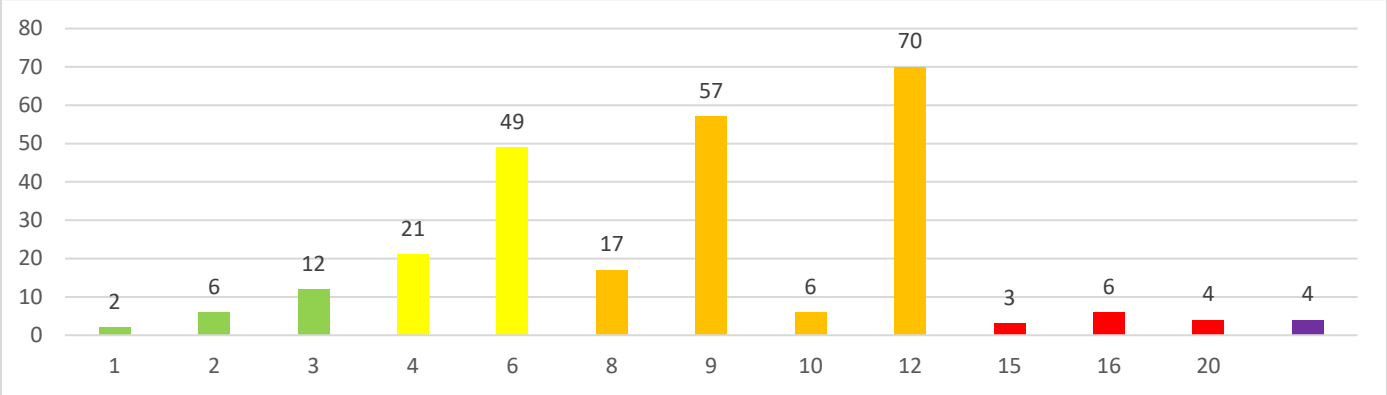
**3 new risks awaiting review and control*

Women & Children's Division (103)



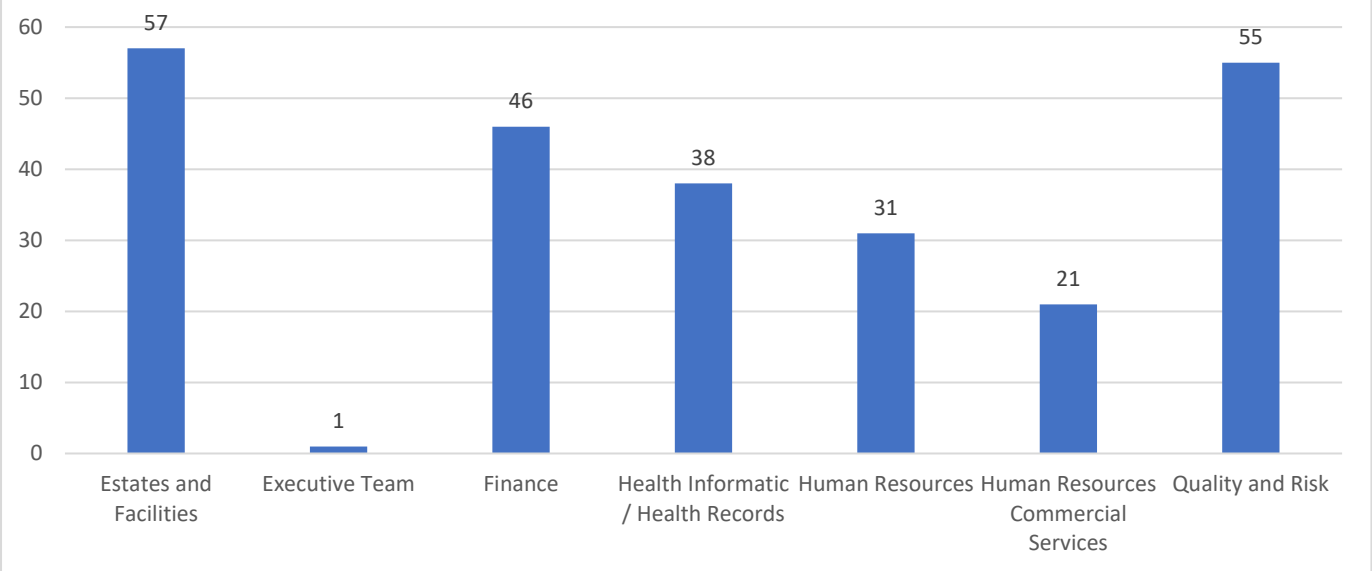
**2 new risks awaiting review and control*

Corporate (257)



**4 new risks awaiting review and control*

The split of the risks across the corporate departments is:



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

Risk No	MWL Risk Id	Title	Risk Owner	Opened	Review date	Grade	Service/Division
1	30	**If** the Trust relies on bank and agency staffing **then** there is a risk to the quality of care, contract delivery and finance performance	Malise Szpakowska	29 Mar 2022	31 Oct 2025	16	Human Resources
2	33	**If** the end-of-life ADS (Automatic Dispensing System) Pharmacy Robot at Southport Hospital malfunctions or fails before replacement, **then** there is a risk to the efficient delivery of the service	Lesley Neary	11 Jan 2023	22 Oct 2025	16	Clinical Support and Community
3	47	**If** the Trust cannot recruit and retain sufficient skilled staff, **then** there is a risk to safe staffing.	Malise Szpakowska	07 May 2013	31 Oct 2025	16	Human Resources
4	80	**If** the critical estates Infrastructure at the Southport and Ormskirk Hospital sites fail, **then** there is a risk to delivery of services and the safety of staff and patients	Nicola Bunce	25 Mar 2025	31 Dec 2025	15	Estates and Facilities
5	263	**If** patients have duplicate hospital numbers, **then** there is a risk of causing patient harm.	Malcolm Gandy	05 Apr 2024	15 Aug 2025	15	Clinical Support and Community
6	361	**If** there is a malicious cyber-attack that the Trust cannot block, **then** there is a risk to the delivery of services and patient/staff information.	Malcolm Gandy	12 Oct 2016	28 Feb 2026	16	Informatics
7	428	**If** the Trust does not replace the end of life/un-supported outpatient letter solution, **then** there would be delays in communicating with patients/GPs etc.	Malcolm Gandy	21 Oct 2021	31 Oct 2025	16	Informatics
8	445	**If** there is insufficient capacity in the Endoscopy Booking Team, **then** there will	Lesley Neary	04 Dec 2024	08 Aug 2025	16	Medicine and Urgent Care

Risk No	MWL Risk Id	Title	Risk Owner	Opened	Review date	Grade	Service/Division
		be delays in booking appointments and waiting times will increase					
9	521	**If** the Trusts cannot deliver sufficient out of hours anaesthetic support, **then** there is a risk to patients in a 2nd time critical maternity emergency at ODGH	Ash Bassi	25 May 2023	24 Sep 2025	20	Women and Children
10	587	**If** the Trust cannot recruit and retain consultant ENT staff, **then** it would not be able deliver the commissioned service	Lesley Neary	02 Nov 2023	24 Sep 2025	16	Surgery
11	591	**If** the Trust does not have effective booking and patient tracking systems in ophthalmology, **then** there is a risk of increased waiting times and patient harm	Lesley Neary	28 Apr 2025	15 Oct 2025	20	Surgery
12	630	**If** the Trust cannot move to a single EPR **then** there is a risk of duplication of effort, barriers to integrating clinical services and suboptimal use of available facilities	Malcolm Gandy	30 Apr 2025	31 Mar 2026	15	Informatics
13	663	**If** the Trusts underperforms against the 2025/26 variable activity plan, **then** it will not generate the expected income to deliver the agreed financial plan	Gareth Lawrence	17 Oct 2024	30 Jul 2025	16	Finance
14	758	**If** the Trust cannot achieve sustainable solutions for the clinical services assessed as fragile **then** patient access and safety will be at risk	Kate Clark	07 Feb 2025	10 Oct 2025	16	Strategy
15	791	**If** the Trust cannot agree a service specification with commissioners, **then** there is a risk to the delivery of a quality Dietetic service for children and young people	Sarah O'Brien	06 May 2025	22 Sep 2025	15	Clinical Support and Community

Risk No	MWL Risk Id	Title	Risk Owner	Opened	Review date	Grade	Service/Division
16	914	**If** the Trust experiences increased demand and bed occupancy above planned capacity, **then** there will be reduced patient flow	Lesley Neary	13 Apr 2015	30 Jul 2025	20	Medicine and Urgent Care
17	934	**If** Commissioners do not honour the revenue funding for the Southport Community Diagnostic Centre, **then** the Trust will have an increased financial pressure	Gareth Lawrence	09 May 2025	10 Jul 2025	20	Finance
18	978	**If** there is insufficient funding from NHS Wales, **then** there is a risk to the level of care MWL can deliver for plastic surgery patients in North Wales	Lesley Neary	15 Sep 2022	30 Jul 2025	20	Surgery
19	1008	**If** Commissioners do not agree contracts for 2025/26 **then** there is a risk to Trust income	Gareth Lawrence	13 May 2025	15 Jul 2025	20	Finance
20	1044	**If** the obsolete Whiston Hospital Decontamination Unit FC4 Washer Disinfectors are not prioritised for replacement, **then** there is a risk of service disruption which will delay patient care	Nicola Bunce	02 Oct 2024	30 Jul 2025	16	Surgery
21	1117	**If** the 2025/26 Block contract for UEC activity does not reflect demand, **then** the Trust will have insufficient income to fund the service	Gareth Lawrence	05 Jun 2025	15 Jul 2025	20	Finance
22	1118	**If** the 2025/26 Financial plan system-wide CIP schemes and risk share opportunities do not materialise, **then** the Trust will not be able to deliver the agreed financial plan.	Gareth Lawrence	05 Jun 2025	15 Jul 2025	20	Finance

Risk No	MWL Risk Id	Title	Risk Owner	Opened	Review date	Grade	Service/Division
23	1125	**If** there are data quality errors and patient number mismatches due to legacy IT systems, **then** there is a risk of patient harm	Malcolm Gandy	04 Sep 2019	31 Oct 2025	15	Informatics

Blue text denotes risks escalated to the CRR since the July report

4. Risks de-escalated from the CRR since the last Report

No	Risk ID	Risk Description
1	319	Interventional Radiology consultant cover
2	400	Audiology Work areas Ormskirk District Hospital
3	565	Fob access system at Southport Hospital
4	861	CPE screening within MWL not being in line or compliant with national requirements
5	925	Back log patients on the partial booking list at Southport hospital

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB25/079**			
Report Title	Board Assurance Framework (October 2025)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

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

Executive Summary

The MWL BAF is reviewed four times a year, the last review was in July 2025, this review captures the changes that have occurred during Q2 (2025/26).

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

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

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

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

Proposed changes to risk scores.

No changes to the BAF risk scores have been recommended at the time, but it is anticipated that the score of BAF 3 will be reviewed in January.

Financial Implications

None directly because of this report

Quality and/or Equality Impact

Not applicable

Recommendations

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

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

Appendix 1

Board Assurance Framework Quarterly Review – Q2 2025/26

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

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

~~Score through~~ = proposed deletions/completed

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Chief Medical Officer/Chief Nursing Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets. • Failure to deliver CQUIN element of contracts, if required • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care. • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness, or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints. • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Midwifery Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • Maternity Incentive Scheme. • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family scores • Quality Ward Rounds • Ward accreditation programme • Patient survey action plans **LEVEL 2** Board Assurance • IPR/CPR/DPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing & Midwifery Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework **LEVEL 3** Independent Assurance • National clinical audits • Annual CQUIN Delivery (if required) • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC ~~Insight and~~ Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • Maternity Incentive Scheme/Saving Babies Lives	Embedded divisional performance management/governance systems. Complete implementation of post transaction corporate nursing and medical management structures. Completion of Quality Impact Assessment and Board Assurance Checklist for the system led financial savings schemes for 2025/26 Close regulatory breaches identified in the CQC UEC Reports (December 2025)	Routinely achieve 30% of discharges by midday 7 days a week to improve patient flow (2025/26 interim target of 20%) Single set of key clinical and quality policies for MWL (March 2026) Finalise N&M strategy on appointment of Chief Nurse ~~DON~~ (Revised to March 2026) Response to the NW Clinical Senate Report and JOSG – Ormskirk Maternity Unit (Revised to December 2025)	Achieve new complaints response time of 60 days (Revised to November 2025) Achieve 2025/26 agreed quality improvement Trust Objectives (March 2026) ~~Implement outstanding actions from the Radiology, Emergency Care and urgent Treatment Centre CQC Inspections (December 2025)~~ Delivery of the GMC trainee survey results action plan (Revised to December 2025) ~~Review of medical bed base and non-elective pathways following clinical summit (December 2025)~~ Review of MWL ward accreditation programme (revised to November 2025) ~~Review the role of the Maternity and Neonatal Safety Champions (September 2025)~~ Review MWL QIA SOP in line with ICB process (Revised to December 2025)

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

Exec Lead: Chief Finance Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty. • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders. • Failure to deliver strategic financial plans. • Failure to control costs or deliver CIP. • Failure to implement transformational change at sufficient pace. • Failure to continue to secure national PFI support. • Failure to respond to commissioner requirements. • Failure to respond to emerging market conditions. • Failure to secure sufficient capital to support additional equipment/bed capacity. • Failure to obtain sufficient cash balances. • Failure to obtain on going transaction support. • Failure to deliver financial plans. **Effect:** • Failure to meet statutory duties. • NHSE Single Oversight Framework rating. **Impact:** • Unable to deliver viable services. • Loss of market share External intervention	• Annual operational and financial plan • System financial plan • Annual Business Planning • Annual budget setting • CIP plans and quality impact assurances processes • Monthly financial reporting – with run rate and forecast • ~~Service line reporting~~ • 3-year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • Provider Licence Conditions • Service Improvement Team capacity to support delivery of CIP and service transformation • ~~Signed Contracts with all ICBs and Spec Comm~~ • Premium/agency payments approval and monitoring processes • Internal audit • ~~Compliance with contract T&Cs~~ • Standards of business conduct • SFIs/SOs • Conflict of interest declarations • Benchmarking and reference cost group • Divisional ownership of finance and CIP plans • Productivity reviews and benchmarking • Underlying financial position review with NHSE/ICB	**LEVEL 1** Operational Assurance • Monthly divisional performance reviews (DPRs) • Finance Improvement Groups • CIP Council Meetings • Agency and locum spend approvals and reporting process. • Operational planning • ~~Premium Payment Scrutiny Council~~ • Vacancy control panel **LEVEL 2** Board Assurance • Finance and Performance Committee and reporting Councils -run rate and forecast • Annual Financial Plan • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT, corporate benchmarking, ERIC) • Internal Audit Programme • Well Led finance self - assessment and peer review **LEVEL 3** Independent Assurance • Audit Committee • ICB & NHSE monthly reporting and MWL review meetings • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit/VFM reports • Head of Internal Audit Opinion • NHSE scrutiny of cash applications • NHSE oversight framework segmentation • PWC Grip and Control Review	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, considering current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites. Long term equipment replacement plans for key equipment (not included in the PFI agreement and for the non-PFI sites), inc. imaging, HSDU Completion of the Finance Well Led Self-Assessment (October 2025)	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances. At the earliest opportunity move back to longer term financial planning with rolling plans for 3 – 5 years. Development and delivery of the 3 year financial recovery plan, aligned to the ICB recovery plan (March 2028) Assurance that the ICB UEC improvement plan will deliver tier 3 CIP savings targets in 2025/26 Agree contracts with the C&M ICB for 2025/26	Deliver the agreed 2025/26 operational and financial plans, including the CIP target (March 2026) Deliver the 2025/26 Capital Programme (March 2026) Cash Management Plans for 2025/26 (March 2026) Work with ICB and NHSE financial improvement programmes to achieve the 2025/26 financial plan (March 2026) Annual Planning Cycle for 2026/27 (February 2026) Implement grip and control review recommendations (November 2025)

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Failure of external parties to deliver required social care capacity **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Patients treated in ED or escalation beds. **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Negative impact on patient outcomes and experience	• NHS Constitutional Standards • Divisional activity profiles and work plans • System Winter Plan • Divisional Performance Review Meetings • ED RCA process for breaches • Tumour specific cancer waiting time recovery plans • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events • Bed occupancy rates • Number of super stranded /patients who no longer meet the criteria to reside	**LEVEL 1** Operational Assurance • Winter resilience plans • Financial Improvement Groups • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans • Monthly Executive Committee Divisional Performance Reviews **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance monthly oversight meetings	Implementation of routine capacity and demand modelling A defined preferred option and capital secured for Shaping Care Together programme. Implementation of CDC at Southport and Ormskirk sites.	Assurance that there is sufficient system response to operational pressures and reducing the number of patients who no longer meet the criteria to reside. Continue to deliver Productive Partners recommendations to improve elective activity productivity and maximise capacity (Revised to March 2026) C&M UEC Improvement Programme for 2025/26 to enable MWL to decrease escalation capacity and improve patient flow, achieve ambulance handover targets, reduce 12-hour breaches and improve ED waiting times (March 2026) ~~2025/26 Winter Plan - for board sign off in July 2025 and testing September 2025. To include Winter Plan BAF Assurance Statements (September 2025)~~ Improve OPD capacity utilisation (March 2026)	Deliver the internal transition and transformation programme to address fragile services by service integration and alignment across MWL (Revised to December 2025) Deliver the 2025/26 elective recovery, and ED, diagnostic and cancer waiting time targets set out the national planning guidance (March 2026) 65 week waits elimination recovery plan (December 2025) and 52 week recovery plan (March 2026) Cancer waiting times recovery plans (January 2026) Elective activity recovery plan (March 2026) Develop operational plan for 2026/27 (February 2026)

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

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff. • Increased external scrutiny/review. **Impact:** • Reduced financial viability and sustainability. • Reduced service safety and sustainability • Reduced operational performance. • Increased intervention	• Communication, Media and Public Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR/FOI • Board media roundups and flash briefings • Work with ICB and NHSE communications teams	**LEVEL 1** Operational Assurance • Winter plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • Daily/weekly media briefings and board flash reports for urgent issues • Quarterly communications and media reports **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan/objectives **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways • Provider representative at Place quarterly ICB performance meetings • Provider Collaboratives/Alliance	Optimise opportunities for Neighbourhood Healthcare Hubs and Integrated Healthcare Organisations for the local population in partnership with Place/LA's and other key stakeholders	Creation of good working relationships with new Healthwatch/PBP areas post transaction. ~~Complete the stage 2 NHSE assurance process for the SCT Pre-Consultation Business Case (PCBC) and plan for period of public consultation July – September 2025 (Revised to October 2025)~~ SCT consultation report and complete Decision Making Business Cases (April 2026) Engagement with the system wide CIP and service change programmes to deliver the C&M financial plan for 2025/26 (March 2026)	Develop the MWL Communications, Media, and Public Engagement strategy for approval by the Trust Board (revised to February 2026) ~~Complete the SCT programme of public engagement/consultation events (September 2025)~~ Continue programme of CQC site visits to maintain understanding of the Trusts issues and responses (March 2026)

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Chief People Officer

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

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

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

Exec Lead: Chief People Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation Loss of market share	• Trust brief live • MWL News • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Workforce & Development Operational Plan • Learning and Organisational Development Operational Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Operational plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • Trust Values • Medical Workforce OD plan • Talent Management action plan • Equality, Diversity, and Inclusion Operational plan	**LEVEL 1** Operational Assurance • Finance and workforce Improvement Group • Monitoring of bank, agency and locum spend • Workforce operational plans and information dashboards • Vacancy control panel **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council and HR Commercial Services Council • Finance and Performance Committee • Committee Performance Report • Staff Survey • Monthly monitoring of vacancy rates Labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group • MWL People Plan 2025-2028 • Nurse safer staffing % **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report	Monthly Provider Workforce Returns (PWR) Achieve bronze level Northwest Anti-Racism Framework (revised to November 2025) ~~Delivery of the Sexual Safety charter action plans and policy (revised to September 2025)~~ Delivery of the updated NHSE Sexual Safety Charter Assurance Framework action plan by April 2026, Delivery of the NHSE12 week, 10 Point Plan to Improve the Working Lives of Resident Doctors published on the 29th August 2025.	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (On-going)	Continue to provide the necessary support for organisational change to implement the remaining management structure for the MWL integrated operating model (continues in 2025/26) Delivery of the 2024 staff survey action plan and engagement events (March 2026) Continue Healthcare Support Worker quarterly recruitment events for each hospital site for substantive and bank staff (on-going) ~~Complete single temporary workforce resourcing solution for MWL. Model approved July 2025 for implementation by Q3 (Revised to November 2025)~~ Complete an updated options appraisal of the service delivery and financial benefits of moving to a single resourcing solution aligned to the current NHS context. (November 2025) Deliver the agreed 2025/26 workforce plans to support the operational and financial targets set out in the National Planning Guidance (March 2026) Deliver the agreed Trust EDI priority developments 2025-2028 (March 2029)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

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

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

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register • Service improvement plans • MWL Digital Strategy 2024-2027 • Microsoft Defender for Endpoints • MFA protection for confidential data – enforced on non-Trust devices • Annual DSPT self-assessments • C&M Major digital Incident planning exercises	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Information security dashboard • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring • Monthly cyber security operational meeting **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • IM&T Council • Information Security Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Groups • Information Governance Group • Quarterly Board Cyber Security Reports • Shared EPR Programme Executive Board • AI and RPA Group **LEVEL 3** Independent Assurance • Internal/External Audits • CareCert, Cyber Essentials, External Penetration Testing • Cyber Essentials Plus accreditation - MMDA. • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments	Annual IT Corporate Governance Structure review Technical Development of staff ~~Mitigation plans to be agreed with current EPR supplier (revised to July 2025)~~ ~~Approval of EPR procurement and implementation timetable to deliver a single EPR for the Trust (September 2025)~~ MWL Artificial Intelligence Policy (November 2025)	IT communications strategy Digital Maturity assessment Cyber Essential Certification/ Accreditation (revised to March 2026) Migration from end-of-life operating system at S&O sites (revised to November 2025)	Achieve HIMMS Level 5 2018 standards and core digital capabilities and WGLL standards (revised to September 2028 due to impact of extended EPR replacement programme) Windows Server 2008 and 2012 Servers are gradually being retired and will be fully replaced, with 3 outstanding (Revised to March 2026) Delivery of the Frontline Digitisation Programme to optimise Careflow EPR and implement new functionality to meet the core digital capability standards (full implementation will only be delivered when the new single EPR is in place) Review of Digital Maturity Benefits that can be delivered within existing system capability Plan to be finalised (revised to November 2025) Delivery of Community EPR (revised to March 2026) Cyber Essentials Plus for MWL (March 2026) Implementation of Maternity Information System (revised to March 2026) Implement EPMA at the Southport and Ormskirk Hospital sites (October 2025) Deliver the 2025/26 IT Capital expenditure plan

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB25/080**			
Report Title	Aggregated Incidents, Complaints and Claims Report (Q2)			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Ash Bassi, Acting Chief Medical Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

The aim of this paper is to provide the Board with an update report on the management of incidents, complaints, concerns and claims during Quarter 2 2025/26.

Executive Summary

Incidents

- A total of 7,713 incidents were reported across MWL in Q2 2025/26.
- Of these, 5,679 were patient safety incidents.
- 56 patient safety incidents were classified as moderate harm or above.
- The most frequently reported patient safety incidents in Q2 were:
  - Pressure Ulcers, including those not acquired under Trust care, were the highest reported Trust wide (901). 79% were community acquired and 21% hospital acquired, which was similar to Q1
  - Accidents including slips, trips, falls, and collisions were the second highest reported incidents in Q2 (851)

Complaints & PALS

- The Trust received 161 first stage complaints in Q2.
- The Trust received 16 stage 2/reopened complaints in Q2.
- The Trust closed 120 complaints in Q2.
- Clinical treatment was the main theme for complaints, in line with previous quarters.
- Emergency Department remained the main areas to receive complaints.
- The Trust received 1,232 Patient Advise and Liaison Service (PALS) contacts in Q2 (not including Ask Rob or Compliments).

Claims & Inquests

- In Q2 the Trust received 24 new claims: 15 for legacy STHK and 9 for legacy S & O (claims relate to pre MWL).
- The Trust received 27 new inquests, and 28 inquests concluded.
- No Prevention of Future Death (PFDs) were issued during that period.

No trends were identified from incident analysis for Q2.

Financial Implications

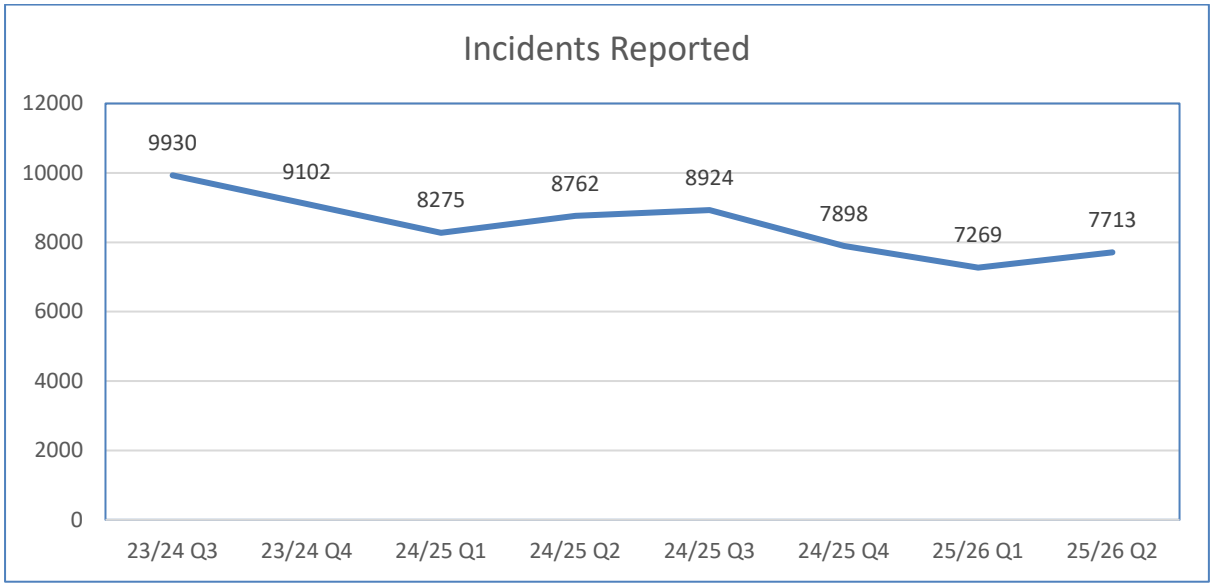
There is a likely financial impact of upheld claims which at this point in time cannot be quantified.

Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Aggregated Incidents, Complaints and Claims Report (Q2).	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

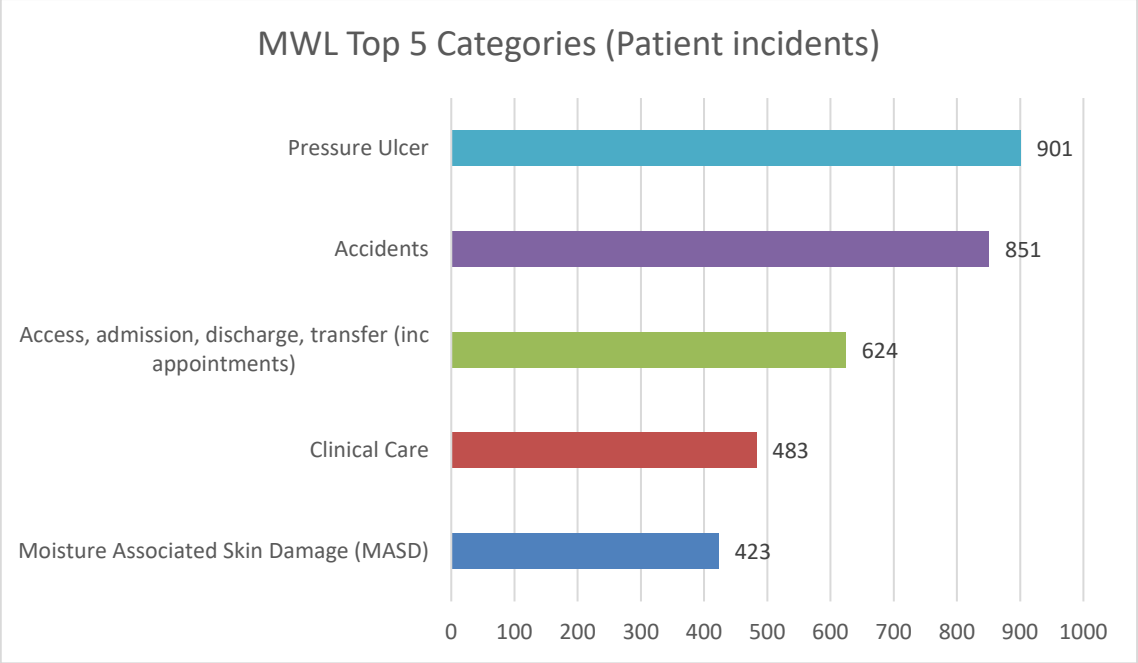
1. Introduction

This paper includes reported incidents, complaints, PALS contacts, claims, and inquests during Quarter 2 2025/26, highlighting any trends, areas of concern and the learning that has taken place. In March 2025 the Trust moved to a new Incident Reporting System, InPhase, which brought all sites onto one reporting platform to record incidents, complaints, PALS, and claims.

2. Incidents



MWL Q2 incidents reported	
5,679	Incidents affecting patients
635	Incidents affecting staff (examples include accidents; staffing or HR incidents)
1,347	Incidents affecting the Trust or other organisation (examples include bed availability; notifications of staffing levels; delayed discharges; equipment issues and queries raised by system partners)
52	Incidents affecting visitors, contractors or members of the public



There was an increase in the number of incidents reported across MWL during Quarter 2 of 2025/26, with a total of **7,713** incidents, up from **7,269** in Quarter 1. The majority of these were patient-related incidents, accounting for **5,679** cases.

Among the highest categories for patient-related incidents:

- **Pressure ulcers** – including both those acquired while under MWL care and those acquired externally – were the most frequently reported in Q2, with 901 cases.

- **Accidents** – including slips, trips, falls, and collisions – were the second highest reported patient events (851).

2.1 Incidents by harm category

The table below illustrates incidents by harm for Quarter 2 2025/26.

In Q2 there were four deaths recorded across all sites which is the same as the previous quarter. The percentage of severe incidents and deaths against the total of all patient incidents is 0.31% for Q2 2025/26 compared with 0.23 % for the year 2024/25. This will continue to be monitored in the coming quarters.

The deaths in Q2 2025/26 relate to a delay in diagnosis, a delay in treatment, delay in observations, and a fall incident. All incidents are subject to Trust review to identify learning and improvement.

MWL	24/25Q 2	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2
Moderate	35	33	54	67	38
Severe	9	9	6	14	14
Death	2	4	2	4	4
Total	46	46	62	85	56

2.2 PSII incidents and Learning

The management of patient safety includes identification, reporting, and investigation of each incident, and the implementation of any recommendations following safety reviews, dissemination of learning to prevent recurrence, and implementation of changes in practice when required. The majority of incidents will not require an in-depth Patient Safety Incident Investigation (PSII) and the Trust will use other review tools to identify learning and recommendations.

One of the four principles of the Patient Safety Incident Response Framework (PSIRF) is to employ a proportionate response to ensure that an incident review is considered and is proportionate to its nature and impact. As such, all incidents are initially reviewed and a collective decision made by both divisional and central safety team colleagues on the appropriate response for the incident.

Initial patient safety reviews will be escalated to the Executive led weekly Patient Safety Panel to determine if incidents should progress to a PSII and where there is significant learning for the organisation. This differs from the former Serious Incident Framework approach of all incidents with a severe harm categorisation progressing to a Root Cause Analysis (RCA). Nationally it has been recognised the number of PSIIs commissioned would be lower than the former number of RCAs to allow more time and resource to focus on improvement work. For quarter 2 there were four PSIIs commissioned and seven expanded learning reviews (less in depth than a PSII but an appropriate systems based approach to identify learning). Please see table below.

Q2 2025/26	**Total**
Learning Reviews	0
Expanded Learning Reviews	7
MDT / AAR	0
Number of Patient Safety Incident Investigations (PSII) commissioned	4

There were four PSIIs commissioned for Q2 2025/26.

Of the PSIIs reported in Q2, the two agreed in July involved failures to recognise a deteriorating patient and were graded as resulting in fatal harm and presented to Patient Safety Panel. The other two, reported in September, included one Maternity and Newborn Safety Investigation (MNSI) case and one Never Event involving a wrong site block.

2.3 Duty of Candour

The duty of candour process has been commenced or completed for all incidents where harm has been confirmed as moderate or above. The investigation and validation of a number of Q2 reported incidents is still ongoing. In accordance with policy, Duty of Candour will be initiated following confirmation of harm.

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

3. Complaints

Closed Complaints	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26
Not Upheld	22	12	22	17
Partially Upheld	86	79	89	86
Upheld	25	16	24	17
Total	**133**	**107**	**135**	**120**

Themes of Closed Complaints (Top 5)	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26
Clinical Treatment	69	63	61	54
Patient Care (Nursing)	18	20	19	17
Values & Behaviours	14	6	2	5
Communication	21	14	14	21
Admission & Discharge	0	1	9	4

*Figures at time of reporting from InPhase

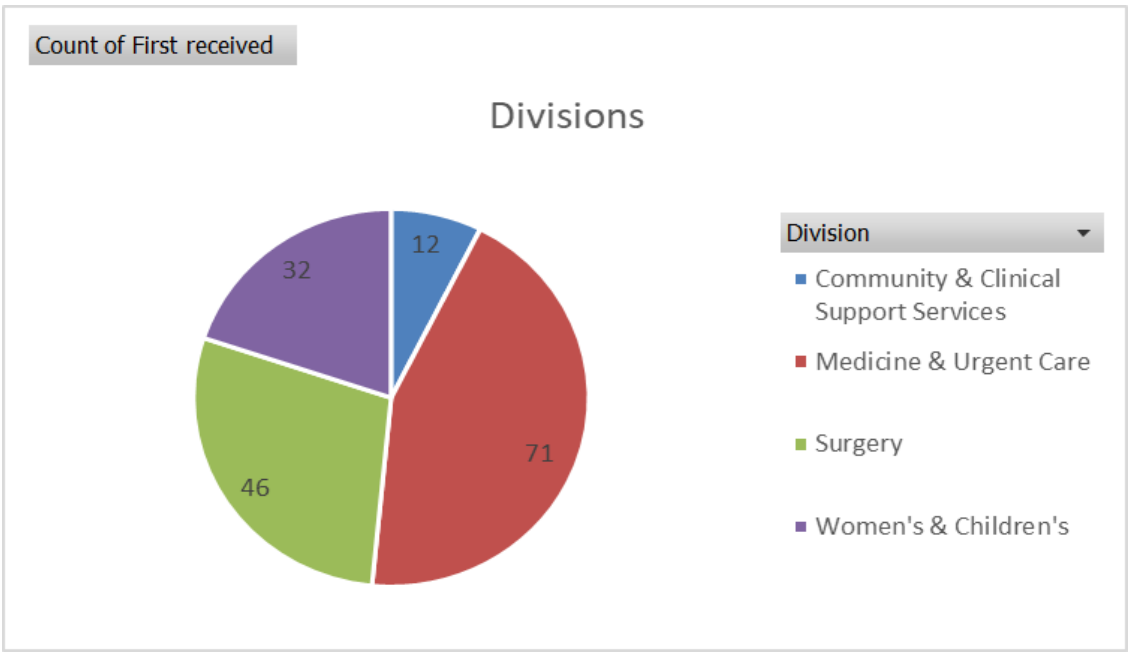
Work is continuing to improve compliance against the Trust 60 working day response timeframe. Of the 120 closed complaints in Q2, 34 were aligned to complaints that had breached the 60 day target.

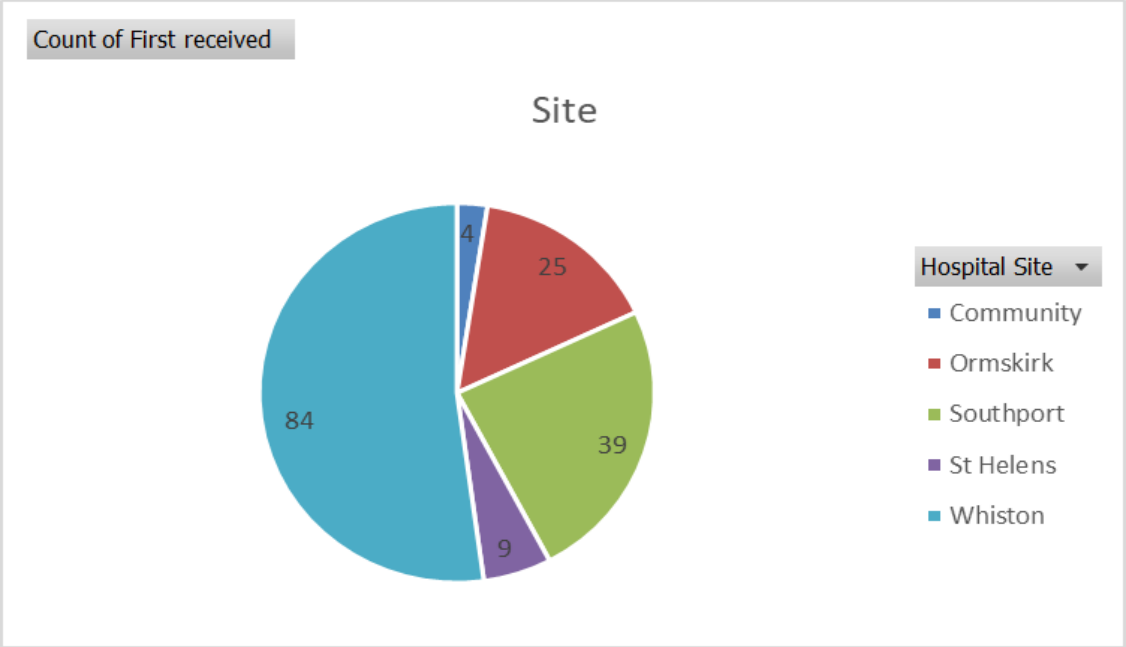
The Trust received 161 new complaints in Q2.

The Trust achieved a 71.6% compliance of complaints being responded to within 60 working days in Q2 and is the highest compliance achieved in the last 12 months as below:

Quarterly comparison of 60 working day compliance	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2
MWL First stage complaint	122	144	142	115	161
Second Response Trust Target Less than 12 per Q	13	12	27	16	16
Response Compliance Trust Target 80%	57.44%	62.9%	64.6%	50.7%	71.6%
MWL number of complaints breached 60 working timeframe	52	54	50	57	34

The charts below depict the Trust sites and divisional breakdown of the 161 first stage complaints received in Q2.





The Trust received 16 second stage/reopened complaints in Q2. This is an improvement on Q1 as 21 complaints required a second response in Q1.

Site	Total 2nd Stage/Reopened
Community	0
Ormskirk	0
Southport	6
St Helens	4
Whiston	6
Total	16

4. Patient Advice and Liaison Service (PALS)

PALS Contacts	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26
Number of contacts received	1179	997	1131	1232

*Figures at time of reporting from InPhase

PALS Contacts by Top Themes

Q1 2025-26 PALS Themes by Division	CSS&C	Corporate / other / external	M&UC	Surgery	W&C	Total
Communications	41	128	185	79	32	465
Appointments	35	46	42	71	24	218
Admissions and Discharges	9	3	42	22	5	81
Clinical Treatment	5	11	29	21	9	75
Patient Care/ Nursing Care	4	4	38	13	7	66
Waiting Times	9	3	12	20	6	50
Access to Treatment or Drugs	5	8	20	11	2	46

Figures that have increase in comparisons to the previous quarter have been highlighted in red within the table below for ease:

Q2 2025-26 PALS Themes by Division	CSS&C	Corporate / other / external	M&UC	Surgery	W&C	Total
Communications	49	104	155	98	43	449
Appointments	81	25	44	89	28	267
Patient Care/ Nursing Care	7	4	60	11	5	87
Clinical Treatment	11	9	28	25	12	85
Admissions and Discharges	12	6	34	29	2	83
Waiting Times	18	2	15	31	5	71
Access to Treatment or Drugs	1	6	16	7	9	39

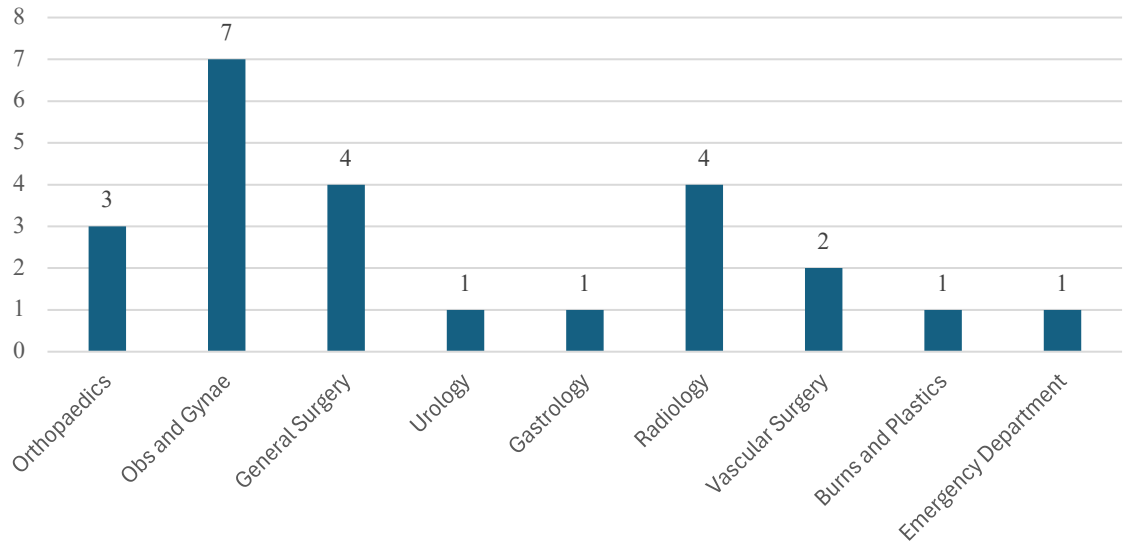
When compiling PALS themes from Q1 to Q2 25/26, CSS&C have received the biggest increase in PALS contacts with concerns relating to appointments.

It is to be noted when comparing the two quarters there is a marked increase in PALS concerns relating to appointments, patient care, clinical treatment, admission and discharge and waiting times. There is a small reduction in concerns raised relating to communication and access to treatment and drugs.

5. New Clinical Negligence Claims

The Trust received 24 new claims during Q2 – 12 in July (six and six across the legacy STHK and S&O sites as claims relate to cases pre MWL) four in August (three and one) and eight in September (six and two). This is higher than the preceding quarter (18), but only one more than Q2 in 2024/25 (23). The average number of claims per quarter since the establishment of MWL is 18.2. The 12 month average, including quarter 2, is 20.25.

5.1 New claims by speciality



General surgery had the highest number of claims in Q4 and Q1 of 2025/26. It is of note that we had a significant number of Obstetrics and Gynaecological claims (seven) as opposed to two in Q1. It should be noted that claims involving Obstetrics and Gynaecological often relate to children, and therefore the incident dates are wider. In these seven cases, two each were from 2022 and 2018, and one each from 2023, 2021 and 2003.

The review of General Surgery claims was completed by Hill Dickinson on 29 August and shared with the General Surgery division on 15 September 2025. Some key points:

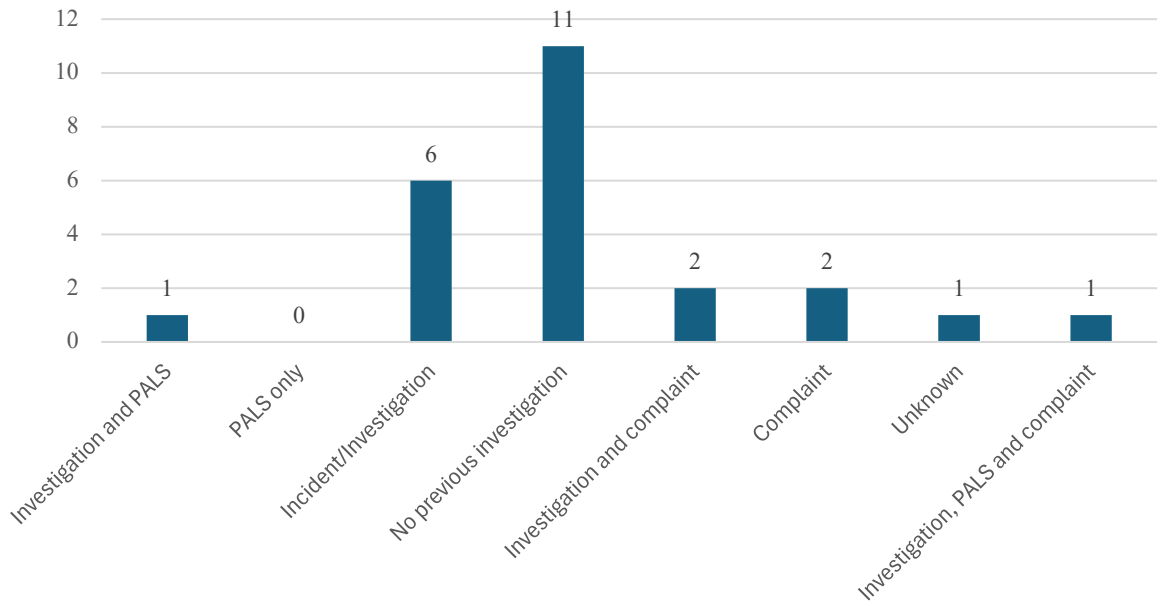
- The review looked at 28 claims in total.
- Liability was admitted in 42.9% of claims.
- Of those claims where we had denied liability, 57.1% had been successfully defended.
- 16 claims had “Failure/delay in treatment” as the cause code. Of these nine related to delays in surgery leading to complications/deterioration – further analysis of these claims is recommended.

5.2 New claims by main reason

The main causes of claims remain failure and delays in treatment and failures/delays in diagnosis. These are the two main cause codes across the last 12 months. We also seem to be seeing more claims/potential claims in relation to nursing care (usually falls related) and failure to correctly interpret radiology investigations.

5.3 Prior knowledge of issues causing claims

We have been able to analyse the claims to see the extent to which the Trust were previously aware of the potential issues.



Just over 41.6% of claims have had a safety review through safety review processes. 50% of claims have had either a safety review; PALS or Complaints review. The remaining 50 % are reviewed at Claims Governance Group every month to confirm if an investigation or review should take place.

5.4 Lessons Learned from Closed Claims

The Trust closed 22 claims in Q2. Some of these concluded due to inactivity, but a number were settled, or the claimant has chosen not to pursue them. No matters reached trial in Q2.

The following learning examples have been identified from two claims closed in Q2:

1. Fall resulting in Fractured Neck of Femur

Damages awarded in the sum of £30,000. There was Strategic Executive Incident System (StEIS) report following the incident in 2019 that determined the root cause of the fall was that staff on the ward were not aware of her high level of risk, had not reassessed her level of risk on transfer to the ward or after her fall in the Emergency Department (ED) thus removing opportunities to implement preventative measures.

The investigation accepted that it was evident from the lack documentation regarding the fall in ED that the fall was not communicated to staff, nor was it recorded in either the nursing or medical notes. There was a missed opportunity to identify her as a high risk of falls and that she shouldn't be left unsupervised whilst in the toilet. The below recommendations have since been implemented:

- New ED falls risk assessment to be embedded in practice.
- Raise awareness of the policy contents for the Reduction and Management of Patient falls and documentation that needs to be completed focusing on risk assessments, care planning and post falls care
- Medical staff to follow the Policy for the Reduction and Management of Patient Falls and document clinical post falls examinations
- Reiterate to nursing staff the importance of good communication for continuity of patient care

Although the learning in this case did not come directly from the claim itself, it is included to illustrate the financial costs associated with these types of claims.

2. Delayed diagnosis of cancer.

Although no admissions were made, this case was settled on a litigation risk basis for a total sum of £240,000. Despite the lack of admissions, learning was identified. All cases of newly diagnosed upper GI cancers in patients who have undergone an upper GI endoscopy within the previous three years are reviewed to identify any lessons learned.
This particular case was also discussed, and the following key learning and recommendations were highlighted:

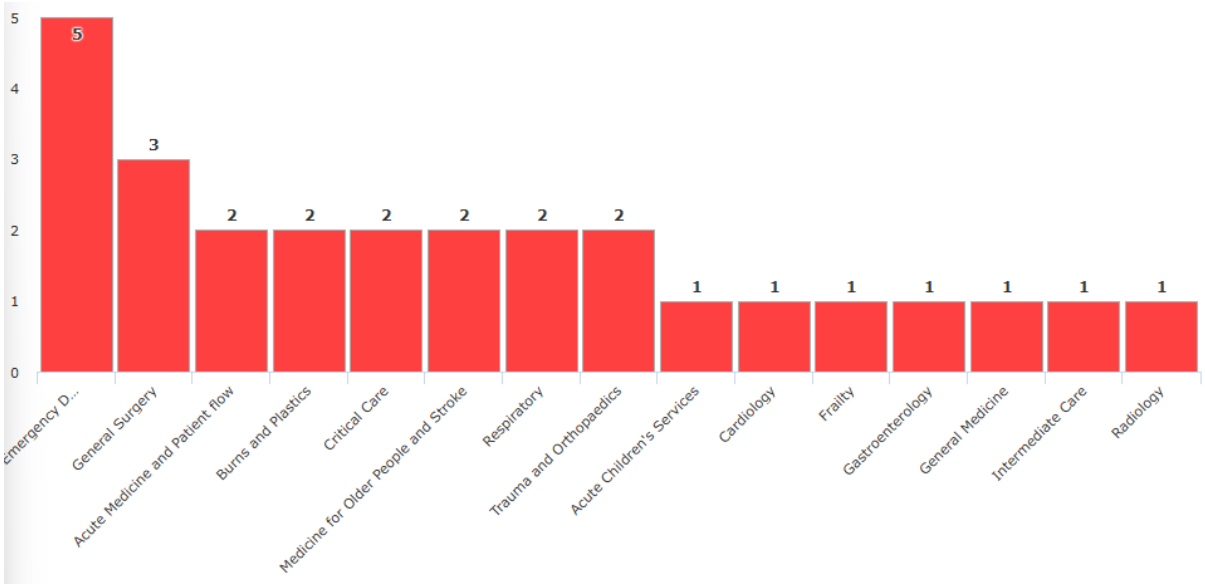
- Retroflexion during gastroscopy should be documented in the endoscopy report.
- High-quality imaging is essential and should adhere to the protocol outlined in the BSG's "Quality Standards in Upper Gastrointestinal Endoscopy" document (2017)
- NBI imaging is valuable for detecting early cancer and precancerous lesions and should be utilised in patients with a high suspicion of malignancy.

6. Inquests

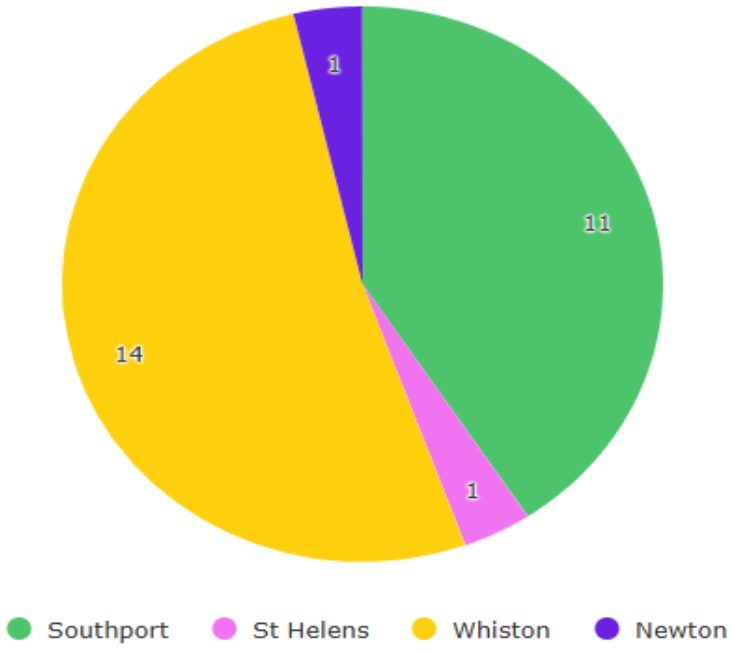
6.1. New Inquests

27 new inquests were opened in Q2. This is slightly below the average number per quarter, which is around 30.

These inquests are broken down by department as follows:



And by site as follows:



6.2. Closed inquests

The Trust closed a total of 28 inquests in quarter 2. A number of inquests have had to be adjourned, although not due to any lack of cooperation or preparation from the Trust.

The Trust has not received any Prevention of Future Death (PFD) notices since July 2023, and this continued in Q2.

6.3 Other news

The new Senior Coroner for Sefton, St. Helens and Knowsley have confirmed it is their intention that all inquests in their jurisdiction should take place in person, and witnesses should also attend in person. Inquests are being listed earlier, with less warning, and the Coroner expects witnesses to have knowledge of the whole period of the patient's care. They also expect all stakeholders to be familiar with the lessons learned, and for the Trust to provide inquest bundles.

7. Recommendations

It is recommended that the Board note the report and the learning from incidents; complaints; inquests and claims for Quarter 2 2025-26.

It is recommended to note there are no identified trends from incident analysis for Quarter 2.

