Mersey and West Lancashire Teaching Hospitals NHS Trust

# Trust Board Meeting (Public)

**To be held at 09.30 on Wednesday 24 June 2026**
**Boardroom, Level 5, Whiston Hospital / MS Teams Meeting**

| Time | Reference No | Agenda Item | Paper | Presenter |
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| **Preliminary Business** | | | | |
| 09.30 | 1. | **Chair's Welcome and Note of Apologies**<br><br>*Purpose: To record apologies for absence and confirm the meeting is quorate* | Verbal | Chair<br>*(5 mins)* |
| 09.35 | 2. | **Employee of the Month (June 2026)**<br><br>*Purpose: To **note** the Employee of the Month presentations for June 2026* | Film | Chair<br>*(10 mins)* |
| 09.45 | 3. | **Declaration of Interests**<br><br>*Purpose: To record any Declarations of Interest relating to items on the agenda* | Verbal | Chair<br>*(10 mins)* |
| | 4. | **TB26/042 Minutes of the previous meeting**<br><br>*Purpose: To **approve** the minutes of the meeting held on 27 May 2026* | Report | |
| | 5. | **TB26/043 Matters Arising and Action Logs**<br><br>*Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions* | Report | |
| **Performance Reports** | | | | |
| 09.55 | 6. | **TB26/044 Integrated Performance Report**<br>6.1. Quality Indicators<br>6.2. Operational Indicators<br>6.3. Workforce Indicators<br>6.4. Financial Indicators<br><br>*Purpose: To **note** the Integrated Performance Report* | Report | S O'Brien<br>L Neary<br>M Szpakowska<br>G Lawrence<br>*(30 mins)* |
| **Committee Assurance Reports** | | | | |

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| 10.25 | 7. | **TB26/045 Committee Assurance Reports**<br>7.1. Executive Committee<br>7.2. Audit Committee (*including approval of annual accounts)*<br>7.3. Quality Committee<br><br>7.4. Strategic People Committee<br>7.5. Finance and Performance Committee<br><br>*Purpose: To **note** the Committee Assurance Reports* | Report | R Cooper<br>S Connor<br><br>G Brown obo<br>M Singh<br>L Knight<br>C Spencer<br>*(35 mins)* |
| **Other Board Reports** | | | | |
| 11.00 | 8. | **TB26/046 Fit and Proper Person Chair's Annual Declaration**<br><br>*Purpose: To **note** the Fit and Proper Person Chair's Annual Declaration* | Report | Chair<br>(*10 mins)* |
| 11.10 | 9. | **TB26/047 2025/26 Safeguarding Annual Report (Adults and Children)**<br><br>*Purpose: To **note** the 2025/26 Safeguarding Annual Report (Adults and Children)* | Report | S O'Brien<br>*(20 mins)* |
| 11.30 | 10. | **TB26/048 Freedom to Speak Up Annual Report 2025/26**<br><br>*Purpose: To **note** the Freedom to Speak Up Annual Report for 2025/26* | Report | S O'Brien<br>*(15 mins)* |
| **Concluding Business** | | | | |
| 11.45 | 11. | **Effectiveness of Meeting** | Verbal | Chair<br>*(5 mins)* |
| 11.50 | 12. | **Any Other Business**<br><br>*Purpose: To **note** any urgent business not included on the agenda* | Verbal | Chair<br>*(5 mins)* |
| | | **Date and time of next meeting:**<br>Wednesday 29 July 2026 at 09:30 | | **11.55 close** |
| 15 minutes lunch break | | | | |

**Chair:** Steve Rumbelow

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

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| **Title of Meeting** | **Trust Board** | | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/000** | | | |
| **Report Title** | Employee of the Month (June 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 June 2026.

**Executive Summary**

The Employee of the Month winner for June is Lisa Shaw, Complaints Co-ordinator in the Surgery Division. She was nominated by Lauren Rodriguez-Vitone, Quality, Risk and Governance Matron, and Ryan Kenyon, Complaints Assistant.

Lisa plays a vital role in supporting patients, at what can often be a very difficult time. She works closely with individuals currently receiving treatment, as well as those experiencing ongoing concerns following surgery, ensuring their voices are heard, issues are handled with sensitivity and the right support and resolutions are in place.

She recently supported a patient through one of the most challenging times in their life, providing compassion, clear communication and reassurance at every stage. After the complaint concluded, the individual shared how much Lisa's support had meant, praising the way she kept them informed, answered questions and maintained open dialogue throughout.

They were especially grateful that Lisa arranged for the opportunity to meet with staff involved in the investigation, allowing them to discuss the findings in more detail - a clear reflection of her commitment to being open, making sure patients and families feel heard and included. Her approach helped make a complex and sensitive situation more manageable and ensured the patient felt truly supported throughout.

Her care extends just as strongly to her colleagues. Following a family bereavement, Lisa regularly checked in with a colleague on their return to work, offering kindness and support that made a real difference. Her thoughtful and genuine approach helps create a caring environment, reflecting the same warmth she always shows to patients.

In her nomination, Lisa is described as empathetic, proactive and highly organised, as well as a truly valued member of the team. She is always willing to share her knowledge and support colleagues through the complaints writing process, helping ensure responses are clear and patient focused. Her positivity, professionalism and strong work ethic make her an excellent role model within the department.

Lisa, it is clear to see that you make a meaningful difference to colleagues, patients and their families every single day. You're an outstanding member of Team MWL who always demonstrates the Trust values through your actions and attitude. Please accept your certificate and wear your badge with pride, congratulations!

| Financial Implications | |
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| 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 27 May 2026**
*(Approved at Trust Board on Wednesday 24 June 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 |
| Steve Connor | SC | Non-Executive Director |
| Simon Dowson | SD | Chief Medical Officer |
| Neil Fletcher | NF | Associate Non-Executive Director |
| Neil French | NFr | Non-Executive Director |
| Lisa Knight | LK | Non-Executive Director |
| Gareth Lawrence | GL | Chief Finance Officer |
| Mini Singh | MSi | Non-Executive Director |
| Sarah O'Brien | SO | Chief Nursing Officer |
| Carole Spencer | CS | Non-Executive Director |
| Malise Szpakowska | MS | Chief People Officer |

**In Attendance**

| Name | Initials | Title |
|---|---|---|
| Yvonne Mahambrey | YM | Quality Matron, Patient Experience (Agenda Item 2 via MS Teams) |
| Nadine McStein | NM | Head of Nursing Quality – Urgent and Emergency Care (Agenda Item 2 via MS Teams) |
| Simon Regan | SRe | Designate Director of Corporate Services (Observer via MS Teams) |
| Tom Vellender | TV | Director of Growth and Partnerships, The Guardian Services Ltd (Observer) |
| Richard Weeks | RW | Corporate Governance Manager |

**Apologies**

| Name | Initials | Title |
|---|---|---|
| Elsie Hayford | EH | Shadow Non-Executive Director (via MS Teams) |
| Malcolm Gandy | MG | Director of Informatics |
| Lesley Neary | LN | Chief Operating Officer |
| Juanita Wallace | JW | Executive Assistant (Minute Taker) |

| Agenda Item | Description |
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| **Preliminary Business** | |
| **1.** | **Employee of the Month** |
| | 1.1. The Employee of the Month for May 2026 was Margaret Duffy, Ward Manager, Ward 14b, Southport Hospital<br><br>1.2. SR read out the citation for MD and RC presented the Employee of the Month certificate and pin badge.<br><br>1.3. MSi commented that it was heartening to hear of such longstanding dedication and commitment amongst staff. SR reflected on the number of staff that had chosen to return to the Trust after leaving, noting that this was a positive reflection of the organisation. GB commented that some members of staff had worked at a single hospital for more than 40 years, which was a remarkable achievement and greatly valued.<br><br>**RESOLVED:**<br>The Board **noted** Employee of the Month for May 2026 and congratulated the winner. |
| **2.** | **Patient Story** |
| | *(YM and NM joined the meeting)*<br><br>2.1. SR welcomed YM and NM to the meeting.<br><br>2.2. YM introduced the Patient Story video, which outlined Rachel's complex clinical journey during late pregnancy. Rachel had initially presented at Ormskirk Hospital and was subsequently transferred to Southport Hospital, where she was diagnosed with a sub-arachnoid haemorrhage. She was then transferred to the Walton Centre for specialist treatment, with close coordination between maternity, emergency and specialist teams to ensure the safety of both Rachel and her unborn baby. Following delivery by emergency caesarean section at the Walton Centre, Rachel required further urgent treatment, including a subsequent readmission and brain surgery. Rachel and her family expressed their gratitude for the collaborative, specialist and compassionate care received throughout her treatment.<br><br>2.3. YM commented that, whilst collaboration between wards and departments within the same organisation was often discussed, this case had demonstrated genuine regional collaboration. Both Rachel and her husband had received seamless care on both occasions that she had been admitted, and this was a testament to the staff within the NHS.<br><br>2.4. NM commented on the strong, close-knit culture within Southport Emergency Department (ED), noting that staff had demonstrated a clear sense of ownership for Rachel's care, and the follow-up telephone call had been |

consistent with established practice within the department. Additionally, staff frequently reflected on patients' progress following treatment, and Rachel's case had remained in the thoughts of many team members. NM observed that staff had been deeply concerned for Rachel and that this had reflected the compassion, commitment and professionalism of the team. The care, thought and attention shown to Rachel, as with all patients, was recognised, and NM commented that this case was a positive and moving example of the team's values in practice.

2.5. SR, on behalf of the Board, thanked Rachel for sharing her story.

2.6. SR commented that the transfer pathway had demonstrated the importance of partnership working, even within a modern NHS setting, in ensuring clear pathways and a seamless transition into specialist services. The commitment demonstrated by the team was an example of outstanding 5 Star Patient Care and even though Rachel had been transferred to specialist services, staff had continued to monitor her progress and wellbeing.

2.7. RC commented that, whilst this case represented a very positive outcome for Rachel, it was also important to consider what learning could be drawn from it, particularly in relation to care pathways. Additionally, RC asked whether any actions had been taken with the Walton Centre to address any potential gaps in the pathway and whether there were any areas that required further improvement. NM responded that the Trust kept care pathways under continual review as services evolved nationally and regionally and, where opportunities for improvement had been identified, proactive discussions had been undertaken with partner organisations. NM advised that the relationship with the Walton Centre was well established and effective and supported by strong clinical links. Additionally, NM agreed to discuss the matter with the wider team, including relevant system partners such as mental health services, to ensure that pathways remained appropriate and responsive to ongoing service development.

2.8. SR suggested that the Patient Story was shared with the Walton Centre and YM agreed to do this.

2.9. GB commented that the Patient Story had demonstrated exceptional collaboration across four hospital services including maternity, the Walton Centre and Liverpool Women's Hospital and noted that the transfer of an obstetric team to support the delivery was an exceptional example of partnership working. GB suggested that the video was also shared with Liverpool Women's Hospital as well as the Trust's Obstetric team at Ormskirk Hospital. GB commented that this was one of the most impactful Patient Stories presented to the Board.

2.10. MSi reflected on the positive comments regarding the close-knit culture within the Southport ED which appeared to be central to the Team's effectiveness and asked if these behaviours and ways of working could be replicated

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| | across larger teams within the Trust. MSi reflected on the challenges associated with maintaining a strong community of practice as organisations grew and experienced increasing operational pressures and, whilst the commitment of staff members remained strong, sustaining this cohesiveness would be more difficult in larger group settings.<br><br>2.11. SR thanked YM and NM for their presentation and commented that Patient Story had demonstrated a positive outcome, alongside significant learning and a number of positive reflections.<br><br>**RESOLVED:**<br>The Board **noted** the Patient Story<br><br>*(YM and NM left the meeting)* |
| **3.** | **Chair's Welcome and Note of Apologies** |
| | 3.1. SR welcomed all to the meeting and in particular welcomed SRe who was observing the meeting, ahead of taking up post as the new Director of Corporate Services in June.<br><br>3.2. SR reported that Councillor Marie Wright (MW), who had represented Halton Council at Board meetings, had not been re-elected in the recent local elections and would therefore no longer be attending Board meetings in that capacity. SR thanked MW for her contributions during her tenure and noted that Halton Council would appoint a successor in due course.<br><br>3.3. SR acknowledged the following awards and recognition for Trust staff and services:<br>3.3.1. Emma Travis, Joanne Chisnall and Tammy Smith, from the Community Nursing Team had recently completed their Registered Nurse Degree Apprenticeships.<br>3.3.2. The Research, Development and Innovation Team was at the forefront of tackling inequalities in children's diabetes care, through an important UK study called UNBIASED, led by Consultant Paediatric Endocrinologist, Professor May Ng, OBE.<br>3.3.3. The maternity units at Whiston and Ormskirk hospitals had met all ten standards in Year 7 of the national Maternity (Perinatal) Incentive Scheme. The scheme supported improvements in the safety and quality of maternity care across the NHS, with a strong focus on learning, assurance and continuous improvement for women, babies and families.<br>3.3.4. The MWL Employment Services Automation Team won the Health Service Journal (HSJ) Digital Awards: Improving Back Office Efficiencies through Digital award for their MWL Systemwide Benefits from Automation project<br><br>Apologies for absence were **noted** as detailed above |

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| **4.** | **Declaration of Interests** |
| | 4.1. There were no new declarations of interests made in relation to the meeting agenda items. |
| 5. | **TB26/032 Minutes of the previous meeting** |
| | 5.1. The meeting reviewed the minutes of the meeting held on 29 April 2026 and approved them as a correct and accurate record of proceedings subject to the following amendments:<br>5.1.1. The Meeting Attendance 2026/27 table to be updated to include NFr.<br>5.1.2. 7.3.2 to be amended to read '*the balance was £1.483m at 30 January 2026*'.<br><br>**RESOLVED:**<br>The Board **approved** the minutes from the meeting held on 29 April 2026 subject to the amendments detailed above |
| **6.** | **TB26/0033 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.<br><br>6.2. The following action was closed:<br>6.2.1. Action Log number 1 (TB26/028 Committee Assurance Reports / 7.4 Quality Committee) – SO circulated the dates for the monthly ED walkabouts at Whiston and Southport Hospitals to the NEDs and invited them to attend. **Action closed**<br><br>6.3. There were no other outstanding actions.<br><br>**RESOLVED:**<br>The Board **approved** the action log |
| **Performance Reports** | |
| **7.** | **TB26/034 Integrated Performance Report** |
| | The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for April 2026 was presented. |
| 7.1. | **Quality Indicators** |
| | 7.1.1. SO, and SD presented the Quality Indicators. SO highlighted the following:<br>• The Infection Prevention and Control (IPC) data was a month behind in relation to the reporting period, and this reflected the timing of the published report.<br>• Complaints responses within 60 days performance was 78% (target 80%) for the second consecutive month. The divisions continued to work to improve the timeliness of complaint responses.<br>• There had been no Never Events reported in month. |

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| | • Two neonatal deaths involving premature babies had been reported and the necessary reviews and reporting had been undertaken. |
| 7.2. | **Operational Indicators** |
| | 7.2.1. GL, on behalf of LN, presented the operational indicators and highlighted the following:<br><br><u>Urgent and Emergency Activity</u><br>7.2.2. The Trust's mapped 4-hour urgent and emergency care performance for April was 77.9%, against the new national target of 82%. It was noted that the mapped position had been affected by changes in the allocation of activity with a neighbouring Trust. This had reduced MWL's reported performance by approximately 1%, although the Trust remained focused on improving delivery against the national standard. Performance against the 4-hour standard will continue to be monitored through the Finance and Performance Committee, with a focus on the actions required to support sustained improvement and delivery of the national target.<br><br><u>Elective Care</u><br>7.2.3. The 18-week Referral to Treatment (RTT) performance was 66.8% which was a 2.8% improvement against plan.<br>7.2.4. 52-week waits were 1.4% against a target of 1% which was an increase in month. The increase was partly due to the introduction of additional services, including the transfer of the maxillofacial plastic service. Further increases in the waiting lists were anticipated as previously closed services reopened to referrals in May.<br><br><u>Cancer Services</u><br>7.2.5. Performance continued to improve in March, and the Trust delivered against all three headline cancer standards:<br>• Performance against the 31-day decision to treatment standard had improved to 96.7% (target 96%).<br>• Performance against the 62-day urgent GP referral to treatment standard was 86.3% (target 85%) and this was a sustained improvement, from 78% in November 2025.<br>• Performance against the 28-day faster diagnosis standard was 80.4% (target 77%).<br><br><u>Diagnostics</u><br>7.2.6. Performance in April was 82.5% (target 95%) compared to 86.6% in March. This compared to 90.2% for Cheshire and Merseyside (C&M) and 78.8% nationally. There were four underperforming specialities: Non-Obstetric Ultrasound (NOUS) and MRI at Southport Hospital and Endoscopy and Echocardiography at Whiston Hospital and these would be performance managed through the Divisional Performance Review (DPR) meetings. |

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| | 7.2.7. SR reflected on the transfer of services to MWL and noted that the impact on waiting lists, staff numbers and finance would need to be considered in future reporting.<br><br>7.2.8. GB reflected on the improved performance against the three cancer targets and asked if there were any specific actions that had contributed to this improvement. GL responded that there had been no single action that had driven the improvement, however, there had been a process of continuous improvement with a focus on maintaining performance, although some pathway elements remained challenging.<br><br>7.2.9. GB asked whether the 'sprint' towards the end of the financial year had impacted on achieving the targets. GL responded that performance had not been driven by a concentrated year-end sprint, but rather by sustained effort over the course of the year. Whilst other organisations had reported achieving of targets through a significant final-month push, MWL's progress had been more variable, with peaks and troughs throughout the year.<br><br>7.2.10. AMS reflected on cancer performance and commented that whilst there had been variation between sites on the creation of MWL, performance had become more closely aligned representing a positive outcome for the populations of Sefton and West Lancashire.<br><br>7.2.11. RC agreed with AMS' comments and added that there had been two tumour sites, namely skin cancer and lower gastrointestinal (GI), that had presented significant challenges. Following targeted work, including collaboration and support from the Cancer Alliance, there had been circa 25-30% improvement in performance within these two specialities. The improvement work had been recognised as exemplars and highlighted at recent regional improvement roadshows. RC highlighted that skin cancer was a high-volume area of activity and that the improvement in performance from 50% earlier in the year to over 90% in March 2026 had made a significant contribution to the overall improvement in cancer metrics. Additionally, further benefits had been realised through the use of skin analytics, artificial intelligence (AI)-supported dermatology, and the continued development of clinical pathways.<br><br>7.2.12. NFr reflected on the benchmarking data which indicated that performance against the 62-day cancer standard was within the best 20%, whereas performance against the faster diagnosis standard was within the worst 20%, and commented that this appeared counterintuitive given the expectation that strong diagnostic performance would support delivery of the 62-day pathway. GL responded that, while it appeared counterintuitive, historically the Trust's strong 62-day standard performance had been driven by better performance in the latter stages of the pathway. This differed from the position at the Southport and Ormskirk sites before integration as there was strong diagnostic performance but less favourable 62-day performance, demonstrating that while earlier diagnosis should support its |

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| | achievement, effort was required to improve the entire pathway to achieve the 62-day standard.<br><br>7.2.13. MSi commented that skin cancer pathways, particularly in trusts providing dermatology and plastic surgery services, continued to present a common challenge, and that it would be of interest to observe performance as service configurations evolved. MSi noted the Trust's performance statistics did not include the conversion rate from referral to diagnosis, despite this being regarded as a key measure. RC assured that the Trust collected and monitored the data relating to conversion rates, however, as this was not one of the nationally reported metrics, it was not reported as a headline measure. RC advised that the conversion rate had been monitored to assess the rates of diagnosis following the post COVID increase in referrals and reported that although referral volumes had increased substantially the number of cancer diagnoses had remained largely unchanged. MSi commented that gastric and skin cancers continued to present particular diagnostic challenges, and that it had been recognised nationally for ten years these tumour groups were among the most difficult for primary care to detect. MSi highlighted the need to work with primary care to strengthen these pathways in light of the diversifying primary care workforce. RC commented that this linked to the wider outpatient transformation agenda, including the use of primary care tier 2 services as well as secondary care specialist services. |
| 7.3. | **Workforce Indicators** |
| | 7.3.1. MS presented the Workforce Indicators and highlighted the following:<br>• The compliance rate for appraisals was 89.6% (target 85%). MS advised that performance was expected to decline initially following the opening of the 2026/27 appraisal window. The appraisal form, which has been updated to include the new Behavioural Framework standards, has been uploaded to the intranet. Additionally, the Trust has launched Appraisal Ambassadors who will be providing support and guidance to enrich the appraisal experience for staff members.<br>• The compliance rate for mandatory training was 89.6% (target 85%).<br>• Sickness absence has reduced to 6.5% in April compared to 6.6% in March (target 5%). It was noted that sickness absence had reduced from 7.8% in December 2025, however, this was slightly higher than the position for the corresponding period in the preceding year. MS noted that, whilst the various interventions implemented might have contributed to this reduction, seasonal variation was also a factor. This remained an area of focus and a report on the work undertaken by the Absence Support Task Force, including the lessons learnt, would be presented at a future Executive Committee.<br>• The three main reasons for sickness absence remained anxiety, stress and depression, coughs, colds and flu, and gastrointestinal illness.<br>• In-month staff turnover was 0.7% (target 1.1%). |

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| | • The average Time to Hire metric was 52 days in April (target 40 days) and MS noted that this metric has now been included in the IPR. |
| 7.4. | **Financial Indicators** |
| | 7.4.1. GL presented the financial performance indicators and reminded the Board that a deficit plan of £16.7m had been submitted for 2026/27, however this excluded deficit support funding. The plan had met the control total issued by NHS England (NHSE) and this would allow the Trust to access deficit funding to achieve a breakeven plan. The plan had assumed the delivery of a recurrent internal Cost Improvement Programme (CIP) of £49.7m (circa 5%).<br><br>7.4.2. At month 1, the Trust was reporting an adjusted position of £2.7m deficit and, if deficit support funding was excluded, the adjusted position was a £4.1m deficit, which was in line with the plan.<br><br>7.4.3. GL highlighted the following:<br>• Agency spend was 1.3% of total pay spend against a target of 1.2% and GL noted that this was a NHSE target.<br>• The Trust had successfully delivered £3.3m of CIP year to date (YTD) against a full year plan of £49.7m.<br>• Capital expenditure YTD was £0.9m which was £1.7m below plan. The Capital plan for 2026/27 was £42.2m.<br><br>**RESOLVED:**<br>The Board **noted** the Integrated Performance Report. |
| **Committee Assurance Reports** | |
| **8.** | **TB26/035 Committee Assurance Reports** |
| 8.1. | **Executive Committee** |
| | 8.1.1. RC presented the Executive Committee Assurance report for the meetings held in April 2026.<br>8.1.2. Bank or agency staff requests that breached the NHSE cost thresholds were reviewed at each meeting, and the Chief Executive's authorisation recorded. Reports from the weekly vacancy control panel were also presented at every meeting.<br><br>8.1.3. The Committee had received the regular monthly reports for:<br>• Nurse Safer Staffing<br>• Freedom of Information<br>• Vacancy Control Panel<br>• Temporary Workforce<br>• Financial Improvement Group<br>• Lost to Follow Up update |

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| | 8.1.4. RC highlighted the following items from the report:<br>• The Committee had received the Outpatient Digital Transformation update which linked to the strategic work currently underway, and a Senior Information Risk Owner (SIRO) had been identified to progress this.<br>• The Committee had reviewed the Pharmacy Tender (Southport and Ormskirk sites) and following a discussion it was recommended to award the tender to Rowlands Pharmacy on a three-year contract.<br>• The Committee had received the update on the progress, risks and plans relating to the transfer of the Knowsley Urgent Community Response (UCR) and West Lancs Community Services to MWL.<br>• The Committee had received the Friends and Family Test (FFT) options following notice of the withdrawal of this service by the current software provider.<br>• The Committee had received the Health Inequalities Strategy Review Paper.<br><br>8.1.5. The Committee had approved the following investments during April 2026:<br>• The retention of the existing Electronic Patients Record (EPR) Programme team capacity for three months, pending the confirmation of national funding, to maintain critical capability and clinical leadership.<br>• Clinical Coding backlog – the recruitment of six Whole Time Equivalent (WTE) Band 2 posts and the extension of 4.4 WTE fixed term roles.<br><br>The remainder of the report was **noted.** |
| 8.2. | **Quality Committee** |
| | 8.2.1. MSi presented the Quality Committee Assurance Report for the meeting held on 19 May 2026, noting the key quality performance indicators had already been discussed earlier in the meeting.<br><br>8.2.2. MSi highlighted the following points from the report:<br><u>Quality Committee Performance Report</u><br>8.2.3. The National Early Warning Score (NEWS) observations in the Emergency Department (ED) remained an area of focus.<br>8.2.4. Southport and Ormskirk Hospital sites had reported low numbers for sepsis, and the small sample size had been noted. Improvement work was ongoing.<br>8.2.5. A review of the stroke indicators against the therapy domains would be undertaken and feedback provided at a future meeting.<br><br><u>Patient Safety Council Assurance Report</u><br>8.2.6. The Trust had compared favourably with other trusts in the North West in relation to the number of notifiable infections overall.<br>8.2.7. There had been a slight increase in the number of falls in March, however, the number of falls with harm had been low and additional training would be provided. |

Patient Experience Council Assurance Report

8.2.8. There had been a slight increase in the number of second stage complaints received, however, the complaints responses within 60 days performance was within the Trust standard (80%).

