Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 29 July 2026
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (July 2026)** *Purpose: To **note** the Employee of the Month presentations for July 2026*	Film	Chair *(15 mins)*
10.15	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.30	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB26/049 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 24 June 2026*	Report	
	6.	**TB26/050 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
10.40	7.	**TB26/051 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*	Report	S O'Brien / S Dowson L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Reports				
11.10	8.	**TB26/052 Committee Assurance Reports** 8.1. Executive Committee 8.2. Audit Committee 8.3. Charitable Funds Committee 8.4. Quality Committee 8.5. Strategic People Committee 8.6. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper G Brown obo S Connor N Fletcher obo N French M Singh L Knight C Spencer *(40 mins)*
Other Board Reports				
11.50	9.	**TB26/053 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register*	Report	S O'Brien obo S Regan *(10 mins)*
12.00	10.	**TB26/054 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	R Cooper obo S Regan *(10 mins)*
12.10	11.	**TB26/055 Aggregated Incidents, Complaints and Claims Report (Q1)** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for Q1*	Report	S O'Brien *(15 mins)*
12.25	12.	**TB26/056 Informatics Reports** 12.1. Data Security and Protection Toolkit (DSPT) 12.2. Information Governance Annual Report 2025/26 12.3. Freedom of Information Act Annual Report 2025/26 *Purpose: To **note** Informatics Reports*	Report	M Gandy *(15 mins)*
12.40	13.	**TB26/057 Emergency Planning Response and Resilience (EPRR) Annual Report 2025/26** *Purpose: To **approve** the EPRR Annual Report 2025/26*	Report	L Neary *(10 mins)*
12.50	14.	**TB26/058 Infection Prevention and Control Annual Report 2025/26** *Purpose: To **approve** the Infection Prevention and Control Annual Report 2025/26*	Report	S O'Brien *(10 mins)*

13.00	15.	**TB26/059 Amended Trust Board Meeting Arrangements 2026/27** *Purpose: To **approve** the amended Trust Board Meeting Arrangements for 2026/27*	Report	AM Stretch *(5 mins)*
Concluding Business				
13.05	16.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.10	17.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 30 September 2026 at 09:30		**13.15 close**
15 minutes lunch break				

Chair: Steve Rumbelow

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

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/000**			
Report Title	Employee of the Month (July 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 July is George Babu, Healthcare Assistant on Ward 7A at Southport Hospital. He was nominated by Mark Lee, Charge Nurse.

As a Healthcare Assistant, George is integral to the smooth running of the ward and plays a key role in supporting both patients and the wider clinical team. His day-to-day responsibilities include assisting with personal care, promoting independence and dignity and carrying out routine observations and monitoring.

Often one of the first people individuals meet during their hospital stay, George is known for his caring, professional attitude, excellent work ethic and his commitment to ensuring everyone feels safe and respected throughout their time in hospital.

George was nominated following an incident in May when he chaperoned a patient to Preston Hospital for a PET scan. During the return journey, the ambulance broke down on the M6, leaving George and the patient at the side of the motorway for more than two hours in temperatures reaching 30°C.

Despite the challenging conditions and limited shelter, George remained focused on the patient's comfort and wellbeing throughout, offering reassurance and support while putting the patient's needs before his own during what could have been a very distressing experience. The patient later spoke highly of George's kindness and selflessness, recognising the lengths he went to in order to protect and support them in a difficult situation.

This act of kindness reflects the values and qualities George demonstrates every day. He regularly goes above and beyond for those around him, treating everyone with respect and compassion. A reliable and hardworking member of the team, he is always willing to lend a hand during busy periods and contributes positively to the ward environment.

George, your selfless actions, unwavering commitment to high-quality care and genuine concern for others make you a much-valued member of Ward 7A and a truly deserving Employee of the Month. Please accept your certificate and wear your badge with pride, congratulations

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable	
Recommendations	
The Board is asked to note the Employee of the Month winner.	
Strategic Objectives	
	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care – Safety
	SO3 5 Star Patient Care – Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/000**			
Report Title	Patient Story			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Yvonne Mahambrey; Matron Patient Experience and the Bariatric Team			
Action Required		**To Approve**	X	**To Note**

Purpose

To present Lisa's experience of weight loss surgery and the impact upon her health and quality of life.

