Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09.30 on Wednesday 25 February 2026
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month (February 2026)** *Purpose: To **note** the Employee of the Month presentations for February 2026*	Presentation	Chair *(15 mins)*
09.45	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.	**TB26/012 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 28 January 2026*	Report	
	5.	**TB26/013 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				
09.55	6.	**TB26/014 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*	Report	S O'Brien / S Dowson L Neary M Szpakowska G Lawrence *(20 mins)*
Committee Assurance Reports				
10.15	7.	**TB26/015 Committee Assurance Reports** 7.1. Executive Committee	Report	R Cooper

		7.2. Audit Committee 7.3. Quality Committee 7.4. Strategic People Committee 7.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*		S Connor G Brown L Knight C Spencer *(35 mins)*
Concluding Business				
10.55	8.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
11.00	9.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 25 March at 09:30		**11.15 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.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	25 February 2026
Agenda Item	**TB26/000**			
Report Title	Employee of the Month (February 2026)			
Executive Lead	Steve Rumbelow, Chair			
Presenting Officer	Steve Rumbelow, Chair			
Action Required		**To Approve**	X	**To Note**

Purpose

To note the Employee of the Month winner for February 2026 is Sophie Trecarichi, Staff Nurse in the Critical Care Unit at Southport Hospital. Sophie was nominated by Amanda Hughes, Quality Matron.

Executive Summary

Sophie has been recognised for her outstanding contribution to patient safety following exceptional feedback during the recent 5 Star Ward Accreditation inspection. Her leadership in the prevention and management of falls is exemplary. She ensures every member of staff is confident, informed and up to date, and she consistently drives the high standards that protect our patients from harm.

During the inspection, Sophie demonstrated genuine enthusiasm and deep pride in her work, showcasing the processes she leads and the documentation that supports safe practice. She even shared a recent post-fall review, highlighting her commitment to learning and continuous improvement. Throughout, she was warm, professional and a credit to her team.

In addition to her role as a Staff Nurse, Sophie also provides invaluable support to the Unit's Lead Educator. She works closely with student nurses on sepsis and Acute Kidney Injury (AKI) pathways, helps maintain and update key information boards, and contributes to essential audit activity. Her commitment to education and quality improvement strengthens the wider team and enhances the learning environment across the Unit.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Employee of the Month winner.

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

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

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 28 January 2026
(Approved at Trust Board on Wednesday 25 February 2026)

Name	Initials	Title
Steve Rumbelow	SR	Chair
Gill Brown	GB	Non-Executive Director and Deputy Chair
Rob Cooper	RC	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Khalid Anis	KA	Associate Non-Executive Director
Nicola Bunce	NB	Director of Corporate Services
Steve Connor	SC	Non-Executive Director
Simon Dowson	SD	Chief Medical Officer
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
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer

In Attendance

Name	Initials	Title
Shaun Bainbridge	SB	Head of Estates and Facilities Risk, Security and Fire Safety (Observer) (via MS Teams)
Clare Fitzpatrick	CF	Lead Midwife, Local Maternity and Neonatal System (Agenda Item 9 via MS Teams)
Neil French	NFr	Designate Non-Executive Director (Observer) (via MS Teams)
Michelle Kitson	MK	Matron - Patient Experience (Agenda Item 2 via MS Teams)
Catherine McClennan	CMc	Senior Responsible Officer (SRO), Local Maternity and Neonatal System (Agenda Item 9 via MS Teams)
Sue Orchard	SOr	Director of Midwifery, Women's and Children (Agenda Item 9 via MS Teams)
Nicola Slilem	NS	Children's Ward Manager, Ormskirk Hospital (Agenda Item 2 via MS Teams)
Kevin Thomas	KT	Divisional Medical Director, Women's and Children (Agenda Item 9 via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager
Marie Wright	MW	Halton Council Representative (Stakeholder Representative) (via MS Teams)

Apologies

Name	Initials	Title
Eslie Hayford	EH	Shadow Non-Executive Director

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for December 2025 was Vamsidhar Rachapalli (VR), Consultant Radiologist, Whiston, Hospital. 1.2. The Employee of the Month for January 2026 was Keri Millington (KM), Senior Staff Nurse, Dermatology Department, St Helen's Hospital. 1.3. SR read out the citations for VR and KM and RC presented the Employee of the Month certificates and pin badges. **RESOLVED:** The Board **noted** Employees of the Month for December 2025 and January 2026 and congratulated the winners.
2.	**Patient Story**
	(MK and NS joined the meeting) 2.1. SR welcomed MK and NS to the meeting. 2.2. MK introduced the Patient Story video which showcased how the Children's Ward at Ormskirk Hospital had made an application to the charity MedEquip4Kids and secured funding to support regular visits for patients by Louby Lou, a trained 'Clown Doctor'. Louby Lou, who had been working as a 'Clown Doctor' since 1997, had trained at Great Ormond Street Hospital and had now been visiting the Children's ward at Ormskirk Hospital for 12 months. 2.3. The video highlighted the positive impact that Louby Lou's visits had on the patients as well as their parents and carers, by helping patients to relax and have fun. This in turn helped children tolerate their treatment and feel less frightened in the hospital environment. 2.4. NS commented on the impact of Louby Lou's visits, and how she made sure to interact with all the children, even those who had to be in isolation rooms due to infections. *(MK and NS left the meeting)* 2.5. GB commented that the funding received was limited and currently only for the Children's ward at Ormskirk and asked whether an application could be submitted to the MWL NHS Charitable Funds to continue with the initiative. RC agreed that this was an option and reflected on the importance of the person to person interaction in these environments. RC proposed the

	Women and Children's Services Division submit the application for funding to the Charitable Funds Committee. GB also noted that dementia patients might benefit from a similar initiative to support diversional activities. 2.6. SR thanked MK and NS for sharing the patient story. **RESOLVED:** The Board **noted** the Patient Story
3.	**Chair's Welcome and Note of Apologies**
	3.1. SR welcomed all to the meeting and in particular welcomed KA who had joined the Trust as a new Associate Non-Executive Director and was attending his first Board meeting. 3.2. SR noted that SOr and KT would be attending the meeting to present Agenda Item 9 Clinical Negligence Scheme for Trusts 2024/25 Self Declaration / Maternity Incentive Scheme Year along with CF and CMc from the Local Maternity and Neonatal System (LMNS) who would be observing this item to provide assurance to the ICB. Additionally, SR welcomed NFr and SB who were attending the meeting as observers. 3.3. The following awards and recognitions were noted: 3.3.1. Rachel Featherstone, Student Midwife at Whiston Hospital, won the Charity Champion of the Year award at the Pride of St Helens Awards on 28 November. 3.3.2. MWL has achieved the National Multi-Profession Preceptorship Quality Mark, awarded by NHS England. This built on the Trust's Interim Quality Mark for Nursing which was awarded in 2024. The Trust has graduated to the full Quality Mark in recognition of the early implementor pilot and acknowledgement to other professional groups including Midwifery and Allied Health Professions 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 meeting agenda items.
5.	**TB26/001 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 26 November 2025 and approved them as a correct and accurate record of proceedings subject to the following amendment: 5.1.1. 8.3.2 to be amended to read '*The Committee <u>had</u> been notified of a significant legacy of a property and the process involved in transferring ownership'*

	RESOLVED: The Board **approved** the minutes from the meeting held on 26 November 2025 subject to the amendment detailed above
6.	**TB26/002 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 24 (TB25/078 Corporate Risk Register) – Following review, it is not considered appropriate at this stage to merge Corporate Risks 5 (MWL Risk ID 263) and 23 (MWL Risk ID 1125). While thematic overlap existed, the risks arose from distinct underlying causes, related to different service areas, and were subject to separate control measures and impact profiles. Risk 1125 was due for further review at the end of March. Subject to the outcome of this review and the effectiveness of existing and planned mitigations, there was an expectation that the residual risk score may reduce. Both risks will be kept under review, and should the risks converge further in cause, control, or impact, the option to merge them would be reconsidered. **Action closed** 6.2.2. Action Log number 28 (TB25/091 Annual Digital Strategy Update) – Following an assessment of the issues around the implementation of Badgernet and the proposed implementation timetable, a report will be presented at Executive Committee to determine the shortest safe go live date. **Action closed** 6.3. There were no other outstanding actions. **RESOLVED:** The Board **approved** the action log
Performance Reports	
7.	**TB26/003 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for December 2025 was presented.
7.1.	**Quality Indicators**
	7.1.1. SO and SD presented the Quality Indicators. SO highlighted the following: • Infection prevention and control (IPC) continued to be a significant challenge, with several Healthcare acquired infections and all hospital sites exceeding the target levels. This remained a key focus for the team, and efforts were ongoing to address the challenges. The challenges included high levels of activity at the acute sites which had necessitated the opening of escalation areas. This was exacerbated by the temporary

	closure of beds in line with IPC guidance as a result of infection outbreaks. • The overall number of falls, including the number of falls which had resulted in moderate or severe harm, had decreased. There were several Patient Safety Incident Reviews (PSIRs) currently in progress relating to falls and a falls deep dive would be presented at the February Quality Committee meeting to provide assurance that interventions were effective and detail any additional proposed actions to minimise the risk of falls occurring. • Three neonatal deaths, which all related to cases of early gestation, had been reported in December. SO noted that the initial reviews had found no evidence to suggest that these incidents could have been prevented through alternative actions or interventions by the Trust. • No never events had been reported in December. • Complaints responses within 60 days performance was 63.5% (target 80%) and the turnaround of complaint responses remained a challenge across the organisation and continued focus for improvement. 7.1.2. SD reported that the latest Hospital Standardised Mortality Ratio (HSMR) for the period April 2025 to July 2025 was 89.5. The national data coding issue had now been resolved.
7.2.	**Operational Indicators**
	7.2.1. LN presented the operational indicators and highlighted the following: <u>Urgent and Emergency Activity</u> 7.2.2. The Trust 4-hour mapped performance for December was 75.4% (2025/26 year to date (YTD) 78.7% against the 78% interim national target). This compared to 73% nationally and 71.5% for Cheshire and Merseyside (C&M). 7.2.3. In December circa 20% of patients had waited for over 12 hours in the Emergency Department (ED) which reflected the impact of the operational challenges, including beds closed as a result of outbreaks, which had impacted patient flow. 7.2.4. In December 69.6% of ambulances were handed over within the 45-minutes (target 100% and YTD performance 84.8%). 7.2.5. Bed occupancy in December was 105.1% (or an additional 103.6 patients being cared for by the Trust) and on the busiest day in December, the Trust had accommodated an additional 162 patients. These pressures had continued during the first few weeks of January. 7.2.6. An internal Winter Summit would be arranged to review the effectiveness of the 2025/26 winter plan and reflect on any learning for the Trust or local system to support planning for next winter. <u>Elective Care</u> 7.2.7. There were two 65 week breeches in December and both had been due to patient choice. This was a significant improvement from the 233 patients

	waiting over 65 weeks in July and the Trust was now one of the best performing acute trusts nationally for this target. 7.2.8. The 18-week Referral to Treatment (RTT) performance was 62.8% in December and the Trust was delivering additional outpatient activity to improve this. <u>Cancer Services</u> 7.2.9. Performance against the 62-day cancer target had improved to 78% (target 85%). This compared to 70.2% nationally and 74.2% for C&M. 7.2.10. Performance against the 28-day cancer target had improved to 75.9% in November (target 77%). This compared nationally to 76.5% and 74.8% for C&M. This represented the strongest performance since November 2024 but would remain an area of focus. 7.2.11. Cancer performance at the Southport and Ormskirk Hospital sites had also improved in December to 72.4%, which was the highest performance level since December 2024 and reduced the historic gap in performance between the legacy trusts sites. <u>Diagnostics</u> 7.2.12. Performance in December was 93.6% (target 95%) compared to 78.3% nationally and 90.8% for C&M. 7.2.13. On behalf of the Board, SR expressed gratitude to all staff, particularly those in Accident and Emergency (A&E), for their significant contributions during such a pressurised period. SR acknowledged that, although some performance targets remained challenged there had been improvements in several areas and the Board fully recognised the considerable efforts required to achieve these. SR also acknowledged that despite extensive and comprehensive planning the organisation had continued to experience severe winter challenges. 7.2.14. LN agreed that there had been progress across several key metrics and highlighted that the Trust had become the most improved acute site in C&M for ambulance handovers within 45 minutes, which was a testament to the teams in the ED's.
7.3.	**Workforce Indicators**
	(NFr joined the meeting) 7.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for appraisals was 90.1% (target 85%). • The compliance rate for mandatory training was 88.7% (target 85%). • Sickness absence had increased to 7.8% in December from 7.3% in November (target 5%) and this remained a key area of focus. MS noted that at a recent C&M Chief People Officers meeting all trusts in the ICB had reported a similar increase in sickness absence and this was now a key area of focus for all Boards. Benchmarking indicated that MWL

	sickness was slightly higher than the average for acute trusts, but similar to other trusts with community services. . The top three reasons for sickness absence remained anxiety, stress and depression, musculoskeletal health (MSK), and gastrointestinal issues. There was a robust sickness absence management plan in place and delivery was being monitored via the People Performance Council with regular updates to the Executive Committee and Strategic People Committee (SPC). Targeted interventions in the 20 teams/services with the highest sickness absence rates had been initiated. • In-month staff turnover remained stable at 0.8% (target 1.1%). • Narrative about the Time to Hire metric had been included in the report, as this was an area of focus for SPC. Time to hire in December has increased to 58.4 days against the target of 40 days, but this represented a significant improvement from July (100 days). 7.3.2. GB commented that the time to hire narrative was useful and asked if this should be an IPR level metric if it was to be an area for continued improvement. MS noted that an improvement plan had been in place since July and the trajectory had been to achieve a time to hire of 60 days by December, which had been exceeded. The team had adopted new processes for recruitment checks and further robotic process automation (RPA) to reduce the time taken for key elements of the pre-employment process. 7.3.3. SR reflected on the excellent appraisal compliance rate of 90% and commented on the importance of these conversations between managers and their staff, which were key for a successful organisation. 7.3.4. SR reflected on the increase in sickness absence and commented that whilst the efforts with the flu vaccinations had been commendable, there had still been staff who had not been vaccinated and although the vaccine wasn't a guarantee, some of the sickness due to flu might have been avoided.
7.4.	**Financial Indicators**
	7.4.1. GL presented the financial performance 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 if £30m of deficit support funding was excluded. This plan had assumed £27m 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 9, the Trust was reporting a £39.6m deficit and if deficit support funding was excluded the adjusted position was a £44.4m deficit, which was £7.6m ahead of plan. 7.4.3. This included the impact of the Resident Doctors industrial action for which some additional funding had been received.