It is recommended to note the highest recorded incidents for the Quarter were pressure ulcers with 79% community acquired (recorded on admission) and 21% hospital acquired which was similar position to Quarter 1.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB25/081**			
Report Title	Learning from Deaths Q4 2024/25 and Q1 2025/26			
Executive Lead	Ash Bassi, Acting Chief Medical Officer			
Presenting Officer	Ash Bassi, Acting Chief Medical Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

At former St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) sites

Total number of SJRs	Q4 2024/25 (Jan – March)	65
Total number of SJRs	Q1 2025/26 (April – June)	51
Total received an SJR	Q4 2024/25 (Jan – March)	13
Total received an SJR	Q1 2025/26 (April – June)	
Total outstanding for review	Q4 2024/25 (Jan – March)	52
Total outstanding for review	Q1 2025/26 (April – June)	29
Total Red SJRs	Q4 2024/25 (Jan – March)	0
Total Red SJRs	Q1 2025/26 (April – June)	
Total Amber SJRs	Q4 2024/25 (Jan – March)	1
Total Amber SJRs	Q1 2025/26 (April – June)	

- *In addition to these overdue cases there are a further 58 historical SJRs overdue for review dating back to Q1 2024-25*

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

Due to recent changes in IT systems, management and the departure of several mortality reviewers, a backlog of Structured Judgement Reviews (SJRs) has developed. The Trust has acknowledged this issue and outlined several mitigation steps, including the recruitment of a new Learning from Deaths lead, efforts to attract new reviewers despite the lack of remuneration, and targeted review assignments to specific staff members.

At former Southport and Ormskirk Hospital NHS Trust (S&O) sites 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 2024/25 and Q1 2025/2026 results are currently under review by the LFD Team at Southport Hospital.
Financial Implications
None
Quality and/or Equality Impact
Learning from Deaths contributes to the Trust's continuous learning culture.
Recommendations
The Board is asked to note the Learning from Deaths Q4 2024/25 and Q1 2025/26.

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

1. Reviews

STHK - Number of reviews carried out Q4 2024/25 January – March 2025

	No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
January	*21 (11)*	5	1	3	1	0
February	*20 (19)*	1	0	0	0	0
March	*24 (22)*	1	1	0	0	0

STHK - Number of reviews carried out Q1 2025/26 April – June 2025

	No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
April	*17*	0	0	0	0	0
May	*12*	0	0	0	0	0
*June**	*22*	0	0	0	0	0

2. Key learning points

Update	**Hypoglycaemia in a non-diabetic patient** The presence of hypoglycaemia in a non-diabetic patient who is not taking insulin / oral hypoglycaemic agents should prompt early clinical review. In patients with sepsis or those with severe frailty, hypoglycaemia is likely to be a poor prognostic sign. Its presence should alert the medical team to deterioration in the patient's condition, which should prompt a clearly documented decision to either escalate treatment or consider palliation.	**Acute agitation** Patients with acute agitation should be appropriately assessed and managed by the treating team. The Trust delirium guideline can be used to advise on the appropriate steps to take. Where symptoms are prolonged or do not respond to treatment, specialist advice should be sought from the Mental Health Liaison Team (inpatient core 24 referral via Careflow) or discuss with a geriatrician.
Update 26	**Sepsis of uncertain origin** When patients presents with sepsis of uncertain origin, it is essential to do a thorough assessment to identify the source of their infection as this allows antibiotics to be tailored appropriately. Assessment should include a skin survey, including removal of any wound dressings / compression bandages. It is also important to consider whether there are any indwelling devices (including prosthetic joints, pacemakers, etc, that may have become infected.	**Careflow Alerts** It is important to review all careflow alerts when patients are admitted to hospital. MRSA/VRE/CPE alerts should trigger review of antibiotic prescribing to ensure that there is appropriate cover for resistant organisms. Failure to do so risks delay to appropriate antibiotic prescription.
Update 25	**Know your Pathways** Trust pathways have been developed following local and national guidance of significant events and learning within the healthcare environment. It is imperative that staff familiarise themselves with what pathways are available within their field of practice, then follow them	**Communication with families / carers** At times of high emotion and distress, it may be that families and carers do not take in what is happening to their loved one and may not be able to comprehend a poor prognosis, this is even more challenging over the phone. Staff must remain aware of verbal of physical cues from families / carers suggesting key messages haven't been fully appreciated, so the communication can be reinforced accordingly

	accordingly. They are there to protect our patients and you.	
Update 24	**Imaging with contrast** Inpatients who receive imaging with contrast are at a higher risk of renal complications if their fluids are not correctly managed. Please consider IV fluids for these patients as they are particularly vulnerable	**Observe caution in the use of Lorazepam in the elderly.** Guidance is given in the Delerium assessment and management pro-forma under the elderly & frail, medication, ED section of the intranet ***Start low and go slow*** Haloperidol or Lorazepam if haloperidol contraindicated
Update 24 Cont.	**DNACPR communications on Transfer** On a transfer form there is a specific box to indicate a DNACPR in place, this must be ticked and they must ensure the lilac form is prominent at the front of the case	

Learning into Action

Following each quarterly submission to Board, examples of learning are reported and shared throughout the organisation to ensure that all staff are given the opportunity to determine how this could impact on their practice and try and make things better.

The leaning is shared at team brief and via all Trust councils.

The learning also appears on the intranet. http://nww.sthk.nhs.uk/about/learning-into-action

3. Patient Safety Incident Investigations (PSIIs) resulting in death

Closed Q4 2024-25 and Q1 2025-26 learning themes

Legacy Site	Incident ID	Summary	Learning identified
S&O	130827	Delay in getting patient home when medically fit for discharge. Care questioned and patient dehydrated when discharged which led to demise	Fluid balance/food charts to be maintained for all patients requiring red tray/assistance. All staff will be aware of the need to fully document and rationalize removal of a catheter. Raise awareness amongst staff regarding patients having multiple moves and the risk to continuity of their care/need for extra vigilance. Early escalation/discussions with

			safeguarding teams are required to ensure plans in place and confirmed. Nursing staff to ensure all aspects of medical care are communicated/escalated and reviewed prior to discharge. Staff to consider sitting patients out if medical condition allows.
S&O	137387	No blood tests during ED stay. Ensuring cardiac arrest and RIP	Remind staff of the importance of adequate handovers. Staff to ensure agency staff are aware of the area before they commence a shift. Patient flow and bed management team to discuss the operational agreement re: - corridor nurse/waiting room nurse. Remind staff of the importance of escalating patients to senior staff when needed. Safety message - if you are unable to cannulate or obtain bloods from a patient, please escalate to a senior.
STHK	189909	Attended ED with right pain and SOB. Extremely unwell and managed in resus. Treated for pneumonia and suspected PE. Intubated and ventilated with CTPA and ITU admission planned. Two cardiac arrests in resus and a further cardiac arrest in ITU where she died on the same day. Had attended ED twice in past few days and did not wait to be seen on the last occasion.	• Observations / NEWS Policy • ED adult left without being seen • Acknowledgement of investigation results prior to discharge on careflow • Review of ED SDEC admissions process

4. Action plan to address back log of SJRs

No.	Action	Lead	Due by	comments
1	Recruitment of new reviewers	Mark Woods	Ongoing	
2	Review of outstanding SJRs to see if any can be eliminated	Mark Woods / Kate Walton	End of Q4 2025/2026	
3	Collaborative working with medical examiners to hopefully reduce the amount of SJRs and to prevent future backlog recurring	Mark Woods	End of Q4 2025/26	
4	Targeted reviews to specific staff members	Jacqui Bussin / Cat Green	Ongoing	

Appendix 1

Categories of death that require for SJR

- Cardiac arrest
- Post operative
- Learning disability
- Autism
- Concern
- CQC Alert
- Diagnosis group
- External request
- Internal request

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB25/082 (12.1)**			
Report Title	Workforce Race Equality Standard (WRES) 2024-2025			
Executive Lead	Malise Szpakowska, Chief People Officer			
Presenting Officer	Malise Szpakowska, Chief People Officer			
Action Required	X	**To Approve**		**To Note**

Purpose

This report provides an overview and analysis of the Trust's Workforce Race Equality Standard (WRES) for 2024-2025 (March 2025) with relevant trended data from MWL and national data were available.

Executive Summary

Summary: The following is an overview of the WRES Highlights for 2024-2025.

The Trust has taken steps to start its journey to become a truly Anti-Racist organisation, including the adoption of the MWL Anti-Racism statement and an updated MWL Anti-Racism Pledge, a series of anti-racism round table events, piloting active bystander training, and embedding cultural competency training within the preceptorship programme.

Overall, the proportion of Ethnic Minority staff continues to increase, with some improvements in the progression of Ethnic Minority staff into higher bands. Staff Survey results are mixed, with reported increases in harassment and discrimination experienced by Ethnic Minority staff.

Overall, key metrics from the WRES assessment are:

Workforce data metrics:

- An increase in the proportion of total Ethnic Minority staff to 16.3%; Non-Clinical staff to 4.3%; Clinical Non-Medical staff to 16.7%; and Clinical Medical & Dental staff to 50.5%
- There was an increase in the proportion of Ethnic Minority Non-Clinical staff on Bands 2-7 and 8b. There were no declared Ethnic Minority staff on Bands 8c,d, 9 or Very Senior Manager (VSM).
- There was an increase in the proportion of Clinical Non-Medical Ethnic Minority staff on Bands 2, 3, 6-8c. There were no declared Ethnic Minority staff on Bands 8d, 9 or VSM.
- There was an increase in the proportion Clinical Medical & Dental staff on Trainee roles and Consultants,
- Ethnic Minority applicants as a population are less likely to be appointed from shortlisting compared to White applicants.
- Ethnic Minority staff are less likely to enter disciplinary process than White staff.
- Ethnic Minority staff are more likely than White staff to access non-mandatory training or CPD
- 5.6% of the Trust Board is from an Ethnic Minority, lower than the workforce, but comparable with the local population, and the Non-Clinical workforce.

Staff survey data:

- 25.6% Ethnic Minority staff state they have experienced bullying and harassment from a patient, family member or member of the public (28.6% nationally), compared to 19.4% of White staff, a difference of 6.2 points.
- 20.0% Ethnic Minority staff state they have experienced bullying and harassment from a colleague or manager, compared to 17.9% of White staff, a difference of 2.1 points.

- 49.5% Ethnic Minority staff state they believe the Trust offers equality of opportunity in career progression (49.5% nationally), compared to 59.4% of White staff, a difference of 9.9 points
- 14.3% Ethnic Minority staff state they have experienced discrimination from a manager or other colleague (15.2% nationally), compared to 5.4% of White staff, a difference of 8.9 points.

Financial Implications

None

Quality and/or Equality Impact

This report is a regulatory requirement under the NHS Contract. It forms part of the Trust's work to promote race equality in line with the Equality Act 2010

Recommendations

The Board is asked to note the Workforce Race Equality Standard Report (WRES) and approve the Action Plan

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

Workforce Race Equality Standard Report
Data Summary

April 2024 – March 2025

1. Executive Summary

This report provides the Trust Board with the Annual Workforce Race Equality Standard (WRES) data for the Mersey & West Lancashire Teaching Hospitals Trust (MWL). The publication of this report is for the period 2024-2025 in line with the NHS Standard Contract requirements to publish the WRES indicators.

2. Introduction

NHS England introduced the Workforce Race Equality Standard (WRES) in 2015. The WRES exists to highlight any differences between the experiences and treatment of white staff and Ethnic Minority staff in the NHS and places an onus on NHS organisations to develop and implement actions to bring about continuous improvements. The main purpose of the WRES is:

- to help NHS organisations to review performance on race equality, based on the nine WRES indicators,
- to produce action plans to close any gaps in workplace experience between white and Ethnic Minority staff,
- to improve Ethnic Minority representation at the Board level of the organisation.

3. A year in review: 2024-2025

The Trust has worked to implement anti-racism actions agreed within the 2024 WRES report, as well as the EDI Operational Plan 2022-2025, activity to support the implementation of the NHS EDI High Impact Actions[1] (HIA), the Equality Delivery System[2] (EDS) and our commitment to join the NW Anti-Racism Framework[3].

Key activities that have taken place between November 2024-October 2025 include:

- **EDI SMART Training Objective (HIA1)**: For the 2025 Appraisal, all members of staff are being asked to identify a person EDI Training and Development Objective. Guidance and examples have been provided as well as things to do, watch, read, and participate in.

- **Senior Anti-Racism Champion**: Rob Cooper (Chief Executive) has been appointed as the Trusts Anti-Racism champion.

- **MWL Anti-Racism Statement**: After an extensive consultation the Trusts new Anti-Racism statement was adopted by the Board in August 2025.

[1] NHS EDI Improvement Plan High Impact Actions
[2] NHS Equality Delivery System
[3] NHS North West BAME Assembly

- **Staff Training**: For 2025-2026 a new training course on Race Equality Awareness was introduced, open to all member of staff to attend. This course is in addition to sessions on Harassment & Civility for Managers, Unconscious Bias, Removing Bias from Recruitment, and Equality Impact Assessments. Cultural Competency training has been trialled as part of the Perceptorship Programme with the plan to roll this out in 2025/26. Similarly, an Active Bystander training package has been piloted, with sessions offered this year (actions support HIA3 & 5).

- **Cultural Awareness**: The Trust has worked to raise awareness of race equality topics by engaging in events including Black History Month and Wear Red Day; as well as promoting/marking dates such as South Asian History Month, Ramadan, Eid, and Diwali.

- **Bullying & Harassment**: In addition to training, the Trust has continued to roll out Zero Tolerance posters across its sites; the Responding to Unacceptable Behaviour [from patients and visitors] policy has been reviewed an updated, and the Trust is looking to expand operational Cavell to Southport Hospital (actions support HIA6).

- **Online Resources**: The EDI (Workforce) Team has continued to expand the online resource available to staff. Anti-racism Hub resources have been expanded to include the NHS Anti-Racism Literacy Guide, and the NW Civility and Respect video series. Event hubs for South Asian History Month, Black History Month, Race Equality Week, Windrush Day, Ramadan, Holi, and Diwali have provided additional self-learning materials for staff.

- **Ethnicity Pay Gap (HIA3)**: Having completed the Ethnicity Pay Gap since 2022, in March 2025 the Trust published its 2024 Ethnicity Pay Gap on the public website. Overall, the Trust and Agenda for Change Ethnicity Pay Gaps are in favour of our ethnic minority staff population, with the pay gap for Medical & Dental staff in favour of our White medics.

4. The 9 WRES indicators

The WRES is an analysis of the following 9 data indicators, relating to workforce, recruitment, disciplinary, staff satisfaction, and board diversity:

1. **Staff Population**: Percentage of White and Ethnic Minority staff who are Non-Clinical, Clinical Non-Medical, by Agender for Change (AfC) pay bands, and Clinical Medical & Dental roles.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Disciplinary**: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. **Training**: Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD).
5. **Harassment from Patients**: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months,
6. **Harassment from Staff:** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months,
7. **Equality in Career Progression**: Percentage of staff believing that the trust provides equal opportunities for career progression or promotion,
8. **Discrimination**: In the last 12 months have you personally experienced discrimination at work from any of the following, a manager/team leader, or other colleagues,

9. **Board Representation**: Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board; By executive membership of the Board.

4.1. Data and Methodology

Before reading the report, please familiarise yourself with the following information which provides a summary of the data sources and limitations. The time periods for the data sets are as follows:

- **Indicators 1 and 9**: snapshot date of the 31st March,
- **Indicators 2-4**: period from the 1st April to 31st March,
- **Indicators 5-8:** the relevant staff survey that took place between the 1st April to 31st March, usually in November/December.

The Trust collates data for Indicators 1-4 and 9 directly from Employee Staff Record (ESR), the TRAC recruitment system and HR Business Partners to create a final data set.

Benchmarking data has been sourced from the national staff survey website and Trust Staff Survey data[4] (2021-2024), Model Health system[5] (2020-2025), and the 2024 national WRES report[6]. Where 2025 data is not available, 2024 data has been provided.

4.1.1. Scope of reported population

The following data principles are applied to the WRES data:

- Data relates to the total substantive workforce on the relevant snapshot date with the exception of Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Bank staff are not included and the Bank WRES pilot was not repeated this year.
- WRES data is only reported on the broad ethnicity categories of Ethnic Minority (aka Black and Minority Ethnic (BME)), White, and Unknown.

The WRES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups, for example staff group is not analysed, nor data disaggregated by UK/Overseas domiciled or educated.

4.1.2. Note on terminology

The report uses the term Ethnic Minority to refer to all staff from a non-white ethnic minority group. This would include all staff who have identified as Asian, Black, Mixed/Dual Heritage, and Other. The term is comparable with Black, Asian & Minority Ethnic (BAME), People of Colour (PoC), Global Majority, Ethnic Minority, and Minority Ethnic.

[4] NHS Staff Survey
[5] Model Health System (log in required)
[6] NHS WRES 2023 Data

5. Workforce WRES Data

5.1. Staff Profile Workforce Overview

In the snapshot date of 31st March 2025, Mersey & West Lancashire Teaching Hospitals Trust (MWL) employed 11,006 staff which consisted of:

- 16.3% Ethnic Minority staff
- 80.7% White staff
- 3.0% Not Stated/ unspecified / prefer not to answer.

Over the past 5 years (2021 v 2025), MWL has seen a year-on-year increase in the number and proportion of Ethnic Minority staff in the total workforce (1057/10.6% to 1795/16.3%), Non-Clinical (65/2.3% to 131/4.3%), Clinical Non-Medical (501/8.1% to 1163/16.7%) and Clinical Medical & Dental (M&D) (355/43.3% to 501/50.5%) (Figure 1). Further details for each category are set out below.

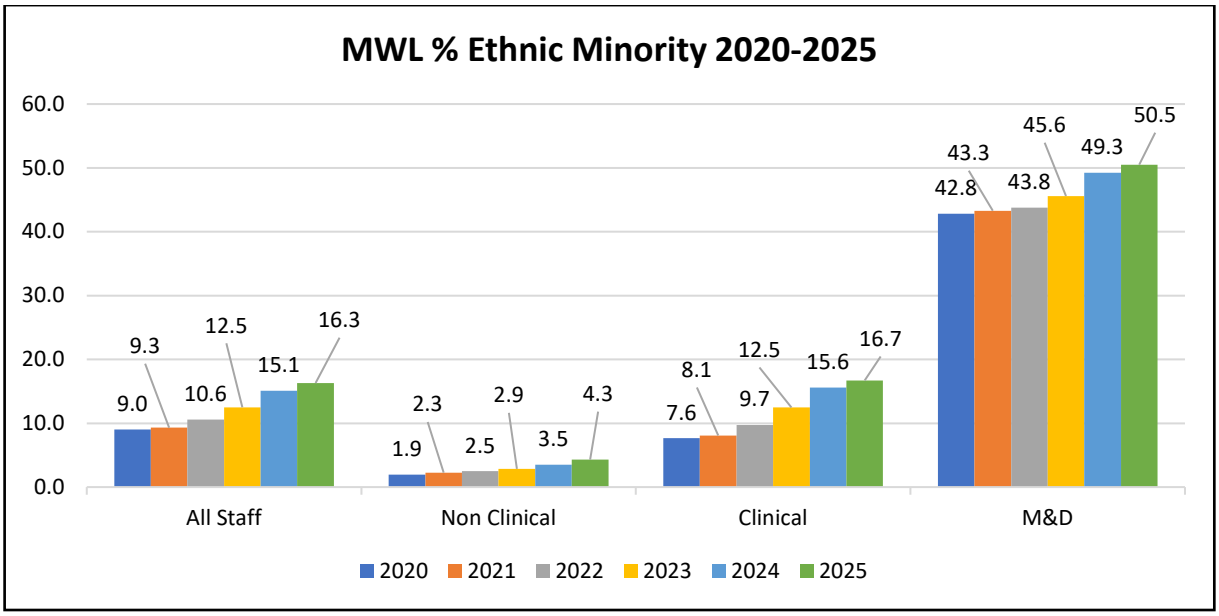


Figure 1

5.2. Indicator 1: Non-Clinical and Clinical Workforce

Indicator 1 is a review of the staff population by Non-Clinical Workforce by Agenda for Change (AfC) pay bands; Clinical Workforce not Medical by AfC pay bands; and Clinical Workforce Medical and Dental.

From March 2024 to March 2025, there was an increase in the number and proportion of Ethnic Minority staff:

- The total workforce from 1623 (15.1%) to 1795 (16.3%).
- Non-Clinical staff from 106 (3.5%) to 131 (4.3%)
- Clinical Non-Medical roles from 1052 (15.6%) to 1163 (16.7%)
- Clinical Medical & Dental roles from 465 (49.3%) to 501 (50.5%)

Overall, the proportion of non-clinical staff who are from a Ethnic Minority is 4.3% (Table 1), higher than the local Ethnic Minority population in all boroughs that MWL is located in, with the exception of

Knowsley (Table 2). The proportion of Ethnic Minority staff in clinical roles is significantly higher than the local population and reflects national trends in nursing and medicine specifically, as well as previous overseas recruitment activities.

Table 1: Staff Headcount

Staff Headcount March 2025	White	Eth Min	Unk	% Eth Min MWL (2025)	% Eth Min National (2024)
Total	8886	1795	325	16.3%	28.6%
Non-Clinical Workforce (AfC)	2824	131	84	4.3%	18.8%
Clinical Non-Medical Workforce (AfC)	5620	1163	191	16.7%	29.4%
Medical and Dental Workforce	442	501	50	50.5%	48.7%

Table 2: Population Benchmarks

Benchmarks	%White	%EthMin	%Unk
MWL Total	80.7%	16.3%	3.0%
National (2024)	67.0%	28.6%	4.3%
North West (2024)	77.0%	19.4%	3.7%
National Census: Sefton	95.8%	4.2%	-
National Census: St Helens	96.5%	3.5%	-
National Census: Knowsley	95.3%	4.7%	-
National Census: West Lancashire	96.9%	3.1%	-
National Census: C&M ICB Area	93.0	7.0%	-
National Census: Liverpool City Region	91.7	7.3%	-

5.2.1. Indicator 1a: Non-Clinical workforce

The Non-Clinical workforce includes staff in administration, clerical and estates type of roles. Key observations:

- The total number of Ethnic Minority Non-Clinical staff increased from 106 to 131, with an increase in the proportion of Ethnic Minority staff on bands 2-7, and 8b (Table 3).
- There were no declared Ethnic Minority staff on Bands 1, 8c-VSM.
- Compared to the lowest local population, the proportion of Ethnic Minority staff are underrepresented on Bands 1, 4, 8a, 8c-VSM, with the remaining bands within the range of 3.4%-5.7%.

Table 3: Staff Headcount Non-Clinical Workforce

	MWL 2024		MWL 2025		National 2024
	%White	%EthMin	%White	%EthMin	%EthMin
Band 1	100.0%	0.0%	100.0%	0.0%	-
Band 2	90.3%	4.4%	90.1%	5.7%	19.9%
Band 3	92.3%	4.4%	91.8%	5.4%	18.2%
Band 4	96.4%	1.6%	96.1%	2.1%	18.4%
Band 5	91.9%	4.5%	92.7%	5.2%	19.9%
Band 6	91.9%	3.1%	94.5%	3.4%	20.9%
Band 7	95.5%	3.2%	95.3%	4.0%	19.1%
Band 8A	92.2%	3.1%	95.9%	2.7%	17.3%
Band 8B	93.1%	1.4%	93.5%	3.9%	15.8%
Band 8C	88.5%	3.9%	96.8%	0.0%	14.7%
Band 8D	100.0%	0.0%	100.0%	0.0%	12.2%
Band 9	100.0%	0.0%	100.0%	0.0%	11.0%
VSM	91.7%	0.0%	92.3%	0.0%	11.8%
Total	92.8%	3.5%	92.9%	4.3%	18.8%

5.2.1.1. Race Disparity Ratio Non-Clinical Staff

At the time of the writing of this report, the Trusts Race Disparity Ratio data had not been provided by NHSE.

The WRES report calculates a "race disparity ratio" which is the difference between the proportion of Ethnic Minority Non-Clinical staff in AfC bands Lower v Middle, Middle v Upper, and Lower v Upper; where Lower means bands 1-5, Middle bands 6-7, and Upper bands 8+. A ratio value of 1 means that there is no difference, a ratio of <1 means Ethnic Minority staff are more represented in the higher bands, and a ratio of >1 means that White staff are more represented in the higher bands.

5.2.2. Indicator 1b: Clinical workforce: Non-Medical

The Clinical Non-Medical workforce includes all allied health professionals, nursing and midwifery staff and relevant support staff. Key observations:

- The total number of Ethnic Minority Clinical Non-Medical staff increased from 1052 (15.6%) to 1163 (16.7%), with an increase in the proportion of Ethnic Minority staff on bands 2, 3, 6-8c (Table 5)
- There were no declared Ethnic Minority staff on Bands 8d, 9 or VSM.
- Compared to the local population, the proportion of Ethnic Minority staff is equal to or exceeds the Knowsley census population of 4.7% on Bands 2-3, 5-8c, and Bands 2, 5, 6, 8a and 8c exceeding the population of the Liverpool City Region.

Table 4: Staff Headcount Clinical Non-Medical Workforce

MWL	2024		2025		National
	%White	%EthMin	%White	%EthMin	%EthMin
Band 1	100.0%	0.0%	100.00%	0.00%	-

MWL	2024		2025		National
	%White	%EthMin	%White	%EthMin	%EthMin
Band 2	85.2%	10.2%	80.43%	15.48%	31.5%
Band 3	92.0%	4.7%	90.38%	6.57%	25.9%
Band 4	88.5%	9.7%	93.70%	4.44%	23.0%
Band 5	63.1%	33.3%	64.63%	32.62%	45.7%
Band 6	86.8%	10.8%	85.68%	12.55%	25.2%
Band 7	92.0%	5.7%	91.30%	6.39%	18.8%
Band 8A	89.0%	8.9%	87.90%	9.51%	17.9%
Band 8B	90.9%	4.6%	90.32%	4.84%	15.7%
Band 8C	94.1%	5.9%	90.00%	10.00%	12.4%
Band 8D	100.0%	0.0%	88.89%	0.00%	13.1%
Band 9	100.0%	0.0%	100.00%	0.00%	14.8%
VSM	100.0%	0.0%	0.00%	0.00%	17.2%
Total	81.2%	15.6%	80.6%	16.7%	29.4%

5.2.2.1. Race Disparity Ratio Non-Clinical Staff

At the time of the writing of this report, the Trusts Race Disparity Ratio data had not been provided by NHSE.

5.2.3. Indicator 1c: Clinical workforce: Medical & Dental

The Clinical Medical & Dental workforce includes all staff on a medical and dental terms and conditions and includes Foundation and Resident Doctors and Consultants. Key observations:

- The total number of Ethnic Minority Clinical Medical & Dental staff has increased from 465 (49.3%) to 501 (50.5%) and the total number of White staff has increased from 414 to 442 (Table 7).
- The main increase of Ethnic Minority staff was for Trainee Grades (166 to 188), and Consultants (194 to 210).
- Compared to the local population, the medical workforce is significantly overrepresented by Ethnic Minority individuals. This is a reflection of national trends on the medical workforce, as well as overseas recruitment into the NHS.

The WRES data does not calculate a race disparity ratio for medical and dental roles and is therefore not reported.

Table 5: Staff Headcount Clinical Medical & Dental Workforce

MWL	MWL 2024		MWL 2025		National 2024
	%White	%EthMin	%White	%EthMin	%EthMin
Consultants	52.8%	42.4%	52.70%	43.57%	41.0%
Consultants also Senior medical manager	100.0%	0.0%	100.00%	0.00%	44.6%
Non-consultant	22.8%	69.1%	24.50%	67.55%	64.3%

Trainees	39.4%	51.9%	40.46%	54.34%	51.0%
Other	70.6%	11.8%	78.57%	7.14%	27.3%
Total	43.9%	49.3%	44.51%	50.45%	48.7%

Medical data does not include Lead Employer doctors in training, including those who are on placement within the Trust.

5.3. Indicator 2: Relative likelihood of Ethnic Minority and white staff being appointed from shortlisting across all posts.