8.2.9. A Patient Story which demonstrated reasonable adjustments and multidisciplinary (MDT) working in support of a young patient living with learning difficulties and autism who required urgent investigations at Ormskirk Hospital had been noted.

8.2.10. A Surgical Admissions Lounge had been opened on the Southport site, and this had improved patient flow by creating a dedicated space for elective admissions as well as improving patient experience.

Clinical Effectiveness Councill Assurance Report

8.2.11. The Acute Kidney Injury (AKI) replacement for Advancing Quality (AQ) date was still under discussion, and an update would be provided at a future Quality Committee.

Patient Safety Report

8.2.12. There had been a reduction in the number of pressure ulcers reported and two validated Hospital Acquired Pressure Ulcers (HAPU) with lapses in care had been reported in February 2026.

Quarterly Safeguarding Report (Q3)

8.2.13. The Committee reviewed the report and noted that only Level 3 Adult Safeguarding mandatory training remained non-compliant.

8.2.14. The challenges in relation to the collection and submission of Deprivation of Liberty Safeguards (DoLS) data, particularly in respect of the information required by local authorities and the completion of associated documentation, were noted. Several submissions had been returned, and work was ongoing to clarify local authority requirements to improve alignment and reduce the administrative burden. The importance of building constructive relationships with local authorities was acknowledged, particularly in providing assurance and seeking to minimise avoidable variations in requests.

8.2.15. The Learning Disability and Autism practitioner had been appointed.

8.2.16. It was noted that no child deaths had been reported in the quarter.

8.2.17. There had been 20 cases of domestic abuse reported by staff members and there were consistent themes emerging.

Infection Prevention and Control Quarterly Report (Q4)

8.2.18. The Committee had reviewed the report, and it was noted that, with the exception of Klebsiella, the Trust was above all thresholds for Healthcare Associated Infections (HAI), however, the rates remained lower than comparable trusts in Cheshire & Merseyside (C&M).

8.2.19. Four cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia had been reported YTD.

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| | Maternity and Neonatal Services Quarterly Report (Q4)<br>8.2.20. The Trust had received formal confirmation of compliance against all ten Safety Actions for the Maternity Incentive Scheme (MIS) Year 7.<br><br>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 20 May 2026 and noted that some of the points noted had already been discussed in earlier reports to the Board and would not be repeated.<br><br>8.3.2. LK highlighted the following:<br>• The Committee had received an update on the Mutually Agreed Resignation Scheme (MARS), and it was noted that of the 183 applications received, 36 had been approved. The primary reasons for declining the 147 applications was the requirement to replace posts on a like for like basis or the material impact on front-line patient care.<br>• The Committee had approved the proposed HR Commercial Services Objectives for 2026/27; however, further information was requested to ensure that the measurements were objective, measurable and tangible.<br>• The Committee had received an update on the launch and embedding of the MWL Behavioural Standards Framework and LK noted that this had been launched at the STAR Conference in April 2026.<br><br>8.3.3. LK alerted to the meeting that the Time to Hire had exceeded the recovery plan target and had increased from 51 to 52 days.<br><br>8.3.4. MS reflected on the HR Commercial Services Objectives 2026/27 and commented that given the current context in which the Trust was operating, some of the requests being made of the provider might change over time. Additionally, there had been feedback about the objectives being more specific and the potential amendments to Year 1 leads would be considered once there was greater clarity on this. It was noted that MS had sent her apologies for the Committee meeting.<br><br>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 21 May 2026. The Committee had reviewed the Finance and Performance CPR and monthly finance report, and CS noted that items discussed in other Board agenda items would not be repeated.<br><br>8.4.2. CS reported that the Trust had made a strong start to the new year, and that the year-end financial and performance position had been confirmed, |

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| | subject to audit. Additionally, the Trust had reported a good M1 in relation for finance and CIP delivery.<br><br>8.4.3. Other points to highlight from the report were:<br>• At M1 agency costs equated to £0.7m (1.3% of total pay spend) and this was an improvement from £12.5m, (1.8% of total pay spend) in M12 and CS highlighted that agency spend underpinned the 2026/27 plan and the grip and control on spend as well as WTE would be important. It was noted that there was strengthening triangulation between finance, the plan and WTE metrics, with greater detail and specificity now coming through.<br>• CS reflected on diagnostic performance and advised that the Committee had acknowledged the department's disappointment with the recent position. C&M had previously been the highest-performing system nationally, and the Trust had performed strongly across the system for some time. However, the increasing demand and a more constrained capacity position had adversely affected performance. Work was underway to support recovery and strengthen forward planning in relation to capacity and demand, recognising the limited timeframe between referral and delivery, and an update would be provided to a future F&P Committee.<br><br>8.4.4. The Committee had received Council Assurance Reports from the Cost Improvement Programme (CIP) Council, Capital Planning Council, IM&T Council Update and Estates & Facilities Management Council Update with no issues escalated.<br><br>8.4.5. SR reflected on the challenge of monitoring the workforce reduction targets alongside the introduction of new services, which could increase workforce numbers and the likelihood of challenge, given regional workforce targets. CS commented that it would be important for MWL to maintain a clear single view of the position and noted that a running appendix of any increases and reductions would be maintained to support this.<br><br>8.4.6. SR commented that, in terms of developed CIP plans, the Trust was in a positive position when compared to other organisations, however, delivery of the CIP plan remained a key priority. GL commented that the Trust had submitted 100% delivery of the 2025/26 CIP plan.<br><br>The remainder of the report was **noted**<br><br>**RESOLVED:**<br>The Board **noted** the Committee Assurance Reports |
| **Other Board Reports** | |
| **9.** | **TB26/036 Aggregated Incidents, Complaints and Claims Report (Q4)** |

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| | 9.1. SO presented the Aggregated Incidents, Complaints and Claims Report (Q4).<br><br>9.2. SO highlighted the following:<br>9.2.1. 7,940 incidents had been reported across MWL in Q4 of which 49 (1%) were classified as moderate harm or above.<br>9.2.2. The most frequently reported patient safety incidents in Q4 were:<br>• Pressure Ulcers, including those not acquired under Trust care (950)<br>• Accidents including slips, trips, falls, and collisions (868).<br>9.2.3. There were three Strategic Executive Incident System (StEIS) reportable incidents in quarter 4:<br>• Two surgical related never events, which were under review.<br>• One Maternity Divert for a two-hour period at Ormskirk Hospital.<br>9.2.4. One incident had been recorded as fatal harm during Q4 and related to a radiology discrepancy. An expanded learning review was underway, and the case has been submitted to the Radiology Events and Learning Meeting (REALM) to determine any further learning.<br>9.2.5. Two Martha's Rule /Call for Concern incidents had been reported in Q4. SO advised that Martha's Rule had been introduced as national guidance following the death of a young patient whose deterioration had not been recognised despite repeated attempts by her parents to escalate concerns. The policy required that all trusts established a patient and family escalation process to enable concerns to be raised where it was felt that a patient was not receiving the necessary review or response. The process had initially been introduced at Southport Hospital and had now been extended to all hospital sites. Work was underway with the digital teams and clinical areas to determine the most effective operational approach to introduce a patient questionnaire which was the last outstanding requirement of Martha's Rule.<br>9.2.6. The Trust had received 1,157 Patient Advice and Liaison Service (PALs) contacts in Q4. Comparing this to the number of complaints, it was clear that PALS was resolving a significant proportion of issues before they became formal complaints. The EDs continued to receive the highest number of complaints and waiting times and standard of care remained the main reasons for complaints.<br>9.2.7. 21 new inquest notifications had been received, and 27 inquests had been closed.<br>9.2.8. No Prevention of Future Deaths notices (PFDs) had been issued during the period.<br>9.2.9. Duty of Candour had been completed for all incidents where harm had been confirmed as moderate or above.<br><br>9.3. GB reflected on the Parliamentary and Health Service Ombudsman (PHSO) cases that had been put forward and asked if future reports could be updated to include information on whether any of these had been upheld. SO agreed to update future reports to include this.<br>**Action:** |

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| | Future Aggregated Incidents, Complaints and Claims reports to include additional information regarding the number of Parliamentary and Health Service Ombudsman (PHSO) cases that had been upheld. **By:** July 2026<br><br>9.4. AMS asked whether any of the calls under Martha's Rule were reviewed and feedback provided to the clinicians as part of the learning process. SO responded that the two calls received had not required escalation, however, there was a process in place and a small oversight working group had been established to ensure appropriate review, learning and feedback.<br><br>9.5. SR asked when the patient questionnaire would be available so that the rollout of Martha's Rule could be completed. SO responded that the key elements of Martha's Rule had been implemented, including the escalation process available to patients and families across inpatient wards. The outstanding work related to the daily patient wellbeing questionnaire, which was intended to enable patients to record how they felt each day. The questionnaire was being trialled on two wards to identify the most appropriate approach and to avoid duplication with existing tools. The challenges associated with digital implementation across sites was noted and a review was underway to determine the most effective method for wider rollout.<br><br>**RESOLVED:**<br>The Board **noted** the Aggregated Incidents, Complaints and Claims Report (Q4) |
| **10.** | **TB26/037 Maternity and Neonatal Services Report Q4 Update** |
| | 10.1. SO presented the Maternity and Neonatal Services Report Q4 Update and noted that the reports had also been presented at the Quality Committee.<br><br>10.2. SO alerted the Board to the following:<br>• There had been five reportable perinatal deaths (all stillbirths) in Q4 including cases of extreme prematurity. This was an increase compared to Q3. All cases had been reviewed through multidisciplinary processes, reported to Mothers and Babies: Reducing Risk through Audits (MBRRACE), and were progressing via the Perinatal Mortality Review Tool (PMRT) and no care themes had been identified to date.<br>• There had been 11 temporary neonatal service suspensions at Whiston Maternity Unit due to workforce pressures and SO assured that emergency care had been maintained throughout these.<br>• Patient feedback had highlighted variability in postnatal pain relief following operative birth and ongoing challenges in supporting partner overnight stay, particularly at Whiston and SO noted that these were continued themes and improvement plans were in place.<br><br>10.3. SO advised that the Trust had achieved full compliance with the Maternity Incentive Scheme (MIS) Year 7 and work had started on the revised MIS Year 8 Framework. It was noted that there had been a reduction in the number of actions from ten in Year 7 to six. |

10.4. SO assured the Board of the following:

- Safe staffing standards were maintained, with 100% compliance for one-to-one care in labour and supernumerary delivery suite coordination across both sites.
- Training compliance was high across maternity and neonatal services, with active management of any gaps. The Trust continued to demonstrate robust governance, learning from incidents and feedback, strong executive and Board oversight, and sustained progress in delivering safe, compassionate, and high-quality maternity and neonatal care.

10.5. SO reported that a substantial programme of quality improvement activity had been undertaken across the maternity teams. The Clinical Audit Department had conducted its annual audit awards process, and several submissions had been received from maternity services. This was evidence of a well-established and embedded quality improvement approach within the maternity teams.

10.6. SO reported that a query had been raised at the Quality Committee regarding an apparent increase in instrumental birth rates in December, particularly at the Ormskirk site. The Director of Midwifery had provided assurance that this had not represented an ongoing trend, and that the figures had subsequently begun to return to expected levels.

10.7. SO reported that implementation of transitional care, which had been raised on several occasions at Board and Quality Committee, had started on the Whiston site during the first quarter of the year.

10.8. GB reflected on her time as the Board Champion for Maternity and Neonatal Safety and commented that the role had contributed to a broader understanding of maternity and neonatal services, and this should be taken into account for future succession arrangements.

10.9. GB commented that, during a visit to the Ormskirk Neonatal Unit, she had asked about the Lucy Letby inquiry and subsequent trial and the potential impact on staff working within neonatal services. Staff had advised that funding had been secured to provide support through a psychologist, which had been beneficial.

10.10. GB noted the positive neonatal patient story that had been presented.

10.11. GB suggested that future reports included more detail on neonatal services as a greater emphasis was being placed on the area nationally.

10.12. CS reflected on the national discussions relating to Saving Babies' Lives, particularly in relation to home births, and the recent coroner's cases concerning women who had wished to proceed with a home birth despite an adverse balance of risk, and whether any regional or national guidance had

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| | been published as a result. SO responded that the publication dates for this had not been confirmed, despite previous indications that guidance would be issued in the spring. However, it was anticipated that two additional maternity inquiries, as well as the Thirlwall Inquiry, would be published imminently and a Trust response to their recommendations would likely be required. It was anticipated that the home birth issue would be included in this.<br><br>**RESOLVED:**<br>The Board **noted** the Maternity and Neonatal Services Report Q4 Update |
| **11.** | **TB26/038 Draft Quality Account 2025/26** |
| | 11.1. SO presented the draft Quality Account 2025/26 for MWL and noted that the report had been reviewed by the Executive Committee and Quality Committee and was recommended to Board for approval.<br><br>11.2. SO advised that this was a mandated annual report. The Quality Account was no longer subject to review by the Trust's external auditors, and the report had been submitted to the Commissioners in draft format and feedback from them was currently outstanding.<br><br>11.3. Following approval at Trust Board, the Quality Account would go through a full proofread and finalisation for publication on the Trust's website by 30 June 2026.<br><br>11.4. SO thanked the Deputy Director of Governance, the Corporate Nursing team, the Head of Clinical Audit and the clinical audit team.<br><br>**RESOLVED:**<br>The Board **approved** the draft Quality Account 2025/26 |
| **12.** | **TB26/039 Learning from Deaths Quarterly Report (Q2 2025/26)** |
| | 12.1. SD presented the Learning from Deaths Quarterly Report (Q2) which provided assurance that deaths occurring in hospital undergo a robust review to identify lessons which could be learnt. It was noted that the report was in line with the National Quality Board's standards for the review of deaths.<br><br>12.2. SD reported that there were no concerns to escalate to the Board.<br><br>12.3. SD advised that work had been undertaken to address a significant backlog of reviews and 200 reviews had been completed during the quarter. This included several reviews which related to periods earlier than those covered within the report. The intention was to ensure that reviews were undertaken in a more timely manner going forward.<br><br>12.4. SD noted that the report had been strengthened through the inclusion of additional sources of information including the Medical Examiner Service, |

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| | Patient Safety Incident Investigations and mortality statistics for the reporting period.<br><br>**RESOLVED:**<br>The Board **noted** the Learning from Deaths Quarterly Report (Q2 2025/26) |
| **13.** | **TB26/040 2025/26 Board and Committee Effectiveness Review** |
| | 13.1. AMS presented the revised Terms of Reference (ToR) for the Board and its Committees which reflected the outcomes of the 2025/26 meeting effectiveness review process.<br><br>13.2. AMS provided an overview of the process and noted that the effectiveness reviews of each Committee had been considered at that Committee, and a full summary would be presented to the Audit Committee to support the Trust's annual Governance Statement.<br><br>13.3. There were no material amendments to the Board or Committee ToR.<br><br>13.4. CS requested clarification on the difference in terminology between programme board and Council. AMS clarified that due to the importance of the programmes of work, the named Councils would act as programme boards.<br><br>**RESOLVED:**<br>The Board noted the 2025/26 Board and Committee Effectiveness Review and **approved** the updated Terms of Reference |
| **14.** | **TB26/041 Review of Trust Objectives for 2025/26** |
| | 14.1. RC presented the Review of Trust Objectives for 2025/26 and noted that at the mid-year review in November 2025 seven objectives had been achieved, 19 were progressing as planned or partially delivered and one had not been delivered.<br><br>14.2. RC reported that at the end of March 2026 nine objectives had been achieved and 14 had been partially delivered. There were no objectives that had not been delivered by the end of March. It was noted that several of the partially delivered objectives had been rolled forward to 2026/27.<br><br>14.3. RC reported that following a review of the objectives at Executive Committee, a significant number of objectives had been recorded as partially delivered. However, many of the objectives had comprised multiple measures, and that a single, red-rated measure could result in the overall objective being classified as partially delivered. It was noted that, in many cases, the majority of metrics had been delivered, reflecting substantial progress across several areas. For example in Objective 1.1 (*Improve measurable success in areas where our patients told us we didn't get it right first time including inpatient* |

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| | *areas, ED, maternity with a focus on antenatal*.) most of the measures were rated either green or amber with one red-rated metric relating to the national inpatient survey and patients' experience of receiving waiting time information meant that the objective could not be rated green overall RC noted the work and improvement achieved by SO and the team on this objective. RC highlighted Objective 2.1 (*continue to ensure the timely and effective assessment and care of patients in the Emergency Department*) as another example.<br><br>14.4. GB reflected on the progress made since the completion of the transaction. SR commented that it was a credible performance with only a small number of red-rated areas identified and several of these were interrelated and reflected measures at differing stages of delivery. SR acknowledged that further work was required in certain areas. GB commented that this reflected that the governance structures were now in place and the relevant work programmes were progressing and starting to deliver tangible outcomes.<br><br>**RESOLVED:**<br>The Board **noted** the Review of Trust Objectives for 2025/26 |
| **Concluding Business** | |
| **15.** | **Effectiveness of Meeting** |
| | 15.1. Board members agreed that meeting had been effective. |
| **16.** | **Any Other Business** |
| | 16.1. SO advised that she had received a communication from the Commissioners confirming a positive endorsement for the 2025/26 Quality Account and that no amendments were required.<br><br>16.2. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.40<br><br>The next Board meeting would be held on **Wednesday 24 June 2026 at 09:30** |

| Meeting Attendance 2026/27 | | | | | | | | | | | | |
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| **Members** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
| Steve Rumbelow | ✓ | ✓ | | | | | | | | | | |
| Anne-Marie Stretch | ✓ | ✓ | | | | | | | | | | |
| Khalid Anis | A | ✓ | | | | | | | | | | |
| Gill Brown | ✓ | ✓ | | | | | | | | | | |
| Steve Connor | ✓ | ✓ | | | | | | | | | | |
| Rob Cooper | ✓ | ✓ | | | | | | | | | | |
| Simon Dowson | ✓ | ✓ | | | | | | | | | | |
| Neil Fletcher | ✓ | ✓ | | | | | | | | | | |
| Neil French | ✓ | ✓ | | | | | | | | | | |
| Malcolm Gandy | ✓ | A | | | | | | | | | | |
| Lisa Knight | A | ✓ | | | | | | | | | | |
| Gareth Lawrence | ✓ | ✓ | | | | | | | | | | |
| Lesley Neary | A | A | | | | | | | | | | |
| Sarah O'Brien | ✓ | ✓ | | | | | | | | | | |
| Mini Singh | ✓ | ✓ | | | | | | | | | | |
| Carole Spencer | ✓ | ✓ | | | | | | | | | | |
| Malise Szpakowska | ✓ | ✓ | | | | | | | | | | |
| **In Attendance** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
| Elsie Hayford | ✓ | A | | | | | | | | | | |
| Richard Weeks | ✓ | ✓ | | | | | | | | | | |
| Marie Wright | ✓ | | | | | | | | | | | |
| ✓ = In attendance A = Apologies | | | | | | | | | | | | |

# Trust Board (Public)

## Matters Arising Action Log (updated 19 June 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.<br><br>Update (19/06/2026)<br>Action added to the Strategic People Committee (SPC) action log and any concerns will be alerted to Board via the Assurance Report. Action completed.<br><br>Update (24/04/2026)<br>Recruitment was ongoing and planned into May 2026. An update would be provided at the Strategic People Committee in June 2026.<br><br>Update (20/02/2026)<br>The medical leadership structure recruitment is underway and an update will be presented to SPC in April.<br><br>Update (23/01/2026)<br>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~~<br>~~Apr 26~~<br>Jun-26 | | Completed |

| Action Log Number | Meeting Date | Agenda Item | Action | Lead | Deadline | Forecast Completion *(for overdue actions)* | Status |
|---|---|---|---|---|---|---|---|
| 29 | 26/11/2025 | **TB25/093 Research and Development Annual Report and Capability Statement** | SD to develop a new MWL Research Strategy.<br><br>Update (19/06/2026)<br>The new MWL Research Strategy to be developed in line with the Clinical Strategy following Clincial Director (CD) development. | SD | ~~Jun 2026~~<br>Oct 2026 | | |
| 31 | 25/03/2026 | **TB26/019 Committee Assurance Reports**<br>8.1 Executive Committee | MG to circulate the Paper Free Work Programme that was in place for Board to be cited on the scope of work to reduce paper processes. | MG | ~~May 26~~<br>~~Jun 26~~<br>Jul-26 | | |
| 33 | 26/04/2026 | **TB26/029 Corporate Risk Register** | SO to review the CRR to determine whether there were any actions to specifically address either urgent care or corridor care, and if not, to consider updating the CRR to address corridor care.<br><br>Update (22/05/2026)<br>Risk on corridor care on CRR, but three on RR. Risks being reviewed and consolidated. | SO | Jul-26 | | |
| 2 | 26/04/2026 | **TB26/031 MWL Health Inequalities Strategy Annual Progress Review** | WL to update the revised action plan for 2026/27 to include digital exclusion and the creation of a map reflecting digital poverty across the MWL footprint: | WL | Sep-26 | | |
| 3 | 27/05/2026 | **TB26/036 Aggregated Incidents, Complaints and Claims Report (Q4)** | Future Aggregated Incidents, Complaints and Claims reports to include additional information regarding the number of Parliamentary and Health Service Ombudsman (PHSO) cases that had been upheld. | SO | Jul-26 | | |

## Completed Actions

| Action Log Number | Meeting Date | Agenda Item | Agreed Action | Lead | Deadline | Outcome | Status |
|---|---|---|---|---|---|---|---|
| 1 | 26/04/2026 | **TB26/028 Committee Assurance Reports**<br>7.4 Quality Committee | SR reflected on GB's comment about NEDs visiting EDs and the discussion at the recent Board Away Day about setting up a schedule for this and including members of the Executive team and asked who would be leading on this. SO agreed to pick this up. | SO | May-26 | **May 2026** - SO circulated the dates for the monthly ED walkabouts at Whiston and Southport Hospitals to the NEDs and invited them to attend | **Closed** |

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| **Title of Meeting** | **Trust Board** | | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/044** | | | |
| **Report Title** | **Integrated Performance Report** | | | |
| **Executive Lead** | Gareth Lawrence, Chief Finance Officer | | | |
| **Presenting Officer** | Gareth Lawrence, Chief Finance Officer | | | |
| **Action Required** | | **To Approve** | X | **To Note** |

**Purpose**

The Integrated Performance Report provides an overview of performance for MWL across four key areas:
1. Quality
2. Operations
3. Workforce
4. Finance

**Executive Summary**

Performance for MWL is summarised across 33 key metrics. Quality has 12 metrics, Operations 11 metrics, Workforce 5 metrics and Finance 5 metrics

**Financial Implications**

The forecast for 2026/27 financial outturn will have implications for the finances of the Trust.

**Quality and/or Equality Impact**

The 10 metrics for Quality provide an overview for summary across MWL

**Recommendations**

The Trust Board is asked to note performance for assurance.

**Strategic Objectives**

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

# Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

## Board Summary

### Overview

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

| Quality | Period | Score | Target | YTD | Benchmark |
|---|---|---|---|---|---|
| Mortality - HSMR | Nov-25 | 96.4 | 100 | 90.4 | Best 30% |
| FFT - Inpatients % Recommended | May-26 | 93.9% | 90.0% | 93.9% | Worst 40% |
| Nurse Fill Rates | Apr-26 | 94.1% | 90.0% | 94.1% | |
| C.difficile | Apr-26 | 11 | 97 | 11 | |
| E.coli | Apr-26 | 11 | 151 | 11 | |
| MRSA | Apr-26 | 0 | 0 | 0 | |
| MSSA | Apr-26 | 5 | 0 | 5 | |
| Falls ≥ moderate harm per 1000 bed days | May-26 | 0.16 | 0.00 | 0.14 | |
| Stillbirths (intrapartum) | May-26 | 0 | 0 | 0 | |
| Neonatal Deaths | May-26 | 1 | 0 | 3 | |
| Never Events | May-26 | 0 | 0 | 0 | |
| Complaints Responded In 60 Days | May-26 | 59.3% | 80.0% | 67.4% | |

| Operations | Period | Score | Target | YTD | Benchmark |
|---|---|---|---|---|---|
| Cancer Faster Diagnosis Standard | Apr-26 | 76.0% | 80.0% | 76.0% | Worst 40% |
| Cancer 31 Days | Apr-26 | 95.5% | 94.0% | 95.5% | |
| Cancer 62 Days | Apr-26 | 80.4% | 80.0% | 80.4% | Best 20% |
| Ambulance Arrival to Vehicle Handover: % <45 mins | May-26 | 74.8% | 100.0% | 77.3% | |
| A&E Standard (Mapped) | May-26 | 77.3% | 82.0% | 77.6% | Best 40% |
| % of Patients With No Criteria to Reside | May-26 | 22.2% | 10.0% | 23.2% | |
| Discharges Before Noon | May-26 | 19.2% | 20.0% | 19.6% | |
| G&A Bed Occupancy | May-26 | 97.3% | 92.0% | 97.1% | Worst 10% |
| 18 weeks: % 52+ RTT waits | May-26 | 1.7% | 1.0% | 1.7% | Worst 40% |
| RTT % less than 18 weeks | May-26 | 67.2% | 70.6% | 67.2% | Best 40% |
| Diagnostic Waits: % <6 weeks | May-26 | 80.6% | 95.0% | 80.6% | |

| Workforce | Period | Score | Target | YTD | Benchmark |
|---|---|---|---|---|---|
| Appraisals | May-26 | 79.5% | 85.0% | 79.5% | |
| Mandatory Training | May-26 | 89.5% | 85.0% | 89.5% | |
| Sickness: All Staff Sickness Rate | May-26 | 6.4% | 5.0% | 6.4% | |
| Staffing: Turnover rate | May-26 | 0.8% | 1.1% | 0.7% | |
| Average time to recruit (days) - All Staff | May-26 | 50 | 40 | 51 | |

| Finance | Period | Score | Target | YTD | Benchmark |
|---|---|---|---|---|---|
| Delivery of CIP savings (000's) | May-26 | | | 6,626 | |
| Reported Surplus/Deficit (000's) | May-26 | | -6,108 | -6,072 | |
| Cash Balances - Days to Cover Operating Expenses | May-26 | 1.6 | | | |
| Capital Spend £ 000's | May-26 | | 5,256 | 1,638 | |
| Value of aged debt >90days overdue £000's | May-26 | | | 16,155 | |

# Board Summary - Quality

## Quality

HSMR
The HSMR for period Apr-25 to Nov-25 (latest data available) was 90.4 for MWL (92.1 for STHK and 107.7 for S&O). All individual diagnosis groups with an HSMR alert for this period have had patient details sent to be reviewed. The latest SHMI data for Dec-25 is 1.02.