	7.4.4. GL highlighted the following: • Agency spend had continued to reduce and was 2.4% of total pay spend. • The Trust had successfully delivered £37.3m of the CIP YTD against the full year plan of £48.2m (£2m ahead of plan at M9) and was on target to deliver the full plan. • Capital expenditure of £48m was forecast and GL noted that this was subject to change in the final quarter as more capital may be allocated to the Trust by NHSE or the ICB. • The Trust's cash balance was £2.3m and there had been a slight reduction in the Better Payment Practice Code (BPPC) performance. • The Trust was still forecasting an adverse variance to plan and the challenges and potential mitigations had been discussed in detail at the Finance and Performance Committee. 7.4.5. GL noted that the Finance Performance Review Meetings (FPRM) with the ICB and NHSE and PricewaterhouseCoopers International Limited (PwC) financial support processes and meetings had taken place in December and January. 7.4.6. SR noted the importance of achieving financial plan, whilst also recognising the challenge this presented. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB26/004 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. RC presented the Executive Committee Assurance report for the meetings held in November and December 2025. Bank or agency staff requests that breached the NHS England (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. The Committee had received the regular monthly assurance reports for: • Nurse Safer Staffing • Freedom of Information (FOI) compliance • Mandatory training and appraisal compliance • Finance and financial improvement • Risk Management Council • Procedural Documents which provided updates on overdue policies and progress with the harmonisation of policies across MWL 8.1.3. RC highlighted the following items from the report:

- The Committee had approved the Breast Reconstruction Service Locum Consultant Business Case and acknowledged the temporary double running costs. RC reported that two candidates had interviewed for the role and both had been appointed to support efforts to reduce waiting lists. The Committee had sought assurances that this increased capacity would be utilised to maximise productivity.
- The Committee had received the General Medical Council (GMC) National Training Survey and action plan. This was mainly related to urgent care; however, it also linked to the 10 point plan to support the working lives of resident doctors. Work to address capacity for post take ward rounds to ensure that patients in the ED at Whiston Hospital were being seen in a timely manner was the core action to be addressed.
- The Committee had been briefed on the Joint Advisory Group (JAG) Endoscopy Accreditation review of the endoscopy unit at St Helens Hospital and the required actions included immediate interim changes to the layout to ensure separation of male and female pathways. Following this JAG accreditation had been awarded, pending some further permanent layout changes that were being planned for 2026/27.
- The Committee had received the National Cancer Patient Experience Survey Results and Improvement Plan. The MWL 2024 survey response rate had been 47%. The survey had included 59 questions and MWL had six responses above the expected range and the remaining questions had scored within the expected range.
- The Committee had received the proposals for the reconfiguration of beds at Southport Hospital to respond to changes in demand, enhance organisational resilience and utilise capacity more effectively. These moves would also facilitate the start of the ward refurbishment programme at Southport Hospital. Additionally, efforts were being made to maximise the utilisation of theatre capacity at Ormskirk Hospital.
- The Committee had received the Maternity Patient Survey Action Plan progress report. There had been a focus on evaluating whether the actions delivered had achieved the expected benefits and outcomes.
- The Committee had received an update on the St Helens and Sefton Neighbourhood Health Pioneer Pilot (NHPP).
- The Committee had received the Leading Operational Excellence Development Programme report with proposals for a development programme for operational leaders, based on key competencies. This programme would support managerial leaders across the organisation and would be based on the national core skills framework. RC commented that at a recent national event the launch of an NHS College for Management and Leadership had been announced. This was linked to the planned regulation of NHS managers, and it was proposed the college would have a role in investigating breaches of the regulations.

8.1.4. CS asked whether leadership and management development should be offered in a similar way to clinical leaders, and RC agreed that there were common skills required of all leaders and many NHS professionals progressed to management and then leadership roles without specific

	training in the competencies required. LN noted that the Trust had partnered with the Kings Fund to develop this programme and they would also deliver some of the modules. Additionally, many of the modules were generic that would apply across all staff groups and professions, for example, how to have difficult conversations, whilst other sections would be specifically developed for operational leaders. MS reported that in addition to the Leading Operational Excellence Development Programme, a bespoke Divisional Triumvirate programme had been developed for the operational, medical and nursing leads. The Trust was also refreshing its mentorship programme to support career development. 8.1.5. AMS commented that operational teams had been identified as the first priority for the programme because they had experienced some of the most significant change since the two legacy trusts came together, however, there had always been an intention to roll this out to other staff groups. SD supported the opportunity for leaders from different professional backgrounds to learn together. SR reflected that specific operational management skills development had often been overlooked in the NHS as this was not a distinct recognised profession and this was a positive development. 8.1.6. NF reflected on the requirements arising from the JAG accreditation and noted that one of the risks relating to decontamination on the Corporate Risk Register had recently been downgraded. NF asked whether this was because the capital had been prioritised for this scheme in 2026/27. RC responded that the investment needed for the endoscopy treatment unit was different from the risk relating to the decontamination equipment. The changes required at the St Helens endoscopy unit to meet the JAG accreditation standard were relatively modest to separate the male and female patient pathways. Endoscopy provision was also being discussed in the broader system context to ensure that all current capacity was being fully utilised. The remainder of the report was **noted.**
8.2.	**Quality Committee**
	8.2.1. GB presented the Quality Committee Assurance Report for the meeting held on 20 January 2026, noting the key quality performance indicators had already been reported. 8.2.2. GB reported that the Committee had considered the Clinical Negligence Scheme for Trusts (CNST) 2024/25 Self-Declaration / Maternity Incentive Scheme (MIS) Year 7 (01 December 2024 to 30 November 2025) and alerted the Board that for Safety Action 1 the Trust had not achieved the required 95% compliance for Element 1c. The Committee had noted both the potential financial and reputational implications associated with not being able to declare full compliance with all the MIS standards. GB provided reassurance that the non-compliance did not constitute a patient

	safety issue but was related to a single missing data point that had not been submitted via the electronic portal within the specified time limit. 8.2.3. It was noted that the Quality Committee and Trust Board had scrutinised the Maternity Service performance throughout the year via quarterly reports and had been alerted to the issue of safety action 1 via these reports. 8.2.4. GB also highlighted the following points from the report: <u>Quality Committee Corporate Performance Report</u> 8.2.5. The focused work on the timely validation of pressure ulcers and the data accuracy improvement project for nutrition metrics had been discussed. 8.2.6. The upward trajectory for the percentage of ventouse births and forceps deliveries at Ormskirk Maternity Unit had been discussed and further information on the reasons for this had been requested. <u>Patient Engagement Portal (PEP) Report</u> 8.2.7. Following the implementation of the Waiting List validation module across MWL, circa 48,000 patients had been validated and circa 3,500 patients had been safely discharged. 8.2.8. The Waiting Well module was being rolled out across MWL, but there were a number of complexities to this that were being addressed. 8.2.9. Patient Experience Surveys were being conducted to assess the effectiveness of the Patient Engagement Portal and feedback received so far had been generally positive. 8.2.10. An update on the Ambient Voice Technology (AVT) project had been presented to assure the Committee of how this would support patient care and experience. <u>Controlled Drug Accountable Officer (CDAO)Annual Report</u> 8.2.11. There had been an increase in the number of controlled drugs (CD) related incidents, however this was largely due to improved reporting and the Committee had been assured by the analysis of the incident themes. 8.2.12. The Trust's CD licence had been resolved following a national Home Office issue. 8.2.13. Work was ongoing on the harmonisation and updating of policies and standard operating procedures for the management of CDs across MWL. 8.2.14. The required training was being provided by the CDAO 8.2.15. Recommendations for future improvements had been noted and these included introducing electronic CD registers and ordering systems, updating of induction materials for lead employer doctors and CDAO role increased visibility and communications. 8.2.16. The Committee had been assured that the Trust complied with the statutory requirements for CD management and had robust internal governance structures. <u>Clinical Effectiveness Report (including Council Chair's report)</u> 8.2.17. The Committee noted that the reported national issue relating to the coding of mortality data to support HMSR reporting, had now been resolved.

	8.2.18. The Council had raised issues in relation to guidance for the treatment of transgender patients and it was confirmed that the Trust's Transgender Policy would be updated once national guidance had been issued by the NHS. 8.2.19. The Council had received a report on the non-medical prescribing risks and mitigations and noted that a review of resources was being undertaken. 8.2.20. GB noted the recent positive recruitment to Histopathology consultant vacancies against the backdrop of national shortages. <u>Care Quality Commission (CQC) Quarterly Report (Q3 2025/26)</u> 8.2.21. There had been no CQC inspection activity in Q3. 8.2.22. 13 enquiries had been received from the CQC and responded to within agreed timescales with no follow up actions. 8.2.23. The CQC had closed their investigation into an incident that had occurred in May 2024 and concluded no further action was required. 8.2.24. The ward accreditation programme was now well embedded and there were seven wards that had achieved 5 Star status across MWL. 8.2.25. The Committee had received the Patient Safety Report (including the Chair's Assurance Report) as well as the six monthly Establishment Review. 8.2.26. The Committee had received the MIAA Spot check review for Infection Prevention and Control (IPC) Observations 2025/26 which highlighted several challenges. An action plan in response to the recommendations would be presented at the next meeting. 8.2.27. The Committee had received the Mid and North Mersey Stroke Services Performance Update for December 2025 for the services being provided at Whiston and Southport Hospitals. 8.2.28. There were no other issues to escalate to the Board. 8.2.29. SO reported that, whilst there had been no direct CQC activity in Q3, the Trust had been advised that a special educational needs and disability (SEND) inspection would be taking place in St Helens, which would be a joint inspection between CQC and the Office of Standards in Education, Children's Services and Skills (OFSTED). As the Trust provided Community Paediatric Services in St Helens it would be part of the inspection process. 8.2.30. SR supported GB's report that the Board was fully aware of the risk to compliance for safety action 1 for the MIS Year 7 Self Declaration, having been previously alerted to this risk. The remainder of the report was **noted**.
8.3.	**Strategic People Committee**
	8.3.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 21 January 2026 and noted that some of the points

	noted had already been discussed in earlier reports to the Board and would not be repeated. 8.3.2. LK highlighted the following: • The Committee had received the staff story presented by the Preceptorship Lead about the Trust's preceptorship programme and the progress made since its inception in 2021. LK reflected on the enthusiasm and success of the programme. The Preceptorship team had been selected to be part of a national pilot for the new multi-Professional standards, which was part of the NHS Commitment Strategy for new registrants. Additionally, the Trust had been selected to be a Case Study Trust for Preceptorships by NHSE. • The Committee had received an update on the Sexual Safety Charter following a letter from NSHE in December 2025 on the actions required to prevent sexual misconduct in the NHS and ensure that the Trust was a sexually safe place for patients and staff. An further update on the delivery of the additional requirements would be presented at the SPC meeting in April 2026. • The Committee received the Employee Relations Oversight Group (EROG) Assurance Report, which included a comprehensive, triangulated analysis of key workforce indicators such as sickness absence rates, employee relations cases, organisational development interventions, and both formal and informal Freedom to Speak Up cases. The report identified several recurring themes, including style and capability, values and behaviours, incidents of incivility, and aspects of organisational culture. LK noted that, although organisational changes had the potential to cause disruption, the impact following the transaction had been less significant than initially anticipated given the scope and scale of change. An action plan was being developed to align the work to promote the Trust's Values and Behaviours Framework. The remainder of the report was **noted**.
8.4.	**Finance and Performance Committee**
	8.4.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 22 January 2026. The Committee had reviewed the Finance and Performance CPR and monthly finance report, but the key points had already been discussed in earlier reports on the Board agenda so would not be repeated. 8.4.2. Other points to highlight from the report were: • The Committee had discussed the variations in the 45 minutes ambulance handovers that existed across the North West, especially in relation to the differing operational approaches by the North West Ambulance Service NHS Trust (NWAS) in the three Integrated Care Boards (ICBs). The Committee had supported LN to continue discussions with the C&M ICB leadership to address and clarify the differences in supply and demand protocols in comparison to those

applied within the Greater Manchester and Lancashire and South Cumbria.