Indicator 2 is an assessment of the Trusts recruitment and selection practices, and whether Ethnic Minority applicants are as likely as White applicants to be successfully shortlisted and appointed.

This indicator is assessed at “whole organisation” level and does not disaggregate the recruitment trends by job group or department where Ethnic Minority individuals may be more or less likely to form part of the talent pool e.g., Ethnic Minority people are overrepresented in the medical and dental profession.

Table 6: Percentage of candidates appointed from shortlisting

MWL	White	EthMin	Unknown
2023-2024	36.33%	20.35%	75.29%
2024-2025	36.95%	22.97%	52.19%

Table 7: Relative likelihood of appointment from shortlisting

MWL	White	EthMin	Unknown
2023-2024	0.36	0.20	0.75
2024-2025	0.37	0.23	0.52

Table 8: Relative likelihood of White candidates being appointed from shortlisting compared to a Ethnic Minority candidates

MWL	Ratio	National	North West
2023-2024	1.79	1.62	2.01
2024-2025	1.61	-	-

A value <1 means that Ethnic Minority applicants are more likely to be appointed, and value >1 means they are less likely to be appointed. For example, a value of "2.0" would indicate that White candidates were twice as likely as Ethnic Minority candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as Ethnic Minority candidates to be appointed from shortlisting.

Key observations:

- White applicants who are shortlisted are more likely to be offered a post compared to Ethnic Minority applicants (Table 8, 9)
- The relative likelihood of White applicant being appointed compared to Ethnic Minority applicants stands at 1.6 times more likely (Table 10), although this is an improvement on the previous year.

5.4. Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Indicator 3 is an assessment of whether Ethnic Minority staff are more likely to face formal disciplinaries compared to White staff. There are relatively few formal disciplinaries each year, with 71 in 2021/2022, and 130 in 2022/2023 (Table 11).

Table 9: Likelihood of staff entering the formal disciplinary process

YES	White	EthMin	Unknown
2023-2024	1.81%	0.98%	0.76%
2024-2025	0.98%	0.50%	0.00%

In 2023/2024 the relative likelihood measure for this indicator was 0.84 (Table 12), meaning that White staff were more likely than Ethnic Minority staff to enter formal disciplinary processes. This was a slight increase compared to the previous year.

A value <1 means that Ethnic Minority staff are less likely to enter formal disciplinary processes, and value >1 means they are more likely to enter formal disciplinary processes. For example, a value of "2.0" would indicate that Ethnic Minority staff were twice as likely as White staff to enter a formal

disciplinary process, whilst a value of "0.5" would indicate that Ethnic Minority staff were half as likely as White staff to enter a formal disciplinary process.

Table 10: Relative likelihood of Ethnic Minority staff entering the formal disciplinary process compared to White staff

	MWL	National	North West
2023-2024	0.54	1.09	0.90
2024-2025	0.84	-	-

Table 11: Proportion of staff entering a Disciplinary process, %Ethnic Minority

	MWL	Peer Median	Provider Median
2023-2024	9.0%	tbc	tbc
2024-2025	14.5%	-	-

Overall Ethnic Minority staff are less likely that White staff to enter a formal disciplinary process (Table 12, 13)

5.5. Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

Indicator 4 is an assessment of whether Ethnic Minority staff have the same access to non-mandatory training and development as White staff.

Non-mandatory training refers to any learning, education, training, or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement or mandated by the organisation. All training and development recorded on ESR that is not classed as mandatory training has been included in this data.

The relative likelihood measure for this indicator was 0.89 (Table 14), meaning that Ethnic Minority staff were more likely than White staff to access non-mandatory training and CPD in the reporting period.

Table 12: Relative likelihood of White staff accessing non-mandatory training and CPD compared to Ethnic Minority staff.

	MWL	National	North West
2023-2024	0.80	1.06	0.99
2024-2025	0.89	tbc	tbc

6. Staff Survey Questions

The 2024 NHS Staff Survey was conducted between October and December 2024 and completed by 3944 staff (36.8% response rate).

For the purposes of this report, the 2023 and 2024 staff survey results have been sourced from the Trusts staff survey reports, with benchmarking data being sourced from the National Staff Survey Dashboard.

6.1. Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (Staff Survey)

Table 13: Harassment by patients

		2022	2023	2024	Change
MWL	EthMin	30.2%	25.9%	25.6%	-0.3
	White	26.4%	21.4%	19.4%	-2.0
	All	26.9%	23.7%	21.5%	-2.2
National	EthMin	30.4%	27.8%	28.6%	+0.9
	White	26.8%	24.1%	23.5%	-0.6
	All	27.9%	25.3%	25.1%	-0.2
North West	EthMin	27.2%	25.2%	26.9%	+1.7
	White	24.6%	21.8%	21.5%	-0.3
	All	24.9%	22.3%	22.5%	+0.2
C&M ICB	EthMin	29.6%	26.8%	26.0%	-0.8
	White	24.4%	20.4%	19.4%	-1.0
	All	24.9%	21.2%	20.3%	-1.9
Acute & Community	EthMin	30.4%	27.6%	28.4%	+0.8
	White	26.7%	23.8%	23.2%	-0.6
	All	28.0%	25.2%	25.0%	-0.2

Overall, there was a decrease in the proportion of staff reporting that they had experienced bullying and harassment from a patient, visitor, family member or member of the public (Table 15); although a higher proportion of Ethnic Minority staff (who are more likely to work in a patient facing role than white staff) report this. Specifically, there was a:

- 2.2 point decrease in the proportion of staff reporting experiencing bullying and harassment from a patient et al,
- 2.0 point decrease in the proportion of White staff reporting experiencing bullying and harassment from a patient et al,
- 0.3 point decrease in the proportion of Ethnic Minority staff reporting experiencing bullying and harassment from a patient et al,
- MWL has a lower proportion of staff, white staff, and ethnic minority staff reported experiencing harassment compared to the National Average, North West, and Acute & Community Trusts.

6.2. Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (Staff Survey)

Table 14: Harassment from Staff (Managers and Colleagues)

Yes		2022	2023	2024	Change
MWL	EthMin		17.6%	20.0%	+2.4
	White		17.6%	17.9%	+0.2
National	EthMin	27.7%	24.9%	tbc	
	White	22.0%	20.7%	tbc	

Overall, the proportion of staff reporting that they have experienced bullying and harassment from another member of staff (manager or colleague) increased for both Ethnic Minority staff (2.4 point increase) and for White staff (0.2 point increase) (Table 16).

6.3. Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Staff Survey)

This staff survey question asks; *"Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?"* with the options to answer; Yes, No or Don't Know.

Table 15: Equal Opportunities in Career Progression

YES		2022	2023	2024	Change
MWL	EthMin	46.5%	52.2%	49.5%	-2.7
	White	61.3%	61.4%	59.4%	-2.0
	All	59.5%	59.9%	58.1%	-1.8
National	EthMin	46.4%	48.9%	49.5%	-0.4
	White	59.1%	59.4%	58.9%	-0.5
	All	56.0%	56.4%	55.9%	-0.5
North West	EthMin	45.5%	47.4%	49.4%	+2.0
	White	58.9%	59.0%	59.0%	0.0
	All	56.9%	56.9%	57.0%	+0.1
C&M ICB	EthMin	44.9%	46.2%	48.9%	+3.7
	White	59.2%	59.1%	59.4%	+0.3
	All	57.6%	57.3%	57.8%	+0.5
Acute & Community	EthMin	46.1%	48.6%	49.2%	+0.6
	White	58.7%	59.0%	58.6%	-0.4
	All	55.4%	55.8%	55.4%	-0.4

Overall, the proportion of staff reporting that they believed the Trust provides equality of opportunity in career progression decreased, with a lower proportion of Ethnic Minority staff likely to say so (Table 17). Specifically:

- 1.8 point decrease in the proportion of staff reporting Yes,
- 2.0 point increase in the proportion of White staff reporting Yes,
- 2.7 point increase in the proportion of Ethnic Minority staff reporting Yes,
- 0.7 point increase in the difference between the response rate of White v Ethnic Minority Staff (9.2 to 9.9 gap).

6.4. Indicator 8: Staff who have personally experienced discrimination at work from a manager, team leader or other colleagues in the last 12 months (Staff Survey)

Table 16: Discrimination from Manager or Colleague

YES		2022	2023	2024	Change
MWL	EthMin	18.0%	12.0%	14.3%	+2.3
	White	4.5%	4.4%	5.4%	+1.0
	All	5.9%	5.7%	6.7%	+1.0
National	EthMin	16.6%	15.5%	15.2%	-0.3
	White	6.7%	6.7%	6.8%	+0.1
	All	9.0%	9.1%	9.2%	+0.1
North West	EthMin	17.4%	16.2%	16.2%	0.0
	White	6.4	6.1%	6.2%	+0.1
	All	8.0%	7.8%	8.1%	+0.3
C&M ICB	EthMin	18.4%	16.9%	15.5%	-1.4
	White	5.6%	5.5%	5.6%	+0.1
	All	6.9%	6.9%	7.0%	+0.1
Acute & Community	EthMin	17.2%	16.0%	15.7%	-0.3
	White	6.8%	6.8%	6.8%	0.0
	All	9.4%	9.5%	9.6%	+0.1

Overall, the proportion of staff reporting that that had experience discrimination from a manager or colleague increased for Ethnic Minority and White staff, although Ethnic Minority staff are 3 times more likely to report experiencing discrimination (Table 18). The Trusts response rates were lower than the National, North West and Acute & Community averages. Specifically:

- 1 point increase in the proportion of staff reporting Yes
- 1 point increase in the proportion of White staff reporting Yes
- 2.3 point increase in the proportion of Ethnic Minority staff reporting Yes
- 1.3 point increase in the difference between White v Ethnic Minority staff, 2023 (7.6 points) to 2024 (8.9 points)

6.5. Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce

Overall, 5.6% of Board Members or 12.5% of Non-Executive Board Members are from an Ethnic Minority (Table 21), representative a slight increase from 2024 of 4.2% and 5.3% respectively. In 2024 (most current benchmark data), nationally 16.5% of Board Members of NHS Trusts were from an ethnic minority background, including 11.8% of Executive Board Members.

Table 17: Board Membership 2023-2024

	EthMin	White	Unknown
Total Board	4.2%	79.2%	16.7%
Of which Voting Board Members	0.0%	100%	0.0%
Non-Voting Board Members	5.3%	73.7%	21.1%
Of which Executive Board Members	0.0%	100%	0.0%
Non-Executive Board Members	5.3%	73.7%	21.1%
Difference Total Board v Workforce	-11	-2	+13
Difference Voting Members v Workforce	-15	+19	-4
Difference Execuitve Members v Workforce	-15	+19	-4

Table 18: Board Membership 2024-2025

	EthMin	White	Unknown
Total Board	5.6%	94.4%	0.0%
Of which Voting Board Members	0.0%	100%	0.0%
Non-Voting Board Members	14.3%	85.7%	0.0%
Of which Executive Board Members	0.0%	100%	0.0%
Non-Executive Board Members	12.5%	87.5%	0.0%
Difference Total Board v Workforce	-10.8	+13.7	-3.0
Difference Voting Members v Workforce	-16.3	+19.3	-3.0
Difference Execuitve Members v Workforce	-16.3	+19.3	-3.0

7. Conclusion

Overall, the Trust continues to improve of key race equality metrics, including the proportion of Ethnic Minority staff within the workforce, and at key unrepresented bands, as well as some improvements in most staff survey results. However key issues remain with the higher proportions of Ethnic Minority staff reporting more negative experiences than White staff in the staff survey.

Overall, the WRES indicators show the following:

Workforce data metrics:

- An increase in the proportion of total Ethnic Minority staff to 16.3%; Non-Clinical staff to 4.3%; Clinical Non-Medical staff to 16.7%; and Clinical Medical & Dental staff to 50.5%
- There was an increase in the proportion of Ethnic Minority Non-Clinical staff on Bands 2-7 and 8b. There were no declared Ethnic Minority staff on Bands 8c,d, 9 or VSM.
- There was an increase in the proportion of Clinical Non-Medical Ethnic Minority staff on Bands 2, 3, 6-8c. There were no declared Ethnic Minority staff on Bands 8d, 9 or VSM.
- There was an increase in the proportion Clinical Medical & Dental staff on Trainee roles and Consultants,
- Ethnic Minority applicants as a population are less likely to be appointed from shortlisting compared to White applicants.
- Ethnic Minority staff are less likely to enter disciplinary process than White staff.
- Ethnic Minority staff are more likely than White staff to access non-mandatory training or CPD

- 4.2% of the Trust Board is from an Ethnic Minority, lower than the workforce, but comparable with the local population, and the Non-Clinical workforce.

Staff survey data:

- 25.6% Ethnic Minority staff state they have experienced bullying and harassment from a patient, family member or member of the public (28.6% nationally), compared to 19.4% of White staff, a difference of 6.2 points.
- 20.0% Ethnic Minority staff state they have experienced bullying and harassment from a colleague or manager, compared to 17.9% of White staff, a difference of 2.1 points.
  49.5% Ethnic Minority staff state they believe the Trust offers equality of opportunity in career progression (49.5% nationally), compared to 59.4% of White staff, a difference of 9.9 points
- 14.3% Ethnic Minority staff state they has experience discrimination from a manager or other colleague (15.2% nationally), compared to 5.4% of White staff, a difference of 8.9 points

8. Action Plan

The Trust has developed a new People Strategy within which Equality, Diversity and Inclusion are embedded. The key **Race related objectives** set out in the People Strategy delivery plan include:

People Plan: Theme	Commitment	Measure	2025-26 Delivery Plan Actions
Looking after our people: We will develop a culture than empowers individuals to lead healthy lives and thrive in work by providing holistic wellbeing support	• Continue to embed health & wellbeing support and initiatives than champion a safe and healthy environment for all • Continue to harness a culture of kindness, openness and inclusivity where everyone is treated with civility and respect • Continue to develop compassionate and inclusive leaders than champion a culture of learning and improvement • Empower staff to work flexible, allowing them to balance both professional and personal commitments	• Improve staff sickness levels year on year • Undertake the Health & Wellbeing Diagnostic tool and implement improvement actions • Improvement in staff survey results for 'health and wellbeing', and 'we are compassionate and inclusive'	• Improve our understanding of our workforce relating to health inequalities and indices of multiple deprivation and ensure targeted and relevant advice, guidance and support is available to them. • Delivery of Sickness Improvement plan • Review our approach to awareness, education and intervention relating to physical health to ensure it is fit for purpose i.e. MSK, moving and handling, work related physical health instances. • Continue to develop and implement an MWL Trauma Support Pathway with key stakeholders. To support staff and managers with a clear process and procedure of practice and to support with a psychological safe environment • Launch a time to flex campaign to communicate the range of

			flexibility available to colleagues across the organisation.
Belonging in the NHS: We will develop an inclusive culture where everyone's voice is represented and celebrated	• Celebrate diversity and promote an environment of openness and inclusion • Tackle all forms of discrimination, harassment and bullying • Ensure that every person has a voice that counts by acting on feedback and involving staff in decision making • Champion and environment that enables all staff to "speak up", raise concerns, makes changes and shape learning • Improve the experience of those people with a protected characteristic	• Trust will be in top 25% for People Promise "we are compassionate and inclusive" • Continue to increase the % staff sharing their disability status with the Trust • Implement all 6 high impact areas under the NHS EDI Improvement Plan • Reduce number of colleagues experiencing harassment, bullying or abuse at work	• Achieve Bronze level anti-racism status • Implement a 'Culture and Engagement events plan' which includes events for EDI Week, Race Equality Week, Black History Month, Wear red Day, and Speak Up Month. • All staff in 2025 Appraisal to be asked to identity a personal EDI Training/Development objective • Provision of a suite of learning and development options in relation to EDI and wider inclusion that includes courses, reading, listening, watching and volunteering. • Implement active bystander training for colleagues across the Trust. • Refine MWL approach for Staff Networks in partnership with Trust Senior Leadership Group
Growing for the future: We will embrace new ways of working and create opportunities to enable our people to achieve their potential	• Grow our relationships with local communities, schools and colleges to develop health workers of the future	• 70% of staff recommend the Trust as a place to work • Review and Improve exit interview processes	• Implement the Band 5 BAME Career Development programme following the pilot. • Define our engagement area and map the High Schools and

	• Continue to develop and improve our recruitment practices and processes • Develop and embed training and development pathways across all levels and professions	• Continue to achieve compliance in appraisals across all staff groups	colleges then identify our key links • Develop and launch defined work experience programme across MWL.

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB25/082 (12.2)**			
Report Title	Workforce Disability Equality Standard Report (WDES) 2024/25			
Executive Lead	Malise Szpakowska, Chief People Officer			
Presenting Officer	Malise Szpakowska, Chief People Officer			
Action Required	X	**To Approve**		**To Note**

Purpose

This report provides an overview and analysis of the Trust's Workforce Disability Equality Standard (WDES) for 2024-2025 (March 2025).

This report provides an overview and analysis of the Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) with relevant trended data from MWL, former St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and former Southport and Ormskirk Hospital NHS Trust (S&O) and national data were applicable.

Executive Summary

The following is an overview of the WDES Highlights for 2024-2025.

Workforce data metrics:

- An increase in the proportion of total disabled staff reported to 6.7%; Non-Clinical staff to 8.7%; Clinical Non-Medical staff to 6.3%; and a decrease Clinical Medical & Dental staff to 2.6%.
- An increase in the proportion of Non-Clinical Disabled staff on all bands excluding 8a, 9 & VSM.
- An increase in the proportion of Clinical Non-Medical disabled staff on bands, excluding band 1, 7, 8c+
- An increase in the proportion of Clinical Medical & Dental disabled staff on Consultant grades, with a decrease for Trainees, and Non-Consultants.
- Disabled applicants are less likely to be appointed than non-disabled applicants. The likelihood of disabled staff being appointed has got worse compared to previous year.
- Disabled staff are less likely than non-disabled staff to enter a formal capability process.
- There are no known disabled individuals on the Trust Board.

Staff survey data:

- 24.2% of disabled staff reported experiencing harassment from patients et al, compared to 18.3% of Non-Disabled staff.
- 11.9% of disabled staff reported experiencing harassment from a manager, compared to 6.4% of Non-Disabled staff.
- 21.2% of disabled staff reported experiencing harassment from colleagues, compared to 11.6% of Non-Disabled staff.
- Disabled staff were more likely than Non-Disabled staff to report harassment if they had experienced it.
- 52.9% of disabled staff believe the Trust provides equality in career progression, compared to 60.2% of Non-Disabled staff.
- 25.6% of disabled staff reported feeling pressured to come to work when ill, significantly higher than non-disabled staff at 16.3%.
- 32.6% of disabled staff reported feeling that the trust valued their work, compared to 47.4% of

non-disabled staff.
- 75.8% of disabled staff that require workplace adjustments reported being provided with them.

Financial Implications
None

Quality and/or Equality Impact
This report is a regulatory requirement under the NHS Contract. It forms part of the Trust's work to promote race equality in line with the Equality Act 2010.

Recommendations
The Board is asked to note the Workforce Disability Equality Standard Report (WDES) and approve the WDES Action Plan.

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

Workforce Disability Equality Standard Report
Data Summary

April 2024 – March 2025

1. Executive Summary

This report provides the Trust Board with the Annual Workforce Disability Equality Standard (WDES) data for the Mersey & West Lancashire Teaching Hospitals Trust. The publication of this report is for the period 2024-2025 in line with the NHS Standard Contract requirements to publish the WDES indicators.

2. Introduction

NHS England introduced the Workforce Disability Equality Standard (WDES) in 2019. The WDES exists to highlight any differences between the experiences and treatment of disabled staff and non-disabled staff in the NHS and places an onus on NHS organisations to develop and implement actions to bring about continuous improvements. The main purpose of the WDES is:

- to help NHS organisations to review performance on disability equality, based on the ten WDES indicators.
- to produce action plans to close any gaps in workplace experience between disabled and non-disabled staff.
- to improve the disabled representation at the Board level of the organisation.

3. A year in review: 2024-2025

The Trust has worked to implement disability inclusion actions agreed within the 2024 WDES report, as well as the EDI Operational Plan 2022-2025, activity to support the implementation of the NHS EDI High Impact Actions[1] (HIA), the Equality Delivery System[2] (EDS) and our work as a Disability Confident Leader[3].

Key actions that have been achieved between November 2024-July 2025 include:

- **Disability Advice Service**: The EDI (Workforce) team have provided information and advice on workplace reasonable adjustments to staff, managers, OH and HR Business Partners. This value-added service is helping to increase disability disclosure and ensure staff are provided with reasonable adjustments and completed passports.

- **Charter Mark Renewal**: The Trust successful renewed the Defence Employers Recognition Scheme (2024) being recognised as Gold.

- **New Policies**: The Trust has approved policies / updated policies on Flexible Working, New Parent Leave, Parental Bereavement Leave, and Neonatal Leave.

[1] NHS EDI Improvement Plan High Impact Actions
[2] NHS Equality Delivery System
[3] Disability Confident

- **Disability Pay Gap (HIA3)**: The Trust published the Disability Pay Gap in March 2025. Overall, the Disability Pay Gaps are in favour of Non-Disabled staff.

- **Widening Recruitment (HIA4):** Work is ongoing to develop a Work Experience offer; and the Trust is currently planning to host a 'Ways to Work' programme with St Helens Council/College for pilot placement starting in 2025-26 academic year.

- **Assistive Software:** ClaroRead, MindGenius, JAWS, Dragon, Co-Pilot, and ZoomText have all been signed off by IT and Information Governance for use by disabled staff.

- **Cultural Awareness**: The Trust has worked to raise awareness of disability equality topics by engaging in events including Disability History Month, Neurodiversity Week, Carers Week, and Menopause Awareness Week.

- **Staff Training**: The Trust continued to implement training courses on Disability Reasonable Adjustments for Managers, Equality Impact Assessments, Harassment & Discrimination (actions support HIA6); and introduced a new course on Neurodiversity Awareness and delivered bespoke Autism Awareness training for Theatre staff.

4. The 10 WDES indicators

The WDES is an analysis of the following 10 data indicators, relating to workforce, recruitment, capability, staff satisfaction, and board diversity:

1. **Staff Population**: Percentage of Disabled/Non-Disabled staff who are Non-Clinical, Clinical Non-Medical, and Clinical Medical by Agender for Change (AfC) pay bands or grade codes.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Capability**: Relative likelihood of staff entering the formal capability process, as measured by entry into a capability process.
4. **Harassment**: Percentage of staff experiencing harassment, bullying or abuse from patients et al, managers, colleagues
5. **Equality in Career Progression**: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
6. **Presenteeism**: Percentage of staff stating that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties
7. **Being valued**: Percentage of staff reporting that they are satisfied with the extent to which their organisation values their work.
8. **Reasonable Adjustments**: Percentage of staff reporting that reasonable adjustments have been provided.
9. **Disabled staff voice**: activities to engage disabled staff and facilitate staff voice
10. **Board Representation**: Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board; By executive membership of the Board.

4.1. Data and Methodology

Before reading the report, please familiarise yourself with the following information which provides a summary of the data sources and limitations. The time periods for the data sets are as follows:

- **Indicators 1 and 10**: snapshot date of the 31st March,
- **Indicators 2-3**: period from the 1st April to 31st March,
- **Indicators 4-9:** the relevant staff survey that took place between the 1st April to 31st March, usually in the November/December.

The Trust collates data for Indicators 1-3 and 10 directly from the Employee Staff Record (ESR), the TRAC recruitment system and HR Business Partners to create a final data set.

Benchmarking data has been sourced from the national staff survey website and Trust Staff Survey data[4] (2021-2025), Model Health system[5] (2020-2025). Where 2025 data is not available, 2024 data has been provided.

4.1.1. MWL Trended Data

The previous years reports were provided for both legacy Trusts. Where it has been possible to do so, data from the legacy trusts has been combined to create a MWL data set for previous years. Where this has not been possible the legacy data has been provided.

4.1.2. Scope of reported population

The following data principles are applied to the WDES data:

- Data relates to the total substantive workforce on the relevant snapshot date with the exception of Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Medical staff are included
- WDES data is only reported on the broad categories of Disabled, this being where ESR has a disability flag, No Disability, this being where ESR has No Known Disability fag; and Unknown, where ESR has a black, unknown or decline flag.

The WDES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups.

4.1.3. Note on terminology

In data derived from ESR and HR processes, the term Disability is a reference to an employee that has disclosed and been recorded in ESR as having a disability (Yes), which is taken to mean “a physical or mental impairment, which has a substantial, adverse effect, on a persons ability to carry out normal day-to-day activities” (Equality Act 2010).

In data derived from the Staff Survey, the term Disability is a reference to respondents who stated YES to the question “Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?”.

[4] NHS Staff Survey
[5] Model Health System (log in required)

5. WDES Indicators

5.1. Staff Profile Workforce Overview

In the snapshot date of 31st March 2025, Mersey & West Lancashire Teaching Hospitals Trust (MWL) employed 11,006 staff which consisted of:

- 6.7% Known Disability,
- 84.7% No Known Disability,
- 8.6% Not Stated/ unspecified / prefer not to answer.

Over the past 6 years (2020 v 2025) (Figure 1), MWL has seen a year-on-year increase in the total number and in the proportion (%) of known disabled staff in the total workforce (573/5.6% to 733/6.7%), Non-Clinical (209/6.9% to 266/8.7%), Clinical Non-Medical (364/5.4% to 442/6.3%) and a decrease in the Clinical Medical & Dental (M&D) (27/2.9% to 25/2.6%) (Table 1).

Further details for each category are set out below.

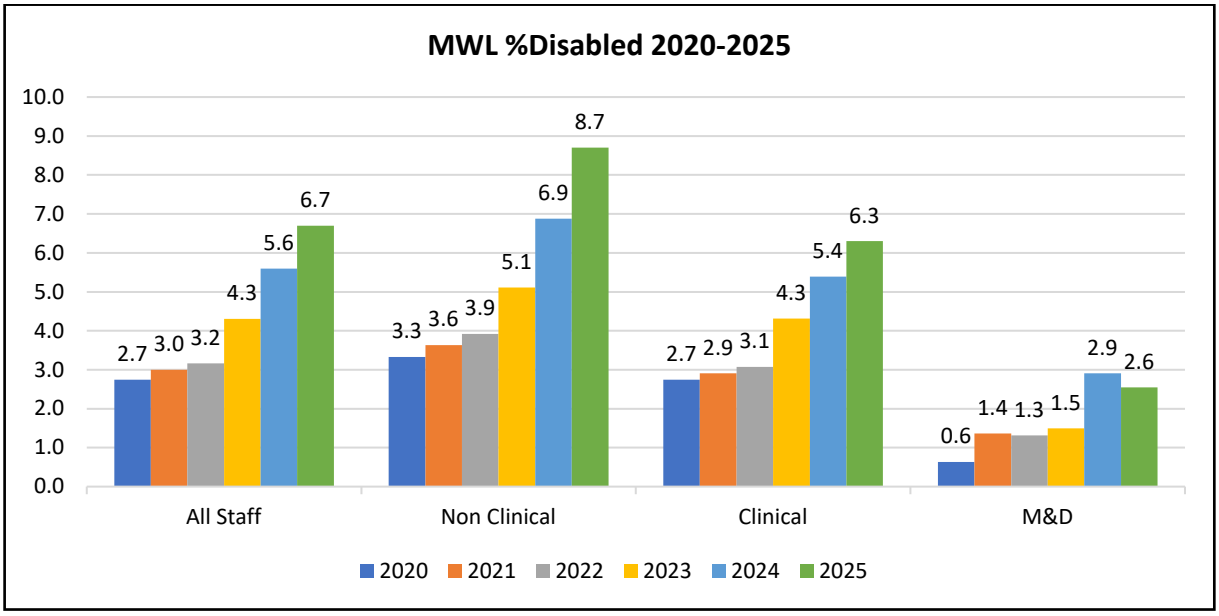


Figure 1

Table 1: 6-year trend and benchmarking

	2019	2020	2021	2022	2023	2024	2025
% MWL	3.0%	2.7%	3.0%	3.2%	4.3%	5.6%	6.7
% National	3.1%	3.5%	3.7%	4.2%	4.9%	5.7%	-
% North West	3.2%	3.5%	3.8%	4.2%	4.9%	5.7%	-
% Acute	3.1%	3.0%	3.2%	3.6%	-	5.6%	-

5.2. Indicator 1: Workforce Staff Data

Indicator 1 is a review of the staff population by Non-Clinical by Agenda for Change (AfC) pay bands; Clinical Non-Medical by AfC pay bands; and Clinical Medical & Dental.