FFT
May positive score 93.9%, 0.1% below internal target of 94% (Most recent national average score March 2026 - 95%). Top themes aligned with negative ratings are staff attitude, care and treatment and waiting times. CQC publication of the results of the 2025 National Inpatient Survey expected September 2026.

Clostridium difficile infection
There were 7 HOHA and 4 COHA cases at MWL in April. 9 of the cases were at the Whiston site and a deep dive into this period of increased incidence is underway.

Gram-negative bloodstream infections, E coli
There were 11 healthcare-associated cases in April, 8 HOHA and 3 COHA. This is one case below threshold.

MRSA
A zero-tolerance approach is still in place to support no MRSA bacteraemia. Reducing MRSA bacteraemia remains a Trust Quality Objective as laid out in the Quality Account 2026/27. There were no MRSA bacteraemia in month.

MSSA
There were 5 healthcare-associated MSSA bacteraemia. The Bloodstream Infection Improvement Plan remains in progress, with a trial of the After Action Review process underway, to optimise timely learning from cases.

Falls
There was 4 Falls with Harm (moderate and above) in April 2026. May data is yet to be validated for harm and learning reviews are currently underway for all falls with harm. The Falls teams provides continue to focus on Medicines and Urgent Care with an ongoing daily presence across the trust including Accident and Emergency departments to provide support, advice and education to colleagues for patients at risk of falls and prevention details.  Falls is an integral part of accreditation and Nursing Care Indicators (NCI) with targeted support in areas requiring improvement.

Never Events
No Never Events were reported in May 2026.

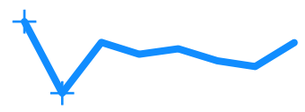
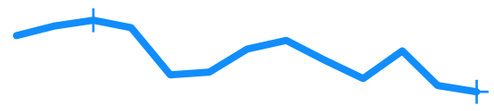
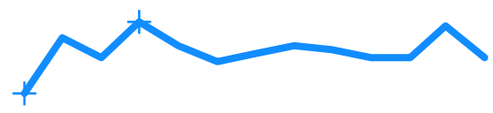
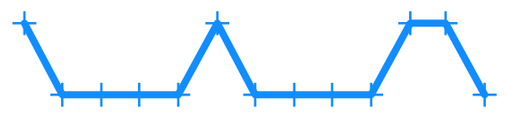
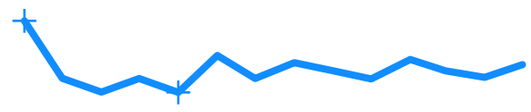
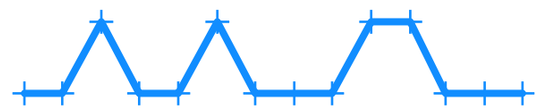
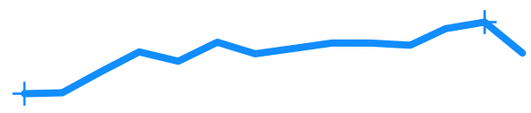
Complaints
In May there were 50 new first stage complaints received and in April there were 55.
54 complaints were closed in May. 27 for S&O sites and 27 at Whiston and within the agreed Trust 60 working day target. May compliance is recorded at 59%. Of the 54 closed in total, 32 were closed in time and 22 were closed out of time.
Figures are reported monthly and subsequently summarised in quarterly reports and complaints cases may be subject to change as per complainants wishes. Because of this, figures may also be subject to change and therefore minor variances can occur between reporting periods.

# Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

## Board Summary - Quality

| Quality | Period | Score | Target | YTD | Benchmark | Trend |
|---|---|---|---|---|---|---|
| Mortality - HSMR | Nov-25 | 96.4 | 100 | 90.4 | Best 30% |  |
| FFT - Inpatients % Recommended | May-26 | 93.9% | 90.0% | 93.9% | Worst 40% | |
| Nurse Fill Rates | Apr-26 | 94.1% | 90.0% | 94.1% | |  |
| C.difficile | Apr-26 | 11 | 97 | 11 | | |
| E.coli | Apr-26 | 11 | 151 | 11 | |  |
| MRSA | Apr-26 | 0 | 0 | 0 | |  |
| MSSA | Apr-26 | 5 | 0 | 5 | | |
| Falls ≥ moderate harm per 1000 bed days | May-26 | 0.16 | 0.00 | 0.14 | |  |
| Stillbirths (intrapartum) | May-26 | 0 | 0 | 0 | | |
| Neonatal Deaths | May-26 | 1 | 0 | 3 | | |
| Never Events | May-26 | 0 | 0 | 0 | |  |
| Complaints Responded In 60 Days | May-26 | 59.3% | 80.0% | 67.4% | |  |

# Board Summary - Operations

## Operations

Urgent Care Pressures A&E
4-Hour performance decreased again in May, achieving 73.0% (all types). Trust performance is below National (75.7%) and C&M (73.8%). The Trusts mapped 4-Hour performance achieved 77.3%.

Patient Flow
Bed occupancy across MWL averaged 105.2% in May equating to 93.6 patients - an ongoing trend of high occupancy. There was a peak of 152 patients (69 at S&O, 83 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 1% lower than last May, with a 2% reduction in 1+ day LOS activity and a 3% increase in 0 day LOS activity. St Helens had a 10.4% decrease in 0 day LOS from May 25 to May 26, however Southport had a 28.8% increase. Average length of stay for emergency admissions remains high, at 8.6 at S&O and 7.7 at StHK, with an overall average of 8.0 days, the impact of non CTR patients being 22.2% at Organisation level, 1.9% lower than April and 3.1% higher than May 25 (19.6% S&O and 18.9% StHK).

Elective Activity
The Trust had 1,343 52-week waiters at the end of May, (199 S&O and 1,144 StHK), 5 65-week waiters and 1 78-week waiter.
The 52-week position is a increase of 233 from April and the 65-week waiters have increased by 1 from April to May. 18-Week performance in May for MWL was 67.2%, S&O 69.8% and StHK 66.2%. This was ahead of national performance (latest month April) of 64.9% and C&M regional performance of 64.7%.

Cancer
Cancer performance for MWL in April deteriorated to 76.0% for the 28 day standard (target 77%), with Southport achieving 72.4% and St Helens performance being 78.2%. Latest published data (April) shows national performance of 75.9% and C&M regional performance of 77.2%. Performance for 62-day also deteriorated, achieving 80.4% (target 85%), with Southport achieving 76.8% and St Helens 82.1%. C&M performance was 76.9% and National 70.0%. 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 2026/27.

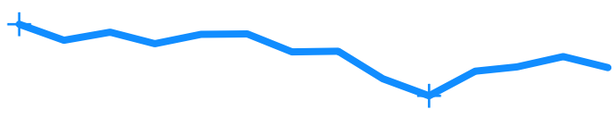
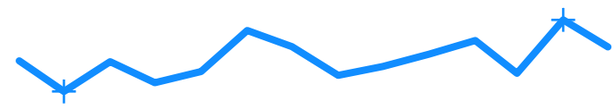
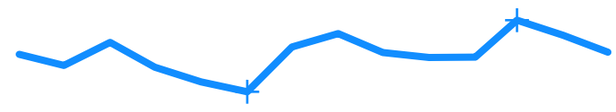
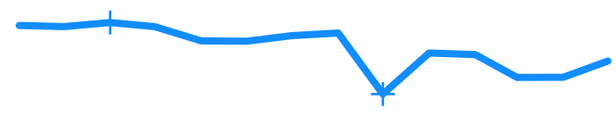
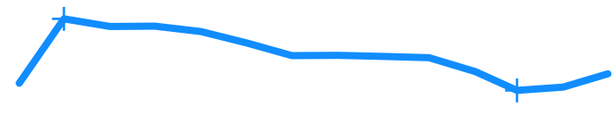
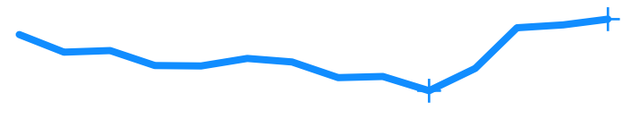
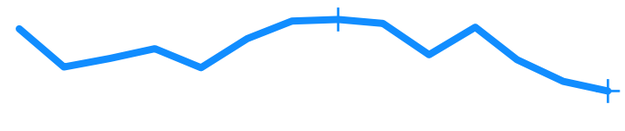
Diagnostics
Diagnostic performance in May deteriorated to 80.6% for MWL, failing to achieve the 95% target, with S&O achieving 71.4% and StHK 89.0%. MWL performance is ahead of national performance (latest month April) of 75.1% and below C&M regional performance of 87.0%.

# Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

## Board Summary - Operations

| Operations | Period | Score | Target | YTD | Benchmark | Trend |
|---|---|---|---|---|---|---|
| Cancer Faster Diagnosis Standard | Apr-26 | 76.0% | 80.0% | 76.0% | Worst 40% | |
| Cancer 31 Days | Apr-26 | 95.5% | 94.0% | 95.5% | | |
| Cancer 62 Days | Apr-26 | 80.4% | 80.0% | 80.4% | Best 20% | |
| Ambulance Arrival to Vehicle Handover: % <45 mins | May-26 | 74.8% | 100.0% | 77.3% | |  |
| A&E Standard (Mapped) | May-26 | 77.3% | 82.0% | 77.6% | Best 40% | |
| % of Patients With No Criteria to Reside | May-26 | 22.2% | 10.0% | 23.2% | |  |
| Discharges Before Noon | May-26 | 19.2% | 20.0% | 19.6% | |  |
| G&A Bed Occupancy | May-26 | 97.3% | 92.0% | 97.1% | Worst 10% |  |
| 18 weeks: % 52+ RTT waits | May-26 | 1.7% | 1.0% | 1.7% | Worst 40% |  |
| RTT % less than 18 weeks | May-26 | 67.2% | 70.6% | 67.2% | Best 40% |  |
| Diagnostic Waits: % <6 weeks | May-26 | 80.6% | 95.0% | 80.6% | |  |

# Board Summary - Workforce

## Workforce

Mandatory Training
The Trust continues to exceed its mandatory training target, maintaining performance at 89.5% in May 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 below the 85% target at 79.5% in May 26. There was an expected downturn post the opening of the Appraisal window on 01st May 2026, which closes on 30th September 2026. Updated Appraisal forms have been uploaded to the intranet, which now include the new Trust Objectives for 26/27.  Supportive toolkits and training are available for managers to ensure staff are getting the most out of their appraisals, which will hopefully support the feedback from staff survey on the quality of appraisals. Regular communications will be cascaded throughout the appraisal window as a reminder to staff to ensure that appraisals are completed timely.

Sickness Absence
Sickness absence reduced to 6.4% in May 2026 from 6.5% in April; however does remain above target of 5%. There's been a positive reduction since December 2025 (from 7.8%).
This continues to be a key priority area for the HR Team and for MWL.
The Absence Support Team continues to provide proactive support and guidance to managers.  Following direct feedback, recent developments have been the introduction of an absence calculator which supports managers with policy application including triggers, along with a form to record when a Welcome Back Conversation hasn't taken place for reasons of leaving or maternity for instance.
The Absence Taskforce Group launched in early January 26 continues to work with the six areas identified as high risk for initial focused action, namely Surgery Medical Secretaries, Spinal Injuries Team, Ward 1B AMU, and Ward 1C AMU, Bevan 1 & 2. The group meets on a weekly basis to report on progress, is led by the AD of HR for LOD and HWWB and is reporting via People Performance Council for monitoring and Strategic People Committee by exception.  Overall there has been a reduction in absence in all six areas since January when the Task Force was initially set up, with four areas showing a significant improvement.  Feedback from services has been positive with a strong focus on developing the skills and confidence to manage absence.  A full paper is being brought to People Performance Council in July to evaluate the progress of the group, consider best practice and to agree on the next steps in relation to further roll out of the actions taken.

Turnover
In-month turnover for May 26 is 0.8% against a target of 1.1%.

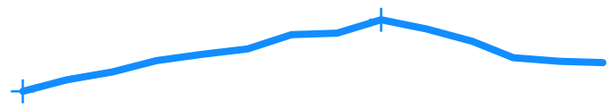
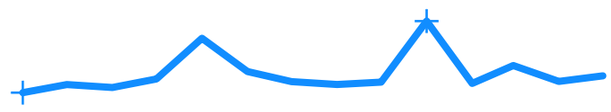
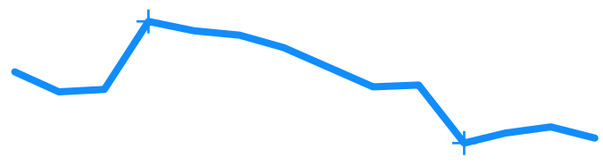
Time to Hire
Time to hire has been a particular challenge for us since the summer months, reporting 100.2 days for in month clearance in July 25.  A recovery plan has been in place in recruitment and HWWB to drive it down.
In May 26, time to hire decreased to 50.2 from 52 days, however still exceeding the recovery plan target. This metric includes from advertising start date to checks complete which includes time spent with Recruiting managers for shortlisting, interview etc.
The increase is attributed to exceptionally high volumes, including transition to an internal bank, TUPE transfers, and FY1 intake which is 3 times the usual volumes for the team at this time of year. Despite this, offers made in-month remain within the 40-day target. The national average for TTH is 50 days.
Weekly (with higher frequency if required) meetings are taking place between Recruitment and HWWB, particularly as both teams are entering their busiest period of the year, to keep track of time to hire. Any concerns will be escalated through to the AD of HR. A full paper is being brought to Strategic People Committee in June 2026 for oversight and assurance on actions taken to address this metric, along with how we're planning for the busy months ahead.

# 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 | May-26 | 79.5% | 85.0% | 79.5% | | |
| Mandatory Training | May-26 | 89.5% | 85.0% | 89.5% | | |
| Sickness: All Staff Sickness Rate | May-26 | 6.4% | 5.0% | 6.4% | |  |
| Staffing: Turnover rate | May-26 | 0.8% | 1.1% | 0.7% | |  |
| Average time to recruit (days) - All Staff | May-26 | 50 | 40 | 51 | |  |

# Board Summary - Finance

## Finance

The approved MWL financial plan for 2026/27 submitted in March 2026 gives a balanced positon, which includes £16.7m Deficit Support Funding and assumes delivery of £49.7m recurrent CIP.

Surplus/Deficit – At the end of Month 2, the Trust is reporting an adjusted position of £6.1m deficit. Excluding deficit support funding, the adjusted position is £8.9m deficit, in line with plan. This includes the impact of the 2026/27 Agenda for Change pay award and industrial action costs which are mitigated within the overall position.

CIP - The Trust's CIP target for financial year 2026/27 is £49.7m, all if which is to be delivered recurrently. As at Month 2, the Trust has successfully transacted CIP of £6.6m year to date, in line with plan.

Cash - At the end of M2, the Trust's cash balance was £3.2m. As part of the plan submitted to NHSE, the Trust assumes the receipt of £16.8m deficit support funding by the end of the financial year. The Trust has also included £32.2m capital PDC funding 2026/27.

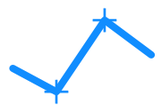
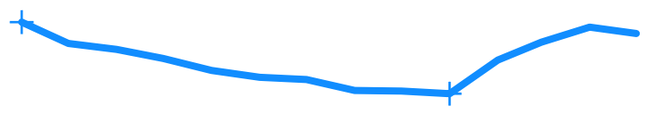
Capital - The Trust's capital plan for 2026/27 is £42.2m (including PFI lifecycle and lease remeasurements). Capital expenditure for the year-to-date [including PFI lifecycle maintenance and lease remeasurements] totals £1.6m, which is £3.6m below plan.

# Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

## Board Summary - Finance

| Finance | Period | Score | Target | YTD | Benchmark | Trend |
|---|---|---|---|---|---|---|
| Value of aged debt >90days overdue £000's | May-26 | | | 16,155 | |  |
| Capital Spend £ 000's | May-26 | | 5,256 | 1,638 | | |
| Cash Balances - Days to Cover Operating Expenses | May-26 | 1.6 | | | | |
| Reported Surplus/Deficit (000's) | May-26 | | -6,108 | -6,072 | |  |
| Delivery of CIP savings (000's) | May-26 | | | 6,626 | | |

## 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.

| Committee Assurance Report | | | |
|---|---|---|---|
| **Title of Meeting** | **Trust Board** | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/045 (7.1)** | | |
| **Committee being reported** | Executive Committee | | |
| **Date of Meeting** | This report covers the four Executive Committee meetings held in May 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 May 2026.<br><br>At each meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded.<br><br>The weekly vacancy control panel decisions were also reported. | | |
| **07 May 2026** | | |
| Budget Wrap-up (setting our recurring budgets and run rate adjustments at Divisional level) | • The Chief Finance Officer introduced the update which summarised the 2025/26 budget position. The Trust delivered its financial position for 2025/26 in line with forecast aside from two areas:<br>○ Elective Recovery - The Trust forecasted a £5m improvement in elective activity performance at M6, which incurred additional cost as part of the sprint exercise, but did not improve the exit run rate or the underlying position.<br>○ Depreciation/Technical adjustment; The Trust forecasted a £3m recurrent improvement in capital charges, the year-end position was £2.5m improvement with a further £0.5m met non-recurrently.<br>• The Deputy Director of Finance and Information provided an update about how run rates and budgets were set for areas. | Assurance |
| Newton Hospital Estates Work Update | • The Deputy Director of Estates and Facilities introduced a paper that provided progress on a range of measures to improve security arrangements with our community-based buildings. | Assurance |

| | | |
|---|---|---|
| | • There have been some delays in progressing outstanding work in some cases, but these have been escalated.<br>• Increased levels of Conflict Resolution Training are being provided for staff. Departments that have experienced the highest proportion of incidents are being contacted as a priority<br>• The first MWL Community Improvement Group met in April 2026, to provide a forum with internal managers where concerns and issues can be discussed and addressed, focusing on collaborative working across the organisation and with partner agencies if required, ensuring that attention remains on security.<br>• The Executive Committee noted the report and offered support if further escalation is required. | |
| Acute Medical Rapid Assessment Unit (AMRU) Progress Report | • The Divisional Director of Operations for Medicine and Urgent Care presented an update on the implementation of an AMRU which is planned to operate within a designated area of the emergency footprint and is intended to drive improved patient experience through efficient ways of working, with a focus on early senior decision-making and co-ordination of care. It provides enhanced opportunities for front door streaming and flow and supports the reduction of corridor care.<br>• Trust Executives and NHS England made a commitment to eradicate corridor care by Winter 2026. The establishment of an AMRU is one of the high impact actions recognised to support this commitment.<br>• The implementation of the AMRU is planned to take a phased approach:<br>o Stage 1 - soft launch;<br>o Stage 2 - operational assurance to confirm safety and system impact;<br>o Stage 3 - Benefits realisation and governance to demonstrate sustainability and value.<br>• There will be a 6-week process review and evaluation, and the team will return to the Executive Committee to present the analysis and for a decision about whether to continue. The committee approved this approach. | Approval |
| Safer Staffing Report | • The Chief Nursing Officer presented an update on safer staffing across wards, including triangulated | Assurance |

| | | |
|---|---|---|
| | intelligence on fill rates, quality indicators, and emerging risks.<br>• The Chief Nursing Officer noted that the additional Health Care Assistants (HCA) investment at the Whiston site had not fully demonstrated the intended impact, with wards still requesting additional HCA resource. A review had been requested to evaluate this and potential next steps.<br>• Further narrative was requested on the sickness/absence dashboard to include why wards/areas appeared as outliers and what actions were being taken to address any identified issues.<br>• The Committee noted the report. | |
| Procedural Documents Update | • The Chief Nursing Officer introduced the paper highlighting the need for short-term help to progress the review and approval of a number of procedural documents.<br>• It was noted that there were 202 overdue documents which is an increase from the 175 since the last report. There were a further 79 also due for review in the next quarter.<br>• The Executive Committee was asked to consider several proposals to improve the position.<br>• Committee agreed that a mandated day for colleagues to address overdue policies would be identified and that options to use artificial intelligence (AI) tools to speed up the process should be considered, with options to come back to the committee for consideration. | Assurance |
| Neighbourhood Health Pioneer Programme | • The Director of Integration provided the Executive Committee with an update on Neighbourhood Health (NH) programmes, principally within the two neighbourhood Pioneer Places of St Helens and Sefton.<br>• The Neighbourhood Health agenda is transitioning from Integrated Care Board (ICB) to partners and the Trust needs to consider its approach as the new forms of contracting models unfold.<br>• A discussion took place about the consequences and opportunities for MWL in this regard.<br>• The Executive Committee noted the report and requested a future discussion about the Trust's next steps in relation to this agenda. | Assurance |

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| Summary from Vacancy Control Panel (VCP) | • The Chief Nursing Officer gave an update on a recent VCP, and the Chief People Officer presented the summary from VCP held on 11 May 2026.<br>• The Executive Committee noted the report. | Assurance |
| **14 May 2026** | | |
| Trust Objectives | • The Chief Executive presented a report reviewing the delivery of the Trust Objectives for 2025/26. Overall, the position was positive with some improvements since the mid-year review, particularly around cancer service improvement, finance objectives and shaping care together.<br>• The Committee considered the red, amber, green (RAG) ratings and progress made in delivering the Trust Objectives and discussed the need for consistency in RAG rating thresholds and the need for clarity around objective descriptions and targets.<br>• The Executive Committee noted the report prior to presentation to Board. | Assurance |
| Electronic Prescribing and Medicines Administration (EPMA) Licences | • The Chief Medical Officer, supported by the Deputy Director of Informatics presented the current position regarding EPMA licences.<br>• The Chief Pharmacist had undertaken a review and identified that 550 licences would be required to cover users across all MWL sites - options for funding the additional licences was presented.<br>• There were some queries at the meeting that required further discussion and benchmarking before a decision could be made and the Executive Committee requested an update be provided at the next meeting. | Approval |
| UTC Staffing Model | • The Chief Medical Officer presented the report which sought approval to transition GP provision within St Helens Urgent Treatment Centre (UTC) to an in-house bank GP model.<br>• The Committee noted the report but had queries about cover arrangements, registration and costings which meant that this could not be approved.<br>• The Chief Finance Officer agreed to discuss with the Division directly and for this to come back for further consideration once queries were resolved. | Approval |
| Gastrointestinal (GI) Bleed Rota | • The Director of Strategy introduced the report which set out the current arrangements for out of hours (OOH) management of patients that suffer a GI bleed on the Southport site, which was | Approval |