- The percentage of non-criteria to reside (NCTR) patients was 20.9% in December and while this was the lowest level for several months, it still equated to one in five beds within the organisation being occupied by NCTR patients and impacted patient flow, staffing and finances.
- The Committee had commended the diagnostics and cancer performance improvements, and the success of the targeted action plans.
- The Trust continued to deliver against the CIP target and it had been noted that planning was underway for 2026/27 which was expected to be another challenging year financially.
- The Committee had received the Estates and Facilities CIP update which outlined the overdelivered position of 2025/26 which had focussed on recurrent CIP and the plans for 2026/27.
- The Committee had received the cash report and noted that whilst the position remained challenging, the Trust was in line with plan.
- The Committee had reviewed the outturn risks and discussed the current risks within the forecast. There was a £4.9m challenge to meet the 2025/26 financial plan.
- The Committee had received the National Cost Collection and Productivity report and the Trust National Cost Collection Index (NCCI) for 2024/25 was 97. CS noted that opportunities for improved productivity were identified across both urgent and elective care.

8.4.3. The Finance and Performance Committee escalated to the Board the risks in delivering the forecast outturn. The Committee had been fully sighted on the actions the Trust could take to deliver the plan and the risks in relation to several longstanding and significant decisions outstanding at ICB level and the Committee was concerned that despite the best efforts of the Executive, these may not be resolved by year end. CS noted that these issues had been raised at the Finance Performance Review Meetings (FPRM) throughout the year.

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

8.4.5. SR reflected on the Trust's cash position, which was unique to the NHS when compared to other sectors. .

The remainder of the report was **noted**

RESOLVED:
The Board **noted** the Committee Assurance Reports

Other Board Reports

9.	**TB26/005 Clinical Negligence Scheme for Trusts 2024/25 Self Declaration / Maternity Incentive Scheme Year 7**

(SOr, KT, CF and CMc joined the meeting)

9.1. SR welcomed SOr, KT, CF and CMc to the meeting.

9.2. SO introduced the Clinical Negligence Scheme for Trusts 2024/25 Self Declaration / Maternity Incentive Scheme Year 7 presentation which summarised the Trust's final position against each of the MIS Year 7 safety actions to optimise the safety of women and babies. It was noted that the report and supporting evidence had been reviewed by the Executive Committee and Quality Committee, before being presented to Board. Additionally, regular Maternity services reports, including the MIS were presented to Quality Committee and Board throughout the year.

9.3. SO reported that the Board was being asked to approve submission of non-compliance for MIS Year 7 in relation to Safety Action (SA) 1, Element 1c (use of the Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard). To date 13 cases had required a PMRT review which had been started within two months of the death. Although all 13 cases had been started within the required time period, a documentation error had occurred which meant that in one case only nine of the ten submission questions had been entered within the time limit and this meant this case was classified as non- compliant against the standard. The missing data point was corrected; however, it was done after the two month timeframe, for the Trust to start the PMRT. SO stressed that this had been an administrative oversight and had not impacted on the care delivered or the completion of the review. SO noted that in terms of the guidance and following discussions with both CNST and LMNS the Trust had been advised to report non-compliance against SA1, and therefore would be compliant overall, as all MIS standards had to be met to make a compliant self-declaration. This outcome could be appealed with NHS Resolution (NHSR) on the basis that there had been no impact on patient care or safety.

9.4. SR advised that SOr had previously informed Quality Committee and Board of this issue in November 2025 and noted that the Board would support an appeal. On behalf of the Board, SR conveyed the disappointment of having to submit a non-compliant self-declaration and emphasised that the omission concerned a mandatory data field which had not been completed. Additionally, SR noted the frustration arising from the lack of notification that this required field had been left incomplete and that the form could be submitted without the omission being flagged.

9.5. SOr and KT presented the detailed evidence of compliance against the safety actions 2-10.

9.6. SR thanked SOr and KT for the presentation and asked CF and CMc if they had any comments. CMc also expressed disappointment on the non-

	compliance for SA 1 and noted that 1, 2 and 10 were data driven and could not be influenced by the LMNS. CMc confirmed the LMNS assessment that MWL was compliant with SAs 2 to 10. 9.7. CMc noted that she had also discussed the non-compliance for SA1 with NHSR and the regional maternity team to determine whether any remedial actions were possible, however, there had been no indication that the outcome could be changed. CMc noted that there was a likelihood that for future years the SA 1 requirements would be changed and this data field would no longer be mandatory. An explanation would be provided to the ICB CEO who was required to counter-sign the self-declaration following the Board's approval. 9.8. CMc provided an update on an action related to SA 7 (Maternity and Neonatal Voices Partnership attendance at PMRTs) and noted that this had been escalated nationally. 9.9. SR thanked CMc for her valuable support and assistance. Additionally, SR thanked SOr and KT for their presentation, noting that, notwithstanding the non-compliance with SA 1, the overall report represented a positive reflection on the quality and safety of the service. 9.10. SR and SD commented on the amount of work that was required to demonstrate that the Trust was ensuring the safety of mothers and babies and thanked the whole team. 9.11. SR noted that, from a Board perspective, that SA 6 and 8 clearly demonstrated the progress that was being made as well as the steps to fully integrate the maternity services across MWL. **RESOLVED:** The Board **approved** the Clinical Negligence Scheme for Trusts 2024/25 Self Declaration / Maternity Incentive Scheme Year 7 and noted the non-compliance for Safety Action 1 Element 1c (use of the Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard *(SOr, KT, CF and CMc joined the meeting)*
10.	**TB26/006 Corporate Risk Register**
	10.1. NB presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the CRR via the Trust's risk management system. NB highlighted that the tolerated risk register, which was part of the legacy Southport and Ormskirk Hospital NHS Trust's (S&O) risk framework, had been closed and the risks had been absorbed into the live risk register and were being actively managed. 10.2. NB highlighted the following:

	10.2.1. The current report reflected a snapshot of the risk registers on 01 January 2026 and reflected the risks reported and reviewed during December 2025. 10.2.2. The total number of risks on the risk register was 1,067 compared to 994 in October 2025 and the increase was partly due to inclusion of risks from the legacy S&O tolerated risk register. 10.2.3. 25 risks were escalated to the CRR compared to 23 in October. 10.2.4. Nine new escalated risks were reported on the CRR compared to October. 10.2.5. Five risks had been closed or de-escalated from the CRR since October. 10.3. In response to NF's earlier comment, NB noted that risk ID 1044 relating to Whiston Hospital Decontamination Unit equipment had been de-escalated but had been superseded by a new Trust wide risk (ID 510) relating to the need for equipment replacement across the Trust, which had been identified following a review of the decontamination services across MWL. 10.4. SR reflected on the improvement in the report. NB commented that reporting had been impacted by the implementation of the new single InPhase Risk Management system earlier in the year but the system and processes were now embedded. **RESOLVED:** The Board **noted** the Corporate Risk Register
11.	**TB26/007 Board Assurance Framework**
	11.1. NB presented the Board Assurance Framework (BAF) and noted that each BAF risk had been reviewed by the lead Executive and updates provided in relation to closed and new actions. 11.2. NB reported that the recommendation from the Executive Committee was that the risk score for BAF 3 remained unchanged due to on-going operational winter pressures. 11.3. NB noted that some additional assurances relating to operational and financial planning for 2025/26 and 2026/27 with system partners that remained outstanding as referred to in the Finance and Performance Committee Assurance report. 11.4. CS reflected on BAF 2 (Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners) and commented that in the current circumstances this felt aspirational and queried if this remained a shared objective. RC responded that the impact of the current organisational changes within the ICB should not be underestimated. The complexity of C&M as a system made the alignment of objectives with each Trust more challenging, however, it was policy for the NHS to be financially sustainable so this remained a fundamental requirement and statutory duty.

	11.5. SC reflected that the situation might become more challenging in 2026/27 and organisations had been allocated individual control totals rather than having a system control total, which could impact collaboration and system working. RC accepted that this might change behaviours. SR commented that MWL still needed to focus on productive relationships with system partners as this provided the best opportunity to improve services for patients and reduce unwarranted variation. **RESOLVED:** The Board **approved** the Board Assurance Framework.
12.	**TB26/008 Aggregated Incidents, Complaints and Claims Report (Q3)**
	(SR stepped out of the meeting briefly and GB took over as Chair) 12.1. SO presented the Aggregated Incidents, Complaints and Claims Report (Q3). 12.2. SO highlighted the following: 12.2.1. The most frequently reported patient safety incidents in Q3 were: • Pressure Ulcers, including those not acquired under Trust care (952). A review of reported community acquired pressure ulcers was due to be presented to Quality Committee in February. • Accidents including slips, trips, falls, and collisions (831). Any falls graded as moderate or severe harm were presented to the Patient Safety Council and subject to review under the Patient Safety Incident Response Framework (PSIRF). 12.2.2. The Trust had received 145 first stage complaints in Q3 (161 in Q2) and no new themes had been identified. The biggest challenge remained the turnaround time across the divisions. 12.2.3. No Prevention of Future Deaths notices (PFDs) had been issued during the period. SO noted that the Home Birth Services – Risk, Benchmarking and Improvement Programme for Northwest Region report included on the agenda was in response to a National PFD. 12.2.4. 38 inquests had been closed in Q3; however, the Trust had been asked to provide additional assurance to the coroner in three of the inquests. 12.3. GB asked if this was a change of practice from the new coroner, but SO did not think so. The additional evidence submitted had provided sufficient assurance to the coroner to not issue a PFD notice. *(SR rejoined the meeting)* 12.4. AMS reflected on the rise in the number of inquests closed during Q3 and asked whether there were any particular factors that may have affected the coroner's decisions. SO responded that occasionally the outcome of an inquest was dependent on outstanding requests from the coroner, however, this had not been the case for these inquests.

	12.5. SC reflected on the turnaround time for complaints and asked if this was due to capacity issues. SO responded that the issue was multifaceted. There was some variation in the complaints response process across divisions, and different volumes and complexity of complaints being addressed. SO felt there was not always sufficient recognition of the importance of providing timely responses to complaints and the consequent effect on patients and relatives. Delays were often due to the time taken to gather the evidence of what happened from clinical, notably medical, colleagues. Although capacity was a factor SO did not believe this was the fundamental cause of the time taken to respond. SD commented that he was frequently asked to follow up with doctors regarding their complaints responses and felt that additional complaints training for doctors might be useful. 12.6. RC suggested that the outcome of Patient Advise and Liaison Service (PALs) contacts should be included in the report, including how many were resolved by PALs or converted in to formal complaints to provide assurance on the efficacy of the service. SO confirmed that this information was collected and would be added to future Board reports. **RESOLVED:** The Board **noted** the Aggregated Incidents, Complaints and Claims Report (Q3)
13.	**TB26/009 Learning from Deaths Quarterly Report (Q2 2025/26)**
	13.1. SD presented the Learning from Deaths Quarterly Report (Q2 2025/26) and noted that this was the first time that the report was being presented in an integrated format for MWL, rather than as separate reports for each legacy organisation. 13.2. SD noted that data from Q1 (2025/26) had also been included in the report to demonstrate activity levels and to highlight the ongoing challenges with capacity for completing Structured Judgement Reviews (SJRs). 13.3. Of those SJRs completed, all had been rated as green. 13.4. SD noted that he was reviewing the report and considering if information from the Medical Examiner, PSIRF investigations into patient deaths and HSMR should also be triangulated. 13.5. SD was assured by the amount of focus on reviewing mortality and outcomes across the Trust. **RESOLVED:** The Board **noted** the Learning from Deaths Quarterly Report (Q2 2025/26)

14.	**TB26/010 National Quality Board Nurse Establishment Review**
	14.1. SO presented the National Quality Board Nurse Establishment Review report to provide assurance that the Trust has the necessary arrangements in place to review the nursing and midwifery staffing establishments in line with regulatory requirements. SO commented that, due to the ongoing financial pressures across the NHS, all staffing levels had been under increased scrutiny and debate, as the workforce constituted the largest component of overall costs. However, the NHSE Chief Nurse had recently confirmed that the National Quality Board's 2016 staffing guidance remained in effect. 14.2. SO highlighted the following: 14.2.1. The Trust continued to use the Safer Nurse Care Tool (SNCT) developed by National Institute for Health and Care Excellence (NICE) and National Quality Board (NQB) recommendations to undertake the establishment reviews. 14.2.2. This review had taken place based in September and October 2025 staffing data. 14.3. The outcome of the review was a recommendation to Board that the current total establishment for registered nurses (RNs) and registered Health Care Assistants (HCAs) remain unchanged. However, the review had highlighted several areas which needed to be monitored and may result in recommendation for establishment changes at the next review in six months. 14.4. One of these areas was Theatres. The SNCT tool was designed for inpatient areas and could not be directly applied to Theatres and some other specialist areas. The review needed to take account of both the Nursing and Operating Department Practitioners (ODP) workforce requirements. 14.5. An establishment review of maternity staffing would also be commissioned as a separate exercise, as new national guidance/ specialist tools for assessing Maternity staffing were anticipated in the near future. 14.6. The nurse staffing model for non-invasive ventilation (NIV) beds across all the MWL hospitals sites was a third area where specific work was required, which would support a service business case. Currently, NIV beds had no substantive staffing establishment agreed and SO believed this was an area of risk. 14.7. The review had indicated that several of the wards at Southport Hospital may require additional HCA support. A recommendation was not being made at this time, because of the previous investment in additional HCA's to support supplementary care, and the full impact of this investment was still to be evaluated. Although the monthly safer staffing reports regularly showed HCA shifts were overfilled, SO wanted to be assured that the use of additional HCA hours was the most effective way to maintain patient safety. Recent research had indicated there was a greater correlation with the number of RNs and reductions in harm, mortality and morbidity.