From March 2024 to March 2025, there was an increase in the number and proportion of known disabled staff (Table 2) as follows:

- The total workforce from 573 (5.6%) to 733 (6.7%)
- Non-Clinical staff from 209 (6.9%) to 266 (8.7%)
- Clinical Non-Medical roles from 364 (5.4%) to 442 (6.3%)
- Clinical Medical & Dental roles from 27 (2.9%) to 25 (2.55%)

Overall, the local populations (Table 3) are far more likely to report having a disability and long-term medical condition than the Trusts workforce, both for the total population and the working age population.

Table 2: % Disabled by Staff Group

Staff Headcount March 2025	Dis	No Dis	Unk	% Dis	% Dis National (2024)
Total Workforce	733	9327	946	6.7%	5.7%
Non-Clinical AfC Workforce	266	2476	309	8.7%	6.7%
Clinical AfC Workforce	442	5989	545	6.3%	5.8%
Medical and Dental Workforce	25	862	92	2.6%	2.4%

Table 3: Census Population Benchmarks

Benchmarks %Disabled	Total Population (16+)	Working Age Population (16-64)
National Census: Sefton	20.6%	18.8%
National Census: St Helens	22.1%	19.9%
National Census: Knowsley	23.7%	20.8%
National Census: West Lancashire	18.7%	16.3%
National Census: C&M ICB Area	20.5%	18.1%
National Census: Liverpool City Region	20.7%	19.9%

5.2.1. Indicator 1a: Non-Clinical workforce

The Non-Clinical workforce includes staff in administration, clerical and estates type of roles. Key observations

- The total number of Disabled Non-Clinical staff increased from 209 (6.9%) to 266 (8.7%), with an increase in the number and proportion of Disabled staff on bands 1 -7 and 8b-d (Table 4).
- There were no known disabled staff on Band 9 or VSM.
- A larger proportion of Band 1, 3, 4, 6, 7, 8c and 8d staff are known to have a disability compared to the Non-Clinical average.
- Compared to 2024 Benchmarking data, in 2024 the Trust had a larger proportion of disabled staff on Bands 2-4, 6, 8d; and comparing MWL 2025 against the national 2024 benchmarks, the Trust had a larger proportion of disabled staff on bands 2-4, 6, 7, 8d. (Table 4, 5).

Table 4: % Disabled Non-Clinical Workforce

	2024 MWL		2025 MWL		2024 National
	% Disabled	% No Dis	% Disabled	% No Dis	% Disabled
Band 1	9.8%	58.8%	10.6%	59.6%	-
Band 2	6.5%	75.6%	8.2%	76.4%	6.3%
Band 3	8.4%	83.6%	10.1%	82.3%	7.5%
Band 4	6.6%	83.6%	8.8%	83.0%	6.3%
Band 5	4.9%	87.8%	5.2%	88.4%	7.0%
Band 6	9.4%	81.3%	11.6%	82.2%	7.4%
Band 7	6.4%	84.1%	10.7%	82.7%	7.1%
Band 8A	6.3%	89.1%	5.4%	90.5%	6.4%
Band 8B	2.8%	80.6%	7.8%	85.7%	6.2%
Band 8C	3.9%	96.2%	9.7%	87.1%	4.9%
Band 8D	11.8%	76.5%	14.3%	78.6%	5.2%
Band 9	0.0%	91.7%	0.0%	90.9%	3.9%
VSM	0.0%	91.7%	0.0%	92.3%	6.3%
Total	6.9%	81.1%	8.7%	81.2%	6.7%

Table 5: % Disabled Non-Clinical Workforce National Comparators

% Disabled	2019	2020	2021	2022	2023	2024	2025
MWL	3.3	3.3	3.6	3.9	5.1	6.9	8.7
National	3.6	4.0	4.3	4.9	5.8	6.7	-
North West	3.6	4.0	4.2	4.7	4.9	-	-
Acute	3.6	3.6	3.9	4.4	-	-	-

5.2.2. Indicator 1b: Clinical workforce: Non-Medical

The Clinical Non-Medical workforce includes all allied health professionals, nursing and midwifery staff and relevant support staff. Key observations:

- The total number of Disabled Clinical Non-Medical staff increased from 364 (5.4%) to 442 (6.3%), with an increase in the number and proportion of disabled staff on bands 2-6, 8a (Table 6).
- There were no known disabled staff on Bands 8c-9 and VSM.
- Compared to 2024 Benchmarking data, in 2024 the Trust had a larger proportion of disabled staff on Bands 2 and 6; and comparing MWL 2025 against the national 2024 benchmarks, the Trust had a larger proportion of disabled staff on bands 2, 3, 5, and 6 (Table 6, 7).

Table 6: % Disabled Clinical Non-Medical Workforce

	2024 MWL		2025 MWL		2024 National
	% Disabled	% No Dis	% Disabled	% No Dis	% Disabled
Band 1	0.0%	0.0%	0.0%	0.0%	-
Band 2	5.1%	85.5%	6.2%	85.8%	5.0%
Band 3	6.0%	81.9%	6.2%	83.7%	6.0%
Band 4	6.9%	83.3%	7.0%	83.7%	7.1%
Band 5	4.9%	88.0%	6.6%	87.7%	5.3%
Band 6	6.5%	83.7%	7.6%	84.1%	6.3%
Band 7	5.5%	84.0%	5.2%	86.0%	5.9%
Band 8A	3.6%	87.2%	4.0%	89.3%	5.3%
Band 8B	3.0%	77.3%	4.8%	77.4%	5.1%
Band 8C	0.0%	100.0%	0.0%	95.0%	4.4%
Band 8D	0.0%	100.0%	0.0%	100.0%	4.1%
Band 9	0.0%	100.0%	0.0%	100.0%	3.6%
VSM	0.0%	100.0%	0.0%	0.0%	4.3%
Total	5.4%	85.3%	6.3%	85.9%	5.8%

Table 7: % Disabled Clinical Non-Medical Workforce National Comparators

	2019	2020	2021	2022	2023	2024	2025
MWL	3.2%	2.8%	2.9%	3.1%	4.3%	5.4%	6.3%
National	3.2%	3.6%	3.9%	4.3%	5.0%	5.8%	-
North West	3.3%	3.6%	3.9%	4.3%	-	-	-
Acute	3.1%	3.0%	3.3%	3.6%	-		-

5.2.3. Indicator 1c: Clinical workforce: Medical & Dental

The Clinical Medical & Dental workforce includes all staff on a medical and dental terms and conditions and includes Foundation and Specialist Doctors and Consultants. Key observations:

- The proportion of Clinical Medical & Dental staff has decreased from 2.9% to 2.6%, although total headcount has increased from 24 to 25 (Table 8).
- By career stage, trainee doctors are far more likely to have disclosed a disability (3.2%) compared to Consultants (2.3%).
- Compared to the known population of disabled people in the 1) population, and 2) workforce, there remains either a significant underreporting of a disability by medics, or there are significant

issues with the recruitment and retention of medics with a disability, both at the Trust and nationally.

- Compared to 2024 Benchmarking data, in 2024 and 2025 the Trust had a larger proportion of disabled staff on Trainee and Non-Consultant roles (Table 8, 9).

Table 8: % Disabled Clinical Medical & Dental Workforce

	2024 MWL		2025 MWL		2024 National
	% Disabled	% No Dis	% Disabled	% No Dis	% Disabled
Consultants	1.5%	82.1%	2.3%	84.2%	1.8%
Non-consultant	3.4%	84.6%	2.0%	86.8%	2.1%
Trainees	4.7%	91.3%	3.2%	93.9%	3.1%
Total	2.9%	85.7%	2.6%	88.1%	2.4%

Table 9: % Disabled Clinical Medical & Dental Workforce National Comparators

	2019	2020	2021	2022	2023	2024	2025
MWL	0.5%	0.6%	1.4%	1.3%	1.5%	2.9%	2.6%
National	1.3%	1.3%	1.5%	1.7%	2.2%	2.4%	-
North West	1.1%	1.1%	1.4%	1.4%	-	-	-
Acute	1.2%	1.2%	1.4%	1.6%	-	-	-

5.3. Indicator 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Indicator 2 is an assessment of the Trusts recruitment and selection practices, and whether disabled applicants are as likely as non-Disabled applicants to be successfully shortlisted and appointed.

This indicator is assessed at "whole organisation" level and does not disaggregate the recruitment trends by band, job group or department.

Table 10: Relative likelihood of being appointed from interview

MWL	Disabled	No Disability	Unknown
2021-2022	18.5%	21.3%	21.1%
2022-2023	21.7%	24.0%	70.1%
2023-2024	28.9%	31.5%	69.3%
2024-2025	26.1%	32.5%	53.2%

Table 11: Relative likelihood of a non-Disabled staff being appointed from shortlisting compared to disabled staff

	MWL	National	North West	C&M ICB
2021-2022	1.2	1.1	1.2	0.9
2022-2023	1.1	1.0	1.1	0.9
2023-2024	1.1	1.0	1.0	1.1
2024-2025	1.2	-	-	-

A value below <1 means that Disabled candidates are more likely than Non-Disabled candidates to be appointed from shortlisting.

Overall disabled staff are slightly less likely to be appointed from interview, at 1.24. Nationally, disabled applicants are slightly more likely to be appointed at 0.98 (2024), and in the North West slightly less likely at 1.08 (2024).

5.4. Indicator 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Indicator 3 is an assessment of whether disabled staff are more likely to be subject to formal capability processes compared to non-disabled staff for non-health related reasons. The data used for this indicated is the average number of cases over a 2-year period e.g. 2022/23 + 2023/24 average, and 2023/24 + 2024/25 average.

Overall disabled staff are less likely to go through a formal capability process than non-disabled staff (0.58), significantly lower than the national average (2.04) (Table 12).

Table 12: Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff

	STHK	S&O	National Average	North West Average
2020/21 + 2021/22	9.96	0.00	2.01	2.01
2021/22 + 2022/23	4.97	0.00	2.17	3.35
2022/23 + 2023/24	0.00		2.04	2.41
2023/24 + 2024/25	0.58		-	-

A figure above 1.00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.

6. Staff Survey Questions

The 2024 NHS Staff Survey was conducted between October and November 2024 and completed by 3944 staff (37% response rate). For the purposes of this report, the 2024-2025 staff survey results have been sourced from the national staff survey website and the Trusts staff survey data, with benchmarking data being sourced from the National Staff Survey results portal and Model Health.

6.1. Indicator 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public (Staff Survey, Q14a)

Table 13: Harassment by Patients et al

		2022	2023	2024	Change
MWL	Disabled	33.7%	26.5%	24.2%	-2.3
	No Dis	24.6%	20.0%	18.3%	-1.7
	All	26.9%	21.9%	20.0%	-1,9
National	Disabled	33.1%	30.0%	29.5%	-0.5
	No Dis	25.9%	23.3%	23.3%	0.0
	All	27.8%	25.3%	25.1%	-0.2
C&M ICB	Disabled	30.9%	26.4%	25.2%	
	No Dis	22.8%	19.2%	18.4%	
	All	24.9%	21.4%	20.3%	
Acute & Community	Disabled	32.9%	29.6%	29.2%	-0.4
	No Dis	26.0%	23.3%	23.3%	-0.0
	All	28.0%	25.2%	25.0%	-0.2

Overall, there was a decrease in the proportion of staff reporting that they had experienced bullying and harassment from a patient, visitor, family member or member of the public (Table 13); although a higher proportion of Disabled staff reported this than Non-Disabled staff. Specifically, there was a:

- 1.9 point decrease in the proportion of staff reporting experiencing bullying and harassment from a patient et al,
- 2.3 point decrease in the proportion of Disabled staff reporting experiencing bullying and harassment from a patient et al,
- 1.7 point decrease in the proportion of Non-Disabled staff reporting experiencing bullying and harassment from a patient et al
- The proportion of disabled staff reporting experiencing bullying was lower than the National and Acute & Community disability averages.

6.2. Indicator 4b: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers (Staff Survey)

Table 14: Harassment by Managers

		2022	2023	2024	Change
MWL	Disabled	13.4%	11.4%	11.9%	+0.5
	No Dis	7.9%	6.5%	6.4%	-0.1
	All	9.3%	8.1%	8.1%	0.0
National	Disabled	16.4%	14.6%	14.1%	-0.5
	No Dis	9.4%	8.3%	7.8%	-0.5
	All	11.1%	9.9%	9.5%	-0.4
C&M ICB	Disabled	14.7%	13.6%	13.0%	-0.6
	No Dis	8.5%	7.2%	5.6%	-1.6
	All	10.1%	8.9%	8.4%	-0.5
Acute & Community	Disabled	17.4%	15.2%	14.7%	-0.5
	No Dis	9.9%	8.7%	8.1%	-0.6
	All	11.7%	10.4%	9.8%	-0.6

Overall, the proportion of staff reporting that they had experienced bullying and harassment from a manager remained the same, with a increase in the number of Disabled staff reporting this.(Table 14). Specifically, there was:

- No change in the proportion of staff reporting experiencing bullying and harassment from a manager,
- 0.5 point increase in the proportion of Disabled staff reporting experiencing bullying and harassment from a manager,
- 0.1 point decrease in the proportion of Non-Disabled staff reporting experiencing bullying and harassment from a manager,
- The proportion of disabled staff reporting experiencing bullying was lower than the National and Acute & Community disability averages.

6.3. Indicator 4c: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Colleagues (Staff Survey)

Table 15: Harassment by Colleagues

		2022	2023	2024	Change
MWL	Disabled	23.6%	20.5%	21.2%	+0.7
	No Dis	14.8%	12.2%	11.6%	-0.6
	All	17.0%	15.0%	14.7%	-0.3
National	Disabled	25.1%	23.8%	23.6%	-0.2
	No Dis	16.6%	15.4%	15.3%	-0.1
	All	18.7%	17.7%	17.6%	-0.1
C&M ICB	Disabled	22.7%	21.7%	20.9%	-0.8
	No Dis	14.9%	12.8%	12.5%	-0.3
	All	17.0%	15.2%	14.9%	-0.3
Acute & Community	Disabled	27.0%	25.5%	25.3%	-0.2
	No Dis	17.9%	16.5%	16.3%	-0.2
	All	20.0%	18.8%	18.6%	-0.2

Overall, there was a decrease in the proportion of staff reporting that they had experienced bullying and harassment from a colleague, however the proportion of disabled staff reporting this is significantly higher than non-disabled staff. For disabled staff themselves there was an increase in reported experience from 20.5% to 21.2% (Table 15). Specifically, there was a:

- 0.3 point decrease in the proportion of staff reporting experiencing bullying and harassment from a colleague,
- 0.7 point increase in the proportion of Disabled staff reporting experiencing bullying and harassment from a colleague,
- 0.6 point decrease in the proportion of Non-Disabled staff reporting experiencing bullying and harassment from a colleague,
- The proportion of disabled staff reporting experiencing bullying was lower than the National and Acute & Community disability averages.

6.4. Indicator 4d: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it (Staff Survey)

Table 16: Reporting Harassment

		2022	2023	2024	Change
MWL	Disabled	52.3%	49.3%	52.0%	+2.7
	No Dis	48.8%	51.9%	49.4%	-2.5
	All	49.8%	50.8%	50.2	-0.6
National	Disabled	51.0%	52.5%	54.4%	+1.9
	No Dis	49.2%	51.4%	53.8%	+2.4
	All	49.9%	51.8%	54.0%	+2.2
C&M ICB	Disabled	54.3%	52.9%	56.1%	+3.2
	No Dis	51.4%	52.3%	53.9%	+1.7
	All	52.3%	52.6%	54.8%	+2.2
Acute & Community	Disabled	48.5%	50.5%	52.3%	+1.8
	No Dis	46.9%	49.3%	51.5%	+2.2
	All	47.6%	49.8%	51.8%	+2.0

Overall, there was a decrease in the proportion of staff stating that they had reported bullying and harassment when they had experienced it. Disabled staff were slightly more likely to report incidents compared to non-disabled staff (Table 16). Specifically:

- The percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it was higher for Disabled staff (52.0%) compared to Non-Disabled staff (49.4%).
- The proportion of disabled staff reporting this increased by 2.7 points compared to a decrease of 2.5 points for non-disabled staff.
- Trust staff were less likely to state that they had reported bullying and harassment than the national and Acute & Community averages.

6.5. Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion. (Staff Survey)

Table 17: Career Opportunities

		2022	2023	2024	Change
MWL	Disabled	54.4%	57.7%	52.9%	-4.8
	No Dis	61.3%	60.9%	60.2%	-0.7
	All	59.5%	59.8%	58.1%	-1.7
National	Disabled	51.7%	52.2%	51.5%	-0.7
	No Dis	57.5%	58.1%	57.7%	-0.4
	All	56.0%	56.4%	55.9%	-0.5
C&M ICB	Disabled	51.4%	51.7%	51.7%	0.0
	No Dis	59.7%	59.5%	60.2%	+0.7
	All	57.6%	57.3%	57.8%	+0.5
Acute & Community	Disabled	50.9%	51.3%	50.7%	-0.6
	No Dis	56.8%	57.4%	57.1%	-0.3
	All	53.3%	55.8%	55.4%	-0.4

Overall, the proportion of staff reporting that they believed the Trust provides equality of opportunity in career progression decreased to 58.1%. However, disabled staff were significantly less likely to believe in equality in career progression. (Table 17). Specifically:

- 1.7 point decrease in the proportion of staff reporting Yes,
- 4.8 point decrease in the proportion of Disabled staff reporting Yes,
- 0.7 point decrease in the proportion of Non Disabled staff reporting Yes,
- The Trusts response rates were higher than the National and Acute & Community averages.

6.6. Indicator 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism)(Staff Survey, Q11e)

Presenteeism refers to where employees come to work despite being physically or mentally unwell, underperforming due to illness, stress, or other issues that affect their ability to function effectively. Unlike absenteeism, where an employee is absent from work, presenteeism is characterised by being present but not fully productive.

Table 18: Presenteeism

		2022	2023	2024	Change
MWL	Disabled	26.4%	26.2%	25.6%	-0.6
	No Dis	18.6%	16.2%	16.3%	+0.1
	All	21.2%	19.9%	20.1%	+0.2
National	Disabled	28.0%	26.6%	25.4%	-1.2
	No Dis	20.1%	18.5%	17.8%	-0.7
	All	22.6%	21.3%	20.3%	-1.0
C&M ICB	Disabled	26.4%	25.5%	24.0%	-1.5
	No Dis	18.9%	16.9%	16.6%	-0.3
	All	21.4%	20.0%	19.3%	-0.7
Acute & Community	Disabled	29.9%	28.3%	27.0%	-1.3
	No Dis	21.2%	19.5%	18.6%	-0.9
	All	23.8%	22.4%	21.3%	-1.1

Overall, the proportion of staff reporting that they felt pressured to come into work when they were not well increased slightly, although Disabled staff were far more likely to report this (Table 18). Specifically:

- 0.2 point increase in the proportion of staff stating they felt pressure to come to work when ill
- 0.6 point decrease in the proportion of Disabled staff stating that they felt pressured to come to work when ill
- 0.1 point increase in the proportion of Non-Disabled staff stating that they felt pressure to come to work when ill.
- The difference between disabled and Non-Disabled staff response has increased from 7.8 points (2022) to 9.3 points (2024).
- The overall Trusts response rates better than the National and Acute & Community averages, however the response rates for disabled staff at the Trust is worse than the national average.

6.7. Indicator 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work (Staff Survey, Q4b)

Table 19: Feeling Valued

		2022	2023	2024	Change
MWL	Disabled	32.9%	37.7%	32.6%	-5.1
	No Dis	45.4%	48.0%	47.4%	-0.6
	All	42.2%	44.7%	42.9%	-1.8
National	Disabled	34.7%	36.9%	36.3%	-0.3
	No Dis	44.6%	47.8%	47.4%	-0.4
	All	42.1%	44.9%	44.4%	-0.5
C&M ICB	Disabled	34.3%	36.9%	36.6%	-0.3
	No Dis	44.8%	48.2%	48.4%	+0.2
	All	42.0%	45.1%	45.1%	0.0
Acute & Community	Disabled	32.4%	34.7%	34.2%	-0.5
	No Dis	43.0%	46.5%	46.2%	-0.3
	All	40.4%	43.6%	43.2%	-0.4

Overall, the proportion of staff reporting that they felt that the Trust valued their work decreased, with Disabled staff far less likely to believe that it does (Table 19). Specifically:

- 1.8 point decrease in the proportion of staff that they felt valued
- 5.1 point decrease in the proportion of Disabled staff stating that they felt valued
- 0.6 point decrease in the proportion of Non-Disabled staff stating that they felt valued
- The difference between disabled and Non-Disabled staff responses increased from 10.3 points (2023) to 14.8 points (2024).
- The Trusts response rates are worse than the National and Acute & Community averages.

6.8. Indicator 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Staff Survey)

The reported figured for this question are only based on those staff that stated that they had a long-term medical condition, and that they required workplace reasonable adjustments

Table 20: Reasonable Adjustments

%YES	2022	2023	2024	Change
MWL	71.3%	73.0%	75.8%	+2.8
National	72.9%	74.5%	75.0%	+0.5
North West	72.0%	73.6%	74.9%	+1.3
C&M ICB	71.7%	73.1%	75.6%	+2.5
Acute & Community	71.5%	73.0%	73.9%	+0.9

Overall, there was a 2.8 point increase in the proportion of staff who stated that they had been provided with adequate reasonable adjustments (Table 20). The Trusts response rate slightly outperformed the National, North West, C&M ICB and Acute & Community averages.

If it worth noting that the NHS Staff Survey disclosure rate of staff with a long-term medical condition is significantly larger (27.6%) than the official data held in ESR (6.4%). This may be because of a number of reasons including the anonymity of the survey, as well as the difference in the wording of the question, which is broader in the survey (see 4.1.3, p6).

6.9. Indicator 9a: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

The NHS Staff Survey engagement theme is a composite score, standardised to give a value out of 10, with a higher value indicating better performance

It draws from responses to 9 questions across 3 subscales: motivation (I look forward to going to work, I am enthusiastic about my job, time passes quickly when I am working), involvement (there are frequent opportunities for me to show initiative in my role, I am able to make suggestions to improve the work of my team/department, I am able to make improvements happen in my area of work) and advocacy (care of patients/service users is my organisation's top priority, I would recommend my organisation as a place to work, if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation) (questions Q2abc, Q3cdf, Q23acd) (Table 21).

Table 21: Staff Engagement

	MWL		National	
	Disabled	No Dis	Disabled	No Dis
22/23	6.9	7.3	6.4	6.9
23/24	6.7	7.2	6.5	7.0
24/25	6.5	7.1	6.4	7.0

The staff engagement score was lower for disabled staff compared to non-disabled staff, and had decreased from 2023. The non-disabled response rate had also decreased but not as substantially. Compared to the national results, the Trust performance slightly better for both disabled and non-disabled responses.

6.10. Indicator 9b: Has your Organisation taken action to facilitate the voices of Disabled staff in your organisation to be heard (yes or no)?

Indicator 9b is an open question asking how the Trust has engaged disabled staff.

The Trust reported doing the following:

- The Trust supports the Building Abilities Network staff network, which is open to disabled staff and allies.
- The network is represented on a number of groups including a regular Staff Network Chair meeting with the Equality, Diversity & Inclusion Team and membership of the Equality, Diversity & Inclusion Steering Group.
- The network has been actively consulted on a number of projects including the development of an annual calendar of events, and events/comms to support the aims of the staff network.

6.11. Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

In March 2025 there were no known disabled member of the Trust's Board (Table 23). This now means that there is a 6.7% difference between the proportion of disabled people on the Board, and the overall workforce.

Table 22: Trust Board Trend

	MWL Disabled	National Disabled
2024	5.6%	6.5%
2025	0.0%	-

Table 23: Trust Board 2025

	Dis	No Dis	Unknown
Total Board	0.0%	88.9%	11.1%
Of which Voting Board Members	0.0%	81.8%	18.2%
Non-Voting Board Members	0.0%	100%	0.0%
Of which Executive Board Members	0.0%	83.3%	16.7%
Non-Executive Board Members	0.0%	100%	0.0%
Difference Total Board v Workforce	**-6.6**	**+4.2**	**+3**
Difference Voting Members v Workforce	**-6.6**	**-2.9**	**+10.2**

7. Conclusion

Overall, the proportion of known disabled staff at the Trust continues to improve, with the gap between MWL and the national average reducing to 0.1% in 2024 and the Trust increasing to +1% point when comparing MWL 2025 with National 2024 figures. The Medical Workforce however, continues to have low disclosure rates, and this year in fact decreased.

Overall, the WDES indicators show the following:

Workforce data metrics:

- An increase in the proportion of total disabled staff reported to 6.7%; Non-Clinical staff to 8.7%; Clinical Non-Medical staff to 6.3%; and a decrease Clinical Medical & Dental staff to 2.6%.
- An increase in the proportion of Non-Clinical Disabled staff on all bands excluding 8a, 9 & VSM.
- An increase in the proportion of Clinical Non-Medical disabled staff on bands, excluding band 1, 7, 8c+
- An increase in the proportion of Clinical Medical & Dental disabled staff on Consultant grades, with a decrease for Trainees, and Non-Consultants.
- Disabled applicants are less likely to be appointed than non-disabled applicants. The likelihood of disabled staff being appointed has got worse compared to previous year.
- Disabled staff are less likely than non-disabled staff to enter a formal capability process.
- There are no known disabled individuals on the Trust Board.

Staff survey data:

- 24.2% of disabled staff reported experiencing harassment from patients et al, compared to 18.3% of Non-Disabled staff.
- 11.9% of disabled staff reported experiencing harassment from a manager, compared to 6.4% of Non-Disabled staff.
- 21.2% of disabled staff reported experiencing harassment from colleagues, compared to 11.6% of Non-Disabled staff.
- Disabled staff were more likely than Non-Disabled staff to report harassment if they had experienced it.
- 52.9% of disabled staff believe the Trust provides equality in career progression, compared to 60.2% of Non-Disabled staff.
- 25.6% of disabled staff reported feeling pressured to come to work when ill, significantly higher than non-disabled staff at 16.3%.
- 32.6% of disabled staff reported feeling that the trust valued their work, compared to 47.4% of non-disabled staff.
- 75.8% of disabled staff that require workplace adjustments reported being provided with them.