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| | provided via a service level agreement (SLA) with a neighbouring Trust, but this was due to end on 31 July 2026.<br>• The Deputy Divisional Director of Operations for Medicine and Urgent Care provided the background to the report and options were presented along with the benefits and risks.<br>• The Committee were advised that the option (2A) to appoint an additional locum, to cover a gap in the rota, would be the preferred option as this could be implemented by 01 August 2026.<br>• The Committee approved this option. | |
| Cost Improvement Programme (CIP) Update | • The Chief Finance Officer presented the report.<br>• It was noted that some areas had not confirmed their CIP and this would be picked up in Divisional Performance Reviews (DPRs).<br>• The Committee noted the report. | Noting |
| Risk Management Council (RMC) Assurance Report – May 2026 | • The Director of Strategy presented the report and noted the following:<br>• There had been 22 new risks added to the Risk Register and 30 risks had been closed.<br>• There had been an increase in the number of risks overdue for review, which required action.<br>• The Executive Committee noted the report. | Assurance |
| Summary from Vacancy Control Panels (VCPs) | • The Chief People Officer presented the summary from the Vacancy Control Panel held on 11 May and noted the following:<br>○ seven vacancies had been approved and six required further information.<br>• The Executive Committee noted the report. | Assurance |
| Corporate Performance Report (CPR) and Integrated Performance Report (IPR) Update | • The Chief Finance Officer presented a report that outlined proposed changes to the Corporate Performance Report (CPR) and Integrated Performance Report (IPR).<br>• A detailed discussion took place regarding the metrics.<br>• The Executive Committee noted the report. | Assurance |
| **21 May 2026** | | |
| Corridor Care Progress Report | • The Chief Medical Officer provided a verbal update regarding corridor care. Meetings had taken place to discuss actions required to eradicate corridor care and review the Escalation Policy, to ensure that internal actions at times of increased pressure are effective, timely and consistent, to prevent corridor care. | Noting |

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| | • The Committee discussed the need to manage and share risk across the organisation in order to create capacity and improve patient flow.<br>• The Committee requested a report be presented on 11 June 2026. | |
| Communications Strategy | • The Chief Executive introduced the report which sought approval of the MWL Communications and Engagement Strategy 2026-31.<br>• The Strategy had been developed following engagement with staff across the organisation and supported the delivery of the Trust Strategy and 5 Star Patient Care.<br>• The Executive Committee approved the draft Communication Strategy for presentation to the Trust Board, noting that MWL branding needed to be added and the 'Strategy on a Page'. | Approval |
| Senior Leadership Group (SLG) Effectiveness Review | • The Deputy Director for Strategy and Chief Pharmacist presented the review.<br>• The role of the SLG and the original Document of Purpose that had been produced at the inception of the Group was noted and it was agreed that SLG did not require a Terms of Reference as it sat outside of the formal Trust governance structure as a leadership group.<br>• The Committee discussed the findings of the review and agreed that as part of the review, the scheduling of the meetings would allow wider attendance from clinical colleagues;<br>• It was agreed that the meeting would be moved to Thursday mornings to prevent the current clash with other meetings attended by senior leaders<br>• The Committee noted the report and that a Document of Purpose and a set of principles would be circulated to SLG members. | Assurance |
| EPMA Licencing Update | • The Chief Finance Officer presented the report which provided an update on queries raised by the Committee on 14 May 2026.<br>• The Chief Finance Officer suggested some feedback was still outstanding and this could be considered outside of the meeting and brought back to Committee if required once costings and options are fully understood.<br>• The Executive Committee noted the report. | Assurance |
| Chaplaincy & Spiritual Care Team Proposal Update | • The Chief Nursing Officer presented the proposal related to the Chaplaincy & Spiritual Care Team following updates from the proposal previously presented to the Committee. | Approval |

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| | • The Committee reviewed the proposed costs and approved the report. | |
| Clinical Director Recruitment | • The Chief Medical Officer presented the report which provided an update on the Clinical Director recruitment at MWL.<br>• There had been successful recruitment to 20 of the 26 posts with Interim Clinical Directors in two specialities.<br>• The Executive Committee noted the report. | Assurance |
| Summary of the Vacancy Control Panel (VCP) | • The Chief People Officer presented the summary from the Vacancy Control Panel held on 18 May 2026 and noted the following.<br>• 17 vacancies had been approved and six required further information.<br>• The Executive Committee noted the report. | Assurance |
| **28 May 2026** | | |
| Clinical Coding Service Provision | • The Chief Finance Officer introduced the report which provided an update regarding the clinical coding position and provided details of the changes to the contract for 2026/27.<br>• The final year-end position showed 99.3% of activity had been fully coded by the deadline. Activity that could not be coded was due to delays in documents being scanned, retrospective activity recording and IT issues.<br>• Uncoded activity has an impact on income and new mandates mean this should be recorded in real time or it will not be accepted and could impact income. In addition, uncoded activity affects other areas, including clinical metrics, such as mortality.<br>• The report sought approval for a 4-month extension to an existing arrangement to build resilience into the team to achieve the new flex coding target.<br>• The Committee approved the proposed 4-month extension with an external agency at a cost of £85k and the recruitment of two whole time equivalent Coders. | Approval |
| Trust Board Agendas – June 2026 | • The Deputy Chief Executive presented the Trust Board agendas for the meeting on Wednesday 24th June 2026 from the annual workplan and outstanding actions. The Trust Board in June was a public Board, followed by a Strategy Board session. | Assurance |

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| | • The Committee selected the Employee of the Month for June, from the nominations received during January. | |
| Information Steering Group Assurance Report | • The Chief Finance Officer presented the Information Group (ISG) Assurance Report from the meeting held on 01 May 2026.<br>• The Committee discussed the report, noting that two alerts had been identified but there were no issues for escalation to the Executive Committee.<br>• The Executive Committee noted the report. | Assurance |
| Summary from the Vacancy Control Panel (VCP) | • The Chief People Officer presented the Summary from the VCP held on 26 May 2026.<br>• The VCP had approved 18 vacancies. Six vacancies had been held awaiting further information.<br>• The Executive Committee noted the report. | Assurance |

**Alerts:**

None

**Decisions and Recommendations:**

**New investment decisions taken by the Committee during May 2026 were:**

- GI Bleed Rota – The recruitment of an additional locum.
- Clinical Coding – Extension of funding for Clinical Coding to build resilience in the service.

Mersey and West Lancashire Teaching Hospitals NHS Trust

| Committee Assurance Report | | | |
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| **Title of Meeting** | **Trust Board** | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/045 (7.3)** | | |
| **Committee being reported** | Quality Committee | | |
| **Date of Meeting** | 16 June 2026 | | |
| **Committee Chair** | Gill Brown, Non-Executive Director | | |
| **Was the meeting quorate?** | Yes | | |

**Agenda items**

| Title | Description | Purpose |
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| Minutes and Action Log | • The minutes of the Quality Committee meeting held in May 2026 were approved and the actions due for update in June were all reviewed and updated. | Assurance |
| Quality Committee Corporate Performance Report (CPR). | • High rates of Clostridium Difficile - April nine cases, May nine cases with improvement plan in place. Evidence in delays in taking samples and isolation of patients. Limited sustainability despite improvement work. Priority is to focus on core practices to sustain improvement.<br>• Complaint performance against 60-day response times has deteriorated, particularly in Medicine and Urgent & Emergency Care. Improvements were previously demonstrated but have not been sustained.<br>• Falls – there is a focus on any areas with moderate or severe harm to improve overall Trust performance.<br>• Variable Venous Thromboembolism (VTE) compliance - targeted interventions are underway.<br>• National Early Warning Score (NEWS) compliance and antibiotic delivery remain below expected levels (approx. 60% range).<br>• Mortality – two neonatal deaths relating to premature births. | Assurance |
| Clinical Effectiveness Council including Assurance Report | • My Kit Check rollout for resus trolleys in the Emergency Department (ED) - noted volume of “Kit” on trolleys currently which will be resolved through this tool.<br>• Do Not attempt Cardiopulmonary Resuscitation (DNACPR) - performance is good. | |

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| | • National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - no findings of concern.<br>• Intensive Care National Audit and Research Centre (ICNARC) - reassurance noted - discharges remain a focus.<br>• Sepsis performance requires improvement and complexity of data reporting noted. Requires review for accuracy. Sepsis lead for Southport and Ormskirk sites appointed. Sepsis group to commence. Noted variation in sepsis nurse roles across MWL.<br>• Caesarean-section rates - review over MWL sites in last five years noted (below national average). As part of the new Maternity Incentive Scheme (MIS) there will be a requirement for annual audit.<br>• Fetal DNA risk noted recognising work ongoing to support resolution - national recommendation to test women early in pregnancy<br>• Assurance provided on maternity Triage noting new recommendations on telephone triage. | |
| Mandatory Training Report | • Core mandatory and compulsory skills overall remain above Trust 85% target.<br>• Consistent approach to align core subjects. Comprehensive review of resuscitation training requirements completed identifying targeted high risks areas, with proposed support through managed implementation to minimise disruption to compliance.<br>• Compulsory skills training - undertaking Training Needs Analysis (TNA) reviews to provide consistent Trust wide assurance.<br>• Naso Gastric tube competency compliance and sepsis identified as high risk areas with fast-track approach to review TNA's.<br>• NHS England (NHSE) new competency-based framework expected April 2027.<br>• Training data now provides individualised training compliance - benchmark exercise with Cheshire and Merseyside (C&M) to support proposed measures to support individuals to be supported to undertake training.<br>• E-Communications commenced to all divisions regarding compulsory training - considered to be impacting Oliver McGowan training, which is required every three years. | |

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| | • Targeted areas for escalation - Medical and dental and Estates and Facilities remain below required standards – deep dive commenced to prioritise subject areas. | |
| Patient Safety Council including Assurance Report | • Report for April received.<br>• Six new Patient Safety Incident Responses (PSIRs) were reviewed at Patient Safety Panel<br>• Zero Maternity and Newborn Safety Investigations (MNSI's)<br>• 234 falls recorded in April 2026 compared to 252 March 202,6 of which two graded as moderate harm and two severe harm and zero fatal. Falls team implementing formal and informal falls prevention training with staff.<br>• Five incidents reported for April recorded as severe harm with learning and actions shared.<br>• Pressure Ulcers (PU) data validated to March 2026, noting decrease to 258 PU related incidents reported in April. Trust acquired PU (60) decrease from March (96).<br>• Learning from Patient Safety Events - InPhase confirmed as compatible with Learning from Patient Safety Events (LFPSE). Version 6 to be implemented in Q1 2026/27 and with work progressing<br>• One Patient Safety Incident Investigation (PSII) closed - actions identified through MNSI<br>• Patient Safety council assurance reports noted. | Assurance |
| Patient Experience Report including Assurance Reports and Council Terms of Reference (TOR) | • June Report received.<br>• Patient experience Tendable audits - the Trust is awaiting the NHSE recommendations on the patient experience of waiting times (elective pathways only)<br>• Some improvement to scores for compliance in the provision of the Trust discharge information booklet. Focus is placed on areas with non-compliant scores<br>• Improvement from March in the results for relatives/friends feeling that their concerns had not been listened to with dignity and respect.<br>• Maternity Patient Experience Tendable Survey - decrease in score on information on where to have a baby (i.e. which site), with work ongoing to support pathway changes and information provided.<br>• Friends and Family Test (FFT) - areas slightly out of range identified and noted, limited | Assurance |

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| | comments to establish themes. Ongoing monitoring to continue.<br>• Good progress noted on the development of new FFT platform with IQVIA and the Patient Experience and Inclusion team-go live August 2026.<br>• Awaiting final draft of Healthwatch reports following visits to Trust Emergency Departments.<br>• Advised on National Patient survey improvement plan and overdue actions supported through Senior Quality and Safety Walkabouts.<br>• MWL Chaplaincy structure approved and appointments ongoing.<br>• Slight decrease in referrals to the Dementia and Delirium team noting reduction in overall activity since the winter months.<br>• Digital systems to record patients' reasonable adjustments. Ongoing work in preparation for the implementation of the NHS Reasonable Adjustment Flag at the end of September.<br>• Healthwatch reports - positive scores and feedback from listening events.<br>• National experience of care week in April supported 87 staff nominations.<br>• Council TOR approved following minor amendment. | |
| Freedom to Speak Up (FTSU) Report | • Q3 & Q4 report received<br>• Supported 89 staff with concerns - 36% increase against previous year.<br>• Worker safety and wellbeing are the biggest themes, some related to staffing.<br>• Staff feeling impacted by HR processes noted with supportive actions being explored.<br>• Anonymous concerns – assurance Trust has 'work in confidence' system to raise concerns.<br>• Q3/4 Estates and ancillary staff largest reporting group.<br>• Cases where staff have felt detriment with the necessary support arrangements in place.<br>• FTSU service feedback from Trust staff is positive and how they value Guardian input and support.<br>• Trust successfully hosted FTSU North West conference and this was well received.<br>• InPhase module developed for the four guardians to centralise reporting. | Assurance |

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| | • Assurance against new reporting lines from National Guardians with transfer of functions initially to NHSE.<br>• Active bystander training rolled out from November 2025 and continues. | |
| Annual Safeguarding Report | • Received and discussed annual report for 2025/26.<br>• Three outstanding actions from the workplan, two relate to digitalisation of documents and one relates to Learning Disabilities risk assessments - all risks associated going forward with processes in place.<br>• Notable achievements against Key Performance Indicators (KPI's) for year included increased staff training completion and improved reporting of safeguarding concerns<br>• Teams KPI's are submitted quarterly. Assurances are in place other than other than Mental Capacity Act (MCA) training and level 3 training (revised KPIs will be lowered from 90% to 85%) following feedback, Trust currently just below 90%.<br>• Good attendance at multi agency meetings<br>• Management of domestic abuse reported positively.<br>• Improvement in KPI's relating to children in care contract - 80% compliance and breaches were related to external issues.<br>• Three child deaths (two Ormskirk Hospital and one Whiston Hospital) - all due process taken with learning identified.<br>• Risk register – medical photography with action identified to support next steps.<br>• Management of allegations - 152 new cases reported and 44 Lead employer cases (increased year on year). Resource impact of this to be provided for Executive level review. | |
| Effectiveness of the Meeting | • Meeting quorate and within timeframe. | Assurance |
| Any other business | • Nil | |
| **Alerts:** | | |
| • No alerts | | |
| **Decisions and Recommendation(s):** | | |
| The Trust Board is asked to note the report. | | |

| Committee Assurance Report | | | |
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| **Title of Meeting** | **Trust Board** | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/045 (7.4)** | | |
| **Committee being reported** | Strategic People Committee | | |
| **Date of Meeting** | 17 June 2026 | | |
| **Committee Chair** | Lisa Knight, Non-Executive Director | | |
| **Was the meeting quorate?** | Yes | | |

| **Agenda items** | | |
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| **Title** | **Description** | **Purpose** |
| Committee Performance Report (CPR) | Mandatory Training – the Trust continues to exceed its mandatory training target, achieving 89.5% compliance in May, above the 85% threshold.<br><br>Appraisals - appraisal compliance in May is at 79.5% against the 85% target. This downturn of performance was anticipated and in line with the annual trend following the commencement of the appraisal window which opened on 01 May 2026 however in month performance is better than last year (May 2025, 74.2%).<br><br>Sickness Absence - all staff sickness has decreased further in May to 6.4%.<br><br>Vacancy Rate - the Trust's overall vacancy rate has reduced to 7.2%, against the 8% target.<br><br>Time to Hire (T2H) - the average time to hire in May has improved to 50 days against the 40 day target.<br>Turnover - Turnover remains stable and below target:<br>• In-month turnover: 0.8%<br>• 12-month rolling turnover: 13.4% (target: 13.2%)<br><br>Health, Work & Wellbeing (HWWB) - Pre-Placement Questionnaires the total number received to cleared key performance indicator (KPI) average days has increased to 17 days. The Did Not Attend (DNA) rate for appointments has decreased in month from 12.4% in April to 9.9% in May. | Assurance |
| Annual Staff Survey Focused Update | The committee received a report focusing on the four key objectives the Trust is prioritising to improve overall staff experience and to inform a longer-term activity plan going forward. These are:<br>• Strengthening leadership<br>• Creating opportunities to listen and learn | Assurance |

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| | • Improving everyday behaviours<br>• Supporting each other<br><br>To support the delivery of the four key objectives the staff survey results have been widely disseminated across the Trust with access through the Business Intelligence (BI) dashboard hosted on the Trust intranets and the divisions have subsequently submitted action plans to the Valuing our People Council (VOPC) to monitor delivery.<br><br>Alongside this the Committee received an update on the targeted 90-day improvement plan for the Southport and Ormskirk sites. This update noted the areas of focus which included Freedom to speak up (FTSU), listening activity, behaviours, career development and advocacy. This included detailed action plans for each of the operational divisions.<br><br>A further update will be provided to the Committee in September. | |
| Time-to-hire Assurance Update | The Committee reviewed Time to Hire (T2H) performance, noting that while overall delivery remains above target at 50.2 days (target: 40 days), there are clear signs of improvement in the earlier stages of the recruitment process. Shortlisting and reference clearance have both improved, indicating that initial process efficiency gains from the Recovery Plan are being realised.<br><br>However, these gains are being offset by persistent delays in the later stages of the recruitment pathway in particular:<br>• Conditional offer to checks completion (31.0 days vs. 14-day target)<br>• Authorisation to start date (73.6 days vs. 55-day target) remains the single largest contributor to delay.<br><br>Occupational Health (OH) remains a key pressure point. While current KPIs are being achieved and process improvements have been delivered, there is a current requirement for a 20-working-day clearance window which leaves minimal flexibility within the end-to-end recruitment timeline.<br><br>Predicted capacity increases are also impacting T2H recovery this is driven by:<br>• Workforce gaps and onboarding of new Occupational Health staff<br>• A 17% increase in Pre-Placement Questionnaires (PPQs)<br>• A 60% increase in scheduling activity<br>• Increasing complexity of cases | Assurance |

<table>
<tr><td></td><td>Mitigations are in place, including resource reallocation, active absence management, bank staffing, and prioritisation frameworks. The Committee will continue to monitor T2H recovery.</td><td></td></tr>
<tr><td>Workforce Operation Plan M2</td><td>The Committee received the M2 Provider Finance Return (PFR) for MWL. The table below demonstrates a positive -1.2% variance to plan.<br><br><table><tr><th rowspan="2">Month 2<br>2026-27</th><th>Plan</th><th>Actual</th><th rowspan="2">WTE Change</th></tr><tr><th>Total WTE</th><th>Total WTE</th></tr><tr><td>Total Workforce</td><td>10435.75</td><td>10312.29</td><td>-123.5</td></tr><tr><td>Total Substantive</td><td>9767.5</td><td>9625.1</td><td>-142.5</td></tr><tr><td>Total Bank</td><td>595.78</td><td>646.5</td><td>+50.8</td></tr><tr><td>Total Agency</td><td>72.5</td><td>40.70</td><td>-31.76</td></tr></table><br>The M2 update included new 87.32 whole time equivalent (WTE) new starters (17.84 WTE related to the Urgent Community Response (UCR) TUPE delayed from April 2026). There were (78.29 WTE) leavers of those (5.60 WTE) were due to Mutually Agreed Resignation Scheme (MARS).<br><br>The Committee noted the report.</td><td>Assurance</td></tr>
<tr><td>Education Experience Survey Action Plan (NETS / GMC) Update</td><td>The National Education and Training Survey (NETS) 2025 Education Quality results present a broadly positive assurance position with learners reporting a particularly strong experience in sexual safety, discrimination, induction, bullying, and raising concern.<br><br>The improvement priorities identified are; workload (67.77%), facilities (68.22%), teaching and learning (69.41%), supervision (72.26%), quality of care (73.78%) and overall learner experience (76.76%). Variation in learner experience is most evident among Health & Social Care and postgraduate medical learners, who report lower scores across several domains, particularly supervision, overall experience, workload and confidence in raising concerns. However, it was noted the sample size of responders was low.<br><br>The report included a Trust-wide improvement programme across four workstreams: workload and learner capacity; facilities and learning environment improvement; teaching, learning, supervision and educator support; and a targeted review of learner groups with lower scores.<br><br>The Committee noted the results and the action plan.</td><td>Assurance</td></tr>
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| Improving Working Lives (IWL) Resident Doctor (10-point plan) Update | The Committee noted the most recent update on the Resident Doctor 10 Point Plan specifically;<br>• A Board Assurance Framework (BAF)<br>• Annual leave guidance<br>• Supporting Resident Doctor Peer Leads (RDPLs) - onboarding, offboarding and a new resource hub<br>• Building a community of practice<br><br>The Resident Doctor Leads will support the Senior Resident Doctor Leads in the completion of the BAF which will be approved by the Executive Committee. Strategic People Committee (SPC) will be responsible for the monitoring of the BAF. | Assurance |
| Volunteers Operational Plan Annual Update | The Committee received the annual update on the Volunteer Operational Plan. The paper provided assurance on the completed actions identified during 2025/26; nine actions are reported as green and one delivered (blue) and presented the proposed actions for 2026/27.<br><br>The Committee also noted that Anita Gillen, Volunteer Service Manager for Whiston, St Helens, and Newton sites will be leaving the organisation at the end of June 2026 and thanked her for the service and support. | Assurance |
| Assurance Reports from Subgroup(s) | The following assurance were received and noted: -<br>• People Performance Council,<br>• Valuing Our People Council<br>• Equality, Diversity & Inclusion Council | Assurance |
| **Alerts:** | | |
| Not applicable | | |
| **Decisions and Recommendation(s):** | | |
| The Board is asked to note the report | | |

Mersey and West Lancashire Teaching Hospitals NHS Trust

| Committee Assurance Report | | | |
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| **Title of Meeting** | **Trust Board** | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/045 (7.5)** | | |
| **Committee being reported** | Finance and Performance Committee | | |
| **Date of Meeting** | 18 June 2026 | | |
| **Committee Chair** | Carole Spencer, Non-Executive Director | | |
| **Was the meeting quorate?** | Yes | | |

**Agenda items**

| Title | Description | Purpose |
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| Chief Finance Officer (CFO) narrative Update on emerging news. | • System Turnaround support remains in place for Q1 2026/27, and the Trust will continue to be invited for monthly meetings with system and region partners.<br>• Update on system performance for M2 2026/27 discussed.<br>• New NHS Operating Framework published for the new financial year. | Assurance |
| Committee Performance Report Month 2 2026/27 | **Urgent care**<br>• Accident and Emergency (A&E) performance was 73% in May, ahead of Cheshire and Merseyside (C&M) and third highest in North West (NW )<br>• Long waits in Emergency Department (ED) continued to be a challenge – 19.6% waited over 12 hours in May, improvement plans have been developed.<br>• Ambulance Handover 45 – 74.8% of patients arriving by ambulance being handed over within 45 minutes. Increase in demand driving the change.<br>• No Criteria to Reside (NCTR) patients accounted for 22.2% of inpatients which was a decrease from March.<br>• Reductions in corridor care despite increases in ambulance arrivals and community bed closures due to improvement works within the Trust.<br><br>**Elective**<br>• 18 Week performance in May was 67.2%, an improvement from April | Assurance |

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| | • The Trust had 1,343, 52-week waiters at the end of May reflecting increased urgent demand and transfer in of patients from other areas.<br>• Diagnostic 6-week performance for May was 80.6% which remained ahead of national performance at 75.1% and below Cheshire and Mersey (C&M) performance at 87.0%. The target remains at 95%.<br>• Cancer performance in April decreased to 76.0% for the 28-day standard (target 77%) and to 80.4% for the 62-day standard (target 85%).<br>• Bed occupancy averaged 97.3% | |
| Finance report Month 2 | • The approved MWL financial plan for 26/27 is a deficit of £16.7m excluding deficit support funding (DSF). Including DSF, the plan is a balanced plan.<br>• The Trust is reporting a M2 deficit of £6.1m (excluding deficit support funding) in line with plan.<br>• Deficit support funding has been confirmed for Q1, future funding will be confirmed based on delivery of the plan on a quarterly basis.<br>• The position takes account of all variable activity. However, contracts (for 2026/27) are not finalised, and negotiations continue.<br>• The reported position includes a proportion of uncoded activity as the activity freeze date had not taken place.<br>• The Trust's 2026/27 Cost Improvement Programme (CIP) target is £49.7m. At M2, the Trust has delivered £6.6m in line with plan.<br>• At M2 agency costs equate to £1.2m (1.1% of total pay costs), which is a continued improvement on prior year.<br>• The Trust had a closing cash balance of £3.2m.<br>• Aged debt has decreased (debt greater than 90 days) at £16.2m in M2.<br>• The revised capital plan for the year totals £42.2m which includes Public Finance Initiative (PFI) Lifecycle and IFRS16 Lease Remeasurement. M2 spend is £1.6m and plans are in place to deliver the programme for the year. | Assurance |