	14.8. The other recommendation in the report was to revise the HCA band 2 and 3 ratios across the Trust. SO reminded the Board of the national grievance by staff side, which claimed that many band 2 HCAs had been undertaking duties that fell within the agenda for change band 3 role definitions. MWL had now completed a complex exercise of reviewing the roles of existing HCA staff and determining the future needs of the organisation for both band 2 and band 3s in each clinical area. These changes in the ratios between band 2 and 3 posts were reflected in this establishment review. If agreed, the next stage would be to start a consultation process with the HCA staff group to implement this change. 14.9. The financial impact of this change in the HCA banding ratios was circa £1.2m, which included the increased pay for existing HCAs who had already be re-banded following the reviews of their individual roles and duties, and was already impacting the monthly run rate. 14.10. SR commented that it was important for the HCA establishment to be based on the needs and requirements of MWL, which this report demonstrated. 14.11. GL noted that the additional costs for this change had been factored into 2026/27 budget setting, however it was a cost pressure for the Trust and the return on this investment in a more highly skilled workforce was expected to be improved performance, which in turn would contribute to achieving the overall financial plan. 14.12. SR asked if there was an agreed standard for nurse staffing levels. SO clarified that in the United Kingdom (UK) there were not mandated nurse to patient staffing ratios, as there were in many other countries. The current tool incorporated a recommended minimum standard but also considered factors such as patient harms, missed nursing care observations, and patient acuity. It was an evidence-based tool which had recently been revised to reflect the increasing population with dementia and higher risks, following observed rises in supplementary care needs within trusts. **RESOLVED:** The Board **approved** the Nurse Establishment Review including the recommended Band 2 and Band 3 ratios for each clinical area
15.	**TB26/011 NHSE Maternity Home Birth Review**
	15.1. SO presented the report, which provided assurance to the Board about the safety of the MWL home birth services. 15.2. SO explained that a Prevention of Future Deaths order had been issued by the Senior Coroner for Manchester North following the inquest into the deaths of Jennifer Cahill and her baby, Agnes. As a result NHSE had written to all

	trusts providing maternity services instructing them to review their home birth provision. In this tragic case the mother had opted for a homebirth against clinical guidance, the birth had been complicated and mother and baby had been transferred to hospital, where both had died despite medical intervention. There was another similar inquest taking place currently which involved Warrington and Halton Hospitals NHS Foundation Trust (WHH). Both cases had highlighted that there were no nationally recommended standards for home births. 15.3. MWL had completed the self-assessment review and submitted this to NHSE Northwest in line with the national deadline. The review had found no immediate causes for concern and had highlighted several areas of good practice. The Director of Midwifery was now working as part of a regional group that was developing home birth standards for the Northwest. Once these were agreed, a further gap analysis would be undertaken against these standards and an action plan developed for any areas of improvement. SO proposed that assurance be provided to the Board via the Quality Committee on both the gap analysis and the delivery of any subsequent actions. 15.4. SO commented that a national focus and standardised guidance on high risk pathways, particularly birthing outside of guidance, would be helpful for all maternity services. Currently the fortnightly oversight Board was monitoring any risks arising from the pathway changes the Trust had introduced at the Ormskirk Maternity Unit, and this included home births. 15.5. SO noted that equipment bags for home births had been standardised across MWL, which provided assurance that all midwives supporting home births were also properly supplied and familiar with the equipment they were using. 15.6. CS asked whether the Trust had a 'red line' in place if there was a disagreement between the mother's birthing preferences and the national guidelines, especially if her wishes did not align with clinical recommendations. SO responded that currently the mother's preference took precedence because of patient choice, which meant that clinicians were put in the position of having to operate outside guidance. However, Manchester University NHS Foundation Trust, had now moved to a position where if there was a significant disagreement about the safety of a home birth and the clinical team was not comfortable proceeding outside the guidelines, they could withdraw from care and advise the woman that the birth would be classified as a free birth. This represented a significant change in maternity care practice. At MWL the current process for high risk pathways (not just home births) was to hold a multidisciplinary team (MDT) meeting and provide comprehensive counselling to the woman, to present and discuss all relevant risks and options. 15.7. SR asked what a 'free birth' meant and SO responded that this was when a woman gave birth without any clinical support and was effectively removed from an NHS care pathway.

	15.8. AMS reflected on the media reports of the WHH case, which had suggested there had been two simultaneous home births, which had put a strain on resources, and asked if MWL had an escalation standard operating procedure if a similar incident were to occur and there were more home births than the Trust team could safely support. SO confirmed that MWL did have a written procedure in place. 15.9. NB asked if the current national review of maternity services taking place included home births. SO responded that this had not initially been included in the terms of reference but the remit may now be expanded. 15.10. GB commented that the current MIS did not include home births and felt this might change in future years. 15.11. GB asked what the legal position was if a patient was denied her choice of a home birth based on clinical risks. SO responded that when a patient chose to act against guidance, it was essential that this was well documented and that the associated risks were clearly communicated to the patient. The patient needed to be aware that, although the decision was theirs, the factors that placed them at an increased risk included the possibility of severe outcomes such as death for themselves or their child. It was the Trust's duty to ensure that when a patient made decisions against guidance the midwives and clinical staff were equipped to have these difficult conversations in a transparent manner, with comprehensive documentation being maintained throughout. **RESOLVED:** The Board **noted** the MWL review of its home birth service.
Concluding Business	
16.	**Effectiveness of Meeting**
	16.1. Board members agreed that meeting had been effective.
17.	**Any Other Business**
	17.1. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.55. The next Board meeting would be held on **Wednesday 25 January 2026 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	✓	✓	✓	✓		✓	✓	✓		✓		
Khalid Anis										✓		
Ash Bassi						A	✓					
Lynne Barnes	✓	✓	✓									
Gill Brown	✓	✓	✓	✓		A	✓	✓		✓		
Nicola Bunce	✓	✓	✓	✓		✓	✓	✓		✓		
Steve Connor	✓	✓	A	✓		✓	✓	✓		✓		
Rob Cooper	✓	✓	✓	✓		✓	✓	✓		✓		
Simon Downson								✓		✓		
Claudette Elliott	✓	✓	✓	✓		A	✓	✓				
Neil Fletcher	✓	✓	✓	✓		✓	✓	✓		✓		
Malcolm Gandy	✓	✓	✓	✓		✓	✓	✓		✓		
Elsie Hayford								✓		A		
Lisa Knight	✓	✓	✓	A		✓	✓	✓		✓		
Gareth Lawrence	✓	✓	✓	✓		✓	✓	✓		✓		
Lesley Neary	✓	✓	✓	✓		✓	✓	✓		✓		
Sarah O'Brien				A		✓	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	✓	A		✓		
✓ = In attendance A = Apologies												

Trust Board (Public)

Matters Arising Action Log (updated 20 February 2026)

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
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. Update 20/02/2026) The medical leadershup structure recruitment is underway and an update will be presented to SPC in April. Update (23/01/2026) The CMO is about to commence recruitment to the new integrated medical leadership structure, and as part of this work the Trust had considered whether aspects of the current medical leadership structure or role design may be perceived as more attractive to male colleagues. This has included reviewing role expectations, the recruitment approach and any potential barriers or unintended impacts to ensure that our leadership opportunities are equitable, inclusive, and accessible to all. A further update once the process has concluded and if any recommendations have been identified will be shared with the Strategic People Committee (SPC).	MS / SD	~~Jan-26~~ Apr-26		**Delegated to Strategic People Committee**

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion	Status
25	29/10/2025	**TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2)**	SO to provide an update on the high rate of community acquired pressure ulcers at a future Quality Committee. Update (20/02/2026) An update was presented at the Quality Committee in February. **Action closed.**	SO	Feb-26		**Closed**
26	26/11/2025	**TB25/087 Integrated Performance Report** 7.1 Quality Indicators	A review of learning from incidents investigations to be undertaken to ensure that learning was being embedded.	SO	Mar-26		
27	26/11/2025	**TB25/088 Committee Assurance Reports** 8.1 Executive Committee	The final draft Service Improvement Strategy to be developed for presentation to Board. Update (20/02/2026) The final draft of the Continuous Improvement Strategy is included on the Strategy Board Agenda for the meeting on 25 February. **Action closed**	KC	Feb-26		**Closed**
29	26/11/2025	**TB25/093 Research and Development Annual Report and Capability Statement**	SD to develop a new MWL Research Strategy.	SD	Jun-26		

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
24	29/10/2025	**TB25/078 Corporate Risk Register**	MG to review risks 5 and 23 to determine if could be combined into a single Corporate Risk Register (CRR) risk.	MG	Jan-26	**23/01/2026** - Following review, it is not considered appropriate at this stage to merge Corporate Risks 5 (MWL Risk ID 263) and 23 (MWL Risk ID 1125). While thematic overlap existed, the risks arose from distinct underlying causes, related to different service areas, and were are subject to separate control measures and impact profiles. Risk 1125 was due for further review at the end of March. Subject to the outcome of this review and the effectiveness of existing and planned mitigations, there was an expectation that the residual risk score may reduce. Both risks will be kept under review, and should the risks converge further in cause, control, or impact, the option to merge them would be reconsidered. **Action closed**	**Completed**
28	26/11/2025	**TB25/091 Annual Digital Strategy Update**	Executive Committee to undertake an assessment of issues around the implementation of Badgernet to determine the actions required to ensure implementation by March 2026.	RC	Jan-26	**23/01/2026 -** 6.2.2.Action Log number 28 (TB25/091 Annual Digital Strategy Update) – Following an assessment of the issues around the implementation of Badgernet and the proposed implementation timetable , a report will be presented at Executive Committee to determine the shortest safe go live date. **Action closed**	**Completed**

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	Aug-25	93.3	100	90.2	Best 30%
FFT - Inpatients % Recommended	Jan-26	92.9%	90.0%	94.0%	Worst 40%
Nurse Fill Rates	Dec-25	95.7%	90.0%	96.4%	
C.difficile	Dec-25	8	97	83	
E.coli	Dec-25	13	151	122	
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-25	0.11	0.00	0.09	
Falls ≥ moderate harm per 1000 bed days	Jan-26	0.13	0.00	0.11	
Stillbirths (intrapartum)	Jan-26	0	0	1	
Neonatal Deaths	Jan-26	0	0	5	
Never Events	Jan-26	1	0	3	
Complaints Responded In 60 Days	Jan-26	65.2%	80.0%	56.3%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-25	77.0%	77.0%	68.8%	Worst 10%
Cancer 62 Days	Dec-25	80.3%	85.0%	78.4%	Best 20%
Ambulance Arrival to Vehicle Handover: % <45 mins	Jan-26	61.6%	100.0%	82.4%	
A&E Standard (Mapped)	Jan-26	77.9%	78.0%	78.1%	Best 30%
Average NEL LoS (excl Well Babies)	Jan-26	3.9	4.0	4.0	Best 20%
% of Patients With No Criteria to Reside	Jan-26	21.7%	10.0%	21.1%	
Discharges Before Noon	Jan-26	19.0%	20.0%	19.0%	
G&A Bed Occupancy	Jan-26	97.4%	92.0%	97.8%	Worst 10%
Patients Whose Operation Was Cancelled	Jan-26	0.9%	0.8%	1.0%	
RTT % less than 18 weeks	Jan-26	61.7%	92.0%	61.7%	Best 40%
18 weeks: % 52+ RTT waits	Jan-26	2.0%	1.0%	2.0%	Worst 40%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-26	90.3%	85.0%	90.3%	
Mandatory Training	Jan-26	89.0%	85.0%	89.0%	
Sickness: All Staff Sickness Rate	Jan-26	7.5%	5.0%	6.8%	
Staffing: Turnover rate	Jan-26	2.0%	1.1%	0.9%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-26		54,255	31,777	
Cash Balances - Days to Cover Operating Expenses	Jan-26	0.8	10		
Reported Surplus/Deficit (000's)	Jan-26		-30,986	-38,281	

Board Summary - Quality

Quality

HSMR
A paper went to CEC in January with a proposal on how the Trust handles the impact of uncoded data on HSMR reporting. An agreement was made and the latest HSMR for the period Apr-25 to Aug-25 is 90.2. The latest SHMI for the period Sep-24 to Aug-25 is 0.99.