8. Action Plan

The Trust has developed a new People Strategy within which Equality, Diversity and Inclusion are embedded. The **key disability related objectives** set out in the People Strategy delivery plan are:

People Plan: Theme	Commitment	Measure	2025-26 Delivery Plan Actions
Looking after our people: We will develop a culture than empowers individuals to lead healthy lives and thrive in work by providing holistic wellbeing support	• Continue to embed health & wellbeing support and initiatives than champion a safe and healthy environment for all • Continue to harness a culture of kindness, openness and inclusivity where everyone is treated with civility and respect • Continue to develop compassionate and inclusive leaders than champion a culture of learning and improvement • Empower staff to work flexible, allowing them to balance both professional and personal commitments	• Improve staff sickness levels year on year • Undertake the Health & Wellbeing Diagnostic tool and implement improvement actions • Improvement in staff survey results for 'health and wellbeing', and 'we are compassionate and inclusive'	• Continue to support disabled staff with reasonable adjustments and utilising the disability passports. • Improve our understanding of our workforce relating to health inequalities and indices of multiple deprivation and ensure targeted and relevant advice, guidance and support is available to them. • 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 • Delivery of Sickness Improvement plan • Review our approach to awareness, education and intervention relating to physical health to ensure it is fit for purpose i.e. MSK, moving and

			handling, work related physical health instances. • Continue to develop and implement an MWL Trauma Support Pathway with key stakeholders. To support staff and managers with a clear process and procedure of practice and to support with a psychological safe environment • Launch a time to flex campaign to communicate the range of flexibility available to colleagues across the organisation.
Belonging in the NHS: We will develop an inclusive culture where everyone's voice is represented and celebrated	• Celebrate diversity and promote an environment of openness and inclusion • Tackle all forms of discrimination, harassment and bullying • Ensure that every person has a voice that counts by acting on feedback and involving staff in decision making • Champion and environment that enables all staff to "speak up", raise concerns, makes changes and shape learning • Improve the experience of those people with a protected characteristic	• Trust will be in top 25% for People Promise "we are compassionate and inclusive" • Continue to increase the % staff sharing their disability status with the Trust • Implement all 6 high impact areas under the NHS EDI Improvement Plan • Reduce number of colleagues experiencing harassment, bullying or abuse at work	• The complete a Reasonable Adjustments Processes Review project in collaboration with AQUA/Service Improvements to improve the processes and support across the Trust • Implement a 'Culture and Engagement events plan' which includes events for EDI Week, Disability History Month, Carers Week, Global Accessibility Day, Staff Network Day, MWL People Week, and Speak Up Month. • All staff in 2025 Appraisal to be asked to identity a personal EDI Training/Development objective • Provision of a suite of learning and development options in

			relation to EDI and wider inclusion that includes courses, reading, listening, watching and volunteering. • Run a campaign to support staff in disclosing their health conditions and expand knowledge of support and advice available for those that have conditions to disclose. • Implement active bystander training for colleagues across the Trust. • Refine MWL approach for Staff Networks in partnership with Trust Senior Leadership Group
Growing for the future: We will embrace new ways of working and create opportunities to enable our people to achieve their potential	• Grow our relationships with local communities, schools and colleges to develop health workers of the future • Continue to develop and improve our recruitment practices and processes • Develop and embed training and development pathways across all levels and professions	• 70% of staff recommend the Trust as a place to work • Review and Improve exit interview processes • Continue to achieve compliance in appraisals across all staff groups	• Career Development programme to be introduced for disabled staff • To develop career development resources and toolkits including on topics aimed at disabled staff and reasonable adjustments • To target promotion of career development opportunities to the Disabled Staff Network • Publish recruitment/why work here information on the external recruitment website aimed at disabled applicants

			• Define our engagement area and map the High Schools and colleges then identify our key links • In collaboration with St Helens Council, to pilot a “disability” placement scheme. • Develop and launch defined work experience programme across MWL.

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB 25/083**			
Report Title	MWL Green Plan 2025 -28			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

For the Board to approve the MWL Green Plan 2025-28.

Executive Summary

In October 2020 the NHS committed to delivering net zero by 2040 and by 2022 each Provider Trust was required to develop a three-year Green Plan, to set out the local ambition and actions to reduce carbon emissions.

As the legacy trusts remained sperate legal entities at that time, two distinct Green Plans were developed and approved by the Trust Board (for St Helens and Knowsley Teaching Hospitals NHST) and Strategic Oversight Committee (for Southport and Ormskirk Hospital NHST).

The 2025-28 Green Plan (appendix 1) is the first MWL plan. It follows the NHS England (NHSE) model template and addresses each of the nine priority areas:

- Workforce and leadership
- Net zero clinical transformation
- Digital transformation
- Medicines
- Travel and transport
- Estates and facilities
- Supply chain and procurement
- Food and nutrition
- Resilience and adaption

The Green Plan addresses the actions taken to date, which will be continued and new actions planned for the next three-year period. The plan has been developed by the Estates and Facilities Management team with support and involvement from HR, Medicines Management, Public Finance Initiative (PFI Partners), IT, Emergency Preparedness, Resilience and Response (EPRR) and Procurement. There are three core objectives:

1. Reduce carbon, waste and water
2. Improve air quality
3. Elimination of avoidable single use plastic

These objectives will be delivered via nine domains for action:

1. Workforce and leadership
2. Clinical transformation
3. Digital innovation
4. Travel and transport
5. Estates and Facilities
6. Medicines

7. Procurement
8. Food and nutrition
9. Adaption to climate change

Since July 2023 MWL has achieved a 3,473 tonne CO_2e reduction, secured £11.8m of new investment to support decarbonisation and solar energy and upgraded a significant proportion of lighting to LED via backlog maintenance and lifecycle investments.

Once agreed and approved the Green Plan is part of the NHS Publication Scheme and will be published on the Trust website and promoted to staff, our stakeholders and partners.

The carbon reductions for each NHS organisation are calculated annually by NHS based on the ERIC data submissions and a base year of 2008. The national guidance includes both emission based, and non-emission based metrics to allow organisations to track progress and this will continue to be reported to the Board on an annual basis.

Financial Implications
Non specifically requested

Quality and/or Equality Impact
The delivery of the NHS Net Zero ambition supports the long term sustainability of healthcare.

Recommendations
The Board is asked to approve the Green Plan 2025-28

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


NHS
Mersey and West Lancashire
Teaching Hospitals
NHS Trust
GREEN PLAN
2025–2028

Date: 14/10/25
Version number: 05
Owner: Nicola Bunce, Director of Corporate Services
Authors: H Ryan, Compliance and Quality Manager
G Turton, Sustainability Manager
D Downs, Senior Facilities Manager
D Clegg, Deputy Director Estates and Facilities
Approval route: Trust Board
Approval status: Approved XX 2025

Forward

In demonstrating our drive and commitment towards achieving net zero Mersey and West Lancashire Teaching Hospitals NHS Trust is pleased to present its first Green Plan. The plan builds on the foundations of our predecessor organisations, established in 2022. It reflects on the achievements to date and sets out the next steps and key milestones towards the organisation achieving net zero. As a large provider of healthcare across Merseyside and West Lancashire we are motivated and dedicated to improving the health and wellbeing of the communities we service and the environment for future generations.

The NHS contributes towards more than 5% of the UK's total carbon footprint and has made a collective commitment to achieving net zero carbon emissions by 2040 for directly controlled sources and 2045 for those we influence, such as supply chains. As an anchor institution, MWL can influence local wellbeing and deliver social, environmental, and economic value. This Green Plan sets out the areas of priority action; energy use, travel, procurement, and waste management and the aspiration to go beyond compliance with legislation and embed sustainability into all aspects of our operations. Achieving these goals will require the involvement and commitment of all staff and key stakeholders.

The MWL Green Plan is rightly ambitious and reflects our commitment to act as a leader in environmental responsibility, to create a healthier future for our patients, staff, and communities.

Rob Cooper
Chief Executive
October 2025

Contents

Executive Summary

Global climate change is one of the key environmental threats facing the world today. Concerns over fossil fuel depletion, rising temperatures, higher sea levels, security of energy supplies and rising energy costs are focussing the attention of individuals, organisations, and governments on the need for energy conservation and carbon emission reduction.

This Green Plan sets out Mersey and West Lancashire Teaching Hospital NHS Trusts approach to mitigating climate change through carbon reduction and embedding sustainable practices within its operations. This plan covers the period 2025 – 2028 and builds on the initial Green Plans approved by the Boards of our predecessor organisations in 2022. In line with National guidance this plan aims to focus on the nine key areas of focus within the organisation to achieve the net zero targets (NHS England 2025. Green plan Guidance). These areas are as follows: -

Workforce and leadership
Net zero clinical transformation
Digital transformation
Supply chain and procurement
Adaptation
Travel and transport
Estates and facilities
Medicines
Food and nutrition

Our Green Plan Goals

In summary there are 12 simple goals that we are aiming to achieve by the implementation of this Green Plan:-

Introduction

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) was formed in July 2023 following the long-term collaboration agreement between St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust.

The Trust serves a population of over 600,000 people with a combined workforce of around 9,000 dedicated and skilled staff.

Our staff provide care from a range of locations including hospitals, community locations and in patient's own homes, delivering Five Star Patient Care to all patients.

Acute care and emergency services are provided at Whiston, Southport and Ormskirk hospitals, Maternity Services are delivered from the Whiston and Ormskirk Hospital sites. Other outpatient and elective services are provided from all of our hospital sites.

Primary care services are also provided from Marshalls Cross Medical Centre, situated in St Helens Hospital.

The Trust delivers adult community services for the borough of St Helens, including an Urgent Treatment Centre, and a wheelchair service for people in Chorley, South Ribble and West Lancashire.

MWL hosts the Mersey Regional Burns and Plastic Surgery Unit at Whiston Hospital and the Regional Spinal Injuries unit at Southport District General Hospital, to more than four million people across the whole of Merseyside and West Lancashire, Cheshire, the Isle of Man and North Wales.

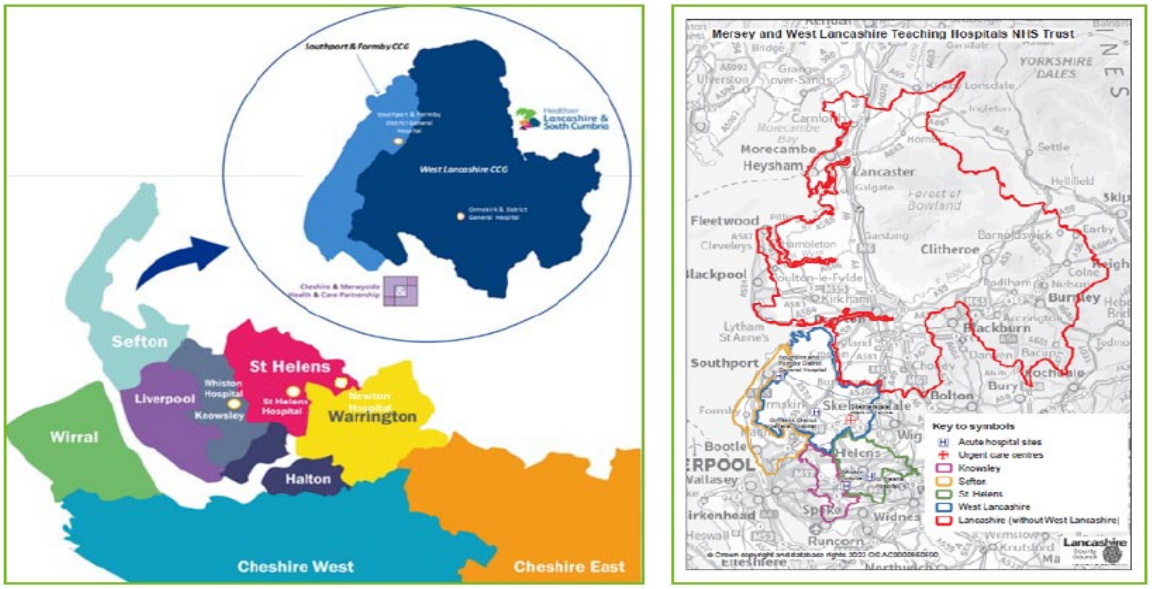
The Trust prides itself on being an anchor institution within the area and as well as having links with local universities and colleges, utilises many local supplies and has numerous links with surrounding communities.

The area we serve has one of the highest proportions of older people in the country and there are many residential and nursing homes. It is also socially and economically diverse with areas of both relatively high income and significant deprivation.

Southport is a coastal resort and as such attracts more than 5m visitors placing an increased seasonal demand on healthcare.

The areas we serve

This infographic shows the areas covered by Mersey and West Lancashire Teaching Hospitals NHS Trust which is based directly in four of the nine Place-based partnerships within Cheshire and Merseyside Integrated Care System (St Helens, Knowsley, Halton, Sefton) and the Central and West Lancashire locality within the Lancashire Place-based partnership in the Lancashire and South Cumbria Integrated Care System.



Geographical area of the Trust's sites across Cheshire and Merseyside and West Lancashire

The Trust consists of five hospital sites:

- Whiston Hospital
- St Helens Hospital
- Southport Hospital
- Ormskirk Hospital
- Newton Hospital

Additionally, we deliver care in and from a number of community sites including:

- Lowe House Health Centre
- Marshalls Cross GP Practice
- St Helens Millennium Centre
- Southport Centre for Health & Wellbeing

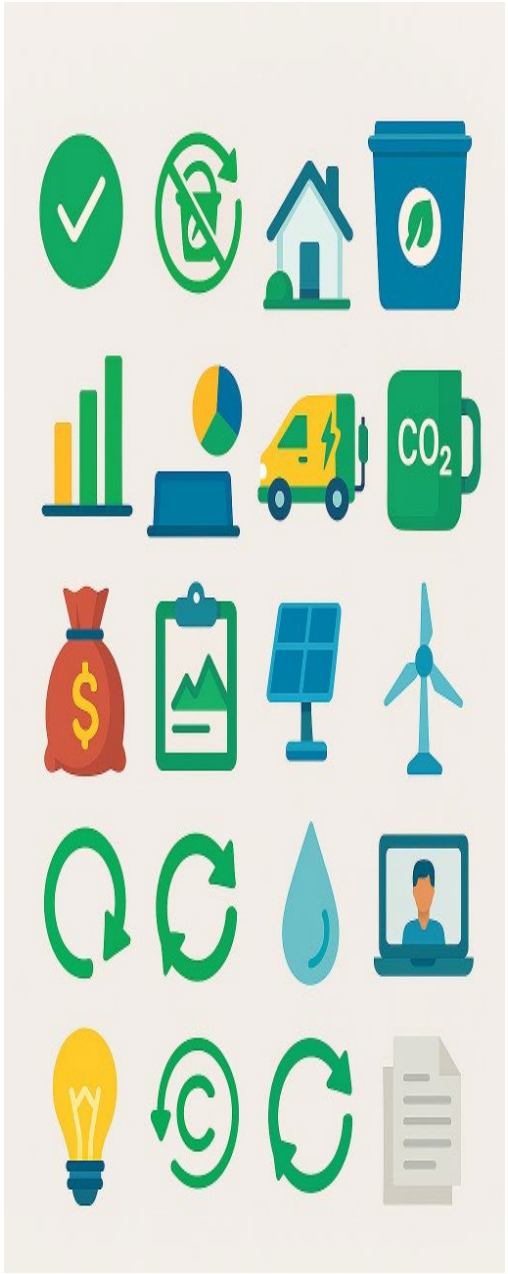
Community Estate

The Trusts community estate continues to expand as new clinical services are successfully tendered for. The community portfolio currently consists of circa 20 differing leased properties which can create challenges when making infrastructure and environmental changes are out of the Trusts direct control or influence.

Key Achievements to Date

Since July 2023 when MWL was formed the organisations carbon emissions has reduced by 3,473 tonnes. This has been achieved through a combination of projects and dedicated workstreams:

- ✓ Achieving zero waste to landfill.
- ✓ Use of re-usable sharps containers across our main sites.
- ✓ Developed and implemented policies for Sustainability, Energy, Waste and Transport.
- ✓ Supported flexible working policies including working from home for part of the week for some groups of staff, thus reducing staff travel miles.
- ✓ Use of MS Teams for meetings reducing travel between sites.
- ✓ All offensive waste is processed via waste to energy.
- ✓ All energy consumption and waste tonnage is monitored and reported
- ✓ Theatre air change set back was introduced throughout the Trust and has operated successfully for many years.
- ✓ Double glazing is installed in all accommodation blocks?
- ✓ Operation of an electric delivery van powered by Trust own electric from CHP.
- ✓ Installation of EV charging points across all sites. 37 at Southport & Ormskirk and 16 at Whiston and St Helens
- ✓ PV panels installed at St Helens, Whiston, and Ormskirk.
- ✓ £10million PSDS funding grant obtained for Southport site, for the retirement of a gas fed CHP, replaced by air source heat pump with CO2 savings of 3,500 tonnes.
- ✓ All main sites have Carbon reduction Plans.
- ✓ Installation of a Flu-Ace heat recovery unit at Whiston.
- ✓ Fitted flange and valve insulation to heat emitting plant across all sites.
- ✓ Removed single use plastics from hospital restaurants.
- ✓ Rolled out Telehealth, thus reducing unnecessary patient travel.
- ✓ Switched to energy efficient filters in our air handling units.
- ✓ Introduced Warp-It; waste, reuse and recycle portal.
- ✓ Increased LED light coverage all sites.
- ✓ Recycled paper is used for all photocopying and printing.



The Aim of the Green Plan

The Trusts Green Plan sets out the strategy for further reducing carbon emissions over the next 3 years and beyond, by detailing a range of measures and actions to reduce both direct and indirect emissions across the estate as a whole and thus embed carbon management in the operational processes and fabric of the Trust. It is therefore hoped to raise and enhance environmental awareness, within the Trust, and the local community.

Internal and External Drivers for Change

In the UK climate change is expected to cause a marked regional difference in temperature and rainfall by the end of the 21st century. The climate in the UK has already changed and has experienced nine of the ten warmest years on record since 1990. Sea-surface temperature around the UK has risen by about 0.7°C over the past three decades and sea levels have risen around 10cm since 1900. It is also clear that Central England temperatures have increased by 1°C since the 1970's and that in most parts of the UK total summer rainfall has decreased.

It is clear from the evidence that our climate in the UK has changed, and if the current rate of change continues the UK may experience: (Source Met Office):

- Greater winter precipitation, potentially causing more flooding.
- Sea level rise by the end of the century of between 11 and 76cm.
- Extreme heatwaves every other year by the 2040's, like the heatwave of 2003 when average summer temperatures were 2°C higher than normal which led to more than 2000 additional deaths in the UK and extra strain on emergency services.
- Summer will become warmer and dryer, therefore droughts are more likely.
- There may be more intense downpours of summer rainfall which could lead to flash flooding.
- Temperatures are expected to rise across the UK with summer average temperatures set to rise between 2°C and 6.4°C above current temperatures.
- The urban heat island effect already warms cities by more than 10°C on some nights, and this is expected to increase still further with increased urbanisation and release of waste heat.

These factors adversely impact the whole population increasing the demand for healthcare services as well as challenge the infrastructure of the healthcare estate. Requiring buildings and services to operate out of the tolerated norms, such as cooling systems during periods of heatwaves.

Waste, energy and fuel costs have seen a dramatic rise in recent years, with energy prices increasing by over 50% since 2020. This trend is not expected to change, and we must take steps to offset cost increases were possible through generating more cost effective energy and decreasing wastage within our operations as an organisation.

Aging Estate: The Trusts Southport and Ormskirk hospital condition surveys highlight the investment needed to modernise the hospitals infrastructure. The cost of this investment is detailed in the Trusts estates returns known as ERIC. Investment in updating windows, insulation, ventilation, water and electrical systems will have a positive impact not only on the condition and appearance but will also contribute to reducing carbon emissions.

Funding Requirements

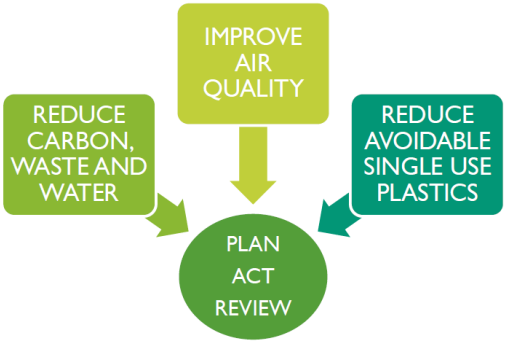
Delivery of this Green Plan requires a significant capital outlay, along with revenue spending for new technologies and innovations that can reduce our NHS carbon footprint plus. The public sector funds that exist to support the transition to net zero are highly competitive, have tight stipulations and are vastly oversubscribed. Capital finance spending caps, requirements for significant efficiency savings, and the maintenance of our aging estate, mean that under current financial arrangements the necessary investment to reach net zero is hard to make. There are not the financial instruments currently in place to support the NHS's net zero ambitions. Recognising this we will undertake as much of our Green Plan as we can within the financial envelope that is, or becomes, available, and will work to secure internal and external funding, where available, and in the short-term will prioritise actions that are proven to be cost and carbon reducing

Objectives and Vision

This plan centres around three core actionable objectives:

1 Reduce carbon, waste, and water
2 Improve air quality
3 Reduce avoidable single use plastics

Our Trust acknowledges this position and our role as an anchor institution within the communities we serve, and so we adopt these new targets in full support of NHS net-zero commitments. Our vision is to be a sustainable Trust. Through implementing this green plan, we aim to embed sustainability into every area of our organisation to help meet these targets and our objectives.



Our Green plan Goals

Achieving the net zero targets

The green plan focuses on the following nine key areas within the organisation to achieve the net zero targets as set out in NHS England Green plan Guidance 2025. These areas are set out below with key work streams linked to each area of focus.

Workforce and System Leadership

Our Trust is committed to creating a healthy, sustainable, and supportive working environment for all staff while reducing our environmental impact. We have a dedicated board lead and Sustainability Group who oversee the delivery of our Green Plan, ensuring that sustainability remains a key priority across everything we do. We continue to run awareness campaigns, staff engagement events, and sustainability days to keep our people informed and inspired to take action. We also benchmark our progress against other Trusts and share success stories to celebrate what's working well.

Flexible and blended working options are promoted to help staff achieve a better work–life balance, supporting wellbeing through initiatives that encourage physical activity, reduce sickness absence, and listen to staff feedback through regular surveys. Sustainability is reflected in our organisational values and is becoming part of our everyday culture from including sustainability information on our website to delivering training in more environmentally friendly ways, such as online learning and live-streamed events.

Looking to the future, we're building on this progress by expanding our apprenticeship and volunteer opportunities, exploring innovative ways to make our healthcare delivery more sustainable, and working closely with local communities to make the best use of shared resources. Clinicians and practitioners are playing a vital role in developing low-carbon approaches to care that improve health outcomes, reduce inequalities, and minimise environmental impact. We'll continue to include sustainability in how we design and deliver services, promote healthy lifestyles, and engage with patients and the public about the positive changes we can all make together.

Our commitment to transparency and ethical practice remains strong, demonstrated through ongoing sustainability reporting and our Modern Slavery Statement. Together, these actions reflect our goal to make sustainable healthcare part of who we are for our people, our patients, and our planet.

Net Zero Clinical Transformation

As part of the Trust's commitment to Net Zero Clinical Transformation, a strategic shift is underway to embed sustainability into every facet of care delivery. Through the Shaping Care Together consultations, the Trust is re-evaluating service locations and models to align clinical transformation with environmental stewardship. Prevention and early intervention are being prioritized to reduce illness and avoid unnecessary hospital admissions, thereby improving population health and conserving resources. Clinically appropriate transitions to low-carbon practices such as favoring Sevoflurane over Desflurane and dry-powder inhalers over metered dose inhalers are actively encouraged.

Future-focused actions include quantifying the environmental and economic impact of care models, integrating sustainability into quality metrics, and appointing leadership to champion sustainable clinical pathways. By leveraging technology, redesigning patient pathways, and tailoring services to community needs, the Trust aims to reduce emissions while enhancing care quality particularly in high-impact areas such as perioperative care, mental health, and chronic disease management.

Digital Transformation

The Trust's Digital Transformation strategy is driving a fundamental shift in how technology supports sustainable healthcare delivery. By implementing Virtual Desktop Infrastructure (VDI) and transitioning to cloud hosting by 2027, the Trust is reducing emissions, power consumption, and physical infrastructure demands. Digitisation initiatives such as Careflow Connect and Narrative are replacing paper-based processes, while agile working and virtual consultations are minimising travel for staff and patients.

Technology enabled care pathways including remote monitoring and telehealth are enhancing access and reducing environmental impact. Looking ahead, the Trust will expand the NHS App as a secure digital front door, reduce printer estate waste, and promote circular IT hardware practices. Training staff in multi-modal digital communication and embedding sustainability into digital service design will further align with the Greening Government ICT strategy. These efforts collectively support a low-carbon, high-efficiency digital ecosystem that improves care delivery while advancing the Trust's environmental goals.

Travel and Transport

The Trust's Travel and Transport strategy is central to its sustainability ambitions, aiming to reduce emissions, promote active travel, and improve access to care. Ongoing initiatives include expanding bike storage and shower facilities, enhancing the EV charging network, and promoting low-emission commuting through shuttle services and salary sacrifice schemes. Partnerships with local authorities are strengthening walking and cycling infrastructure, while e-health solutions are helping reduce patient travel.

Looking ahead, the Trust will develop a comprehensive sustainable travel plan by December 2025, with a focus on zero-emission vehicles, public transport, and active travel. Measures such as staff travel surveys, improved fleet monitoring, and carbon footprint assessments will inform future decisions, and incentives will be introduced to encourage greener commuting. Digital alternatives to in-person meetings and procurement decisions that factor in transport emissions will further support the Trust's goal of minimising pollution and unnecessary travel while enhancing health outcomes and operational efficiency.

Estates and Facilities

The Trust's Estates and Facilities strategy is a cornerstone of its sustainability agenda, focused on reducing environmental impact while enhancing operational efficiency and wellbeing. Ongoing efforts include comprehensive monitoring of energy, water, waste, and transport metrics, widespread installation of LED lighting and passive infrared sensors, and expansion of photovoltaic systems. Initiatives such as the Warp-it reuse portal and designated virtual consultation spaces are reducing resource consumption and improving service delivery.