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| Cost Improvement (CIP) Programme<br>and<br>Estates and Facilities Update | • Trust CIP target for 2026/27 is £49.7m. To date £53.7m schemes have been identified in year, £62.6m recurrently with £49.7m implemented or fully developed.<br>• Trust Project Management Office (PMO) are supporting in aligning CIP plans with transformation workstreams to support further delivery of targets.<br>• Estates and Facilities reported their progress on CIP delivery in 2026/27 schemes including work to further develop ideas. The Division have identified more than £2.7m across 23 schemes for 2026/27 and are continuing to add to this. | Assurance |
| Contract Update | • Update provided and discussed on current contract queries/disputes and progress to resolve.<br>• System changes resulting in longer timescales for resolving issues. | Assurance |
| Productivity | • MWL implied productivity is 4.4% compared to the previous year (latest published data is January 2026.)<br>• Productivity and efficiency bubble graph shared linking key non-financial indicators from the NHS Operating framework to the size and financial picture by specialty.<br>• Further development of metrics and usage across the organisation discussed. | Assurance |
| National Cost Collection | • Committee reviewed the costing processes in place at the Trust and confirmed that the Trust has appropriate systems in place to support the submission of the 2025/26 National Cost Collection. | Approval |
| NHS Oversight Framework Q4 | • Committee received the Q4 NHS Oversight Framework (NOF) scores for Q4 2025/26 and discussed the movements. | Assurance |
| Diagnostic Targets Review | • The Committee received an update on diagnostic performance at the Trust and the actions ongoing to improve care against the key performance indicators.<br>• Information shared regarding diagnostics demand, workforce constraints and lessons learned.<br>• The Committee discussed the work ongoing to deliver and further develop short, medium and long term improvement plans and associated trajectory for the key performance metrics. | Assurance |

| | | |
|---|---|---|
| Assurance Reports from Subgroups: | • Procurement Steering Council<br>• CIP Council Update<br>• Capital Planning Council Update<br>• IM&T Council Update<br>• Estates & Facilities Management Council Update | Assurance |
| **Alerts** | | |
| There are no issues requiring escalation to Board | | |
| **Decisions and Recommendation(s):** | | |
| The Board is asked to note the report. | | |

| | | | | |
|---|---|---|---|---|
| **Title of Meeting** | **Trust Board** | | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/046** | | | |
| **Report Title** | Fit and Proper Person Chair's Annual Declaration | | | |
| **Executive Lead** | Steve Rumbelow, Chair | | | |
| **Presenting Officer** | Steve Rumbelow, Chair | | | |
| **Action Required** | | **To Approve** | **X** | **To Note** |

**Purpose**

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

**Executive Summary**

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

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

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

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

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

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

# Annual NHS Fit and Proper Persons Test

| NAME OF ORGANISATION | TYPE OF ORGANISATION *Select organisation* | | NAME OF CHAIR | FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST: |
|---|---|---|---|---|
| Mersey and West Lancashire Teaching Hospitals NHS Trust | X | Trust | Steve Rumbelow | June 2025 – May 2026 |
| | | Foundation Trust | | |
| | | ICB | | |

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

| **Non-Executive Directors** | | | |
|---|---|---|---|
| **Name** | **Date of appointment (Start Date)** | **Position** | **Outcome** |
| Dr Khalid Anis MBE | 01/01/2026 | Associate Non-Executive Director | Confirmed Fit & Proper |
| Gillian Brown | 01/09/2019 | Non-Executive Director | Confirmed Fit & Proper |
| Steve Connor | 01/02/2024 | Non-Executive Director | Confirmed Fit & Proper |
| Neil Fletcher | 01/04/2025 | Associate Non-Executive Director | Confirmed Fit & Proper |
| Dr Neil French | 01/02/2026 | Non-Executive Director | Confirmed Fit & Proper |
| Lisa Knight | 01/07/2019 | Non-Executive Director | Confirmed Fit & Proper |
| Stephen Rumbelow | 01/05/2025 | Chairman | Confirmed Fit & Proper |

| Non-Executive Directors | | | |
|---|---|---|---|
| **Name** | **Date of appointment (Start Date)** | **Position** | **Outcome** |
| Professor Minal Singh | 09/04/2026 | Non-Executive Director | Confirmed Fit & Proper |
| Carole Spencer | 01/05/2024 | Non-Executive Director | Confirmed Fit & Proper |

| Executive Directors | | | |
|---|---|---|---|
| **Name** | **Date of appointment (Start Date)** | **Position** | **Outcome** |
| Nicola Bunce | 10/07/2017 | Director of Corporate Services | Confirmed Fit & Proper |
| Robert Cooper | 06/06/2016 (CEO from 01/12/2024) | Chief Executive | Confirmed Fit & Proper |
| Dr Simon Dowson | 10/11/2025 | Chief Medical Officer | Confirmed Fit & Proper |
| Malcolm Gandy | 01/04/2024 | Director of Informatics | Confirmed Fit & Proper |
| Gareth Lawrence | 01/04/2022 | Chief Finance Officer | Confirmed Fit & Proper |
| Lesley Neary | 01/07/2023 | Chief Operating Officer | Confirmed Fit & Proper |
| Professor Sarah O'Brien | 30/06/2025 | Chief Nursing Officer | Confirmed Fit & Proper |
| Anne-Marie Stretch | 07/07/2003 | Deputy Chief Executive | Confirmed Fit & Proper |
| Malise Szpakowska | 01/06/2024 | Chief People Officer | Confirmed Fit & Proper |

| Executive Directors | | | |
|---|---|---|---|
| **Name** | **Date of appointment (Start Date)** | **Position** | **Outcome** |
| Simon Regan | 01/06/2026 | Director of Corporate Services | Confirmed Fit & Proper |

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

| Leavers | | | | |
|---|---|---|---|---|
| **Name** | **Date of appointment (Start Date)** | **Position** | **Date of leaving and reason** | **Board member reference retained** |
| Claudette Elliot | 01/04/2025 | Non-Executive Director | 31/12/2025<br>Appointment as Chair of Pennine Care NHS FT | Yes |
| Charanjiv Rani Thind | 28/09/2021 | Associate Non-Executive Director | 30/09/2025<br>End of tenure | Yes |
| Professor Hazel Scott | 01/11/2023 | Non-Executive Director | 30/09/2025<br>End of tenure | Yes |

| Leavers | | | | |
|---|---|---|---|---|
| **Name** | **Date of appointment (Start Date)** | **Position** | **Date of leaving and reason** | **Board member reference retained** |
| Nicola Bunce | 10/07/2017 | Director of Corporate Services | 31/03/2026<br>Retirement | Yes |

## Part 2: FPPT reviews / inspections

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

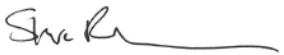
| Reviewer / inspector | Date | Outcome | Outline of key actions required | Date actions completed |
|---|---|---|---|---|
| No reviews in 2025/26 | | | | |
| | | | | |

# Part 3: Declarations

| DECLARATION FOR MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST 2026 | | | | |
|---|---|---|---|---|
| **For the SID/deputy chair to complete:** | | | | |
| FPPT for the chair (as board member) | Completed by (role) | Name | Date | Fit and proper? Yes/No |
| | Deputy Chair | Gill Brown | 11/06/2026 | Yes |

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

*As Chair of Mersey and West Lancashire Teaching Hospitals NHS Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.*

| | |
|---|---|
| Chair signature: |  |
| Date signed: | 11/06/2026 |

| **For the regional director to complete:** | |
|---|---|
| Name: | |
| Signature: | |
| Date: | |

| | | | | |
|---|---|---|---|---|
| **Title of Meeting** | **Trust Board** | | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/047** | | | |
| **Report Title** | Safeguarding Annual Report 2025/2026 | | | |
| **Executive Lead** | Sarah O'Brien, Chief Nursing Officer | | | |
| **Presenting Officer** | Sarah O'Brien, Chief Nursing Officer | | | |
| **Action Required** | | **To Approve** | X | **To Note** |

## Purpose

The Safeguarding Annual Report for 2025/2026 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 01 April 2025 to 31 March 2026. The purpose of the annual report is to inform the Board of safeguarding activity, providing assurance that the organisation has robust processes in place to safeguard those who use Trust services and to highlight areas of challenges in safeguarding provision.

## Executive Summary

All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2026); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

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

The Trust Safeguarding Team based across sites is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the unborn, children, young people and adults who are at risk of abuse or neglect.

The Safeguarding Team is a multi-functional team providing both operational and corporate responsibilities across the hospital sites, with the adults' team based at Southport and Whiston Hospitals and the children's team based at Whiston and Ormskirk Hospitals. The team works closely with the relevant Local Authorities and support the work of the Local Safeguarding Boards and Partnerships for Merseyside and Lancashire.

This report demonstrates the work MWL has in continuing to fulfil its responsibilities to safeguard children, young people and adults, in line with statutory requirements and national standards. The report details the effectiveness of safeguarding arrangements for children, young people and adults, including the Mental Capacity Act (MCA). It illustrates continued engagement with key partners and demonstrates compliance with the requirements and key objectives of the Local Safeguarding Children Boards (LSCBs/CSAP), and Local Safeguarding Adult Boards (LSABs). These Boards aim to ensure agencies in Merseyside and Lancashire are working together effectively to keep children, young people and adults safe.

| Financial Implications |
|---|
| None |
| **Quality and/or Equality Impact** |
| Not applicable |
| **Recommendations** |
| The Board is asked to note note the Adult and Children Safeguarding Annual Report. |

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

We are KIND

We are OPEN

We are INCLUSIVE

# Adult and Children Safeguarding Annual Report 2025/2026


## Authors: Sharon Seton, Anne Monteith

## Assistant Directors of Nursing Safeguarding

# Contents

1. EXECUTIVE SUMMARY ..... 4
2. INTRODUCTION ..... 5
3. GOVERNANCE ARRANGEMENTS ..... 7
4. ENGAGEMENT WITH EXTERNAL PARTNERS ..... 8
5. TRAINING COMPLIANCE ..... 9
6 SAFEGUARDING ADULT ACTIVITY ..... 11
8 SUDDEN UNEXPECTED DEATH IN CHILDREN (SUDiC) ..... 16
9 DOMESTIC ABUSE and SEXUAL ABUSE ..... 17
10.0 EXTERNAL REVIEWS ..... 21
11 MENTAL CAPACITY ACT and DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) ..... 22
12. LEARNING DISABILITY ..... 23
13. MENTAL HEALTH ..... 25
14. INITIAL HEALTH ASSESSMENTS (IHAs) ..... 27
15.PREVENT ..... 27
16.MANAGING ALLEGATIONS ..... 28
17.SAFEGUARDING AUDITS ..... 29
18. EXTERNAL SCRUTINY ..... 31
19. RISK REGISTER ..... 31
20. SAFEGUARDING WORK PLAN 2026/2027 ..... 32
21. CONCLUSION ..... 32
22. RECOMMENDATIONS ..... 333
23. Appendix 1: Trust Safeguarding Structure ..... 34

## Glossary of terms

| | |
|---|---|
| AED | Accident and Emergency Department |
| ASC | Adult Social Care |
| CCG | Clinical Commissioning Group |
| CDOP | Child Death Overview Panel |
| CE | Child Exploitation |
| CP | Child Protection |
| CQC | Care Quality Commission |
| CSC | Children's Social Care |
| CSPR | Child Safeguarding Practice Review |
| DBS | Disclosure and Barring Scheme |
| DARDR | Domestic Abuse Related Death Review |
| DHR | Domestic Homicide Review |
| DoLS | Deprivation of Liberty Safeguards |
| ESR | Electronic Staff Records |
| ICB | Integrated Care Board |
| IDVA | Independent Domestic Violence Advisor |
| ISVA | Independent Sexual Violence Advisor |
| KPI | Key Performance Indicator |
| LD | Learning Disability |
| LA | Local Authority |
| LADO | (Local Authority) Designated Officer |
| LSAB | Local Safeguarding Adult's Board |
| LSCP | Local Safeguarding Children Partnerships |
| MACE | Multi Agency Child Exploitation |
| MARAC | Multi Agency Risk Assessment Conference |
| MASH | Multi Agency Safeguarding Hub |
| MCA | Mental Capacity Act |
| MSP | Making Safeguarding Personal |
| NHSE | National Health Service England |
| PMRT | Perinatal Mortality Review Tool-Review when baby's die from 22 weeks gestation onwards, including late miscarriages, stillbirths, and neonatal deaths within 28 days. |
| RAG | Red / Amber / Green |
| Section 42 Inquiry | Safeguarding Adults investigation coordinated by the Local Authority |
| S47 | Investigation when suspect child at risk of or is suffering harm |

## 1. EXECUTIVE SUMMARY

1.1 The safeguarding annual report for 2025/26 provides an overview of Safeguarding Adults and Safeguarding Children activity for the period 1st April 2025 – 31st March 2026. The purpose of the annual report is to provide a summary of safeguarding activity in order to evidence assurance that the organisation has robust processes in place to safeguard those who use Trust services, and to highlight areas of challenges in safeguarding provision.

1.2 All NHS bodies have a statutory duty to ensure they make arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk from abuse, and support the Home Office Counter Terrorism strategy (CONTEST), which includes a specific focus on PREVENT (preventing violent extremism / radicalisation). Some of the key legislative frameworks to support safeguarding include: The Children Act (2004); Working Together to Safeguard Children (2026); Mental Capacity Act (2005); The Human Rights Act (1998); The Care Act (2014); Equality Act (2010).

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

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

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

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

1.7 From the quarterly submissions of KPIs, the Trust achieved a RAG rating of green in all areas other than not achieving 90% training compliance in all levels. There has been a marked improvement in the compliance with statutory timescales for completion of Initial Health Assessments for Children in care.

1.8 Positive feedback has been received from the ICB in relation to the KPI's noting significant assurance in safeguarding activity and multi-agency working, support and assessment of risk for victims of domestic abuse, and improvements made within the Developmental Paediatric Team to accommodate appointments for Initial health Assessments.

1.9 The data for 2025/26 shows an overall slight decrease in referral activity, other than DoLS applications, however contact to the teams has continued to increase and the teams have supported with some extremely complex cases; the requests secondary to external reviews has also continued to increase, particularly for cases relating to domestic abuse related deaths.

## 2. INTRODUCTION

2.1 The team structure is set out in Appendix 1. As detailed in both the Adult and Children; Roles and competencies for healthcare staff intercollegiate documents (2024, 2025), robust internal governance processes are in place to safeguard children and adults. There is an Executive lead, Named Doctors, Named Nurses for Safeguarding Children, Named Nurses Safeguarding Adults and Named Midwives in post, supported by an Assistant Director for Nursing Safeguarding on each legacy site. In accordance with LSCP's child death processes and detailed in Working Together to Safeguard Children (2026), Paediatric Consultants are allocated to take a lead role in the child death review process.

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

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

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

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

2.6 The table below represents the achievements in 2025-2026 against the work plan in the previous report.

| Work plan | Update | |
|---|---|---|
| Implement the digital DoLS process across all sites | The digital DoLS was extended to the Whiston sites in February 2026 and has seen early improvements in the completion of the DoLS authorisation | |
| Update mental capacity assessment forms to be in line with current case law | Capacity assessments documents are regularly reviewed and are aligned to current case law | |
| Explore a digital solution to support the quality of the capacity assessments completed | A digital capacity has been developed with the IT team although implementation is delayed due to IT priorities | |
| Continue to harmonise audits across sites where possible | A number of audits have been harmonised across the sites and this is reflected in the audit section of the annual report | |

| | | |
|---|---|---|
| Explore funding for additional posts such as the HIDVA and Emergency Department Navigator | Lancashire PCC has continued to provided funding to support both the HIDVA and HISVA roles. There was initial agreement to provide an ED Navigator but due to delays in recruiting following the AFC process the funding was withdrawn for 26 – 27. | |
| Harmonise learning disability and autism data collection and recording | The dashboard was harmonised across sites | |
| Explore the development of BI reports to support missed opportunity and to streamline processes for the Safeguarding Practitioners | BI reports developed:<br>-Homelessness<br>-Patients discharged from AED to mental health hospital<br>- DoLS assessments | |
| Explore with Mersey Care the costings to extend the MHA administration SLA to all sites | The pilot was completed and costings are being provided in Q1 26/27 | |
| We will work with the training department to implement the harmonised training needs analysis for all sites | The TNA has been harmonised and work completed to ensure all staff roles are aligned to the correct competency | |
| Review the learning disability risk assessment and associated processes | This has been delayed due to maternity leave and vacancy. Following successful recruitment this can be reviewed in 26/27 | |
| Review with colleagues in AED how safeguarding process can be embedded in their documentation | There has been a delay in the implementation of digitalised process in AED due to the priorities within the digital team | |
| Monitor any changes to legislation and amend policy accordingly | Policies and process updated as per legislation | |

## 3. GOVERNANCE ARRANGEMENTS

3.1 Quarterly safeguarding activity reports are presented to Quality Committee from which a summary is provided to Trust Board. In addition, a safeguarding report is presented quarterly to the four Divisional Governance meetings.

3.2 During this period quarterly KPI data was submitted to the Integrated Care Board (ICB) St. Helens Place and scrutinised by the Designated Nurses, who share assurance reports to the other neighbouring Place leads. The Assistant Directors of Safeguarding and Named Nurses attended quarterly business meetings with the Designated Nurses for St. Helens. Feedback from the submissions has been extremely positive for both the acute contract, which notes significant assurance in activity, referrals and multi-agency working, and the children in care contract, where a significant improvement in the completion of initial health assessments has been commended.

3.3 The Safeguarding Adult and Children Teams support collaborative working relationships with other departments in the Trust including Patient Safety, Complaints, and Human Resources for cases that meet safeguarding thresholds. The teams provide representation at internal meetings including:

- Patient Safety Panel,
- Divisional Patient Safety
- Harm-Free Care
- Patient Experience Council
- Patient Safety Council
- Mortality Review Group
- Professional Standards meeting
- Paediatric Department Meeting

The Safeguarding Teams provide planned and ad hoc supervision in line with the supervision policy. A suite of harmonised safeguarding policies is available to support staff; all are in date and reviewed regularly to ensure they are compliant with national and local policy.

## 4. ENGAGEMENT WITH EXTERNAL PARTNERS

4.1 The Assistant Directors of Safeguarding provide membership at the relevant Local Safeguarding Adult Boards (LSAB) and Local Safeguarding Children Partnerships (LCSPs). Membership at the Boards ensures that the Trust is sighted on and able to contribute to all aspects of the national and local safeguarding agendas; it further allows the Trust to develop policies and practices that are aligned to the Local Safeguarding Boards/Partnerships.

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

4.3 The Safeguarding Children Teams work closely with the Named Doctors for Safeguarding to ensure that there is a robust process in place to support the management of child deaths, attending internal review panel meetings, and external strategy meetings in the case of a sudden or unexpected death. The Team are also responsible for sending notifications to the Child Death Overview Panel (CDOP), sharing information when requested and attending panel meetings and associated subgroups.

4.4 The Safeguarding Teams endeavour to attend all requested strategy meetings and monitor attendance by other staff to child protection conferences and core group meetings when relevant to attend. The Safeguarding Teams support the Safeguarding Adult review (SAR) and Child safeguarding Practice review (CSPR) processes and Domestic Abuse Related Death Reviews (DARDR), also known as Domestic Homicide Reviews (DHRs), by providing requested chronologies; panel membership; ensuring participation at practitioner events. The Safeguarding Teams contribute to other multi agency meetings such as Multi-Agency Child Exploitation Meeting (MACE) and the Multi Agency Risk Assessment Conference (MARAC) where high risk cases of domestic abuse are discussed, either through attendance or information sharing.

## 5. TRAINING COMPLIANCE

5.1 Across all sites in this period a compliance of greater than 90% was achieved consistently throughout the year other than in level 3 safeguarding adult training. This has been attributed to the harmonisation of the training needs analysis which resulted in a number of staff moving to level 3 from level 2 training; this training is delivered face-to-face and is dependent on staff being released to attend. At the end of Q4 there were just 31 staff non-compliant. The mental capacity training has been maintained greater than 90% other than in the last quarter of the year.

5.2 In Q4 the Executive Board was compliant at 92.9% as of March 2026.

5.3 The training compliance level has been reduced within the 2026/27 KPIs and will be 85% rather than 90%, this will support the Trust in maintaining significant assurance.

5.4 The table below represents the Safeguarding and Mental Capacity Act training compliance achieved in 2025/26

| **MWL Training Data** | Q1 MWL | Q2 MWL | Q3 MWL | Q4 MWL |
|---|---|---|---|---|
| Safeguarding Adults Level 1 | 94.9% | 94.3% | 94.4% | 93.3% |
| Safeguarding Adults Level 2 | 93.2% | 93.4% | 92.3% | 91.7% |
| Safeguarding Adults Level 3 | 87.2% | 70.6% | 84.2% | 87.1% |
| Safeguarding Children Level 1 | 93.8% | 93.8% | 93.3% | 91.2% |
| Safeguarding Children Level 2 | 92.2% | 92.7% | 92.5% | 91.6% |
| Safeguarding Children Level 3 | 92.2% | 90.5% | 90.0% | 90.98% |
| Mental Capacity Act | 92.5% | 91.9% | 90.3% | 88.3% |

5.5 Each month the Departmental Managers receive the Trust compliance report, and the Divisions can monitor compliance levels for their areas. Training data for each Division is included in the quartile Safeguarding Divisional Governance report. The Safeguarding Teams actively seek to send monthly reminders to staff who are highlighted as non-compliant.

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

- Preceptorship programmes, covering general safeguarding, MCA, DoLS and Learning Disability
- Bespoke sessions to clinical areas and ward staff covering safeguarding, MCA and DOLS
- Local 1 hour Face to Face training for Paediatric, Midwifery & Obstetric staff on the Southport & Ormskirk Site
- Bespoke sessions to Managers to support in the management of disclosures of domestic abuse from staff
- Safeguarding and Domestic Abuse training delivered as part of the Midwifery Mandatory Training Session
- Ad Hoc training to other staff groups is delivered as requested

5.7 All relevant LSAB and LCSP training opportunities are shared through safeguarding ambassadors, champions and leads, Trust news and other relevant forums. Safeguarding Children at Southport and Ormskirk Hospitals further provide a “Lesson of the Week” bulletin to the Paediatrics Departments and Adult Accident & Emergency Departments. This bulletin contains key learning points and guidance relevant to departmental practice, using both internal and external safeguarding cases to support continuous learning and improvement.

5.8 Senior Safeguarding Team members attend an array of multi-agency training to maintain their compliance to level 4 training for children and / or adults.

## 6. SAFEGUARDING ADULT ACTIVITY

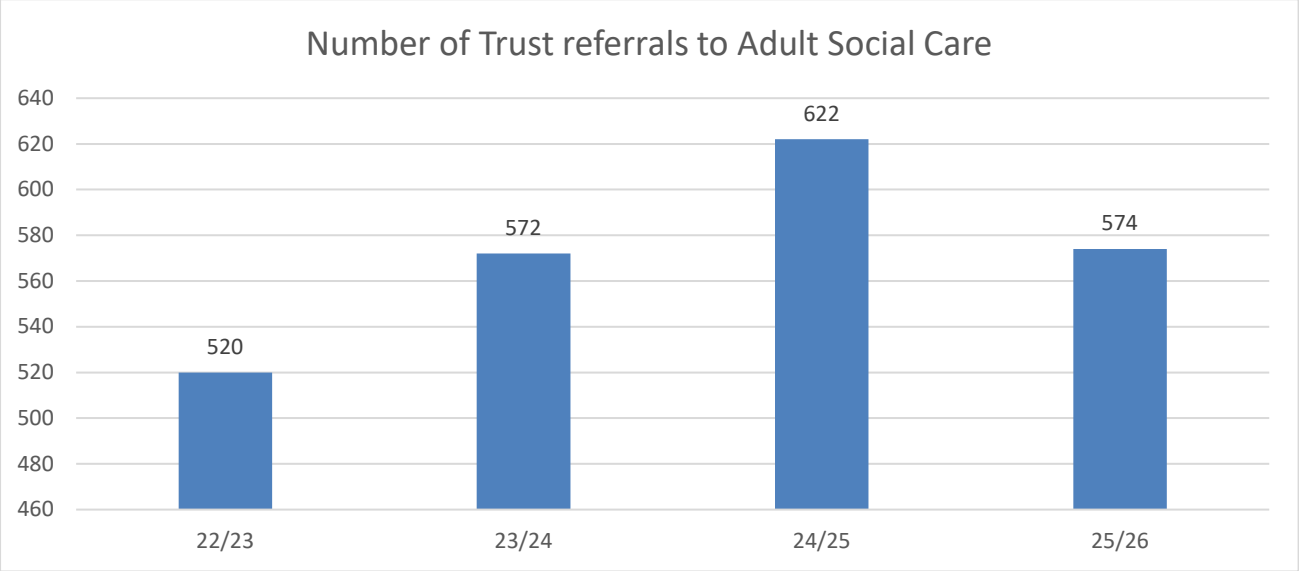
6.1 For adult safeguarding referrals, other than in an emergency when the Local Authority (LA) ‘duty team’ will be contacted, staff complete a referral to the Safeguarding Adult Teams. All safeguarding concerns will be quality assured and reviewed prior to submission to the LA, again this excludes emergency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

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

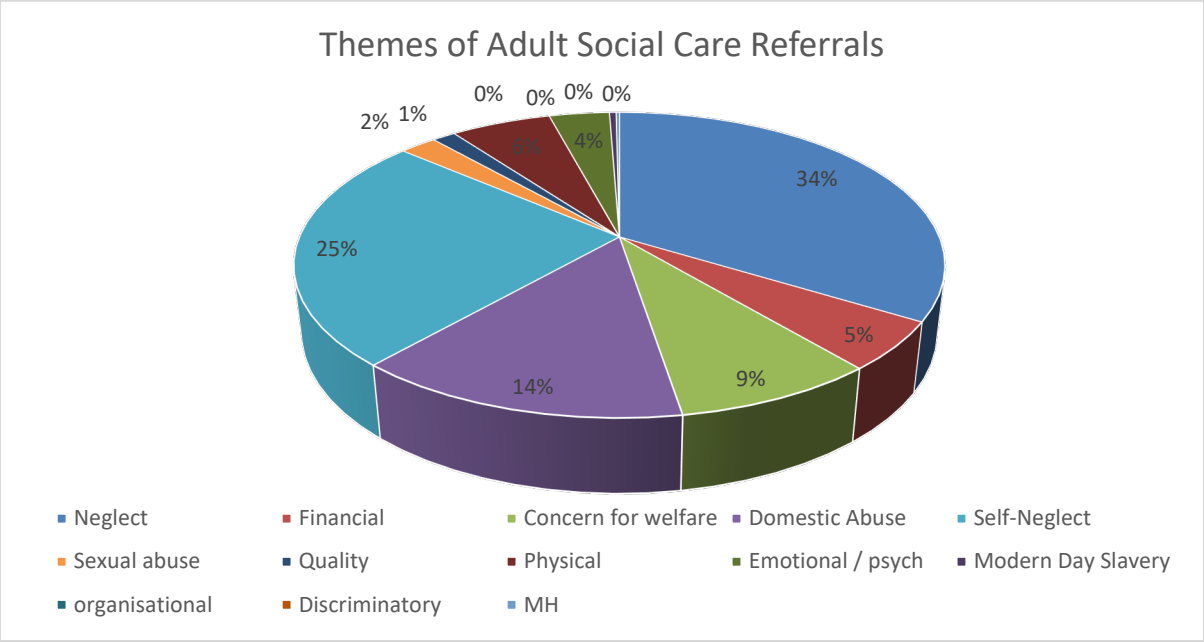
6.3 There has been 3756 initial safeguarding contacts raised to the adult teams, including reports of domestic abuse and sexual abuse. This is a 47% increase in comparison to the previous year (2540); it is recognised that data collection processes have also improved. There are a variety or reasons that the team may be contacted, and a referral is not always necessary; often support, advice and signposting is required.