Clostridium difficile infection
There were 4 HOHA and 4 COHA CDT cases in December, with 83 healthcare-associated cases YTD, one cases above 24/25. MWL remains at 11 cases above NHSE threshold. The IPC Team continues to support wards and departments with improving diarrhoea management (timely testing and isolation) across the Trust.

Gram-negative bloodstream infections, E coli
There were 6 E coli HOHA and 7 COHA cases. YTD there has been 122 cases against a threshold of no more than 113 cases.

Pressure Ulcers
Pressure ulcers have been validated for November with 3 cat 2 and 1 cat 3 HAPU validated with lapses. Recruitment to the TV teams is currently underway with a review of the alignment of the North West Tissue Viability formulary with MWL, led by the TVN leads.

Falls
Trust wide there were 2 fall incidents graded as severe harm in November and 3 in December plus 1 incident reported as fatal in November. Further detail is provided in the Patient Safety Paper. Overall there is a 1.89% reduction in falls compared with previous year. 1 WTE falls practitioner commenced in January 2026.

Neonatal Deaths
There were no reported Neonatal Deaths for the month of January

Never Events
1 Never Event was declared within the Surgical Division. This was a wrong site nerve block and was assessed as a no harm event. This incident is currently under review with some immediate actions undertaken with surgery on site marking and planned observational insight visits across MWL theatres.

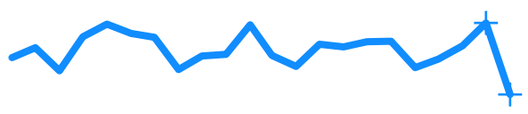
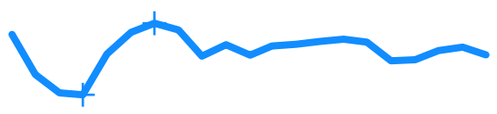
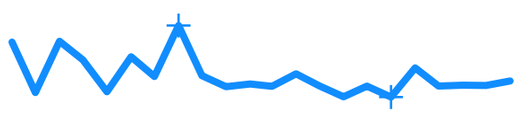
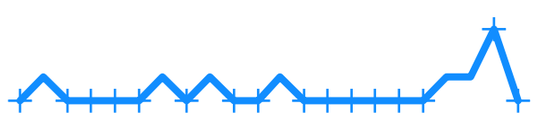
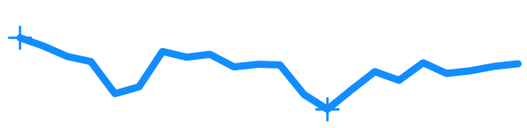
Complaints
January has shown a significant increase in the number of stage 1 complaints received. In January there were 58 received and in December there were 35. This illustrates a 66% increase on the previous month which is significant but not unexpected due to winter pressures and increased acuity.
46 complaints were closed in January, 65% within the agreed Trust 60 working day target.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Aug-25	93.3	100	90.2	Best 30%	
FFT - Inpatients % Recommended	Jan-26	92.9%	90.0%	94.0%	Worst 40%	
Nurse Fill Rates	Dec-25	95.7%	90.0%	96.4%		
C.difficile	Dec-25	8	97	83		
E.coli	Dec-25	13	151	122		
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-25	0.11	0.00	0.09		
Falls ≥ moderate harm per 1000 bed days	Jan-26	0.13	0.00	0.11		
Stillbirths (intrapartum)	Jan-26	0	0	1		
Neonatal Deaths	Jan-26	0	0	5		
Never Events	Jan-26	1	0	3		
Complaints Responded In 60 Days	Jan-26	65.2%	80.0%	56.3%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E
4-Hour performance increased in January, achieving 72.6% (all types). Trust performance is now just above National (72.5%) and also above C&M (71.5%). The Trusts mapped 4-Hour performance achieved 77.9%.

Patient Flow
Bed occupancy across MWL averaged 107.4% in January equating to 120.6 patients - an ongoing trend of high occupancy. There was a peak of 173 patients (70 at S&O, 103 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 2% higher than last January, driven by a 6% increase in 0 day LOS activity, 1+ day LOS activity was 1% lower than last year. Southport had a 42.9% increase in 0 LOS from January 25 to January 26, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 9.3 at S&O and 7.3 at StHK, with an overall average of 7.9 days, the impact of non CTR patients being 21.7% at Organisation level, 0.8% higher than December and 2.8% higher than January 25 (16.4% S&O and 20.3% StHK).

Elective Activity

The Trust had 1,455 52-week waiters at the end of January, (292 S&O and 1,163 StHK), 6 65-week waiters and zero 78-week waiters.
The 52-week position is a decrease of 40 from December and the 65-week waiters have increased by 4 from December to January. 18-Week performance in January for MWL was 61.7%, S&O 61.3% and StHK 61.9%. This was ahead of national performance (latest month December) of 60.6% and C&M regional performance of 58.7%.

Cancer
Cancer performance for MWL in December improved, at 77.0% for the 28 day standard (target 77%), with Southport achieving 72.0% and St Helens performance being 80.4%. Latest published data (December) shows national performance of 77.4% and C&M regional performance of 75.3%. Performance for 62-day also improved, achieving 80.3% (target 85%), with Southport achieving 75.7% and St Helens 82.8%. C&M performance was 74.6% and National 71.9%. Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2025/26.

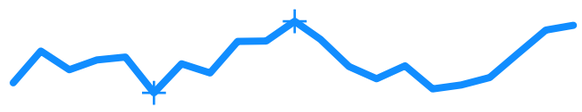
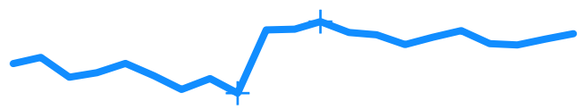
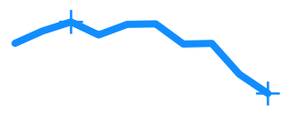
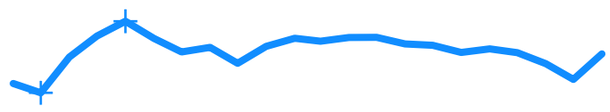
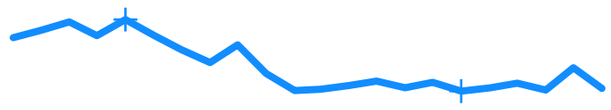
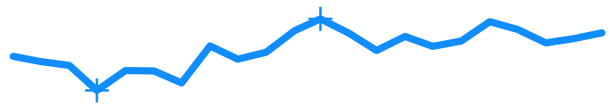
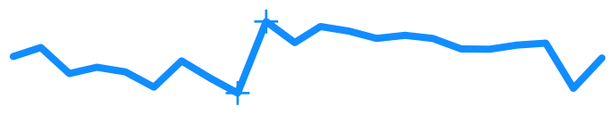
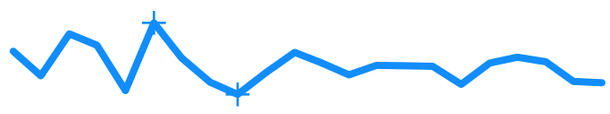
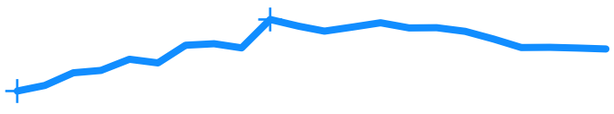
Diagnostics
Diagnostic performance in January dropped to 87.0% for MWL, failing to achieve the 95% target, with S&O achieving 80.7% and StHK 93.0%. MWL performance is ahead of national performance (latest month December) of 75.2% and C&M regional performance of 89.8%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Dec-25	77.0%	77.0%	68.8%	Worst 10%	
Cancer 62 Days	Dec-25	80.3%	85.0%	78.4%	Best 20%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Jan-26	61.6%	100.0%	82.4%		
A&E Standard (Mapped)	Jan-26	77.9%	78.0%	78.1%	Best 30%	
Average NEL LoS (excl Well Babies)	Jan-26	3.9	4.0	4.0	Best 20%	
% of Patients With No Criteria to Reside	Jan-26	21.7%	10.0%	21.1%		
Discharges Before Noon	Jan-26	19.0%	20.0%	19.0%		
G&A Bed Occupancy	Jan-26	97.4%	92.0%	97.8%	Worst 10%	
Patients Whose Operation Was Cancelled	Jan-26	0.9%	0.8%	1.0%		
RTT % less than 18 weeks	Jan-26	61.7%	92.0%	61.7%	Best 40%	
18 weeks: % 52+ RTT waits	Jan-26	2.0%	1.0%	2.0%	Worst 40%	

Board Summary - Workforce

Workforce

Mandatory Training
The Trust continues to exceed its mandatory training target, maintaining performance at 89% in January 2026 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 at 90.3% in January 26.

Sickness Absence
Sickness absence is at 7.5% remaining above the Trust target of 5%. This is a key priority area for the HR Team and for MWL.

Top 3 reasons for sickness absence:

Anxiety/stress/depression/other psychiatric illnesses
Cough/cold/flu
Other musculoskeletal problems

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. Despite the high levels of support, it is recognised that absence continues to be a key area of concern.

A deep dive into absence data has taken place, and a Taskforce Group started in early January 26 to further consider the data and where we may need to focus efforts in areas of high need - the Trust has identified 4 areas as high risk for initial focussed action. The group are considering what immediate, medium and long term actions can be taken forward to drive down absence in a sustained way, informed by the data. Strong leadership and an organisational approach to holistic wellbeing is required to ensure we Look After Our People in a way that helps them to stay in work. This group is led by the Assistant Director's of HR for Learning and Organisational Development & Health work and wellbeing and will report via People Performance Council for monitoring and Strategic People Committee by exception.

Turnover
In-month turnover for January 26 is 2% against a target of 1.1%.

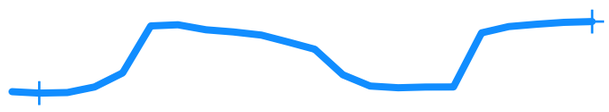
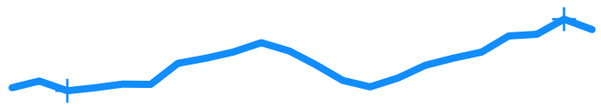
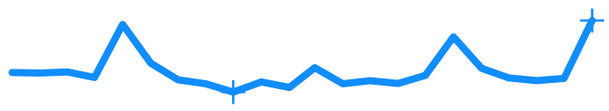
Time to Hire
Time to hire has been a particular challenge for us since the summer months, and a recovery plan has been in place in recruitment and HWWB to drive it down. The average time to hire in January 26 was at 58.7 days against a target of 40; however for context, since the recovery plan, time to hire has decreased from 100.2 in July 25. Additionally, for those offered in month was an average of 45.34 days which is slightly above target but significantly improved. Occupational Health clearance is down to 6.09 days from 53.5 days in August when the recovery plan launched, which has contributed to the overall position around Time to Hire. It is planned for full recovery back to our target position by April 26.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Jan-26	90.3%	85.0%	90.3%		
Mandatory Training	Jan-26	89.0%	85.0%	89.0%		
Sickness: All Staff Sickness Rate	Jan-26	7.5%	5.0%	6.8%		
Staffing: Turnover rate	Jan-26	2.0%	1.1%	0.9%		

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 10, the Trust is reporting an adjusted position of £38.3m deficit. Excluding deficit support funding, the adjusted position is £45.8m deficit, £10.3m 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 and additional industrial action funding of £3.9m.

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 10, the Trust has successfully transacted CIP of £41.6m year to date, £2.0m above plan. 100% of the £48.2m recurrent target is covered by fully developed schemes.

Cash - At the end of M10, the Trust's cash balance was £2.1m. 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 M10, only Q1 2025/26 has been received, the Trust continues to monitor cash closely and implement mitigations to the removal of deficit support funding. To date, the Trust has received PDC support of £10.9m (September), £11m (October) and £15.6m (November).

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 £31.8m, which is £22.3m below the original plan. However, if we exclude ePR and CDC schemes from this profile, the revised variance is c. £4.1m below plan. Since submitting its plan, the Trust has been awarded an additional c. £12.8m in national PDC funding. The Trust anticipates that its revised programme of c. £55.5m will be delivered in full by the end of the year.

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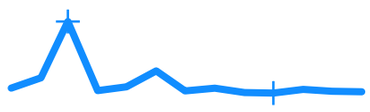
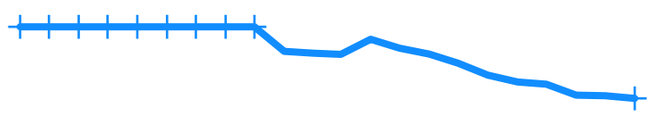
NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Jan-26		54,255	31,777		
Cash Balances - Days to Cover Operating Expenses	Jan-26	0.8	10			
Reported Surplus/Deficit (000's)	Jan-26	-30,9...	-38,2...			