Looking ahead, the Trust will embed sustainability into capital projects by adopting renewable energy tariffs, enforcing green standards for leased buildings, and designing spaces that promote biodiversity and resilience to climate change. Annual carbon footprint assessments, occupancy surveys, and life-cycle costing will guide strategic estate planning. Training for capital teams, sub-metering, and water conservation retrofits will further enhance resource efficiency. Through collaboration, innovation, and leadership, the Trust aims to deliver high-performing, low-carbon environments that support patient care, staff wellbeing, and community engagement**.**

Medicines

The Trust's Medicines strategy is advancing sustainability by transforming prescribing practices, reducing pharmaceutical waste, and lowering emissions from clinical treatments. Current actions include phasing out desflurane in line with national guidance, switching to low-carbon inhaler alternatives, and using the nitrous oxide waste mitigation toolkit to monitor anaesthetic gas usage. Looking ahead, the Trust will enhance pharmacy waste management, explore reuse of pharmaceuticals, and introduce carbon cost indicators for prescriptions to promote environmentally conscious choices. Systems will be implemented to monitor gases and disposables, while prescribing guidelines will be reviewed to reduce inappropriate medication use. Where clinically appropriate, evidence-based therapies such as cognitive behavioural therapy or lifestyle interventions will be prioritized over pharmaceuticals. The Trust will also

investigate sustainable approaches to medical instruments and single-use items and collaborate with primary care to optimize respiratory care and inhaler disposal. These efforts will ensure that medicines management supports both clinical excellence and environmental responsibility**.**

Supply Chain and Procurement

The Trust's Procurement Strategy is focused on embedding sustainability into every stage of the procurement lifecycle from sourcing and purchasing to usage and disposal. Current actions include improving stock management to reduce waste, engaging with SMEs and local suppliers, and leveraging NHS buying power to align with the Public Services (Social Value) Act 2012. The Trust is also promoting reuse through the Warp IT scheme and applying environmental impact scoring in bid evaluations.

Future plans include adopting a standard equipment list to streamline refurbishment, developing a Board-approved Sustainable Procurement Policy, and encouraging suppliers to disclose and reduce their carbon footprints. Whole-life costing, energy efficiency, and recyclability will be central to future tendering processes. The Trust will also support staff in making sustainable choices, promote access to eco-friendly products, and collaborate across agencies to address wider determinants of health. By reducing reliance on single-use items and fostering circular procurement practices, the Trust aims to build a resilient, low-carbon supply chain that supports both environmental and community wellbeing.

Food and Nutrition

The Trust's Food and Nutrition Strategy is focused on delivering healthy, sustainable meals while minimising environmental impact and food waste. Current efforts include implementing the National Standards for healthcare food and drink, reducing waste from inpatient meal services and food packaging, and promoting responsible consumption.

Future actions will involve measuring food waste in line with ERIC standards, setting reduction targets, and designing menus that are healthier and lower in carbon featuring seasonal, plant-based options and fewer heavily processed foods. Strategic procurement will prioritise local, ethical, and sustainability-certified suppliers, while supply chains will be reviewed to track food miles and disposal patterns. Staff and patient engagement in food growing initiatives and feedback on wellbeing improvements from access to green spaces will further support the Trust's holistic approach to sustainable nutrition. These initiatives aim to enhance health outcomes, reduce carbon emissions, and foster a culture of environmental responsibility across the Trust.

Adaptation

The Trust's Climate Change Adaptation and Resilience strategy is designed to safeguard healthcare services against the growing risks posed by climate change. Current actions include developing adverse weather and business continuity plans, updating the risk register to reflect climate-related threats, and aligning local protocols with national heatwave, cold weather, and flood response frameworks.

The Trust is actively building an evidence base to inform future resilience planning. Looking ahead, a board approved adaptation plan will be created to assess the financial implications of climate change and the cost of inaction. Key initiatives will include climate risk assessments, flood risk mapping, and the formation of a dedicated adaptation working group. Infrastructure decisions will factor in climate projections, with enhancements such as green spaces, passive cooling, and improved drainage. Partnerships with local authorities, schools, and community groups will support environmental initiatives and identify vulnerable populations. By integrating climate resilience into emergency preparedness, infrastructure design, and public health planning, the Trust aims to ensure continuity of care and protect the wellbeing of patients, staff, and communities.

Monitoring and Reporting

The Sustainability Group will monitor progress and identify any new opportunities with a green plan report produced quarterly. An action Group has been formed which will meet and report on initiatives, barriers to progression and future opportunities on a quarterly basis. All findings will be detailed in an associated Green Plan annual summary reported to Board.

The Task Force on Climate-related Financial Disclosures (TCFD) requirements have been applied to NHS bodies since 2023/24 requiring disclosure of Scope 1, 2 and 3 emissions in the Trusts annual report. These are now calculated by NHS England.

Locally the Trust will also continue monitoring and understanding local carbon footprint trends. Emissions data for Whiston and St Helens Hospitals will continue to be updated internally, building on the foundations laid by the first STHK Green Plan. While all current data primarily focuses on Whiston and St Helens, and includes emissions categories such as Trust Vehicles, Gas& Oil, Electricity, Energy Well to Tank, Waste and Water for the Southport and Ormskirk sites, future reporting will be expanded to also capture comprehensive emissions from all Trust owned sites.

Mersey West Lancashire Teaching Hospitals NHS Trust Carbon Footprint Scope Summary

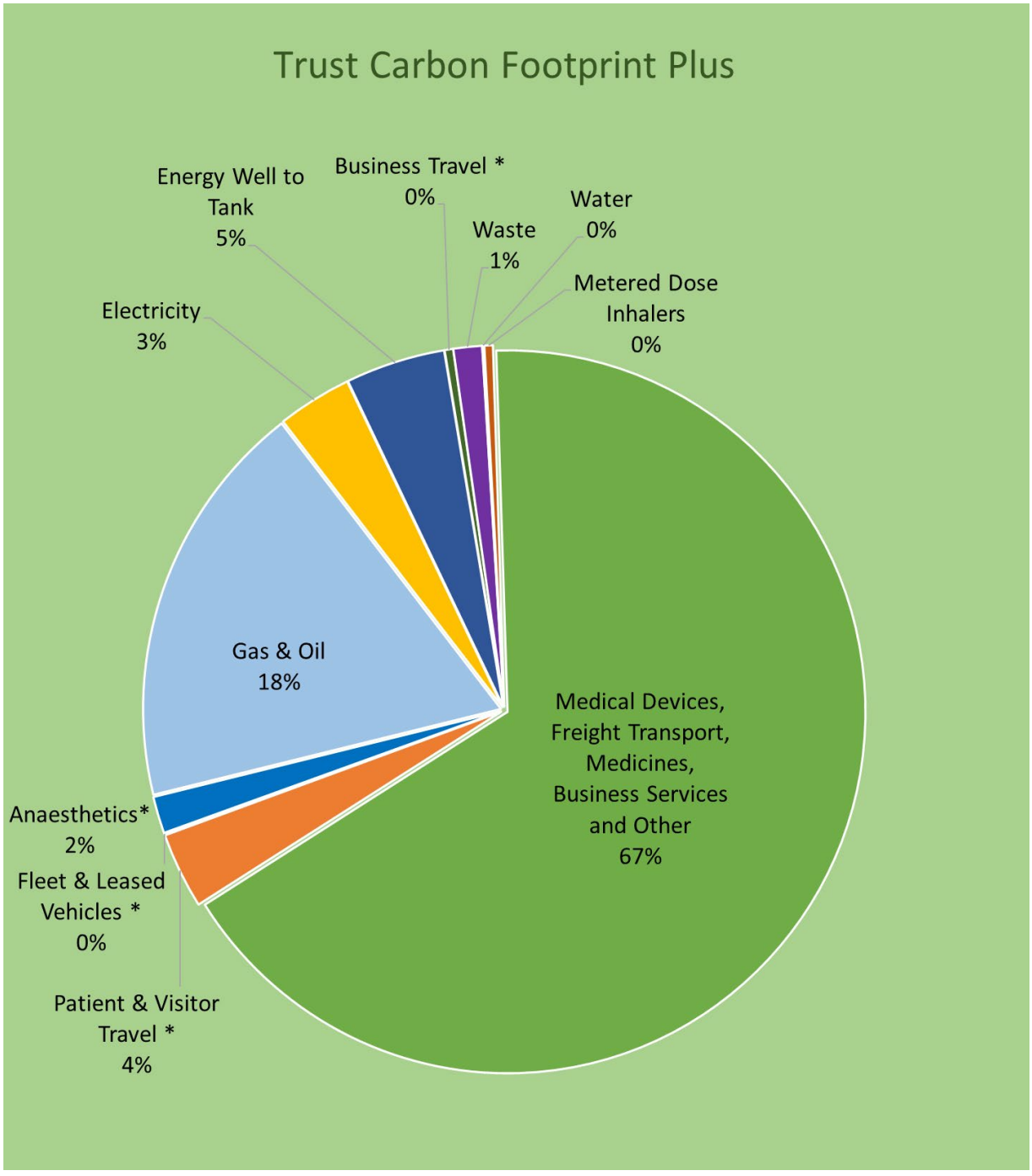
NHS Mersey and West Lancashire Teaching Hospitals NHS Trust			Category	Carbon Footprint (TCO2e)		% Change to Date	% of Trust Carbon Footprint Plus
				2008 Baseline	2024/2025		
Trust Carbon Footprint	Scope 1 - Direct		Fleet & Leased Vehicles *	98	90	-8%	0.09%
			Anaesthetics*	2,571	1,660	-35%	2%
			Gas & Oil	13,492	18,426	37%	18%
	Scope 2- Indirect		Electricity	11,073	3,379	-69%	3%
	Scope 3 - Indirect		Energy Well to Tank	4,015	4,526	13%	4%
			Business Travel *	206	386	87%	0.4%
			Waste	1,572	1,296	-18%	1%
			Water	326	89	-73%	0.1%
			Metered Dose Inhalers	362	388	7%	0.4%
			Total Trust Carbon Footprint	33,715	30,242	-10.30%	30%
Trust Carbon Footprint Plus	Scope 3 - Indirect		Medical Devices, Freight Transport, Medicines, Business Services, Food & Catering, Construction, Commissioned Health Services, Manufacturing, ICT, Staff Commuting, Other Supply Chain #	74,655	66,964	-10%	67%
	Travel Outside GHGP Scopes		Patient & Visitor Travel *	5,013	3,423	-32%	3%
			Total Trust Carbon Footprint Plus	113,383	100,628	-11%	

Note: * later Baseline
Informed approximation

The gas and oil increase of 37% is due to CHP installation on sites since the baseline year with the Trust producing its own electrical power and therefore a reduction of 69% be achieved for electric. This trend will change over the next 3-5 years as the Trust decommissions some of its CHP's and becomes more reliant on air-source heat pumps powered by electric.

Business travel has also seen an increase since 2008, due to the Trust taking on more community services and improved reporting of business travel. As it only accounts for 0.4% of the whole estate this increase is not wholly significant, but we will still focus on reducing this where possible.

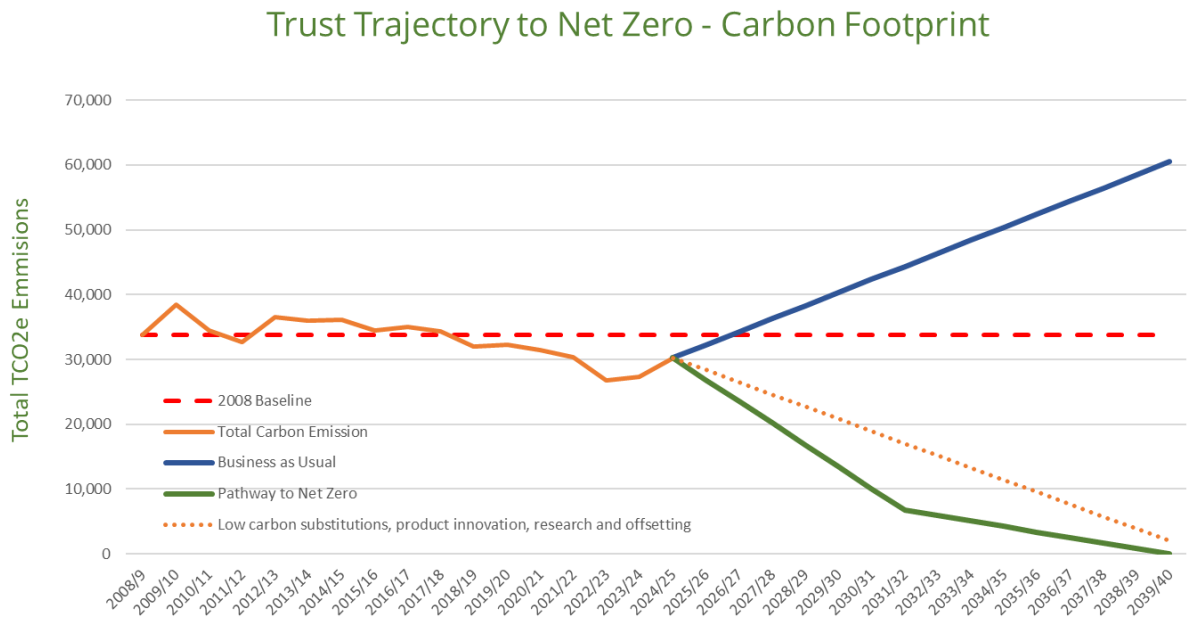
Mersey West Lancashire Teaching Hospitals NHS Trust Emissions by % of Carbon Footprint



Since the first Green Plans were developed 5 years ago the chart above now incorporates the Southport and Ormskirk estate, however the only changes to the

percentage mix are an increase in gas and oil of 3% and a corresponding decrease in electric from 6% to 3%, due to extensive CHP usage at both Southport and Ormskirk hospitals.

Mersey West Lancashire Teaching Hospitals NHS Trust Trajectory to Net Zero for Carbon Footprint Plus (updated as 2024/25)



This trajectory highlights if the Trust continues business as usual without working towards implementing the green plan the carbon footprint will increase, and we will fail to achieve net zero by 2040. Keeping on track and closely monitoring the positive actions taken we have a plan for meeting the target of achieving net zero by the 2040 target date.

Increase over the last two years has been due to a combination of a several elements:

- Addition properties being purchased
- Several extensions and building expansion
- Construction cabins on site and ongoing construction works
- Improved utilisation of estate

However, in 2022/23 CO2 emissions were 8 tonnes/m2 but emissions in 2024/25 had reduced to 7.6 tonnes/m2 indicating that Trust initiatives have been working to reduce emissions.

Governance and Leadership

The Green Plan will be overseen by a designated board-level net zero lead (Director of Corporate Services), on behalf of the Board.

The Executive Team will ensure participation and support is given from all Divisions within the organisation with designated representatives who will champion the green plan workstreams. Therefore, ensuring senior ownership across the organisation in working towards the carbon reduction targets.

The Sustainability Group will report to the Board via the Estates and Facilities Governance Council, which reports to the Finance and Performance Committee. The multi-disciplinary group will include as a minimum: -

Private sector Partners (NewHospitals, Gension, GE, Medirest and Vinci FM),

Director of Corporate Services

Deputy Director of Estates and Facilities

Quality and Compliance Manager

Sustainability Manager

Procurement Lead

HR Lead

Finance lead

Divisional Leads

Quarterly reports and green plan metrics will be reported through this governance structure with an annual report produced for the Trust Board.

Green action funding will be tracked to ensure a clear financial plan, detailing sources such as the Capital plan, lifecycle, and revenue budgets.

Succession Planning

The Board is committed to maintaining a focus on carbon reduction and will ensure this is factored into succession planning and any future organisational change, so that roles and responsibilities remain clearly defined.

Engagement

There is a network of sustainability champions across the organisation to support engagement, awareness raising and information sharing. The Trust will provide updates about the Green Plan, including progress and information about new projects, through this network, on the intranet and Trust publications such as newsletters and awareness days. Staff are encouraged to participate in sustainability initiatives. The Trust invites feedback and suggestions on how sustainability can be improved within your area of work. Participation as a Green Champion is also encouraged, to find out more or to send feedback and/or suggestion email EFMCompliance@merseywestlancs.nhs.uk Speak with your Line manager about how you can contribute to sustainability in your department.

Appendix A – The national mandatory KPIs shown in the table below are reported through the Greener NHS dashboard and ERIC (Estates Return Information Collection).

Focus Area	Metric	For use by	Data source	Quantification approach	Indicative Example Impact
Workforce	Named board-level lead for green plan delivery	Trusts and systems	Greener NHS dashboard (from Q1 25/26)	% increase in delivery of green plan actions	Indirect – could accelerate other measures by 10–30%
Medicines	Emissions (tCO2e) and volume (litres) of nitrous oxide by trust	Trusts and systems (aggregate of trust data)	Greener NHS dashboard	Litres reduced × 1.59 kg N_2O/litre × 273 GWP	10% cut in usage at 5,000 L saves ~2,170 tCO_2e/year
Medicines	Emissions (tCO2e) and volume (litres) of nitrous oxide and oxygen (gas and air) by trust	Trusts and systems (aggregate of trust data)	Greener NHS dashboard	Litres reduced × emission factor for N_2O content	10% cut in usage at 5,000 L saves ~2,170 tCO_2e/year
Medicines	Average inhaler emissions per 1,000patients	Systems (aggregate of primary care data)	Greener NHS dashboard (from Q1 25/26)	Δ in MDI use × ~11 $kgCO_2e$ per MDI	Switching 1,000 MDIs to DPIs saves ~11 tCO_2e/year
Medicines	Mean emissions of Short-acting beta-2agonists (SABAs)inhalers prescribed	Systems (aggregate of primary care data)	Greener NHS dashboard	Fewer SABAs × emission factor	Cutting 2,000 MDIs saves ~22 tCO_2e/year
Medicines	% of non-SABA inhalers that are MDIs	Systems (aggregate of primary care data)	Greener NHS dashboard	% drop × prescribing volume × emission factor	20% drop in MDIs could save 50–100 tCO_2e/year
Travel	% of owned and leased fleet that is ultra-low emission vehicle (ULEV) or zero-emission vehicle (ZEV)	Trusts and systems (aggregate of trust data)	Greener NHS dashboard	New ULEV/ZEVs × avg. annual ICE emissions avoided	Each ICE → ZEV saves ~1.5–2.5 tCO_2e/year
Travel	Total fleet emissions	Trusts and systems (aggregate of trust data)	Greener NHS dashboard	(Baseline – post-action) tCO_2e	50% electrification of -22 vehicle fleet saves ~~44 tCO_2e/year
Travel	Does the organisation offer only ZEVs in its salary sacrifice scheme	Trusts and systems (aggregate of trust data)	Greener NHS dashboard	Uptake × avg. ICE emissions avoided	If 50 staff switch, ~100 tCO_2e/year saved

Travel	Does the organisation operate sustainable travel-related schemes for staff (for example, salary sacrifice cycle-to-work)	Trusts and systems (aggregate of trust data)	Greener NHS dashboard	Km avoided × 0.18 $kgCO_2e$/km	100 staff cycling 10 km/day saves ~45 tCO_2e/year
Estates	Emissions from fossil-fuel-led heating sources	Trusts and systems (aggregate of trust data)	Greener NHS dashboard	kWh gas/oil avoided × carbon factor	Removing 1 GWh gas saves ~183 tCO_2e/year
Estates	Number of oil-led heating systems	Trusts and systems (aggregate of trust data)	Estates Return Information Collection/Greener NHS dashboard (from Q4 24/25)	MWL has 0 Oil-led heating systems	If MWL operated even one oil-led heating system, it would add approximately 250 tCO_2e/year to the trust's carbon footprint.
Estates	% of gross internal area covered by LED lighting	Trusts and systems (aggregate of trust data)	Estates Return Information Collection/Greener NHS dashboard (from Q4 24/25)	kWh saved × carbon factor	LED retrofit of 1,000 MWh saves ~183 tCO_2e/year
Estates	% of sites with a heat decarbonisation plan	Trusts and systems (aggregate of trust data)	Estates Return Information Collection/Greener NHS dashboard (from Q4 24/25)	% of sites covered × prob. of implementation	Indirect – enables high savings if executed
Supply Chain	Inclusion of Carbon Reduction Plan and Net Zero Commitment requirements in all relevant procurements	Trusts and systems	Greener NHS dashboard	% spend covered × est. Scope 3 reduction	5% cut on £100m spend @ 0.2 $kgCO_2e$/£ = ~1,000 tCO_2e/year
Supply Chain	Inclusion of requirements for a minimum 10% net zero and social value weighting in procurements, including defined KPIs	Trusts and systems	Greener NHS dashboard	(Number of suppliers meeting or exceeding 10% net zero/social value weighting ÷ Total number of suppliers) × 100%	5% cut on £100m spend at 0.2 $kgCO_2e$/£, could save approximately 1,000 tonnes CO_2e annually.

Food	Weight (tonnes) of food waste, with further break down by spoilage, production, unserved and plate waste	Trusts and systems (aggregate of trust data)	Estates Return Information Collection	Tonnes waste avoided × 3.9 tCO_2e/tonne	Cut 10t saves ~39 tCO_2e/year
Adaptation	Number of overheating occurrences triggering a risk assessment (in line with trust's "heatwave" plan)	Trusts and systems (aggregate of trust data)	Estates Return Information Collection	Δ incidents × risk severity avoided	Carbon impact minimal; resilience benefits high
Adaptation	Number of flood occurrences triggering a risk assessment	Trusts and systems (aggregate of trust data)	Estates Return Information Collection	Δ incidents × risk severity avoided	Carbon impact minimal; resilience benefits high

References

Mersey and West Lancashire Teaching Hospitals Clinical Strategy 2024-2026 [online] Available at https://www.merseywestlancs.nhs.uk/media/.resources/66cda684f24960.40633610.pdf

Mersey and West Lancashire Teaching Hospitals People Strategy 2022-2025[online] Available at https://www.merseywestlancs.nhs.uk/media/.resources/65dcc11a5b5f59.61816661.pdf

Mersey and West Lancashire Teaching Hospitals SO Green Plan 2022-2025 [online] Available at https://www.merseywestlancs.nhs.uk/media/.resources/65ddb118035204.11435999.pdf

Mersey and West Lancashire Teaching Hospitals STHK Green Plan 2022-2025 [online] Available at https://www.merseywestlancs.nhs.uk/media/.resources/65ddb10345a913.36044943.pdf

National Health Service (2019). The NHS Long Term Plan. [online] Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf.

NHS England (2022). Delivering a 'Net Zero' National Health Service. [online] Available at: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2022/07/B1728-delivering-a-net-zero-nhs-july-2022.pdf.

NHS England (2025). Green plan Guidance. [online] Available at https://www.england.nhs.uk/long-read/green-plan-guidance/

NHS England (2023) Net Zero Travel and Transport Strategy. [online] *Available at: https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/*

Data and analytics sources

- FutureNHS: Greener NHS Data and Analytics (login needed)
- Greener NHS Dashboard (login needed)
- FutureNHS: Green Plan Support Tool (login needed)
- **Workforce and leadership**
- FutureNHS: Greener NHS training hub (login needed)
- Building a Net Zero NHS, an accessible introduction to climate change and healthcare
- Carbon Literacy for Healthcare eLearning Pathway, more advanced training to support staff drive positive net zero change
- Sustainability Leadership for Greener Health and Care, to support system leaders to deliver net zero.
- Centre for Sustainable Healthcare Networks
- FutureNHS: Nursing and Midwifery Sustainability Network (login needed)
- Estates and facilities workforce action plan and NHS estates recruitment and career pathways guidance
- **Net zero clinical transformation**
- Critical and perioperative care – Green Theatre Checklist (Royal College of Surgeons of England, Royal College of Surgeons of Edinburgh, Royal College of Physicians and Surgeons of Glasgow) and Green Surgery report (UK Health Alliance on Climate Change, Brighton & Sussex Medical School, The Centre for Sustainable Healthcare)
- Mental health – Net Zero Mental Health Recommendations (Royal College of Psychiatrists)
- Urgent and emergency care – GreenED (Royal College of Emergency Medicine)
- Diagnostics – Green Endoscopy (British Society of Gastroenterology)
- Renal care – Sustainable Kidney Care Committee (UK Kidney Association)
- General practice – Net Zero Hub (Royal College of General Practitioners)
- Pharmacy – Royal Pharmaceutical Society Sustainability Policies
- Allied Health Professionals – Greener Allied Health Professional hub

Digital transformation

- FutureNHS: Digital Net Zero (login needed)
- What good looks like framework
- Greening government: ICT and digital services strategy 2020 – 2025
  Greenhouse Gas Protocol ICT Sector Guidance

Medicines

- Nitrous Oxide – Nitrous Oxide Waste Mitigation Toolkit and Health Technical Memorandum 02-01 – Medical gas pipeline systems
- Desflurane – Guidance: Desflurane decommissioning and clinical use
- High-quality, lower-carbon respiratory care:
- NICE NG245 Patient decision aid on asthma inhalers and climate change
- Asthma + Lung UK inhaler choices (for people living with a lung condition)
- Greener practice visual aid and asthma toolkit
- RightBreath – Information for clinicians on different inhalers
- Core20PLUS5 – an approach to reducing health inequalities
- Medicines optimisation – National Medicine Optimisation Opportunities and National Overprescribing Review (NOR)

Travel and transport

- FutureNHS: Net zero travel and transport (login needed)
- NHS Net Zero Travel and Transport Strategy

Estates and facilities

- FutureNHS: Estates Sustainability Hub (login needed)
- FutureNHS: Estates Net Zero Delivery Plan (login needed)
- NHS net zero building standard
- Green leases framework
- Greening the business case
- NHS clinical waste strategy and Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste

Supply chain and procurement

- FutureNHS: CCF sustainability hub (login needed)
- NHS Net Zero Supplier Roadmap
- Evergreen Sustainable Supplier Assessment
- NHS Net Zero Product Savings Calculator (login needed)
- DHSC Design for Life roadmap

Food and nutrition

- FutureNHS: Food and nutrition (login needed)

Adaptation

- NHS Climate Change Risk Assessment Tool
- Third National Adaptation Programme *(fourth report pending in 2024/25)*
- Emergency preparedness resilience and response (EPRR) core standards
- UK Health Security Agency Adverse Weather and Health Plan

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 October 2025
Agenda Item	**TB25/084**			
Report Title	Freedom to Speak Up Annual Report 2024/25			
Executive Lead	Professor Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Anne-Marie Stretch, Deputy Chief Executive			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide assurance that the appropriate systems and processes are in place for staff to raise concerns safely and confidently, knowing that appropriate action will be taken.

Executive Summary

This report provides assurance to the Board of an established and functioning Freedom to Speak Up Guardian (FTSU) Service. In addition, it will provide a summary of the FTSU activity during the year 2024/25 along with examples of any lessons learnt.

There were 132 concerns raised by FTSU Guardians in 2024/25, which was a 10% increase compared to the previous year. Increased awareness sessions, leadership training input and the addition and the development of Champions in more areas have been effective in raising the profile of Freedom to Speak Up. The report highlights key themes and trends, as well as some of the lessons learnt and changes as a result of speaking up.

In response to staff survey and feedback, and in recognition of multi-site working, 39 Freedom to Speak Up champions have been recruited to support staff in raising concerns.

Financial Implications

None

Quality and/or Equality Impact

None

Recommendations

The Board is asked to note the Freedom to Speak Up 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
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

Freedom to Speak Up Annual Report: 2024/25

Introduction

Freedom to Speak Up Guardians were a recommendation following the Mid Staffordshire Inquiry. It is the ambition and ongoing goal of Mersey and West Lancashire Teaching Hospitals (MWL), that everyone working at the Trust should feel safe and confident to speak up and that all Trust managers and leaders welcome the opportunity it gives them to learn and improve.

This report provides assurance to the Trust Board of an established and functioning Freedom to Speak Up Guardian (FTSU) Service. In addition, it will provide a summary of the FTSU activity during the year along with examples any lessons learnt.

It should also be noted that staff speak up informally through several routes including through their Line Manager, through contact with Human Resource and through contact with /reporting to the Risk and Governance Teams. This report does not cover this activity.