6.4 Across all sites 574 of the concerns raised required a referral to the LA, an 8% decrease compared to the previous year (622); although there has been a decrease no concerns have been raised in relation to missed opportunity to refer, and contacts to the team have continued to increase. It is worth noting that not all referrals to the LA would have progressed to a safeguarding enquiry under S42 of the Care Act (2014).

6.5 The table below represents the number of Adult Social Care Referrals with comparison to previous years.




6.6 The themes related to the social care referrals made is represented in the table below; neglect and self-neglect account for nearly 60%, with domestic abuse accounting for 14%. It is to be noted that self-neglect is a particularly complex to manage for the Local Authority and partners, and are often required to follow a multi-agency complex case management process.



6.6 In addition to referrals, across all sites there has been 3777 applications for a Deprivation of Liberty Safeguards (DoLS) authorisation; all applications are quality assured and submitted by the safeguarding adult teams, level of restrictions is monitored and notifications to the CQC completed at the point of discharge.

**6.7 Meeting Attendance**

The adult teams attend several meetings with partners to discuss and review any current or ongoing risks to individual patients/individuals, these include LA Strategy meetings, best interest meetings, multi-agency risk management meetings and discharge planning meeting. The attendance at strategy meeting is monitored within the Safeguarding Adult KPI and is evidenced in the table below.

| MWL | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Strategy Meetings | 14/14 | 14/14 | 14/14 | 15/15 | 57/57 |

**6.8 Section 42 Enquiries**

As well as completing safeguarding referrals, the Safeguarding Teams coordinate safeguarding concerns raised against the Trust, known as Section 42 (s42) enquiries. The LA, under Section 42 of The Care Act, has the authority to request partners to investigate concerns raised.

6.9 All s42s against the Trust are sent via the associated LA Safeguarding Teams to the Adult Safeguarding Teams, who oversee the investigation and liaise with the LA regarding the outcomes. In this reporting period across all sites there were 99 enquiries or requests for information received. Feedback regarding the outcome is not consistently shared with the Trust, although it is known for the Southport and Ormskirk sites 18.6% were substantiated, 10.2% partially substantiated, 8.5% unsubstantiated, 11.9 % inconclusive, with an outcome still required for 27.1%, and to note 23.7% were closed at triage. Feedback is not consistently provided for referrals submitted from the Whiston and St. Helens sites.

6.10 The themes from the S42s remain relatively consistent and are mostly in relation to concerns raised by external partners relating to discharge, and hospital acquired pressure ulcers. The main learning from enquiries relate to incomplete communication, including lack of information sharing such as the discharge checklist and summaries, body maps, transfer

letters, notification to care homes/care providers regarding the date of discharge, failure to request further assessments from Adult Social Care when care needs are known, or lack of referrals to community colleagues. There are also re-occurring themes regarding medication errors on discharge, and decision specific capacity assessments not being completed where there is reason to doubt capacity, and concerns relating to restrictive practice.

6.11 Themes are discussed at both Divisional Governance Meetings and Ward Managers and Matrons meetings. Across sites all outcomes are shared with the wards, and the Ward Managers are responsible for the action plans to improve practice. If the criteria is met the Divisional Patient Safety Teams will request a Patient Safety Investigation Report to identify any gaps and highlight any associated actions.

### 6.12 Making Safeguarding Personal

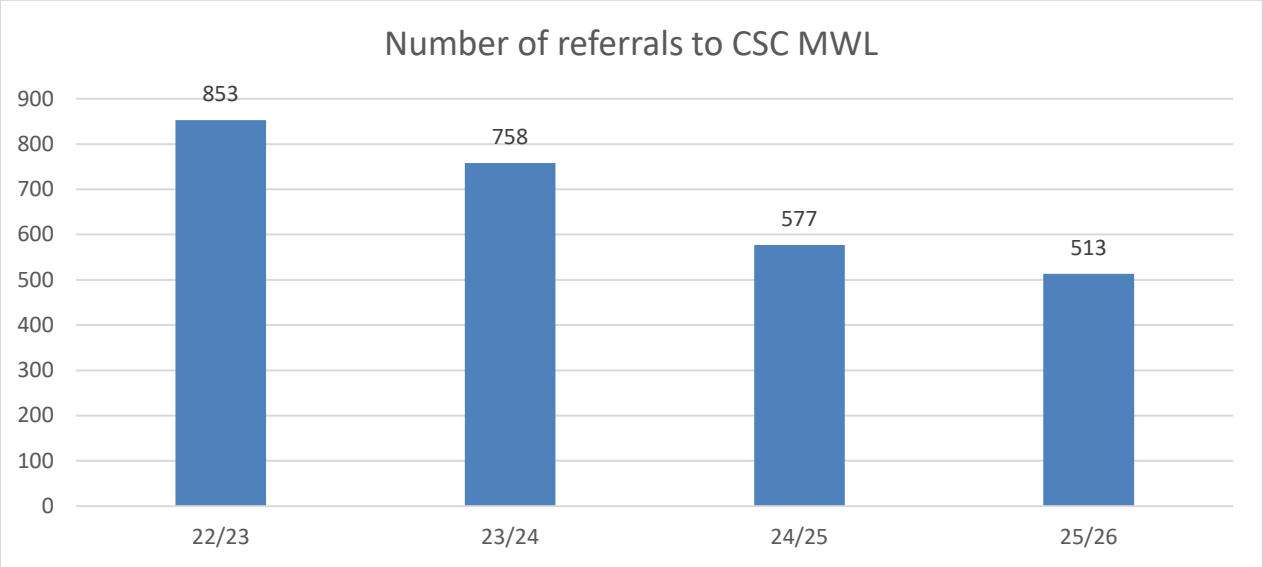
Where adults have capacity 'Making Safeguarding Personal' (MSP) allows them to express the outcomes they would want, and to uphold their right to refuse a referral, (where there is no concern regarding the wider public interest, or risk of serious harm to themselves). In accordance with the principal of MSP there were 39 individuals who had capacity and decided to refuse intervention; therefore, a referral was not made.

## 7. SAFEGUARDING CHILDREN ACTIVITY

Contacts in to the Safeguarding Children Teams was not collected consistently during 2025/26 as is not required within the KPI dataset, however, will be available for future reports.

### 7.1 Referrals to Children's Social Care

During 2025/2026 there were 513 referrals to Children's social care (CSC), the table below represents the data in comparison to previous years.




7.2 It is noted that the number of referrals has continued to decrease; this is partly attributed to a change in the referral process for Sefton Local Authority, who introduced a 'conversational model' of referral. The impact is such that a direct conversation is undertaken with the frontline staff and with the Social Worker who has access to additional information, which may negate the need for a referral. In addition, the Safeguarding Teams continue to work with staff to ensure that they refer in line with the Threshold of Need guidance, and this increased awareness has resulted in a reduction of referrals that may not meet threshold. There is no indication that the reduction in referrals is a cause for concern.

7.3 The team actively seek the outcome from CSC for referrals made in 2025/26. For outcomes that have been received across all sites, 304 progressed to further assessment by the local authority or partner agency. It is recognised that the LA may report an outcome as 'no further action,' however this may be after the LA undertakes further initial enquiries and gathering information from other agencies, it does not indicate the referral was inappropriate. The ICB and Local Authorities recognise that staff working in an acute setting may have limited information when considering the risk to children and a potential referral.

**7.4 Meeting Attendance**

7.5 The teams provide 100% attendance at meetings where it is relevant and appropriate for the Trust to be represented. It is worth noting the number of records checked for each meeting

is significant, as it includes reviewing the records for the children, parents and significant others involved. These meetings have included but not limited to those in the table below.

| MWL Activity | 23/24 | 24/25 | 25/26 |
|---|---|---|---|
| Strategy Meetings | 338 | 288 | 334 |
| CP Conferences (Initial & Review) | 195 | 131 | 178 |
| Pre-birth assessment meetings | 420 | 467 | 592 |

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

## 8. SUDDEN UNEXPECTED DEATH IN CHILDREN (SUDiC)

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

8.2 The CDOP panel has responsibility to review all child deaths (up to but not including the age of 18); the panel has an independent chair with representation from police, health (including public health), education, and social care. The purpose of the panel is to:

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

8.3 During 2025/26 there were a total of 3 Child deaths that were certified within the Trust, 2 in Ormskirk and 1 in Whiston. All 3 children, sadly, suffered sudden collapse or cardiac arrest in a community setting. All relevant processes were followed within the Trust. A concern was raised with the CDOP Manager relating to a child being transported directly to the mortuary from home under direction of the Coroner which is not the correct process; the nearest Emergency Department should accept the deceased in order to complete relevant examinations and complete necessary paperwork, as well as supporting family. The learning from the case was discussed with mortuary staff and local funeral directors to ensure that the correct process would be followed going forward.

## 9. DOMESTIC ABUSE and SEXUAL ABUSE

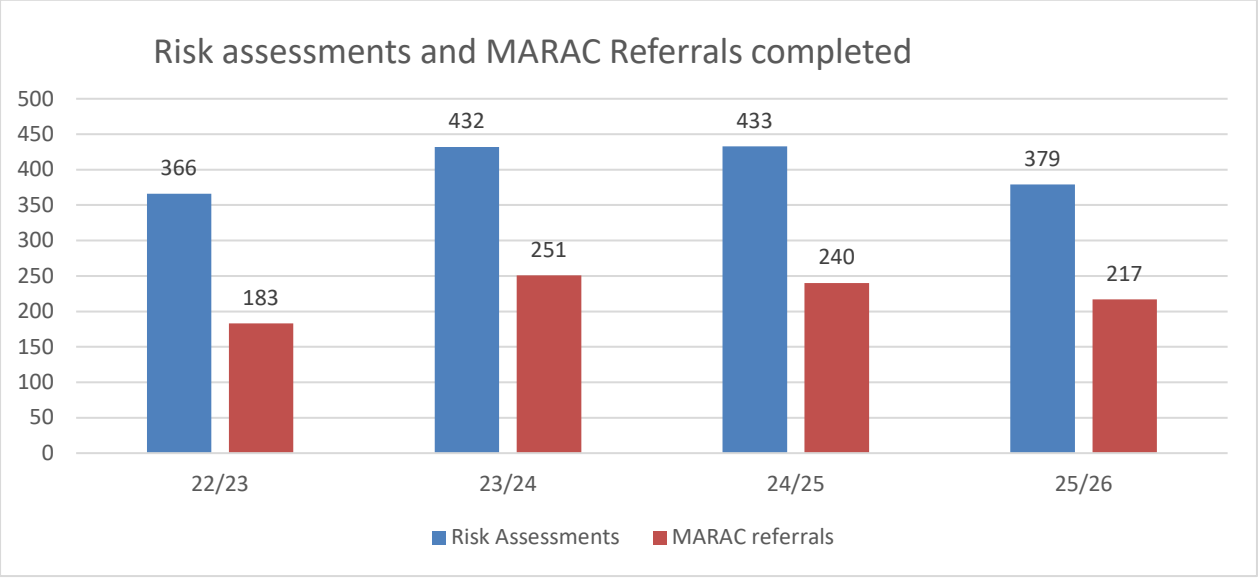
9.1 There is recognition that domestic abuse (DA) covers a range of behaviors, and relationships, and is recognised within The Care Act 2014 as a standalone category of abuse. The Domestic Abuse Act 2021 provides a legal definition of ‘Domestic Abuse’. It emphasises that DA is not just physical violence,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

9.2 At the Southport and Ormskirk sites domestic abuse is supported by the Police and Crime Commissioner in Lancashire. From January 2025 until March 2026 the additional funding has been utilised to increase the capacity in the Safeguarding Team based at Southport. Furthermore, the funding has been used to enable two Safeguarding Practitioners to undertake their Independent Domestic Violence Advocate (IDVA) training, and with another seeking to complete next year. This will seek to continue the delivery of an enhanced, high-quality service for individuals experiencing domestic abuse.

9.3 The Safeguarding Teams attend or share information at local MARAC meetings, which are undertaken to review and support high risk victims and to try and prevent further abuse. The teams receive the information via MARAC coordinators and complete a review of all individuals listed within the case summaries. If individuals are known to the Trust any relevant information will be shared at the meeting.

**9.4 Domestic Abuse Risk Assessments & Referrals**

9.5 When there is a concern or disclosure of actual or suspected domestic abuse, staff use a domestic abuse risk assessment to determine the safeguarding actions required. For high-risk cases a referral to the local MARAC is completed by the Safeguarding Team following a review of the risk assessment and the patient record, with engagement of the victim where possible. The table below represents the number of risk assessment completed and those leading to a MARAC referral.




9.6 Whilst victims of DA are referred to the Team based at the Southport and Ormskirk sites, staff are not always completing the DA risk assessment in a timely manner or before the patient has left the Trust. Positively, the Management of Domestic Abuse Audit completed in Q2, provided good assurance that when domestic abuse is identified, staff are able to support victims by ensuring internal safeguarding processes are followed, appropriate referrals made and risk to victims and children reduced.

9.7 When a disclosure of domestic abuse is made, the staff member receiving the disclosure should explain the reason for completing the risk assessment and attempt to gain consent from the victim to share information with other agencies if appropriate. If this consent is not given the staff member should explain that information can be shared without consent if the victim is deemed to be high risk, or if there are concerns in relation to Child Protection.

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

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

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

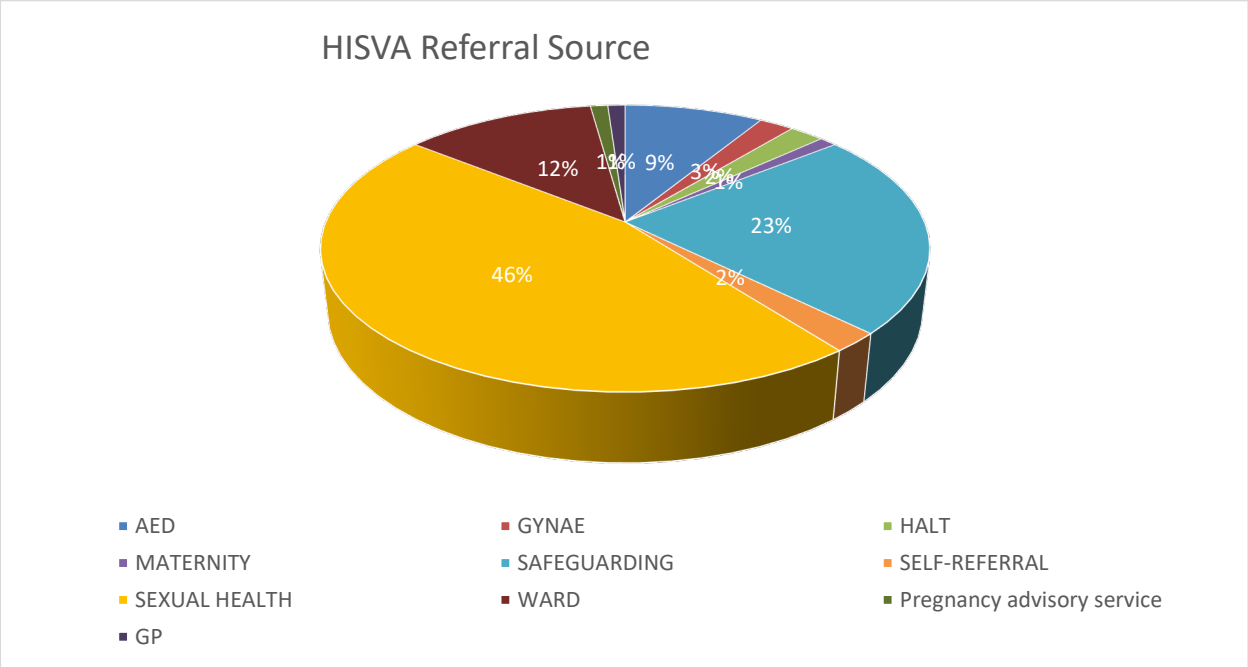
- Professional judgement and/or
- Pattern of behaviour historically linked to a recent event that may cause concern (for example, a recent release from custody and contact being made with the victim)
- ANY instance of abuse between the same victim and perpetrator(s), within 12 months of the last discussion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

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

### 9.10 Health Independent Sexual Violence Adviser (ISVA)

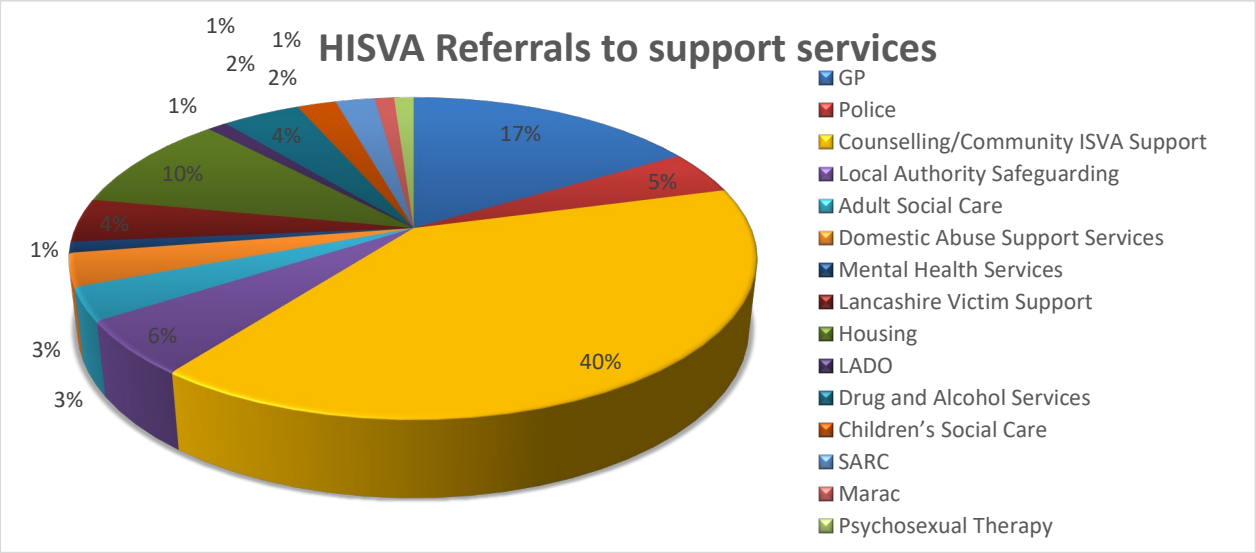
The Health Independent Sexual Violence Adviser (ISVA) is based within the Safeguarding Team at Southport and due to funding arrangements works only on the Southport and Ormskirk sites. The role provides specialised support to victims of sexual abuse, male or female, aged 16 years and above, who have recently or in the past been subjected to any form of sexual abuse. In this year there have been 91 referrals from a range of sources. This is directly comparable with the previous year. The number of referrals has been 60% higher

for Q3 and Q4 in comparison with Q1 and Q2. It is likely that this can be attributed to the new HISVA commencing in post in late August. The table below represents the source of referrals.




9.11 From the patients attending the S&O sites with reports of sexual abuse, 34% reported incidents within the previous 10 days with the remaining 66% reporting less recent incidents.

9.12 The table below represents the onward referrals made to support Services and Partners by the HISVA.



## 10. EXTERNAL REVIEWS

The Safeguarding Teams contribute to multiple external reviews, providing initial information summaries and, when required, detailed chronologies and panel representation.

### 10.1 Domestic Homicide Associated Reviews

10.1.1 During this year the Trust has been notified of 14 for which information requests were received. To date MWL have received confirmation that 7 are progressing to DARDR's and 4 are awaiting confirmation. The Trust has provided the required Internal Management Review (IMR) and chronology reports to support the review process. Where there is Trust involvement, representation will be provided by the Safeguarding Team.

10.1.2 While for some the cause of death is still to be shared, at this time it is known 2 cases were recorded as death by suicide, 1 case is awaiting a decision and 2 have been confirmed to be domestic homicides with the criminal process superseding the DARDR.

10.1.3 Of the 3 confirmed DARDR's, there has been significant Trust involvement in 2 cases and representation at panel will be required.

10.1.4 The Trust continues to provide representation by attending the panel meetings for 6 reviews dating back to 2023/24.

### 10.2 Child Safeguarding Practice Reviews (CSPR)and Safeguarding Adult Reviews (SAR)

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

10.2.2 Regarding CSPRs the Trust received 27 rapid review information requests, 19 of which required the submission of chronologies; panel meetings were attended when requested. Of these 4 have progressed to a CSPR, and 2 of these are being examined via an independent thematic review of Child Sexual Abuse.

10.2.3 The Safeguarding Team also attended two Learning Circles involving cases that did not quite meet the threshold for a Rapid Review, but where valuable learning had been

identified. These sessions provided an opportunity to explore practice issues, identify themes, and share learning across agencies.

10.2.4 Regarding SAR referrals, these are submitted to the relevant Safeguarding Adult Review Group, who triage and decide if a review is to be undertaken, when it will be transferred to the LSAB for completion. Across all sites there have been 11 requests for information in relation to potential Safeguarding Adult reviews for Halton, Knowsley, Lancashire, Sefton, St Helens and Oldham.

10.2.5 In addition to this, the Safeguarding Adults Teams submitted 3 referrals for consideration of a SAR, these progressed to the Merseyside SAR Group but did not meet threshold for review, a recommendation was made for local learning in one of these cases to be presented at Safeguarding Adult Partnership Board.

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

## 11. MENTAL CAPACITY ACT and DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

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

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

who are placed under an urgent 14-day DoLS authorisation, which expires before the Supervisory Body has been able to complete a best interest assessment.

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

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

11.5 Across all sites there has been 3,777 authorisations for an urgent DoLS across all sites. The Adult Safeguarding Teams quality assure and process all urgent authorisations, monitor restrictions and complete notifications to the CQC.

11.6 Assessments by the Local Authority are minimal due to capacity issues; those that are not authorised by the Supervisory Body are due patients being discharged before the assessment is undertaken; patients regaining capacity; patients who have died.

11.7 The Safeguarding Teams have been approached by adjoining Local Authorities to request a review of the DoLS criteria in an effort to reduce the number of applications. There will be no change to criteria until legal advice has been sought and considered.

## 12. LEARNING DISABILITY

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

- Respecting and protecting rights of those with a Learning Disability, ensuring the Trust meets the Equality Act requirements, provides reasonable adjustments and flagging to identify patients and support the additional care required.

- Inclusion and engagement ensuring the patient, family and carers are all empowered and included in the care provided as a partnership
- Ensuring the workforce is resourced and skilled to care for those with a Learning Disability

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

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

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

12.5 The LDAPs support the Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) agenda. The LDAPs ensures the Trust reports, within the required timeframe, the deaths of those with a learning disability and or autism. This year the Trust submitted 17 notifications.

12.6 As per internal mortality review process, all deaths for LD patients receive a Structured Judgement Review. It has been noted that improvements are required regarding the lack of evidence within the medical notes for the consideration of the Mental Capacity Act, specifically in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. It has been further noted that inaccurate information has been recorded on DNACPR forms. The Safeguarding Teams are working collaboratively to improve practice.

12.7 The table below represents some of the activity undertaken by the LDAPs and the number of attendances to the Trust for those with an LD and or autism alert in their electronic patient record. The numbers for attendances could in fact be higher as it relies on the person having an alert on their clinical record. It is to be noted that the post holder at the Southport site left the Trust in January 2025, and a new practitioner had been recruited to the role.