How to Interpret - Summary Table

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

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

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

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

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

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

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

Metric Category Description - Quality

Quality Metrics

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

FFT – Inpatients % Recommended (high score is good)
The Percentage of Acute Inpatients that rate the service as Very Good or Good from the Friends and Family Test

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

Number of Healthcare Associated C.Difficile (low is good)
The number of Hospital Onset Hospital Acquired (HOHA) and Community Onset Hospital Acquired (COHA) Clostridium Difficile cases.

Number of Healthcare Associated E.Coli (low is good)
The number of Hospital Onset Hospital Acquired (HOHA) and Community Onset Hospital Acquired (COHA) Escherichia coli cases.

Hospital Acquired Pressure Ulcers per 1,000 bed days (low is good)
Validated Hospital Acquired pressure ulcers (Categories 2-4) with lapse in care rate per 1,000 bed days

Falls ≥ moderate harm per 1,000 bed days (low is good)
Number of falls in hospital (Inpatients only excluding Maternity) resulting in either moderate harm, severe harm or death, per 1,000 bed days

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

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

Complaints Resolved in 60 working Days (high is good)
The percentage of new (Stage 1) complaints resolved in month within 60 working days

Metric Category Description - Operations

Operational Metrics

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

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

Ambulance Arrival to Vehicle Handover: % <45 mins (high is good)
Number of ambulances waiting less than 45 minutes from arrival to vehicle handover as a percentage of ambulance arrivals with a ‘measurable’ vehicle handover time.

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

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

% of Patients with No Criteria to Reside (low is good)
Number of patients who do not meet the criteria to reside on the last day of the month as a percentage of adult G&A beds available on the last day of the month

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

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

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

RTT % less than 18 weeks (high is good)
The percentage of patients waiting less than 18 weeks for treatment to commence from referral.

18 weeks: % 52+ RTT waits (low is good)
The percentage of patients waiting 52 weeks or more for treatment to commence from referral.

Metric Category Description - Workforce

Workforce Metrics

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

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

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

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

Metric Category Description - Finance

Finance Metrics

Capital Spend £M
Capital Spend £M

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

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary

Legacy STHK

Mersey and West Lancashire Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.
The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.
The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-25	93.5	100	87.2	
FFT - Inpatients % Recommended	Jan-26	92.4%	94.0%	93.6%	
Nurse Fill Rates	Dec-25	95.0%	90.0%	96.3%	
C.difficile	Dec-25	4		54	
E.coli	Dec-25	10		79	
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-25	0.04	0.00	0.06	
Falls ≥ moderate harm per 1000 bed days	Jan-26	0.16	0.00	0.14	
Stillbirths (intrapartum)	Jan-26	0	0	0	
Neonatal Deaths	Jan-26	0	0	5	
Never Events	Jan-26	1	0	1	
Complaints Responded In 60 Days	Jan-26	69.7%	80.0%	55.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-25	80.4%	77.0%	76.8%	
Cancer 62 Days	Dec-25	82.8%	85.0%	84.4%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Jan-26	52.8%	100.0%	77.1%	
A&E Standard (Mapped)	Jan-26				
Average NEL LoS (excl Well Babies)	Jan-26	3.9	4.0	4.0	
% of Patients With No Criteria to Reside	Jan-26	19.7%	10.0%	19.6%	
Discharges Before Noon	Jan-26	21.0%	20.0%	19.9%	
G&A Bed Occupancy	Jan-26	98.1%	92.0%	98.2%	
Patients Whose Operation Was Cancelled	Jan-26	0.9%	0.8%	1.0%	
RTT % less than 18 weeks	Jan-26	61.9%	92.0%	61.9%	
18 weeks: % 52+ RTT waits	Jan-26	2.3%	1.0%	2.3%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-26	90.9%	85.0%	90.9%	
Mandatory Training	Jan-26	89.4%	85.0%	89.4%	
Sickness: All Staff Sickness Rate	Jan-26	7.3%	5.0%	6.8%	
Staffing: Turnover rate	Jan-26	2.6%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-26				
Cash Balances - Days to Cover Operating Expenses	Jan-26				
Reported Surplus/Deficit (000's)	Jan-26				

Board Summary

Legacy S&O

Mersey and West Lancashire Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.
The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.
The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-25	92.6	100	97.8	
FFT - Inpatients % Recommended	Jan-26	93.7%	90.0%	95.0%	
Nurse Fill Rates	Dec-25	96.8%	90.0%	96.6%	
C.difficile	Dec-25	4		29	
E.coli	Dec-25	3		43	
Hospital Acq Pressure Ulcers per 1000 bed days	Nov-25	0.24	0.00	0.14	
Falls ≥ moderate harm per 1000 bed days	Jan-26	0.08	0.00	0.07	
Stillbirths (intrapartum)	Jan-26	0	0	1	
Neonatal Deaths	Jan-26	0	0	0	
Never Events	Jan-26	0	0	2	
Complaints Responded In 60 Days	Jan-26	53.8%	80.0%	57.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-25	72.0%	77.0%	56.6%	
Cancer 62 Days	Dec-25	75.7%	85.0%	65.1%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Jan-26	76.0%	100.0%	91.8%	
A&E Standard (Mapped)	Jan-26				
Average NEL LoS (excl Well Babies)	Jan-26	3.8	4.0	4.0	
% of Patients With No Criteria to Reside	Jan-26	25.0%	10.0%	23.6%	
Discharges Before Noon	Jan-26	16.9%	20.0%	18.1%	
G&A Bed Occupancy	Jan-26	96.3%	92.0%	97.0%	
Patients Whose Operation Was Cancelled	Jan-26	0.8%	0.8%	1.1%	
RTT % less than 18 weeks	Jan-26	61.3%	92.0%	61.3%	
18 weeks: % 52+ RTT waits	Jan-26	1.4%	1.0%	1.4%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-26	88.8%	85.0%	88.8%	
Mandatory Training	Jan-26	88.2%	85.0%	88.2%	
Sickness: All Staff Sickness Rate	Jan-26	7.8%	5.0%	6.8%	
Staffing: Turnover rate	Jan-26	0.6%	1.1%	0.7%	

Finance	Period	Score	Target	YTD	Benchmark
Reported Surplus/Deficit (000's)	Jan-26				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 February 2026
Agenda Item	**TB26/015 (7.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in January 2026		
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 January 2026. No meeting was held on Thursday 01 January, due to the bank holiday. 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.		
08 January 2026		
Sterile Services Contract	• The Director of Corporate Services introduced the report which detailed the outcome of the negotiations for a three year commercial contract for the provision of sterile services to the Whiston and St Helens sites, following the end of the current contract in February 2026. • The paper detailed the procurement process followed and the changes in terms. • It was noted that although there continued to be discussions at Cheshire and Merseyside (C&M) level about a collaborative approach to sterile services this was not a short term option, and the Trust needed to enter a new medium term contract, whilst continuing to explore longer term options that could deliver MWL wide provision. • The Committee approved the service contract with the selected provider.	Approval
Electronic Patient Record (EPR) Governance Structure	• The Director of Informatics presented proposals for an Executive EPR Oversight Council to optimise the functionality of the existing EPR systems. • Committee made several suggestions to be incorporated in draft Terms of Reference) ToR), which would then be further considered by the Committee.	Assurance

Fleet Solutions Cyber Incident	• The Director of Informatics presented the report which updated the Committee on the recent incident involving Fleet Solutions. • An independent review had been undertaken by Price Waterhouse Cooper LLP (PwC). This had confirmed there were no issues with the MWL systems and processes. This was now subject to a police investigation. • The Committee agreed that additional assurances were required from Fleet Solutions that the personal data accessed by them was secure.	Assurance
Maternity data validation	• The Director of Informatics reported on the data quality, validation, and cleansing of maternity information as part of the preparations for the implementation of the Badgernet Maternity Information System (MIS). • The trial data loads from Careflow Maternity into the Badgernet maternity solution had been successful with 99.7% of records loaded successfully. • The number of issues had been minimal with most failures due to duplicate records or missing NHS numbers. • There were plans in place for the full transfer to Badgernet with experts on site to rectify any failed migrations. • The full report on the revised single MIS implementation programme was due to be presented to the Committee. • The Committee noted the report.	Assurance
Same Day Emergency Care (SDEC) timestamps.	• The Chief Operating Officer reported on the process for recording decisions to admit and confirmed that the Standard Operating Procedure and Trust guidelines were aligned to national guidance. • It was noted that Whiston Hospital operates differently from most other trusts, as it has an SDEC unit within and managed by the Emergency Department. As a result, a review had been initiated with the Chief Medical Officer to review the medical model and develop proposals for a standardised approach across MWL.	Assurance
Safe Staffing Report – November 2025	• The Chief Nursing Officer presented the Nurse safe staffing report for November. • Total Registered Nurse (RN) staffing was 96.64% and total Health Care Assistant (HCA) staffing was 111.18% (inclusive of supplementary care).	Assurance

	• RN and HCA sickness rates continued to be a concern and impacted fill rates on some wards. • Any ward that had fallen below a 90% fill rate had been reviewed for red flag quality incidents, but there had been no correlation with reported incidents.	
Temporary Workforce Utilisation Report	• The Chief People Officer presented this new monthly report, which tracked temporary workforce trends. • Year to date there had been an 11% reduction in bank usage, and this was now better than plan for all staff groups except Nurses and HCAs. • Year to date there had been a 67% reduction in agency staff usage, which was better than plan for all staff groups except Medical and Dental, with the highest use areas being the Emergency Department, General Medicine and General Surgery. • Committee agreed that bank and agency use needed to be tracked against bed numbers (including escalation beds), as this had a direct impact on the demand for RNs and HCAs.	Assurance
Outpatient Transformation Project	• The Chief Operating Officer introduced the update report. • The clinic cleanse workstream was now almost completed, which would provide a clear view of Outpatient capacity. • The review of digital patient communications was also progressing to standardise the messages across MWL and investigate how to prevent repeated late appointment cancellations by patients, which resulted in clinic capacity being underutilised. • Work to review current clinic templates had commenced and room booking systems were being investigated.	Assurance
Newton Incident	• Committee discussed the incident that had occurred at Newton Hospital, where staff had been attacked by a member of the public entering the building. • It was agreed that a security review of all premises would be undertaken, of both wholly owned/occupied premises and those with shared occupancy where MWL was a tenant. • The hot debrief from the incident and the actions being taken with Community Health Partnerships to repair the damage at Newton Hospital were	Assurance

	reported to be progressing and services were expected to resume normal operations from 12 January. • Support for staff based at Newton and other community sites continued.	
15 January 2026		
National Review of Home Birth Services	• The Chief Nursing Officer introduced the Trust's review of home birth services. • This followed a recent prevention of future deaths order issued by the coroner in Greater Manchester after the inquest of a mother and child who had both died during a home birth. This had led to NHS England (NHSE) asking all providers to review their home birth services. In the Northwest the Home Birth Scoping Tool had been developed to ensure consistency of the risk assessments across the region. • The review provided assurance that the MWL home birth teams met the safety standards. • The report was to be presented to the Trust Board in accordance with the NHSE directive. • It was noted that in the Northwest a Task and Finish Group had been established to develop a Home Birth Charter.	Assurance
Maternity Incentive Scheme (MIS) Year 7	• The Chief Nursing Officer introduced the report which summarised the Trusts compliance against the 10 MIS safety actions for year 7 of the Scheme. • As previously reported to the committee Safety Action 1 (SA1) could not be reported as compliant because of the 13 cases that required investigation, a single data field on one of the cases had not been entered within the required timescale. The actual investigation had commenced within the specified time, but the recording of this on the national system showed a gap, and therefore technically this case could not be counted as compliant. Discussions were on-going with the Local Maternity and Neonatal System (LMNS) and Clinical Negligence Scheme for Trusts (CNST) teams, regarding this data field entry, and the Committee discussed the option to appeal, on the basis that this omission had no impact on patient care or safety. • The Committee reviewed the evidence against the other nine safety actions and supported the assessment of compliance.	Assurance