Freedom to Speak Up Resource

The Trust has four Guardians across its sites. Two Guardians have an exclusive Guardian role and make 1.0 WTE, both of whom were recruited through a fair and transparent recruitment process as recommended by the National Guardian's Office (NGO). There are two other Guardians conducts in the FTSU role in addition to their substantive roles as Medical Consultant and Assistant Director of Patient Safety. The FTSU Guardians are supported by a Specialist Administrator who also acts as a FTSU Champion.

In addition to the above, the FTSU Guardians seek and support FTSU Champions from the staff resource and an increasing number of champions in place, these staff provide visible support to the developing speaking up culture, within the Trust and there are ongoing efforts to recruit more champions.

Report on Submission to National Guardian's Office

The following information has been submitted to the National Guardian's Office (NGO), in accordance with recently revised guidance, that came into effect on the 01 April 2024. The Trust is required to submit data on a quarterly basis, via an online portal.

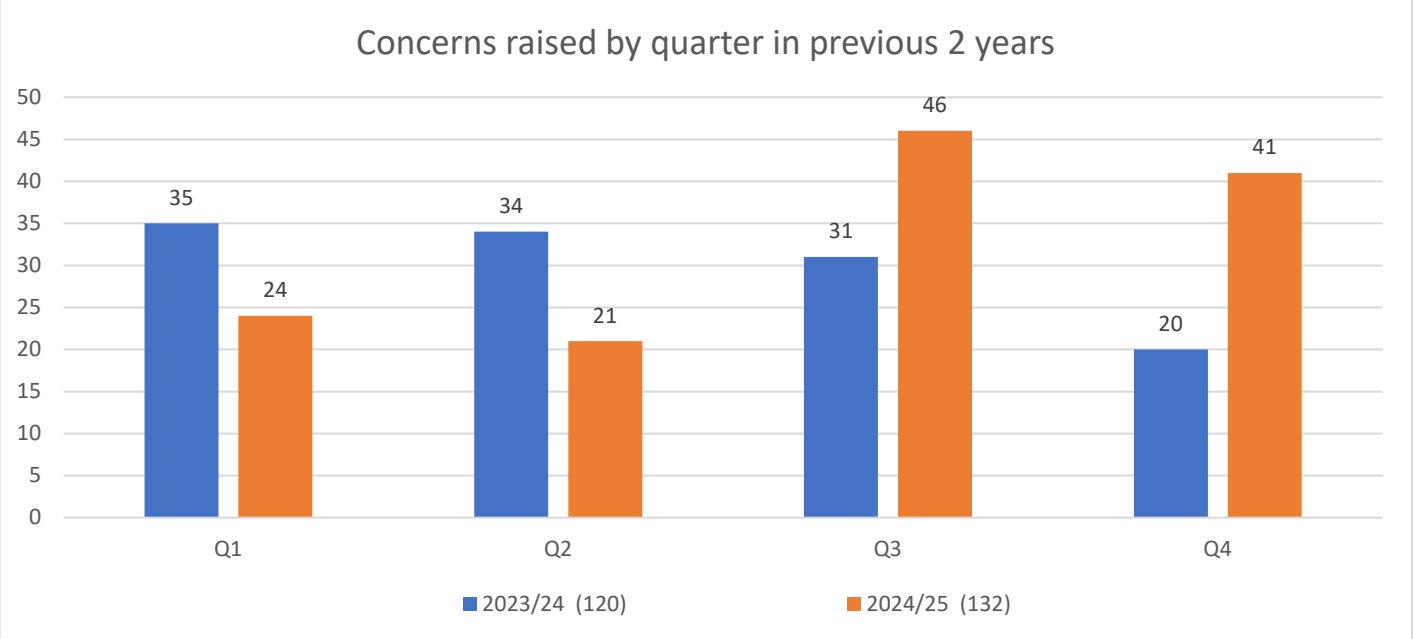
As previously stated, this report does not include those informal concerns/ areas raised and resolved through line management/ FTSU Champion structure or other mechanisms for staff in the Trust. When concerns are raised directly with FTSU Champions, the FTSUG is available to offer support and advice, which may include meeting those who have raised a concern and acting in a consultative role.

Quarter 1	1st April – 30th June 2024
Date submitted to NGO:	23rd July 2024
Date National Data to be published:	This data is available on the NGO website.
Number of Concerns Raised:	24

Quarter 2	1st July – 30th September 2024
Date submitted to NGO:	16th October 2024
Date National Data to be published:	This data is available on the NGO website.
Number of Concerns Raised:	21

Quarter 3	1st October – 31st December 2024
Date submitted to NGO:	27th January 2025
Date National Data to be published:	This data is available on the NGO website.
Number of Concerns Raised:	46

Quarter 4	1st January – 31st March 2025
Date submitted to NGO:	22nd April 2025
Date National Data to be published:	This data is available on the NGO website.
Number of Concerns Raised:	41



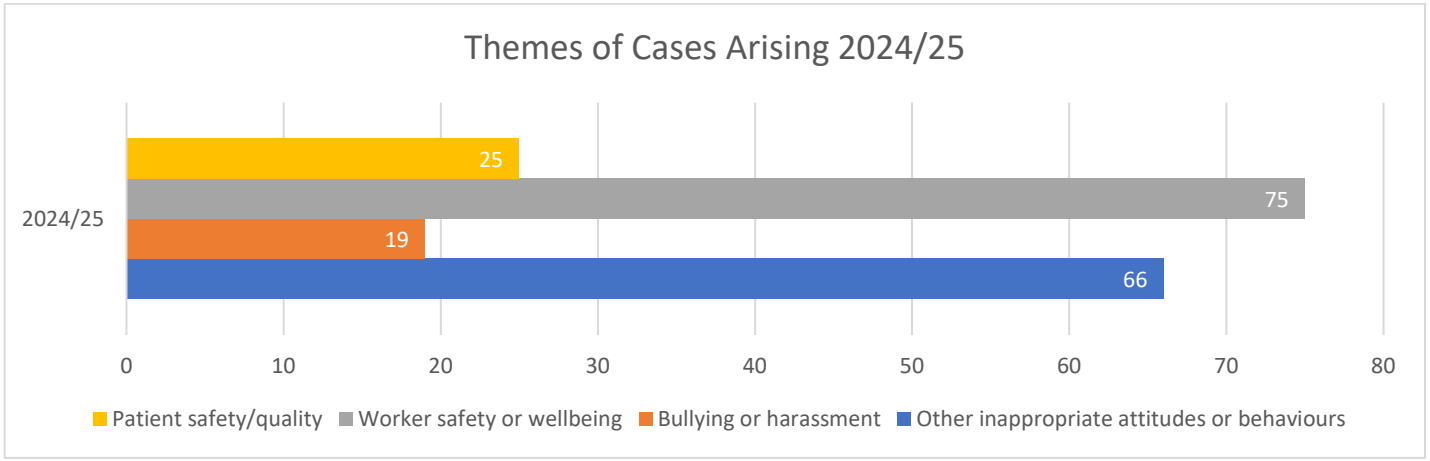
There were 132 concerns raised by FTSU Guardians in 2024/25, which was a 10% increase compared to the previous year. Increased awareness sessions, leadership training input and the addition and development of Champions in more areas raising the profile of Freedom to Speak Up, may have contributed to this.

An increase in the number of referrals is deemed to be a positive indication. The two top performing acute trusts from the Staff Survey results had higher numbers of referrals compared to MWL, therefore a higher number of referrals is not seen to be a negative indication but rather an open reporting culture. Trust will continue to analyse themes from concerns raised to identify any systemic issues.

1.1 Categories and Themes/Trends Arising from Concerns

The National Guardian's Office (NGO) requires all concerns to be categorised against a pre determined category list, to enable consistent national reporting. The following chart highlights the categories of the concerns raised.

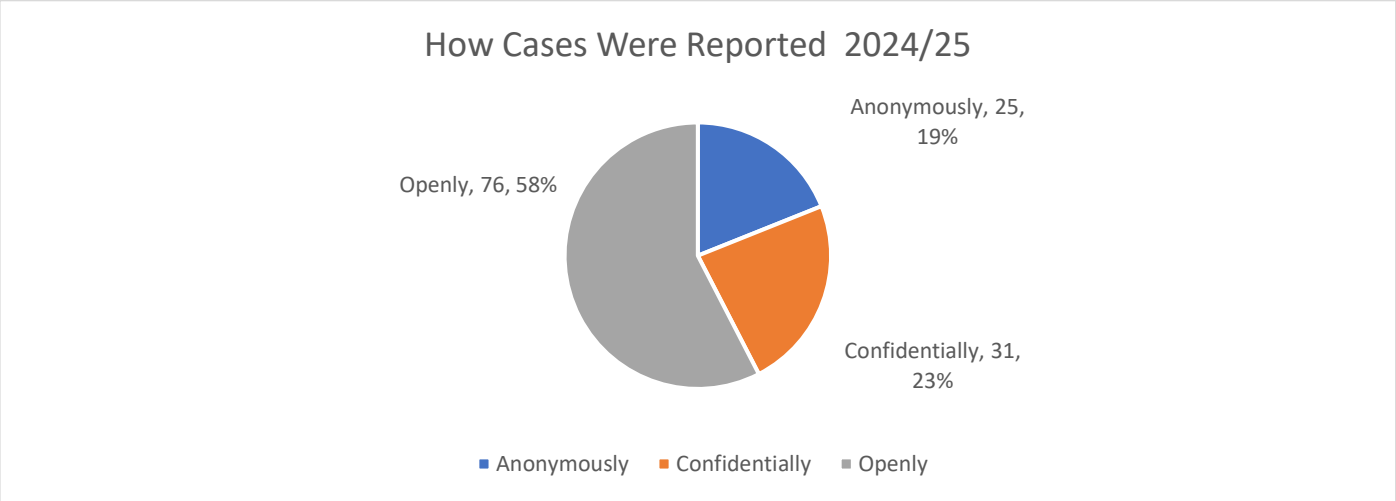
The chart below shows annual themes of cases. Worker safety and wellbeing is the biggest theme, however much of this is because of the concern being raised by a member of staff and how their issues can impact on their personal health and wellbeing. Inappropriate attitudes and behaviours and concerns regarding bullying, lead to the increased number of worker safety and wellbeing figures. The NGO requires Trust to report in each of the set categories, therefore the number of themes collated may be more than the number of referrals. The themes within the Trust do not suggest that the Trust is an outlier with the themes nationally, however it is important to acknowledge the themes and trends and for the Trust to provide support to staff members through Health Work and Wellbeing (HWWB) and other appropriate pastoral support as relevant.



***Please note that each concern can fall into multiple categories, in line with NGO reporting guidance*

1.2 Anonymous Concerns

The chart below shows whether staff chose to report their concerns anonymously, confidentially or openly, during 2024/25.



19% (25) of the concerns raised were done so anonymously. The identity of the person raising the concern is not known to anyone. Staff can use the Work in Confidence system, adopted by the Trust, to raise a concern anonymously. The system keeps staff unidentifiable to the Guardian; however, they can email further questions and give feedback through this system. Most anonymous concerns were raised this way. A small number of concerns were also raised anonymously by phone, unknown email addresses and Google confidential email.

In addition to the above, out of the 132 concerns raised, 23% (31) of staff members did not want to be identified and associated to the concern being raised and therefore their details remain confidential, other than to the FTSU Guardian. The main reason for staff wishing not wishing to be identified is cited as fear of detriment.

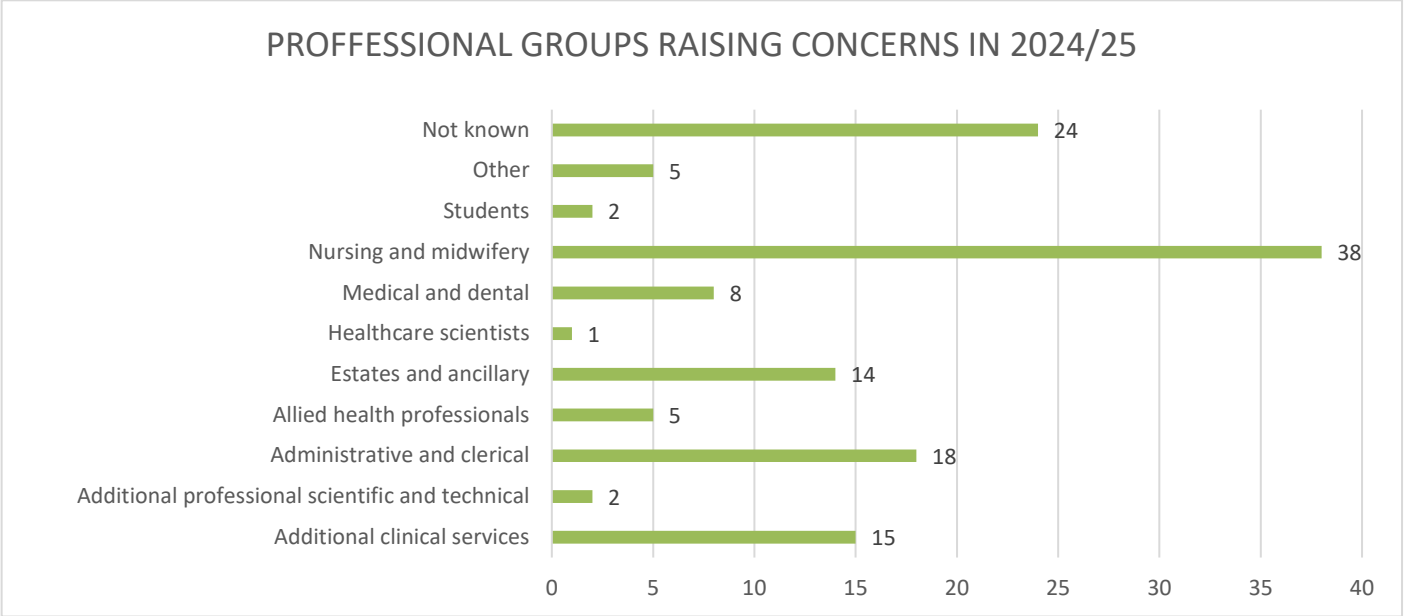
Anonymous cases are reviewed by the Guardians to consider why staff may have felt they could not raise a concern openly or confidentially, to understand if there are themes that need to be addressed by the Trust. Generally, those reporting anonymously are concerned about retribution where the issue is regarding inappropriate behaviours or concerns about the futility of raising the concern.

1.3 Professional Groups Raising Concerns

The charts below highlight the breakdown of staff groups who have raised a concern during 2024/25. These professional groups are pre-determined by the NGO, to enable consistent reporting. Many anonymous referrals do not share their job role and are therefore not known.

Nurses and Midwives are the largest cohort of staff who report to Freedom to Speak Up, however they are also the largest cohort of staff in the organisation.

During the year concerns being raised may indicate a particular concern, by themes or cohort of staff. Guardian's monitor and review to determine if / when there is a need to address more widely or escalate to the Executive team.



1.4 Situations where detriment was expressed because of speaking up.

During the year there was one case detriment, as a result of speaking up was reported. Initial concern raised by the staff member was reviewed and appropriate action had been undertaken.

Guardians discuss detriment with all staff, with whom they have contact, although this may be difficult in cases received anonymously. Guardians maintain contact with staff members, until their concern has been reviewed and a response given. A follow up contact is also made after three months; however, staff are also asked to contact the Guardian immediately if they feel they are suffering detriment.

The National Guardian's Office published guidance on Detriment in January 2025. The NGO states organisations have a responsibility to:

- Protect workers who speak up from detriment, disadvantageous or demeaning treatment.
- Ensure the working environment is a safe one.
- Respond to concerns of disadvantageous or demeaning treatment by examining the facts, reviewing outcomes, providing feedback, and reflecting and learning.
- Act – and be seen to act - when detriment, disadvantageous or demeaning treatment does occur.
- Communicate that detriment from speaking up will not be tolerated.
- Include any reports of detriment following speaking up in regular reporting and review as a whole and not just on an individual basis. These principles are transferable across different organisations and responsibilities for each of these should be agreed locally.

The Trust may need to consider if policies are sufficiently clear regarding actions should detriment occur. Currently any action would likely fall under Human Resource policies should behaviour constitute misconduct, gross misconduct or under the Respect and Dignity at work policy.

Any reports of detriment are highlighted to the Chief Executive Officer and the Chief Peoples Officer and are highlighted to an appropriate manager for review/investigation, with the staff members permission.

1.5 Staff survey

NHS Staff survey 2025 results continues to identify the Trust having a positive and higher than national average scores in NHS Staff Survey for domain of 'We have a voice that counts. In response to Question *'I feel safe to speak up about anything that concerns me in this organisation*', scoring 64.02% compared with national average of 60.2%. Supportive response in the survey, for the Question '*If I spoke up about something that concerned me, I am confident my organisation would address my concern'* scoring 53.53% compared with national average of 48.23%.

Departments showing lesser scores have been identified and received visits from Freedom to Speak Up Guardians, to raise awareness of raising concerns processes and Freedom to Speak Up support available.

1.6 Feedback Post Raising Concerns

The National Guardian's Office requires the FTSU Guardian to invite those who are identifiable and have raised concerns, to offer feedback once their case is closed, the NGO requires us to specifically ask:

- Would they use the FTSUG again to raise a concern?
- Would they like to offer further comments about the service or the process?

The feedback received in 2024/25 is demonstrated on the diagram below, however, please note that this feedback may not relate to concerns raised within the same timeframe given that some concerns remain open for several months and feedback is only requested when a case is closed.

1.7 Changes as a Result of Speaking Up

The question is often asked '*What things have changed as a result of people speaking up?'.* Key themes of concerns raised in 2024-25 and the actions taken at/or following review/investigation. Sharing of actions taken as a result of speaking up is balanced with the need for strict confidentiality expected under Freedom to Speak Up and not being able to identify staff involved. Details of individual concerns are not included for reasons of maintaining staff confidentiality.

Area of Concern	Actions Taken
HR related concerns	Bespoke support and guidance to managers in organisational change management. Facilitation of mediation process in resolution of team dynamics. Support with flexible retirement process. Team development
Safety related concerns	Development of SOP and guidance for relevant teams. Education and training for staff members.
Staff welfare concerns	Development of estates and staff facilities

1.8 How Concerns are Managed

Concerns are managed on a case-by-case basis, in line with the Trust's FTSU and Raising Concerns policy. Guardians have established links with the Human Resources Team. Two of the Divisions have invited guardians to attend a divisional meeting to discuss FTSU. There is ongoing work to develop consistent approach across all divisions.

1.9 Guardians Support

The FTSU Guardians continue to be members of the Regional and National Network of Guardians. They attend monthly regional support meetings or workshops held on online, with input from the national office. The Guardians can also access training and further support direct from the NGO office, if required in addition to undertaking the required yearly update to maintain being a Guardian.

Three of the Guardians attended the Northwest FTSU Conference during Q3, this was a face-to-face event and covered topics such as recruitment of FTSU Champions and attending Employment Tribunals as a FTSU Guardian.

2. Governance

The Trust to report cases to the National portal, which have been raised through a FTSU Guardian that is registered with the NGO on Quarterly basis. Freedom to speak up report is presented to Quality committee biannually and an annual report is scheduled to be presented to the Trust Board. The Trust Board undertakes Freedom to Speak Up self-assessment annually, to ensure timely evaluation and enhancement of speaking up process.

Valuing our People Council and Divisional Governance meetings receives periodic operational updates from Freedom to Speak Up Guardians.

The Chief Executive, the Chair of the Board (NED Lead), Chief People Officer and Chief Nursing Officer (Executive Lead for FTSU) have quarterly meetings with FTSU Guardians to review themes and trends.

3. Protected Characteristics

The Freedom to Speak Up Guardians want to meet the aims and commitments set out in the Trust's equality policy. This includes not discriminating under the Equality Act 2010 and building an accurate picture of the make-up of the workforce who raise concerns.

In July 2024 the Guardian's began to ask staff who raise concerns to complete an Equality and Diversity Monitoring Form once their concern has been addressed and their case is being closed. Participation is entirely voluntary and the response rate back from staff has been poor, which does not support gaining an accurate reflection of those staff who raise concerns. Where staff volunteer the information to the Guardians this is captured by the means of a survey (Appendix: A). Guardians continue to monitor the staff survey for any staff groups who may have barriers to speaking up. Guardians attend variety of staff network forums to create awareness of support available.

4. Freedom to Speak Up Champions

The champion's role is to support the development of a speaking up culture within local teams and to act as a support to staff by signposting them to either their line manager or the FTSU Guardians, if they wish to raise concerns. This is an additional role to the job they perform daily within the Trust. The FTSU Guardians have recruited further champions, and a number have stepped down from their role, we currently have 39 champions across the Trust. Monthly meetings are held for champions to attend to support their development and to offer support. An Away Day for the Champions took place on 01 October 2024 to coincide with Freedom to Speak Up month. The day had good support, with input from both the Interim Director of Nursing and Governance and the Medical Director. The day gave an opportunity to clarify roles, learn from cases and to set a plan for the year ahead, to develop and support the Champions.

A request to support information gathering, by talking to staff who may not feel comfortable discussing their experience, led to a bespoke session being commissioned by the Guardians from AQUA. This session was in relation to Motivational Interviewing in the context of speaking up. The session was delivered in November and was well received by those who attended who found the session beneficial.

5. Quality and Safety Audit

An audit was undertaken in Q3 to assess staff knowledge of routes to speak up across 22 wards including community facilities. The results were positive with 100% of staff knowing at least one route they could use to speak up. 89% of staff knew how to contact a FTSU Guardian. Those areas that indicated a lower confidence of how to speak up, or a lack of confidence in issues being addressed, have been visited by Guardians for an awareness raising session and information shared to support staff understanding. Repercussions and fear of a lack of confidentiality were referenced by some staff members, as barriers to speaking up.

6. Awareness

The FTSU Guardians continued to partake in awareness and drop-in sessions to teams - both in person and online, host information stands and attend induction events to deliver formal presentations.

6.1 Freedom to Speak Up month.

Freedom to Speak Up Month took place in October 2024 and had a national theme of “Listen Up”.

Planned events and activities were hosted on various platforms across the Trust, including Trust Brief Live Team take-over, Champion’s away day, Executive walkabouts, Guardian and Champion walkabouts. In addition, information stands, and drop-in sessions were held across five sites during the month.

Staff were encouraged to participate in “Wear Green Wednesdays” and the Lead Employer team hosted a competition for the greenest outfit.

Regular communication with staff members using various communication means like Team Brief Live, Market style stalls, Newsletter, Freedom to Speak Up Walk abouts have been undertaken as a rolling programme to enhance awareness of Freedom to Speak Up Process.

6.2 Leadership Courses

The FTSU Guardians are delivering sessions on the Trust leadership courses regarding how Manager’s foster an open culture and encourage staff to speak up. Evaluation of the sessions has been very positive, with staff attending taking a very active part in discussions, finding the sessions of value and generating interest in becoming Champions.

6.3 Board Self Assessment

The Trust Board undertook a FTSU Self Assessment exercise in Quarter 4 2024 , whilst the national guidance suggests the assessment should be undertaken every other year, a decision was taken to complete annually for the next few years due to the merger of the two former organisations. The

assessment has been used to identfiy areas for increased focus over the next 12 months, including ongoing development for leaders , collecting data in realtion to protected characteriscs of those who use the FTSU service and further work relating to reported detriment. The Trust's FTSU strategy and action plan were also updated and has been agreed by the Trust Board.

7. The National Picture

The NGO have published a revised strategy in 2025 covering the next three to five years, this outlines the following strategic goals:

- Continue to improve resources and offer to FTSU Guardians
- Develop additional support and guidance for organisational leaders.
- Use the NGO's independent voice to champion Freedom to Speak Up for workers.
- Use our insight to drive recommendations to improve speak up measures and culture.
- Improve partnership working with key organisations to deliver change.
- Improve organisational maturity and internal infrastructure to support our ambitions.
- The Trust strategy was reviewed to ensure it reflects the national strategy.

In 2025, the NGO also published its annual speaking up data report titled: Culture is a Patient Safety Issue. A summary of speaking Up to FTSU Guardians 1 April 2023 to 31 March 2024. The report highlights the following:

- The number of cases being reported to FTSU guardian is rising nationally with over 30,000 cases reported during the reporting period, this is a rise of 27.6%.
- 4% of people who raise a concern continue to report experiencing detriment.
- Nurses and midwives account for the biggest proportion of cases raised.
- Two in every five cases relate to inappropriate behaviours and attitude.
- As more people are speaking up, the emerging challenge is how they are heard.
- Many cases highlight the pressure the NHS is under and the impact this has on the health and wellbeing of staff.

The NGO undertook a FTSU review involving overseas working. This involved a survey for Guardians and for overseas workers. The link to the survey was shared within the Trust for staff to participate in. Several focus groups and one to one interview were also undertaken. Results from the review is scheduled in 2025 and will be reviewed by the team of Guardians.

8. Next Steps

- Pilot and roll out of Active Bystander training to take place in 2025 to equip staff on how to challenge appropriately to generate more confidence in staff speaking out.
- Review / Implement the recommendations from relevant National enquiries e.g. Thirlwall Inquiry due to be published early 2026.

Appendix A

Equality and Diversity Monitoring Forms Received Q2-Q4 2024/25

*Please note data returned to us during this period, may not necessarily relate to concerns raised within the same period.

Information Received 2024/25 Q2-Q4

Forms Returned: 10

What is your Sex					
Female	7	Male	3	Prefer Not to Say	
Is the gender you identify with the same as your sex registered at birth?					
Yes	10	No		Prefer Not to Say	
Age					
16-24		25-29		30-34	
35-39	1	40-44	1	45-49	1
50-54	3	55-59	1	60-64	1
Over 65	1	Prefer not to Say			
What is your ethnicity					
Asian or Asian British					
Indian		Pakistani		Bangladeshi	
Chinese		Prefer Not to Say		Any other Asian Background	
Black, African, Caribbean or Black British					
African		Caribbean		Prefer Not to Say	
Any other Black, African or Caribbean background					
Mixed or Multiple ethnic groups					
White and Black Caribbean		White and Black African		White and Asian	
Prefer not to say		Any other Mixed or Multiple ethnic background			
White					
English	5	Welsh	1	Scottish	
N. Irish		Irish	1	British	1
Gypsy or Irish Traveller		Prefer not to say		Any other White background	1
Other ethnic group					
Arab		Prefer not to say		Any other ethnic group	1
Do you consider yourself to have a disability or health condition?					
Yes	2	No	7	Prefer not to say	1

What is your sexual orientation?					
Heterosexual	9	Gay		Lesbian	
Asexual		Pansexual		Undecided	
Prefer not to say	1	Any other identity			
What is your religion or belief?					
No religion or belief	2	Buddhist		Christian	7
Hindu		Jewish		Muslim	
Sikh		Prefer not to say		Any other religion or belief	1
What is your working pattern?					
Full-time	10	Part-time	4	Prefer not to say	
What is your flexible working arrangement?					
None	7	Flexitime		Staggered hours	
Term-time hours		Annualised hours		Job-share	
Flexible shifts	1	Compressed hours		Homeworking	
Prefer not to say	1	Any other arrangement			
Do you have caring responsibilities?					
None	6	Primary carer of a child/children (under 18)			2
		Primary carer of disabled child/children			
		Primary carer of disabled adult (18 and over)			1
		Primary carer of older person			
		Secondary carer (another person carries out the main caring role)			1
Prefer not to say					