12.8 The table below represents the LDAP activity

| MWL | Inpatients | Outpatients Attendances | Contacts to the LD Team | Information sharing contacts only |
|---|---|---|---|---|
| 2025/26 | 1860 | 3040 | 1886 | 520 |

## 13. MENTAL HEALTH

### 13.1 Mental Health Act Detentions

13.2 Following approval for the SLA with Mersey Care, who provide the Mental Health Act administration on the Southport and Ormskirk sites, to be extended to include all sites, a pilot was commenced in February 2025, and the Trust is reviewing the costings for the SLA for 2026/2027.

13.3 To note there has been a difference in the number of patients detained across sites which is partially attributed to a variance in process across sites, where at Whiston patients awaiting a bed from an Emergency Department (ED) attendance were detained to an in-patient area within AED, while patients attending Southport AED are not detained while awaiting a mental health bed. This has since been reviewed and where able, people are no longer being detained the inpatient area in AED on the Whiston site.

13.4 The table below represents the number of detentions with comparison to previous years

| Year | No of detentions |
|---|---|
| 2023/2024 | 152 |
| 2024/2025 | 140 |
| 2025/2026 | 177 |

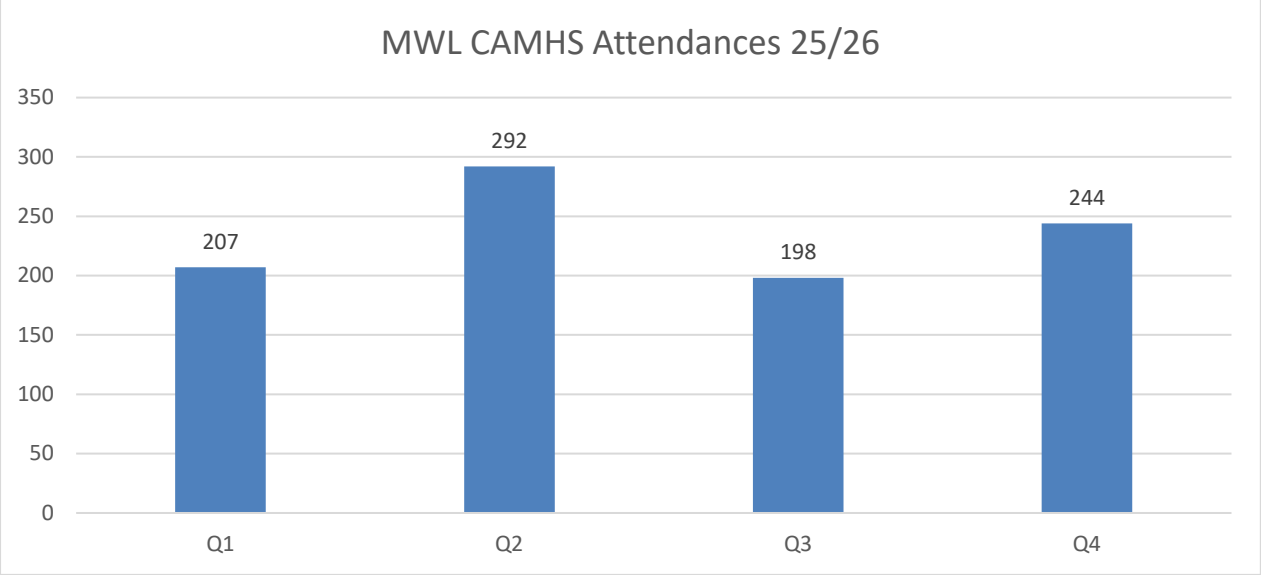
### 13.5 Tribunal Applications

There were 2 applications completed by patients requesting a tribunal, a hospital manager panel was not required in these cases and the MHS Administrator supported with coordination and collation of the reports.

### 13.6 Children and Adolescent Mental health Services (CAMHS)

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

13.7 CAMHS attendance for this reporting period are detailed in the table below.




### 13.8 Trust Assurance

A Mental Health steering group commenced in 2024, which is now chaired by the Chief Nurse. The aim of this group is to ensure there is a consistent level of care for patient who attend with mental health problems, that staff are suitably trained to support and that national and local guidance including legislation is adhered to. The work of the group is underpinned by a 3 Year Trust Mental Health Framework and an associated action plan

## 14. INITIAL HEALTH ASSESSMENTS (IHAs)

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

14.2 During 2025/26 for those completed for St. Helens, 80% (n112) of the 140 assessments were completed within the statutory timescale, this is a significant improvement compared to 2024/25 when only 58% of the 130 assessments were completed within timeframe. There have been no issues with appointments being available, as breaches have been due to external factors and children not brought to appointments, or requiring an alternative date. The ICB have commended the Developmental Paediatric Team for the improvements made in the service.

14.3 For those completed for West Lancashire of the 29 assessment requests, 62% were offered an appointment within 20 working days. For 6.9% the subsequent report was completed within timeframe. There were multiple external and internal factors relating to the breaches including late notifications from the LA, children not brought to appointments, the requirement for interpreters, and issues with appointment allocation secondary to gaps in medical staffing.

## 15.PREVENT

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

15.2 The Trust has made no referrals made during this reporting period under the PREVENT agenda

### 15.3 Training Compliance

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

| Competency | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| PREVENT Basic Awareness | 94.6% | 93.9% | 95.1% | 93.2% |
| PREVENT Advanced | 90.8% | 90.5% | 90.3% | 91.2% |

## 16.MANAGING ALLEGATIONS

16.1 The Assistant Directors Safeguarding and Named Nurses continue to support the Trust with management of allegations. These cases may be allegations in relation to abuse or neglect of a patient, or concerns raised in relation to a staff member and their suitability to work with children and or vulnerable adults; this could include criminal activity, drug and alcohol issues or concerns of abuse to a child or family member. Depending on the details of the allegation cases can take several months if not longer to resolve, particularly when there is police involvement.

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

16.3 During 2025/26, 152 new concerns were raised to the safeguarding teams across sites, all cases were reviewed and managed as per the Management of Allegations Policy supported by the Assistant Directors. The majority of allegations related to incidents / behaviours outside of the workplace which can involve external agencies such as police and children's social care; 23 cases involved agency staff for whom onward referrals were made.

16.4 Within Lead Employer, 44 new concerns were raised in relation to Doctors in training, with key themes relating to allegations of abuse, and incidents outside of the workplace, predominantly alleged perpetrators of domestic abuse.

16.5 In order to complete initial fact finding and determine immediate action 120 internal allegations meetings were convened; in addition, 36 LADO meetings were attended. Where applicable cases will progress through the Trust Disciplinary process and, if required notifications will be made to Professional Bodies and to the DBS.

16.6 In cases where potential harm to a patient was identified referrals were made to the Local Authority Safeguarding Teams

## 17.SAFEGUARDING AUDITS

17.1 Throughout this year the Safeguarding Teams have undertaken an array of audits across various sites in the Trust. For those where assurance is not achieved the teams will liaise with the clinical team regarding how improvements can be made.

17.2 The table below provides a summary of audit findings

| Audit title | Findings |
|---|---|
| Management of Domestic Abuse Audit | This audit provided good assurance that when domestic abuse is identified staff can support victims by ensuring internal safeguarding processes are followed, appropriate referrals made and risk to victims and their dependants is reduced. |
| Audit of Young Person's Drug and Alcohol Attendances at MWL ED Sites | For Whiston ED there was assurance that staff can identify when a young person's drug and alcohol screening tool needs to be completed and can complete this. The audit demonstrated that S & O ED have made appropriate referrals to children's social care regarding relevant drug misuse and contacted relevant social workers for those who were involved. All attendances were reported to 0-19 and GP via a paediatric liaison form |
| Audit of Mental Capacity Act and Deprivation of Liberty Safeguards Compliance | Whilst the overall level of assurance was below 100%, it demonstrated that at the Southport and Ormskirk sites where the DoLS process, including the capacity assessment, has been digitalised since November 2022, the level of assurance was higher. This evidenced the importance of the digitalised process being aligned across all sites, which has now been achieved. An action plan was developed including training for staff, guidance tools and escalation of the requirement for the digitalised DoLS process across all sites. |

| | |
|---|---|
| Audit of maternity compliance for routine domestic abuse questioning during the antenatal period | This was the first MWL audit. The audit provided assurance that woman are being asked routine enquiry at least once and, in most cases, more than once. The audit did not provide assurance that routine enquiry is embedded at all ante-natal appointments, and the action plan seeks to improve this. |
| Audit of A&E Compliance with under 18 Clinical Assessment Service (CAS) Card | The audit identified good practice in capturing the voice of the child and documenting safeguarding-related information. CAS card usage, CP-IS recording and checks, and completion of safeguarding assessment required improvement across both sites to enhance assurance and meet expected safeguarding standards. Variation still exists between sites due to differing documentation systems. |
| Audit of compliance of Children's Social Care referrals MWL Sites | This audit provided assurance on the quality and appropriateness of Children's Social Care referrals made across the Trust and demonstrated generally good practice across all sites. Improvements have been noted when compared with previous audits, particularly in relation to analysis of risk, most notably within maternity services at Whiston site. The audit identified ongoing areas for development across both sites. Documentation of Trust involvement, analysis of risk, recording and sharing contact details. |
| Audit of Quality of Adult Safeguarding Referrals | This audit provided significant assurance in relation to the quality of referrals completed by the Trust Safeguarding Team. Of the 20 referrals scrutinised, this audit demonstrated a conversion rate of 85% in relation to safeguarding enquiries completed. It is recognised that due to the fast pace of the hospital setting and the need to make onward safeguarding referrals in a timely manner, a conversion rate of 100% could never be achieved. |
| Audit of Care of Patients with a diagnosis of LD or Autism | The audit provided assurance for the use of the hospital passport and that reasonable adjustments are being considered and documented. The audit demonstrated that improvements are required for the completion of capacity assessments for relevant decisions other than for accommodation for care and treatment, and that when serious and or invasive care and treatment is being considered, evidence of a separate capacity assessment and best interest decision meeting is required. It has provided assurance that when required consent form 4 is being used. |

## 18. EXTERNAL SCRUTINY

### 18.1 Commissioning Standards

In Q3 2025/26 the Trust submitted the Cheshire and Mersey Commissioning Standards. Feedback will provide in Q1 2026/27, and it is anticipated that a green status will be achieved in all areas other than training. The Assistant Directors Safeguarding have developed action plans for each site, as there are some differences with the action's required across the Trust. The action plans are monitored by the Designated Nurses with further evidence submitted with the KPIs quartile submission to St. Helens PLACE.

### 18.2 Section 11 Scrutiny

In 2024/25 St. Helens Safeguarding children's Partnership (SCP) and the ICB sought to reduce duplication for providers, by acknowledging the scrutiny already undertaken by the ICB in the commissioning standards submission. In view of this the requirement was for the providers, via the ICB, to submit only the commissioning standards action plans for any ambers and reds, recognising that ongoing scrutiny of the action plans is provided by the ICB. The same is expected for 2026/27.

## 19. RISK REGISTER

There were 2 risks relating to safeguarding in 2025/26:

- For the Southport and Ormskirk sites Lancashire LA is not undertaking Best Interest Assessments; therefore, the Trust may be depriving patients of their liberty without the necessary legislation in place. This has been escalated via the Lancashire Safeguarding Board, and the Local Authority has a process for prioritising their waiting list. This has been mitigated as detailed in risk register.

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

## 20. SAFEGUARDING WORK PLAN 2026/2027

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

- We will endeavour to develop an MWL electronic level 3 adult training package
- We will extend the Service Level Agreement for the Mental Health Act Legal Administration across all sites
- We will harmonise the Mental Capacity training across all sites
- We will review all policies required this year
- We will update the MCA and best interest process, based on developing case law
- We will support data collection with the development of BI reports
- We will identify additional staff member to complete IDVA training on S&O sites
- We will review and complete the Liberty Protection Safeguards consultation if released in the next reporting period
- We will collaborate with Local Authority's regarding changes to the DoLS process in line with case law and MCA Code of Practice
- We will support Local Authorities with the implementation of family first programme
- We will implement CP-IS to scheduled areas
- We will review recommendations and any actions required following the Southport enquiry
- We will review changes to Working Together 2026 and update processes as necessary
- We will review the Safeguarding Training Needs Analysis ensuring it aligns with the current Inter Collegiate Documents for Adults and Children

## 21. CONCLUSION

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

21.2 The Safeguarding Teams oversee and monitor key areas to ensure appropriate referrals and actions are undertaken to safeguard the un-born, children, young people, and adults at risk of abuse. This has been enhanced by the additional roles of LDAP and HISVA. The

Safeguarding Team will continue to improve and simplify processes, embed training into practice, ensuring quality referrals are undertaken, and enable staff to use their time with patients effectively to identify and manage safeguarding concerns.

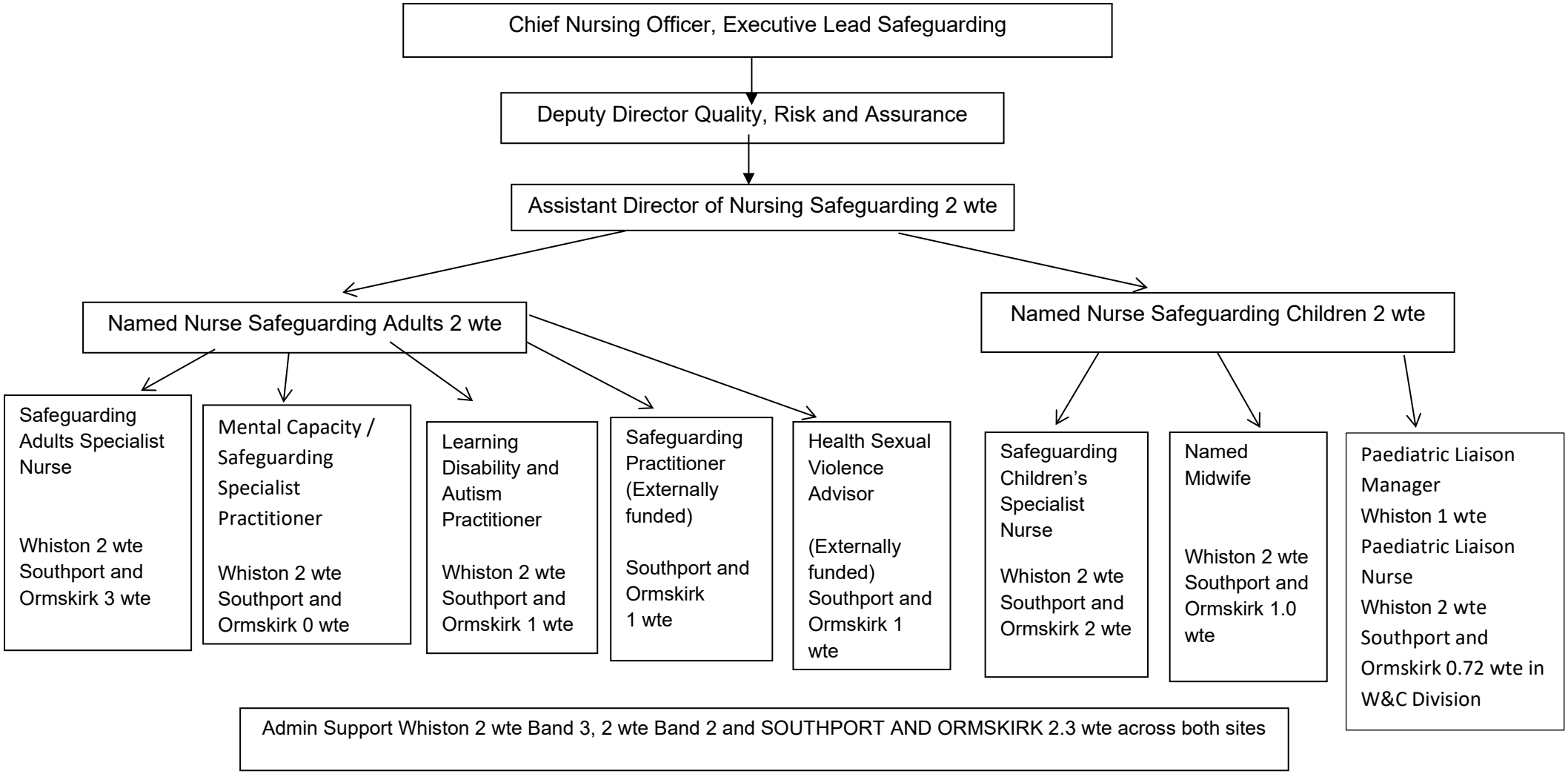
21.3 The Safeguarding Teams on all sites have continued to demonstrate a high volume of activity in relation to Safeguarding Adults, Children and Unborn infants. This provides significant assurance that safeguarding continues as a priority across the organisation. There is evidence of commitment to multi-agency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

21.4 The teams across sites continue to work together to review and harmonise ways of working and safeguarding processes, including the safeguarding reporting process. Training compliance has improved although there is still improvement required to achieve 90% in all areas.

## 22. RECOMMENDATIONS

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

## 24. Appendix 1: Trust Safeguarding Structure



| | | | | |
|---|---|---|---|---|
| **Title of Meeting** | **Trust Board** | | **Date** | 24 June 2026 |
| **Agenda Item** | **TB26/048** | | | |
| **Report Title** | **Freedom to Speak Up Annual Report 2025/26** | | | |
| **Executive Lead** | Sarah O'Brien, Chief Nursing Officer | | | |
| **Presenting Officer** | Sarah O'Brien, Chief Nursing Officer | | | |
| **Action Required** | | **To Approve** | X | **To Note** |

## Purpose

Trust Board is asked to receive this report, to note Freedom to Speak Up (FTSU) activity and the response to staff members who have raised concerns. The purpose of the report is to provide assurance that the appropriate systems and processes are in place for staff to do this safely and confidently, knowing that appropriate action will be taken.

## Executive Summary

This report provides assurance to the Trust Board of an established and functioning Freedom to Speak Up Guardian (FTSU) Service. In addition, it will provide a summary of the FTSU activity during the year 2025/26 along with examples of any lessons learnt.

There were 180 concerns raised by FTSU Guardians in 2025/26, which was a 36% increase compared to the previous year. Increased awareness sessions, leadership training input and the addition, and continued development of FTSU Champions in more areas have been effective in raising the profile of Freedom to Speak Up. The report highlights key themes and trends, as well as some of the lessons learnt and changes made as a result of staff speaking up.

In response to staff survey and feedback, and in recognition of multi-site working, 41 FTSU Champions have been recruited to support staff in raising concerns.

The Trust successfully hosted the Northwest Regional FTSU Conference in November 2025 with excellent evaluations of the day, the Trust's Chief Executive spoke at the event, which was well received.

Feedback from those staff who have raised concerns, continues to be very positive and indicate how they value FTSU Guardian input and support.

## Financial Implications

None

## Quality and/or Equality Impact

None

## Recommendations

The Board is asked to note the Freedom to Speak Up Annual Report 2025/26.

## Strategic Objectives

| | |
|---|---|
| X | **SO1** 5 Star Patient Care – Care |
| X | **SO2** 5 Star Patient Care - Safety |

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

# Freedom to Speak Up Annual Report 2025/26

## 1. Introduction

Freedom to Speak Up (FTSU) Guardians were introduced following the Mid Staffordshire Inquiry. Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) is committed to ensuring that everyone working in the Trust feels safe and confident to speak up, and that managers and leaders welcome the opportunity to learn and improve.

This report provides assurance to the Trust Board that an established and effective FTSU service is in place. It also summarises FTSU activity during the year 2025/26 and highlights examples of lessons learned.

It should also be noted that staff speak up informally through several routes, including via their line manager, Human Resources, 'Ask Rob' and through Governance teams. This report does not cover that activity, but only describes concerns raised through Trust FTSU arrangements.

## 2. Freedom to Speak Up Service

The Trust has four Guardians supporting staff across all sites. Two Guardians hold dedicated Guardian roles, totalling 1.0 whole time equivalent (WTE). Both were recruited through a fair and transparent process, as recommended by the National Guardian's Office (NGO). The other two Guardians undertake the FTSU role alongside their substantive roles as a Medical Consultant and Assistant Director of Patient Safety. The Guardians are supported by a part-time Specialist Administrator, who also represents the service as an FTSU Champion. There is no national guidance on the number of Guardians required relative to organisational staffing numbers; however, this should be guided by activity and demand, geography, and staff survey and feedback data. The Trust will continue to monitor Guardian workload and, if necessary, will consider further investment.

In addition, the FTSU Guardians recruit and support FTSU Champions from across the workforce, and the number of Champions continues to grow. There are currently 41 FTSU Champions across MWL, from various professional groups and services, volunteering their time to support staff. These staff provide visible support for the Trust's developing speaking-up culture, and work is ongoing to recruit Champions in more areas.

## 3. Report on Submission to the National Guardian's Office

The following information has been submitted to the NGO in accordance with revised guidance that came into effect on 1 April 2024. The Trust is required to submit data quarterly via an online portal.

As previously stated, this report does not include informal concerns raised and resolved through line management, the FTSU Champion structure, or other mechanisms within the Trust.

Quarterly submissions to the National Guardian's Office

| Quarter 2025/26 | Reporting period | Submission date | Concerns raised |
|---|---|---|---|
| Quarter 1 | 1 April – 30 June 2025 | 5 August 2025 | 56 |
| Quarter 2 | 1 July – 30 September 2025 | 4 November 2025 | 35 |
| Quarter 3 | 1 October – 31 December 2025 | 15 January 2026 | 53 |
| Quarter 4 | 1 January – 31 March 2026 | 15 April 2026 | 36 |

The chart below (Fig 1) highlights the number of concerns raised through FTSU Guardians per quarter over the previous three years.

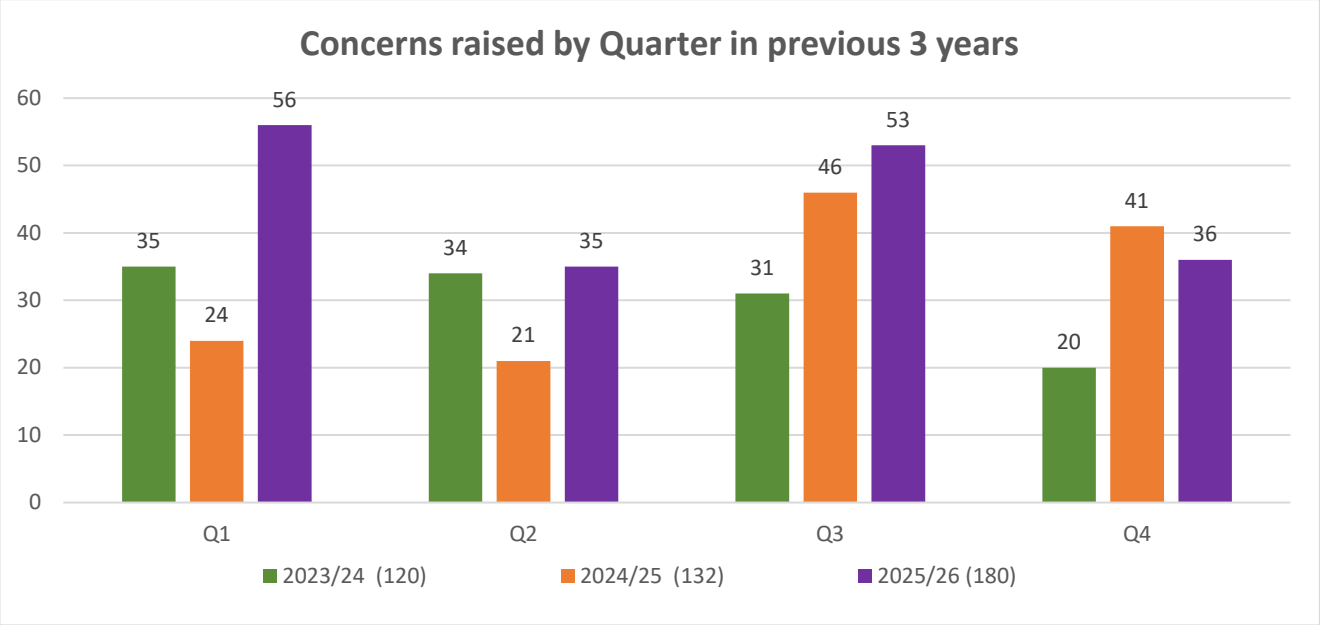



*Figure 1. Number of concerns raised*

There were 180 concerns raised with FTSU Guardians in 2025/26, representing a 36% increase compared with the previous year. There was also a 10% year-on-year increase from 2023/24 to 2024/25. This may reflect increased awareness sessions, leadership training input, and the continued development of Champions across more areas, all of which have helped to raise the profile of Freedom to Speak Up.

An increase in referrals is considered a positive indicator. The two highest-performing acute trusts in the Staff Survey reported higher referral numbers than MWL; therefore, a higher volume of referrals is not viewed negatively, but rather as a sign of an open reporting culture. The Trust will continue to analyse themes arising from concerns to identify any systemic issues.

## 4. Categories, Themes and Trends Arising from Concerns

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

The chart below shows the annual themes of cases. Worker safety and wellbeing is the largest theme; however, this is often because the concerns raised by staff can have a direct impact on personal health and wellbeing. Inappropriate attitudes and behaviours, including bullying concerns, contribute to the higher number of cases recorded under worker safety and wellbeing.