	• Committee endorsed the report to be taken forward to the Quality Committee and then Trust Board, as required by the LMNS, to allow the Integrated Care Board (ICB) endorsement of the Trust declaration.	
Month 9 Financial Position	• The Chief Finance Officer presented the Month 9 (M9) financial position and outturn projection. • The M9 position was an £11m deficit which was in line with plan, however deficit support funding for quarter 4 (which was assumed in the Board approved plan) had again been withheld by NHSE Northwest, which meant the true deficit was £41m. • The year to date position included the financial impact of the Resident Doctors Industrial Action impact of £3.1m. • Committee discussed the actions being taken to impact the run rate and the on-going discussions with the ICB and PwC. • Committee noted that if all Cost Improvement Programme (CIP) was delivered the Trust would achieve 7.5% of cost improvements in 2025/26, significantly above plan, and compensating for the failure of the system wide schemes, that had not yet delivered.	Assurance
Actions to Prevent Sexual Misconduct	• The Chief People Officer presented the MWL action plan, following the letter from NHSE outlining further actions trusts needed to take to help prevent sexual misconduct in the workplace. • One of the actions was for senior Human Resources professionals to undertake sexual misconduct training. NHSE were still developing the training modules, but once these were live, relevant staff would undertake this training. • The Trust Chaperoning Policy had already been reviewed and updated, following the publication of the sexual safety charter, noting that this was compliant with the national guidance, and was being rolled out to the lead employer. • Assurance on delivery of the full sexual safety charter action plan would continue to be reported via the Strategic People Committee.	Assurance
Nurse Staffing Establishment Review	• The Chief Nursing Officer presented the six monthly nurse staffing establishment review. • The paper recommended the revised establishment of band 2 and 3 care assistant	Assurance

	posts, following the reviews undertaken of HCA roles as part of the national band 2 -3 dispute. • Committee recognised that this was a necessary first step in enabling the organisational change process to move forward. • There were no other immediate recommendations from the review, although a few areas were being kept under scrutiny and it was anticipated recommendations could be forthcoming following the next review. • Committee acknowledged the need for the band 2 and 3 establishment review and noted this would need to be picked up as part of budget setting for 2026/27. • Committee endorsed the paper for presentation to the Trust Board.	
Patient Safety Incident - Ophthalmology	• The Chief Nursing Officer introduced a report from the Surgical Division, which detailed the review process of all patients on the waiting list, following an incident where follow-up had been missed which had resulted in patient harm. • All patients were being reviewed and any that could have been impacted would be subject to a formal harm review. • Committee discussed the different processes for tracking patients at the legacy trusts, the complexity of patients on multiple pathways and the need for standardisation (as far as the legacy systems would allow). • It was agreed that the Committee would continue to receive fortnightly reports from the Division until the review process was completed.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services presented the quarterly review of the BAF, with proposed changes that would be recommended to the Trust Board. • Committee reviewed and agreed the recommended changes.	Assurance
22 January 2026		
Clinical Coding Capacity Business Case	• The Chief Finance Officer introduced the case, which set out a proposal for outsourcing of clinical coding to reduce the backlog. • The case set out the historic challenges in recruiting and retaining coding staff, and the actions that had been taken by the Trust to address this, including introducing automation	Approval

	and other innovations to support the team to be as productive as possible. • However, there had continued to be a reliance on agency staff to maintain sufficient coding capacity, whilst MWL team members were trained and developed. • The coding capacity had now reached a steady state, to keep on top of the current workload, but not to reduce the historic backlog. • Therefore, a one off outsourcing option was proposed, which would eliminate the backlog by 31 March 2026, at a cost of £135k. • This would result in the target of a three day turnaround for coding, which would support the Trust's income position. • The business case was approved.	
General Medical Council (GMC) National Training Survey (NTS)	• The Chief Medical Officer introduced the update on the GMC NTS action plan for Emergency (ED) and Acute Medicine. • It was agreed to undertake some benchmarking with other trusts that have similar levels of activity via their ED and acute medical admissions units, to identify best practice in supporting trainees. • Committee also noted that post take ward rounds had now been formalised, and the impact of this change should be reflected in the next survey. • The actions completed included monthly forums with the trainees to provide regular feedback and pick up any emerging concerns and strengthened educational supervision; however, it was recognised that these were busy and pressurised services to work in, particularly at times of escalation. • Committee had requested that the Division undertake a review of the service model and considered that moving away from the historic service model at Whiston Hospital, for the care of patients following a decision to admit, could provide a more supportive environment for the trainees.	Assurance
Standards of Care for Acutely Unwell Patients in their first 72 Hours of Care	• The Chief Medical Officer presented the self-assessment against these best practice standards that had been issued by NHSE. • Self-Assessments of Whiston and Southport had been undertaken and were to be submitted to NHSE Northwest.	Assurance

	• There was concern that the self-assessment criteria were open to interpretation, with no clear definitions of each criterion against the different ranking options. It was therefore agreed that some benchmarking would be undertaken with local trusts to ensure consistency of interpretation within C&M, before the submission deadline. • To meet all the best practice guidance 24/7 at both sites would require additional investment. • It was agreed that the Chief Medical Officer and Urgent and Emergency Care leadership team would review the draft submission considering the local benchmarking. Once the baseline position had been established an action plan would be developed and monitored via the Divisional Performance Review meetings. • For assurance, progress against the action plan would be reported via the Clinical Effectiveness Council, twice a year.	
Mutually Agreed Resignation Scheme (MARS)	• The Chief People Officer reported that the proposed Trust MARS had been approved by NHSE. • It was proposed that the application process would run from 02 February to 31 March 2026, and most staff approved would likely leave the Trust by June 2026. • Committee discussed the eligibility criteria, the selection and approval processes and the communications plan. • Committee approved the introduction of the MARS.	Approval
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the RMC assurance report for the meeting held 13 January. • At the end of December there had been 1,067 risks on the Trust risk register, with 42 new risks added in month and 25 closed. • 25 risks were escalated to the Corporate Risk Register (CRR). The InPhase system had now been modified so that anyone raising a high or extreme risk, had to identify the Director to whom this needed to be escalated for approval, within the system. • The RMC had received an assurance report from the Claims Governance Group. • There were no issues of concern escalated to the Executive Committee.	Assurance

29 January 2026		
Single Temporary Staffing Model Implementation and Communications Plan	• The Chief People Officer introduced the report which outlined the timetable and communications plan for the introduction of the single temporary staffing model across MWL. • The proposal was to commence the new model on 05 May 2026. • Changes in process for temporary staffing requests would be communicated to all managers over the next three months. • The Committee approved the implementation timetable and communications plan.	Approval
Conflict Resolution Training	• The Director of Corporate Services and Chief People Officer presented a proposal for the reinstatement of conflict resolution training across the Trust. • Previously temporary funding for the training had expired, and this now needed to be formalised. • One off funding for 12 months (£42k) to engage an external provider was approved, whilst options to develop in-house expertise were explored as a more resilient longer term option. • It was agreed that the Training Needs Analysis (TNA) also be reviewed by the Mandatory Training Oversight Group, to ensure that all staff that could benefit from the different levels of conflict resolution training were included.	Approval
Electronic Patient Record (EPR) Governance Draft Terms of Reference (ToR)	• The Director of Informatics presented the draft ToR for the EPR governance with a Council and supporting groups. • The Committee members made several comments to be incorporated into a revised draft, that would clarify accountability and reduce duplication, whilst supporting clinical and operational involvement.	Assurance
Maternity Services Patient Experience Quarterly Report	• The Chief Nursing Officer introduced the report, which detailed the 2025 survey results (women who had given birth in February 2025). • The survey response rate had been 36% (national response rate 38%) and 47% of respondents were first time mothers. • The results for MWL had improved with the majority being better than expected. • There remained three areas, which had improved, but remained below the national average score. • These were; sufficient time to ask questions during antenatal check-ups, partners being able	Assurance

	to stay as much as they wanted and contacting the triage telephone line. • The issue of partners being able to stay overnight related to the Whiston unit and was due to a lack of recliner chairs for partners. Committee discussed the purchase of additional chairs to resolve this issue. • Audits had been undertaken of telephone triage and there was assurance that the correct clinical advice had been given, however a standard opening and closing script had been introduced to improve the quality of the communications. • The new actions from the 2025 survey results had been added to the outstanding actions from the 2024 survey and delivery would continue to be tracked via the quarterly reports. • It was noted that the 2026 survey would rely on the feedback from women giving birth in February 2026, so may not reflect some of the changes being implemented following the publication of the 2025 survey results.	
Trust Board Agenda – February	• The Director of Corporate Services presented the draft Trust Board agenda for February, from the annual workplan and outstanding actions. The Trust Board in February was a public Board, followed by a Strategy Board session. • It was also noted that an extraordinary Trust Board meeting had been arranged for 11 February to approve the 2026/27 Operational and Financial Plan submission, as the national timetable was not compatible with the planned board cycle. • The Committee selected the Employee of the Month for February, from the nominations received during January.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during January 2026 were:</u> • One off funding for outsourcing to clear the Clinical Coding backlog • Funding for Conflict Resolution Training for 12 months		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 February 2026
Agenda Item	**TB26/015 (7.2)**		
Committee being reported	Audit Committee		
Date of Meeting	18 February 2026		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
External Audit Plan	GT provided an overview of their approach to the external audit process for 2025/26.	Assurance
Informing the 2025/26 Audit Risk Assessment – Management Responses	The Assistant Director of Finance – Financial Services summarised the purpose and content of the report, detailing management responses to GT's audit risk assessment for 2025/26.	Assurance
Internal Audit Report	MIAA summarised the internal audit progress reports key messages section. MIAA confirmed three reports had been issued and six reports were at various stages of progress.	Assurance
MWL Audit Log	Committee received the audit log report which highlighted key movements on the audit log, both in relation to internal and external audit recommendations.	Assurance
Anti-Fraud Progress Report	MIAA presented the Anti-Fraud Progress report from September to October, which summarised the anti-fraud and investigations activity for the period.	Assurance
Use of the Trust Common Seal	The Director of Corporate Services summarised the purpose and content of the report, highlighting that the Trust seal had been used on 12 occasions for the period 01 April 2025 to 04 February 2026.	Assurance
Financial Reports	The Losses and Special Payments report was presented. Total losses identified as at 31 January was approximately £245k. £372k in total was recorded in 2024/25.	Assurance

	The aged debt report was presented. Specific attention was paid towards the age and value of aged debt in the >90 day category, and what actions would be needed to help reduce these values down going forward. The tenders and quotation waivers report was presented and its contents noted.	
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 February 2026
Agenda Item	**TB26/015 (7.3)**		
Committee being reported	Quality Committee		
Date of Meeting	17 February 2026		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes and Action Log	• The minutes of the Quality Committee meeting held in January were approved following some minor amendments. • Actions due for update in February were all reviewed and updated as part of the agenda.	Assurance
Monitoring of Annual Trust Objectives aligned to the Quality Committee - Including the Quality Account Improvement Priorities Q3 2025/26	• Improvements and areas of challenge noted - nutrition, discharge and information for patients, sepsis and timely effective assessment and care of patients in the Emergency Department (ED). • Improvements in Maternity Care noted in National survey. • Trust approach / methodology / ownership / improvement discussed, including Never Events and long- standing issues – escalated to Executive Committee to action.	Assurance
Quality Committee Corporate Performance Report (CPR).	• Additional narrative noted. • Learning / actions / themes from Never Event discussed. Report to follow to be presented to QC. • No new Mortality data: variation noted, no concerns to note.	Assurance
Patient Safety Report (Inc. Chair's Assurance Report)	• No PSIIs reported November and three reported in December. • No Maternity and Newborn Safety Investigation (MNSIs) reported in November. Two MNSIs reported in December. • Harm profile – no significant changes in levels of moderate or severe harms. • One category 3 hospital acquired pressure ulcer reported November with lapses in care with key learning and interventions completed.	Assurance

	• Inpatient falls: three severe harm and above inpatient falls reported in November and three in December. • Medication reporting – no significant concerns. • Agreed future reporting narrative on Trust community acquired and Inpatient Pressure Ulcers. • Patient Safety Council assurance reports noted.	
Falls Deep Dive/Thematic Review	• Committee received presentation. • Falls reduction and harm reduction trajectory is positive – falls with harm reduced by 36%. • Falls per 1,000 bed days - 6.1 year to date (YTD) lower than national average of 6.63. • Falls with harm profile 0.11 comparable to region 0.12. • Falls with fragility fractures for MWL 2.% compared with national average of 2.6%. • External review of Falls for MWL identified positive work currently undertaken at MWL and areas for continued focus include continuous review of falls data, focus on inpatient harms reduction from avoidable falls and use of Falls Risk Assessment Tool (FRAT) in ED. An audit of the FRAT process requested for future assurance. • Work ongoing to provide further understanding / assurance and improvements required against falls against assessed levels of supervision.	Assurance
Quarterly Safeguarding Report	• Q3 84.2% for level 3 training noting increase in staff requiring the training. • Biggest increase in Deprivation of Liberty (DOLs) referrals for Q3 • Oliver McGowan e-learning training code of practice from Sept 2025 requires all staff to complete additional training to e-learning - options appraisal to Executive Committee noting collaborative regional review. • Briefing to follow to provide an update on the Trust Board responsibilities in relation to Safeguarding Adults and Children. • Noted West Lancashire Children and Adolescent Mental Health Services (CAMHS) service longer response time to referrals with gaps in CAMHS provision flagged for escalation through the Trust Mental Health Group.	Assurance

Infection Prevention and Control (IPC) Quarterly Report MIAA IPC Quality Spot Checks Report	• Q3 report presented. • Trust above MWL threshold for all Healthcare Associated Infections (HCAIs) and below rates of infection regionally • Two Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteraemia reported YTD, no cases reported in Q3. • Bloodstream Infection Improvement Plan remains in place. • Q3 outbreaks totals 27 for MWL related to respiratory Infections and Norovirus. • Monthly Peripherally Inserted Vascular Cannula (PIVC) spot-check audits reports slightly below 90% target at 84.7%. • Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) – 10% internal reduction YTD 60 cases (reduction of 11 cases on previous year). • Aseptic Non Touch Technique (ANTT) level 1 met Trust target 85% level 2 just below at 83.6%. • Covid-19 cases reducing across MWL site. • Flu cases increasing across MWL - reflective of region position. • Clostridioides difficile (CDIFF) 25 cases in Q3 YTD and below Cheshire and Mersey rate. • Bristol Tool Chart improvement plan – areas for improvement noted. • NHS England (NHSE) Antimicrobial prescribing - presentation to Board Q1 2026/27. • Positive refurbishment of the Southport & Ormskirk estate noted. • MIAA IPC Audit report discussed and actions noted - overall assurance of Moderate noted. • Standard Operating Procedures (SOPs) and Policies – MWL harmonisation project noted and assurance tracked through Executive Committee.	Assurance
Maternity and Neonatal Services Quarterly Report	• Q3 report received. • Four Neonatal deaths - reviews noted. • No Never Events • Two serious incidents (one neonatal death, one therapeutic cooling). • 20 Neonatal medication incidents in Q3 (50% admin errors with no harm). Key themes and learning identified.	Assurance

	• Saving Babies Lives: Improved compliance to 97% in Q3. • Antenatal and Newborn Screening Quality Assurance – 38 total recommendations, 13 actioned and closed with remaining actions progressing well. • Workforce reviews noted and to be presented to Trust Board. Birthrate+ reviews to commence by Q42025/26. • National Maternity Patient Experience survey - improvements noted. • Timeline for Badgernet implementation confirmed as November 2026.	
Patient Experience Report	• Bi-Monthly report received for November 2025 to January 2026. • Trust wide Tendable audits in December demonstrate sustained high-quality care, with minor declines in some areas. Patient satisfaction - consistently very high across almost all domains with most scores above 95%. • Patient Experience Tendable audit questions reviewed and aligned to the results of the National patient surveys. • Friends and Family Test (FFT) October to December 2025 positive satisfaction rates except for Accident and Emergency Department. • Procurement of new FFT provider under review. • Committee noted the actions against the NHS medium term planning and Experience of Care Improvement Framework. • Updates received for National Surveys. • Assurance on Patient Engagement Portal and survey outcomes provided.	Assurance
Mandatory Training compliance	• Trust achieved and sustained 85% and above compliance in core mandatory training for over 24 months and in compulsory skills training for over 12 months. • Focused support to areas / staff groups below trajectory. • Mandatory Training Project to be finalised in Q4 with report to Executive Committee • Committee requested additional focus on Nasogastric Tube and Resuscitation training – Executive Team requested to action.	Assurance

	• MWL Mandatory Learning Oversight Group now operational – four areas of priority identified, with a further 12 subjects to review. • NHSE - implementing new national competency framework in 2026.	
Any Other Business	• Effectiveness of current MWL Audits and surveys - considered focused review. • New National Quality Board.	Assurance
Alerts:		
• None		
Decisions and Recommendation(s):		
The Trust Board is asked to note the report.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 February 2026
Agenda Item	**TB26/015 (7.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	18 February 2026		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Q3 Workforce Plan Update	As at M9 the MWL workforce plan versus actual (Provider Workforce Return (PWR) data) is reporting overall 108.89 Whole Time Equivalent (WTE) positively below plan. The majority of this (97.97 WTE) relates to a positive improvement against plan for reduced agency usage. Bank workforce has remained under plan in M8 and M9 and Agency workforce has continually remained below plan consistently throughout 2025/26. Overall, there has been reductions in bank, agency, and overtime combined with targeted growth in clinical roles demonstrate effective workforce planning and a focus on recruiting to patient facing roles. A summary of the planning guidance for the 2026/27–2028/29 workforce plan was presented alongside the MWL workforce operational plan. The plan is based on the worked WTE position for 2025/26 and incorporates the required reductions in bank and agency usage to meet NHS England (NHSE)-mandated spend caps, as well as planned Cost Improvement Programme (CIP) savings. Each division/directorate have produced draft integrated plans covering: • Activity trajectories – Referral to Treatment (RTT), cancer, diagnostics, urgent care, backlog recovery. • Workforce – consultant job plans, resident doctor rotas, safe nursing rosters, Allied Health Professionals (AHP) cover. • Quality and Safety – Quality Impact Assessments (QIA) for major changes. • Finance – budgets, CIPs, cost pressures, productivity analysis. • Estates and Digital – theatre capacity, ward space, Electronic Patient Records (EPR) requirements.	Assurance

Corporate Performance Report (CPR)	Mandatory Training – the Trust continues to exceed its mandatory training target, achieving 89% compliance in January, above the 85% threshold. Appraisals - Appraisal compliance in January is at 90.3% against the 85% target. Sickness Absence - all staff sickness has decreased in January to 7.5% from December to 7.8%. The Absence Taskforce have produced a detailed action plan and targeted improvement approach which will focus on four areas where sickness absence is consistently high. The action plan will be shared with the Executive Committee for approval during February 2026 with an update being shared with the Committee in March 2026. Vacancy Rate - the Trust's overall vacancy rate remains favourable at 6.8%, below the 8% target. The reported 15.9% Healthcare Assistant (HCA) vacancy rate remains provisional while Corporate Nursing complete a detailed review of the Band 2 and Band 3 establishments. The review so far does indicate a potential over-establishment in Band 2 HCAs in some areas, meaning the overall headline vacancy figure may not accurately reflect the overall true vacancy position. Once the establishment review is finalised, the Trust will have a validated vacancy baseline and will move to a coordinated, large-scale recruitment plan, with the anticipated emphasis on Band 3 roles. Time to Hire (T2H) - the average time to hire in January 2026 was at 58.7 days against a target of 40. For context, since the recovery plan, time to hire has decreased from 100.2 in July 2025. Additionally, for those offered in month the time to hire is on average 45.34 days which is slightly above target but significantly improved. Occupational Health clearance is down to 6.09 days from 53.5 days in August when the recovery plan launched, which has contributed to the overall position around Time to Hire. It is anticipated that full recovery back to our target position will be achieved by April 2026. Turnover - turnover remains stable and below target: In-month turnover: 2% (target: 1.1%) however this is linked to the movement of HR Commercial Services work moving from Electronic Staff Records (ESR) 409 to ESR 096. Without this change the turnover is 0.61%. The 12-month rolling turnover: 12% (target: 13.2%) Health, Work & Wellbeing (HWWB) - Pre-Placement Questionnaires the total number received to cleared Key Performance Indicators (KPI) average days: 2 days. The Do Not Attended (DNA) rate for appointments has improved in month	Assurance

	(11.2%) and year to date (YTD) is within tolerated thresholds (10%).	
Mutually Agreed Resignation Scheme (MARS) Update	A report was presented to the Committee on the design, governance, implementation arrangements and controls for the launch of the MWL Mutually Agreed Resignation Scheme (MARS), confirming alignment with national requirements and the organisation's eligibility criteria. NHS England approved the scheme on 12 January 2026. Applications opened on 02 February and will close on 16 March 2026. MWL has applied an additional local criterion that staff requiring a live clinical professional registration are out of scope, to protect patient-facing capacity and safeguard safe services. Each application will be approved only where there is a clear, evidenced cost–benefit case. The total cost of the MARS payment, including on-costs and liabilities, must be demonstrably offset by recurrent savings from the removal or redesign of the post. All releases must deliver permanent, cash-releasing savings aligned to the Trust's financial and workforce plans, without compromising service delivery, quality or statutory obligations. The Committee received assurance that robust governance is in place to support a compliant implementation of the MARS scheme.	Assurance
Monitoring of Q3 Trust Objectives aligned to the Strategic People Committee	An update on progress made in Q3 2025/26 against the workforce Trust objective: 'developing organisational culture and supporting our workforce.' Progress and achievement to date was noted.	Assurance
Team MWL – Q3 Values/Culture Update	The Committee received an update on the development of the MWL Behaviours Framework. Improved behavioural standards were identified as a High Impact Action at the April 2025 STAR conference, recognising their importance to achieving MWL's vision for five-star patient care. A senior working group was convened in May 2025 to lead this work. The group has developed a draft Behaviours Framework, which was shared for feedback at the December 2025 STAR conference. The framework sets clear expectations for behaviours aligned to the new MWL Values. Feedback was highly positive, and approval was given to proceed with a supporting toolkit. This work is nearing completion, with the full framework and launch plan scheduled for presentation at the April 2026 STAR conference. The	Assurance

	Committee was assured that the programme is progressing to plan, and on track for implementation.	
Assurance Reports from Subgroup(s)	The assurance reports for the People Performance Council and the Valuing our People Council were noted.	Assurance
Items for Escalation to Trust Board	None	Assurance
Any Other Business	None	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	25 February 2026
Agenda Item	**TB26/015 (7.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	19 February 2026		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Chief Finance Officer (CFO) Update	• Confirmation that Agenda for Change staff will receive a 3.3% uplift from April. This is higher than within the tariff uplifts, so adjustments will need to be made in the contract to fund. • NHS forecasting is break even as at M9. • Cheshire and Merseyside (C&M) system forecasting non delivery of plan for this financial year, with final figures still to be resolved. • It was noted that the Integrated Care Board (ICB) continue to try and reclaim funds paid in 2024/25. If their claim is successful, this will deteriorate the Trust's financial position. The Trust is currently challenging their approach in line with contractual procedures.	Assurance
Committee Performance Report Month 10 2025/26	• Accident and Emergency (A&E) performance was 72.6% in January, above the national at 72.5%, and ahead of C&M at 71.5%. • Long waits in emergency department (ED) are a challenge – 20.3% waited over 12 hours in January. This was an increase from the previous month. • Handover 45 – a decline in performance to 61.6% of patients arriving by ambulance being handed over within 45 minutes. • No Criteria to Reside (NC2R) patients was at 21.7% • 18 Week performance in January was 61.7%. • The Trust had 1,455 52-week waiters at the end of January; six 65-week waiters. • Diagnostic 6-week performance for January was 87% which remained ahead of both national performance at 75.2% but below C&M	Assurance

	performance at 89.8%. The target remains at 95%. • Cancer performance in December improved again to 77% for the 28-day standard (target 77%). Continued improvement for the 62-day standard at 80.3% (target 85%). • Bed occupancy averaged 97.4%	
Finance report Month 10	• The approved MWL financial plan for 2025/26 is a deficit of £10.7m. This is a £41m deficit excluding the deficit support funding. • The plan includes £35m of system led strategic opportunities/cost reductions to be realised or reallocated by C&M during 2025/26. • The Trust is reporting a M10 deficit of £45.8m (excluding deficit support funding). • Income assumes all variable activity and the Southport Community Diagnostic Centre (CDC) being funded by Commissioners. Contracts are not yet finalised, and negotiations continue. • The Trust's combined 2025/26 Cost Improvement Programme (CIP) target is £48.2m. In M10, the Trust has delivered £41.6m. • At M10 agency costs equate to £11.3m (2.1% of total pay costs). • The Trust had a closing cash balance of £2.1m. • Aged debt has increased (debt greater than 90 days at £18.3m in January. • The revised capital plan for the year totals £55.5m 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.	Assurance
M10 Forecast	• Current plan less deficit support stands at £40.9m deficit • Current run rate would give a £57.1m deficit, therefore improvement required of £16.1m. • Current forecast is break even • 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. • Conversations with commissioners ongoing regarding non-payment for activity undertaken.	Assurance

	• CDC contractual issue has now been agreed. • Continue to improve the position as we work to ensure the organisation meets the financial plan. • There remains an ongoing risk around payments made in 2024/25 that would affect the Trust's forecast in year if resolution is unsuccessful.	
Cash Update	• Key risks to cash remain deficit funding being withdrawn and delivery of Income and Expense (I&E) forecast • Two Provider Revenue Support cash applications have so far been approved at £10.9m and £11m • The application for further £8m cash support in November has been declined. • Low risk cash mitigations are being implemented such as ensuring supplier payments are not early and ensuring debt is paid to ensure we can meet financial obligations for the remainder of the financial year. • MWL have been exploring options with the regional NHS England (NSHE) team. • Trust Lead Employer arrangements are not factored in to the current cash regime. This is being picked up with NHSE.	Assurance
Month 10 2025/26 CIP Programme Update Medicine & Urgent Care (M&UC) Division	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, which equates to 5% for all departments. • At M10, 229 schemes have been delivered with a further 140 schemes at finalisation stage. Current delivered/low risk schemes have a value of £69m. • M&UC reported their progress on CIP delivery. The Division are forecasting full delivery of their CIP target for 2025/26.	Assurance
Urgent and Emergency Care (UEC) Update	• The Committee reviewed the ongoing improvements and risks within the UEC. • Improvements in triage time, ED Length of Stay (LoS), ambulance handover and +1 LoS were all noted, compared to performance last year. • The Committee noted that further improvements were required in terms of 12 hours performance, corridor care and Same Day Emergency Care (SDEC), given the ambitions had not been achieved.	Assurance

Planning 2026-27 – 2030-31	• The Committee reviewed the full planning pack that included the updates from the Extraordinary Board.	Assurance
Assurance Reports from Subgroups:	• CIP Council Update • Capital Planning Council • Estates & Facilities Management Council Update • IM&T Council update • Procurement Council update	Assurance

Alerts

Contractual Challenges

- The Committee noted the ongoing risk previously discussed at Board around the contractual challenges that has the potential to effect the in year forecast outturn (FCO).

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Decisions and Recommendation(s):

The Board is asked to note the report