The NGO requires trusts to report against each of the set categories, so the total number of themes recorded may exceed the number of referrals. The themes identified within the Trust do not suggest that MWL is an outlier nationally; however, it remains important to acknowledge these themes and trends and to ensure that staff can access support through Health, Work and Wellbeing (HWWB) and other appropriate pastoral services, where relevant.

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

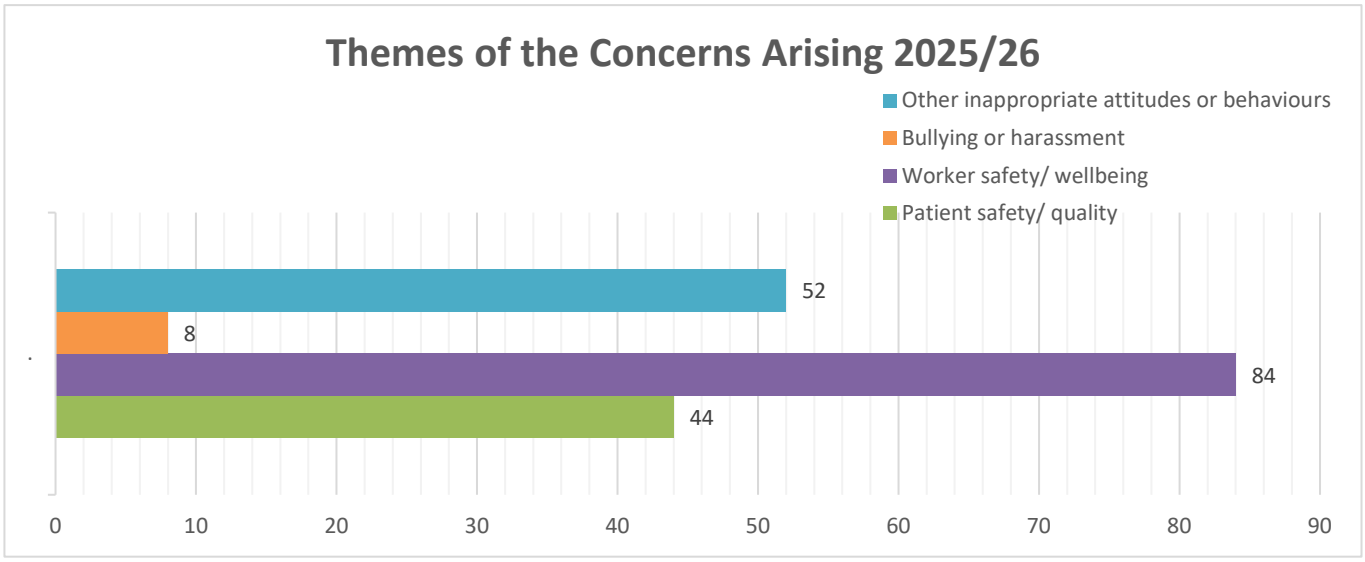



*Figure 2. Themes of concern 2025/26*

Focussed work has involved engagement and partnership working with the teams from Human Resources and Equality, Diversity and Inclusion.

## 5. Anonymous Concerns

The chart below (fig 3) shows whether staff chose to report concerns anonymously, confidentially, or openly during 2025/26.

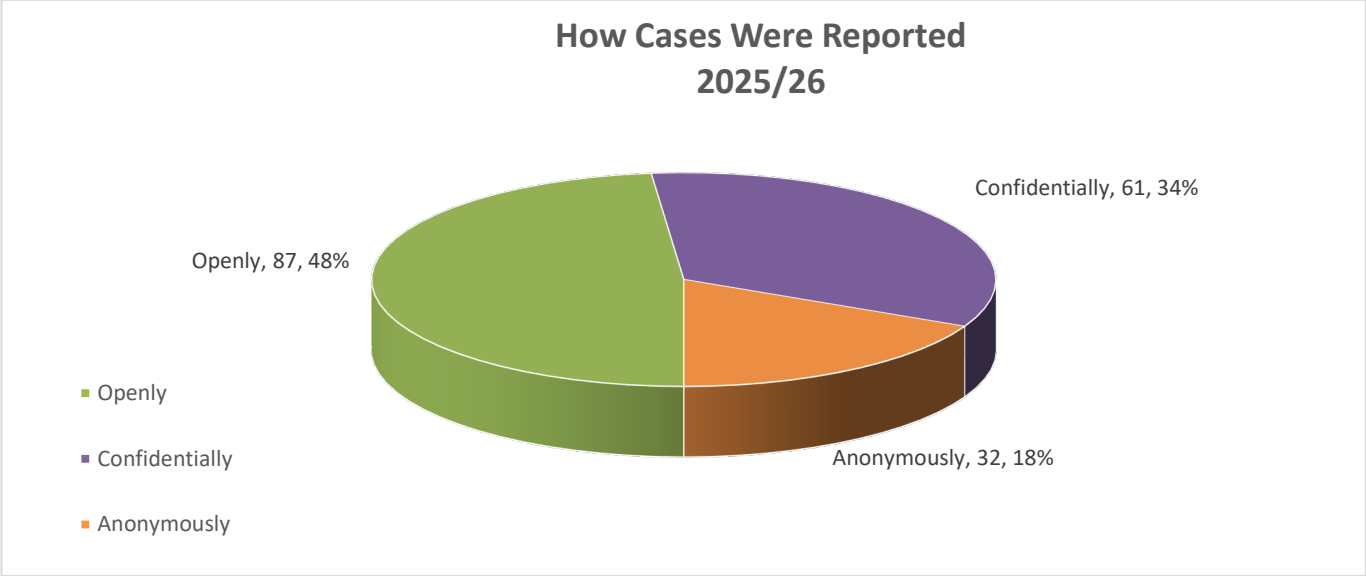



*Figure 3. Reporting category*

18% (32) of concerns were raised anonymously. In these cases, the identity of the person raising the concern is not known. Most of these concerns were raised via the Trust's Work in Confidence system, which keeps staff anonymous, including to the Guardian. This anonymised messaging system enables dialogue between the staff member and the Guardian to gather information, share outcomes, and offer feedback. A small number of concerns were also raised anonymously by telephone, letter, unidentifiable email addresses, and Google confidential email.

Previous benchmarking with other trusts does not indicate that MWL is an outlier in terms of the number of concerns raised in this way. Significantly more anonymous concerns are typically seen in trusts that use the Work in Confidence system.

It should be viewed positively that the Trust provides several routes for staff to report concerns, even though the preferred position is that staff feel able to raise concerns openly. It is better to hear the staff voice and review a concern than not to receive it at all.

In addition, of the 180 concerns raised, 34% (61) of staff members asked Guardians to keep their identity confidential. In these cases, the individual did not wish to be identified as having raised a concern and was known only to the supporting FTSU Guardian.

Guardians review cases to understand why staff may not have felt able to raise a concern openly and to identify any themes that the Trust may need to address. Staff are particularly concerned about retribution where the issue relates to inappropriate behaviours.

## 6. Professional Groups Raising Concerns

The charts below (fig 4) show the breakdown of staff groups that raised concerns during 2025/26. These professional groups are predetermined by the NGO to enable consistent reporting. In many anonymous referrals, job role information is not shared and is therefore unknown.

Concerns raised during the year may indicate issues affecting a particular theme or staff cohort. Guardians monitor and review this information to determine whether wider action is required or whether escalation to the Executive Team is appropriate.

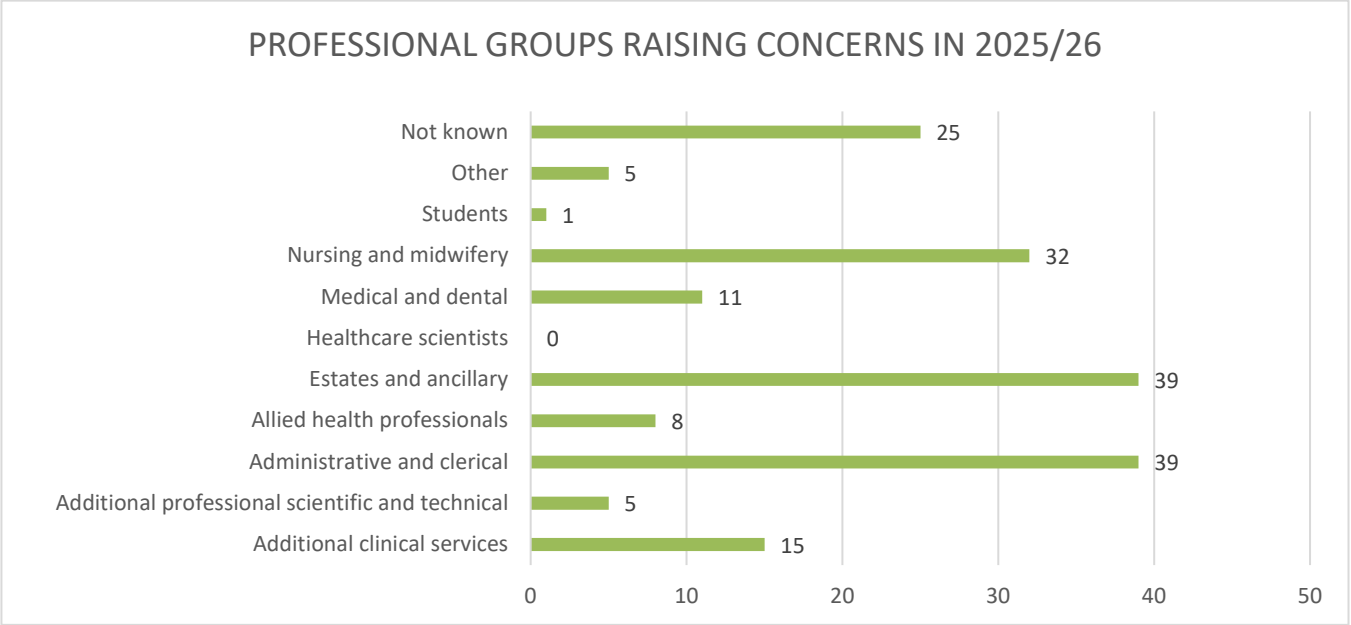



*Figure 4. Professional groups raising concerns*

Staff groups and areas are supported with ongoing work with continuous engagement, training by the Equality, Diversity and Inclusion Team, Civility training ,delivered by Human Resources, Active By-Stander Training and lunch time marketplace with stalls from a number of teams, including FTSU, to raise awareness to staff of what support is available to staff.

## 7. Situations where detriment was reported following speaking up

The National Guardian's Office published guidance on detriment in January 2025, which emphasises that organisations have a responsibility to protect workers who speak up from detriment and from disadvantageous or demeaning treatment; and act, and be seen to act, when detriment or disadvantageous or demeaning treatment does occur

During the year, there were seven reported cases of detriment following speaking up. The nature and causes of detriment are varied on all individual concerns.

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

Staff members reporting perceived or actual detriment have been supported by Guardians. Issues raised by staff members have been escalated to appropriate managers and leaders. Where required organisational development intervention or appropriate HR intervention, have been undertaken.

The Trust will continue to review and assess whether Trust policies and support to staff are sufficiently clear regarding the actions to be taken when detriment occurs. FTSU Guardians have a close working relationship with Human Resources colleagues to support staff members and initiate appropriate interventions.

## 8. Staff Survey

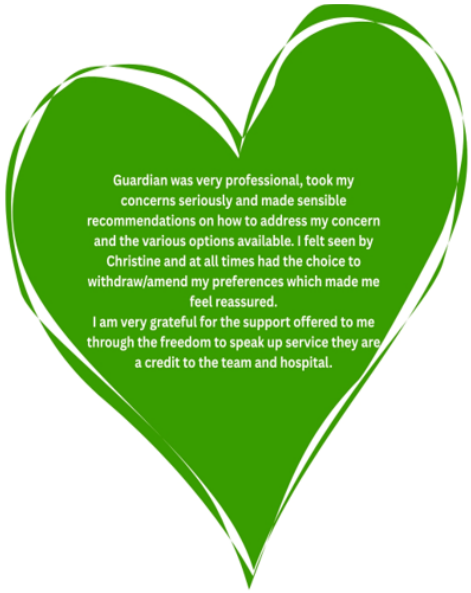
The NHS Staff Survey 2025/26 results continue to show that the Trust performs positively and above the national average in the domain "We have a voice that counts". In response to the question, *"I feel safe to speak up about anything that concerns me in this organisation"*, the Trust scored 64.02%, compared with the national average of 60.2%. For the question, *"If I spoke up about something that concerned me, I am confident my organisation would address my concern"*, the Trust scored 53.53%, compared with the national average of 48.23%.

Departments with lower scores have been identified and have received visits from Freedom to Speak Up Guardians to raise awareness of speaking-up processes and the support available through Freedom to Speak Up.

## 9. Feedback Following Concerns Raised

The NGO requires FTSU Guardians to invite identifiable staff who have raised concerns to provide feedback once their case is closed. The NGO specifically asks us to seek feedback on the following:

- Would they use the FTSUG again to raise a concern?
- Would they like to offer further comments about the service or the process?
- Feedback from staff to the FTSU team has been consistently positive throughout the year.




## 10. Changes as a Result of Speaking Up

A common question is: "What has changed as a result of people speaking up?"

The table below shows the key themes of concerns raised in 2025/26 and the actions taken during and/or following review or investigation. Sharing actions taken as a result of speaking up must be balanced with the strict confidentiality required within Freedom to Speak Up and the need to avoid identifying individual staff members. Key learning from Freedom to Speak Up has also contributed to the development of the Trust Behavioural Strategy 2026/27. Details of individual concerns are therefore not included.

| Area of Concern | Examples of actions taken |
|---|---|
| HR-related concerns | • Bespoke support and guidance to managers in organisational change management.<br>• Facilitation of mediation processes to support the resolution of team dynamics.<br>• Support with the flexible retirement process.<br>• Team development. |
| Safety-related concerns | • Development of SOP and guidance for relevant teams.<br>• Education and training for staff members. |
| Staff welfare concerns | • Development of estate and staff facilities. |

The above table should provide assurance that when staff raise concerns, actions are taken if their concerns are confirmed following review/investigation.

## 11. How Concerns Are Managed

Concerns are managed on a case-by-case basis, in line with the Trust's FTSU and Raising Concerns Policy. Guardians have established links with the Human Resources team. They also hold regular meetings with the FTSU Executive Lead and quarterly meetings with members of the Executive Team.

Divisions have invited Guardians to attend divisional meetings to discuss FTSU. Work is ongoing to develop a consistent approach across all divisions.

## 12. Guardians' Support

Two of the Guardians met with the Guardian at Alder Hey in June 2025, following Alder Hey's positive results in relation to the Freedom to Speak Up questions in the Staff Survey. Significant work and staff support had been put in place at Alder Hey following a high-profile media case that caused considerable stress for many staff. A psychology-led staff drop-in service (named SALS) has a high profile and appears to be well used for a wide range of issues. This is considered to have made a significant contribution to staff survey responses.

The FTSU Guardians continue to be members of the regional and national Guardian networks. There is a monthly regional support meeting or workshop on Teams, with input from the national office. Guardians can also access training and additional support directly from the NGO, where required.
Guardians completed their annual update training from the NGO and attended the North West Regional Network Conference, which was hosted by the Trust in November 2025.

Michelle Cox was the keynote speaker at the conference. Michelle is a distinguished nurse with more than 30 years of experience in the NHS, and her extensive clinical background has informed her commitment to promoting anti-racism practices within healthcare.

In a landmark employment tribunal in early 2023, Michelle successfully challenged NHS England (NHSE) on grounds of race discrimination, harassment, victimisation, and whistleblowing detriment. Her case highlighted the systemic challenges faced by many staff from the global majority within the NHS, particularly those who speak out against injustice.

The event was well attended, and evaluation of the relevance of the content, the speakers, and the facilities was excellent.

The Chief Executive, Rob Cooper, attended the event and spoke about the role of chief executives in fostering a positive speak-up culture. Support from, and networking with, the North West FTSU Guardian network will be particularly important during the closure of the NGO and the transition arrangements that follow.

## 13. Governance

The Trust reports cases raised through an FTSU Guardian registered with the NGO via the national portal on a quarterly basis.

A Freedom to Speak Up report is presented to the Quality Committee twice a year, and an annual report is scheduled for presentation to the Trust Board. The Trust Board also undertook an annual Freedom to Speak Up self-assessment in 2025 to support timely evaluation and continuous improvement of speaking-up processes. In accordance with the current NHS standard contract, self-assessment will be carried out biannually, next due in 2027.

The assessment has been used to identify areas requiring increased focus over the past 12 months, including the continued development and implementation of engagement events, profile-raising activity, and further work in relation to reported detriment. The Trust's FTSU strategy and action plan were also updated and approved by the Trust Board.

The Valuing Our People Council and divisional governance meetings receive periodic operational updates from Freedom to Speak Up Guardians.

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

## 14. Protected Characteristics and Equality Monitoring

The Freedom to Speak Up Guardians aim to meet the commitments set out in the Trust's equality policy. This includes avoiding discrimination under the Equality Act 2010 and developing an accurate picture of the workforce profile of those who raise concerns. All staff who raise concerns are invited to complete an Equality and Diversity Monitoring Form; participation is entirely voluntary.

The response rate is low, with 16 responses from 180 cases (9%), and this does not provide an accurate reflection of the staff who raise concerns. Guardians continue to monitor the Staff Survey for any staff groups who may face barriers to speaking up. Guardians also attend a range of staff network forums to raise awareness of the support available.

## 15. Freedom to Speak Up Champions

The Trust actively recruits FTSU Champions from all areas of the organisation. They provide vital support to FTSU Guardians in promoting a safe speaking-up culture and signposting staff to appropriate help and support. There are 41 champions in the register. This is an additional role alongside their substantive posts within the Trust. Champions are invited to attend monthly meetings, where possible, to share information for local cascade and to access peer support. Guardians actively monitor Champion engagement and, where additional support is needed, hold one-to-one meetings with Champions.

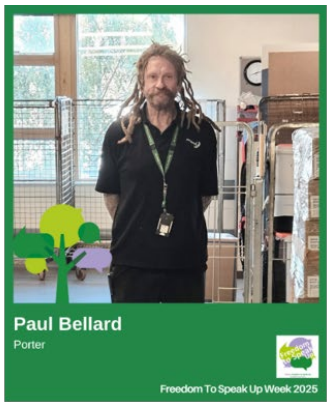
In April 2025, four FTSU Champions attended the Active Bystander training pilot and provided valuable feedback to support its development.

In May 2025, three Champions supported Patient Safety Summit information stands alongside Guardians across MWL sites.

In October 2025, Champions attended an away day to coincide with FTSU Week.

The day focused on equality, diversity, and civility. All attendees undertook Active Bystander training in the afternoon. The event was supported by colleagues from the Equality, Diversity and Inclusion Team and Human Resources. The Chief Executive opened the event and attended for part of the day, which was welcomed by Champions and reflected the value Trust executives place on speaking up.

Additionally, as part of FTSU Week, a number of Champions were profiled on the Trust's social media channels and in Trust News. This highlighted the positive contribution Champions make to the working environment and to developing a speak up, listen up, and follow up culture.



A list of current FTSU Champions is available on the staff intranet (Appendix 1).

## 16. Awareness

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

### 16.1 Freedom to Speak Up Week

Freedom to Speak Up Month took place in October 2025 and had the national theme “Follow Up in Action”.

Planned events and activities were hosted across the Trust on a range of platforms, including a Trust Brief Live team takeover, Champions’ away day, FTSU team walkabouts for night staff, presentations for preceptees and the Monday Medical Meeting, and Team Talks. Staff were also encouraged to participate in “Wear Green Wednesday”.

### 16.2 Communication and staff engagement

Regular communication with staff has continued through a range of channels, including MWL social media, Team Brief Live, MWL News, Global Mail, and Freedom to Speak Up walkabouts. This rolling programme supports ongoing awareness of the Freedom to Speak Up process.

## 17 Active Bystander Training

Active Bystander training was developed at the start of the year with the support of the Executive Leadership Team. The training equips staff with the tools to create and support a culture of accountability, support, and safety by intervening constructively when they witness harmful behaviour, discrimination, harassment, or injustice. Courses are designed for a minimum of 10 and a maximum of around 20 participants to allow meaningful discussion and the sharing of experience. Following a successful pilot, courses have been delivered monthly since November 2025, rotating across all sites. To date, 65 staff members have participated, and evaluation has been very positive, with staff booking in advance for future sessions and bespoke courses being requested by clinical educators.

## 18 InPhase Case Management Development

Freedom to Speak Up Guardians have worked with the InPhase Team to develop an FTSU module for use by the FTSU team. This will support standardisation, harmonise the data collection process, and strengthen case management.

## 19 The National Picture

The NHS 10-Year Plan announced that the National Guardian's Office will cease to exist. The NGO is due to close in June 2026, and a Board has been established to oversee the transfer of functions to NHS England (NHSE) in the first instance. Guardians have attended NHS England engagement events regarding the closure of the NGO and the subsequent arrangements for Freedom to Speak Up. Further information and direction are awaited in relation to future oversight of FTSU. The Care Quality Commission (CQC) will include Freedom to Speak Up within Well-Led reviews of trusts.

The NGO has recently published its Annual Report for 2024/25. The report highlights the following:

- The year saw the highest number of cases reported to guardians since the reporting began.
- Staff continue to express positive views about the Freedom to Speak Up Guardian role.
- Inappropriate attitudes and behaviours remain the most common theme of concern.
- Concerns related to worker safety and wellbeing are increasing.
- Confidence in organisations to address concerns is in decline.
- NHS trusts are showing a positive shift, with more full-time Guardians being appointed. The report calls for organisations, leaders, and managers to take deliberate and timely action to create a culture where speaking up is a routine part of organisational life.

## 20 Next Steps for 2026/27

Review and implement recommendations arising from relevant national inquiries, for example the Thirlwall Inquiry.

Review Trust requirements following direction from NHSE and after the closure of the NGO, including guidance on the future of Freedom to Speak Up: https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up/

Work with the wider Trust to review and address any actions arising from the Staff Survey, supporting divisions and departments to strengthen the speaking-up culture in their areas.

Continue to deliver Active Bystander training and organisational leadership development programmes.

## 21 Summary

This report provides assurance that an effective Freedom to Speak Up (FTSU) service is in place. The increase in concerns reflects a maturing and positive speaking-up culture.

## Appendix 1 - List of current FTSU Champions

### Freedom to Speak Up Champions

| Champion | Site | Role |
|---|---|---|
| Amanda Foulkes | Southport | Centre Technician |
| Andrew Perkins | Whiston | Practice Education Lead |
| Angela Ashurst | Ormskirk | Clinical Audit Officer |
| Ann Holden | Southport | Consultant |
| Barbara Marshall | Southport | Health Care Assistant |
| Carol Fowler | Southport | Deputy Director of Governance |
| Caroline Attwood | Newton | Lead Nurse |
| Chika Okere | Whiston | Clinical Educator |
| Claire Byrne | Whiston | Staff Nurse |
| Christine Alessandrelli | Southport | Anti-coagulant Administrator |
| Diane Charnley | Whiston | Therapy Directorate Manager |
| Elaine Power | Newton | Staff Nurse |
| Erica Isherwood | Southport | Clinical Procurement Matron |
| Felicity Gordon | Newton | Band 6 RGN |
| Helen Baliszewski | Southport | Nursing Associate |
| Jill Leigh | Whiston | Medical Secretary |
| Juliette Weldon | Whiston | Medical Secretary |
| Kate Edmondson | Southport | Patient Experience Facilitator |
| Kerry Lawrence | Southport | Assistant Practitioner |
| Laura Bailey | Whiston | Care Assistant |
| Lee Birchall | St Helens WIC | Senior Nurse Practitioner |
| Lesley Fawcett | Ormskirk | Infant Feeding Midwife |
| Linda Bradley | Southport | Clinical Coding Manager |
| Martin Abrams | Southport | Trust Chaplain |
| Michelle Davenport | Jubilee Court | HR Operations Manager |
| Neil Davies | Ormskirk | Health Care Assistant |
| Paul Bellard | St Helens | Porter |
| Paul McNevin | Ormskirk | Operating Department Practitioner |
| Paula Roughley | Whiston | Hospital Discharge Nurse |
| Pauline Wallace | Southport | FTSU Specialist Administrator |
| Rachael Byers | Lowe House | Community COPD Nurse Specialist |
| Ruth Fahey | St Helens | Health Care Assistant |
| Sally Snape | Southport | Diabetes Specialist Nurse |
| Sanjumol Yohannan | Southport | Infection Control Nurse Specialist |
| Sreebha Rajesh | Ormskirk | Consultant Obstetrics & Gynaecologist |
| Stacey Shirley | Lowe House | Care Co-Ordinator |
| Susan Curran | Ormskirk | Directorate Manager |
| Swathi Upadrasta | Whiston | Consultant Paediatrician |
| Tracey Lloyd | Ormskirk | Health Care Assistant |
| Yvonne Mahambrey | Whiston | Matron- Patient Experience |
| Zoe Whiteside | Southport | Postgraduate Coordinator |