Executive Summary

The NHS is currently confronting obesity as a significant public health crisis, which is placing additional pressure on healthcare services. Obesity is closely associated with a range of comorbidities, including obstructive sleep apnoea (OSA), diabetes, and cardiovascular disease. To address this issue, the NHS offers weight loss surgery to patients who meet specific clinical criteria. By reducing their body mass index (BMI), patients can significantly improve and in some cases even resolve these conditions. This can lead to a decreased reliance on medication, enhanced quality of life, improved physical and mental wellbeing, and a greater ability to return to work.

Lisa's story highlights impact that this service has for its patients. Lisa experienced ongoing challenges with weight management which significantly impacted her family life, confidence, mobility and overall wellbeing. Having been approved for bariatric surgery, Lisa reduced her BMI from 48 to 26, achieving a weight loss of over nine stone (58 kg) and loosing 94% of her excess body weight, an excellent outcome. She has now been discharged from the service following the standard two year follow up period, during which patients are supported to adapt to and sustain their new lifestyle. Lisa is now looking forward to continuing her progress and creating more positive memories with her two sons.

Lessons Learned:

During the early stages of service development, there were a high volume of complex cases. These cases required advanced management and created a perception amongst staff that bariatric patients were inherently complex and difficult to manage. This perception did not accurately reflect the broader elective patient population. To address this, targeted educational sessions for the ward staff and pre-operative teams were delivered. These sessions helped to address common concerns, improve confidence, and establish a clear point of contact for ongoing support. Additionally, bariatric resource folders were introduced on the ward. These included discharge templates outlining expected medications, as well as guidance from the British Obesity and Metabolic Surgery Society (BOMSS) on post-operative medication management. A feedback section was also incorporated and is reviewed regularly to ensure continuous improvement.

Also, in response to trends observed in clinical practice, such as an increase in patients experiencing constipation, sessions focused on the 'importance of fibre'. This session provided an opportunity to educate patients on the role of fibre, strategies to improve intake, and practical ways to incorporate these changes into daily life.

This session proved beneficial for both patients and clinical practice. As a result, fibre education has now been incorporated into routine post-operative discharge discussions. Additionally, pre-operative

education sessions (bariatric school) have been adapted to include information on what patients can expect in terms of lifestyle changes, rather than focusing solely on medications and when to seek medical support. Supporting patients to understand their "new normal" has been identified as a key component of care, fed back from our support group.

Lisa, in addition to other patients was invited to attend the first support group session, during which patients were consulted on what they would like from the group, and which topics should be covered. There was a high level of engagement and enthusiasm, with many patients expressing a willingness to participate actively.

It was observed that some patients discontinued their proton pump inhibitor (PPI) medication once reflux symptoms resolved. While symptom relief may no longer be required, patients are now advised that continuation of PPI therapy is necessary for a defined period to protect surgically affected tissue, regardless of symptom presence. This has now been incorporated into pre-operative education, so patients understand which additional medications they are taking and why.

Attendance at an educational session (bariatric school) is required for all patients to ensure they have realistic expectations before, during, and after surgery. Educational content is regularly updated to reflect trends identified in follow-up clinics and feedback from the wider team including ward staff. For example, medication compliance post-operatively has been highlighted as an area of concern. Patients are now provided with detailed explanations regarding their prescribed medications, including the risks associated with non-compliance.

Patients from the initial support group also recommended involving a former patient in educational sessions. To implement this, patients were consulted on what messages, experiences, or reflections they would wish to share, including both positive and challenging aspects. This addition has introduced humour, authenticity, and a valuable personal perspective to the sessions.

Next Steps:
Bariatric surgery can be life-changing, even life-saving, but it's also life-restructuring. People choose it not just to lose weight, but to reclaim health, mobility, and added years for their life. The most successful outcomes come when surgery is paired with deep, lasting behavioural and psychological change. Work continues alongside patients to develop and refine the service and includes plans to;

- Introduce a patient with lived experience of surgery into face-to-face pre-operative educational sessions to enhance realism and relatability.
- Use patient narratives to contextualise clinical outcomes and bring to life the measurable improvements in health associated with bariatric surgery.
- Formalise a feedback form to capture patient experiences.
- Establish an additional specialised diabetes support group to provide patients with a face-to-face forum, enabling them to better understand and manage their expectations following surgery, which I am currently in the process of arranging for two of our patients with Type 1 diabetes.
- Upload the digital story onto the staff intranet to support both patient and staff education.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board is asked to note the Patient Story.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

DRAFT **Minutes of the Trust Board Meeting**
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 24 June 2026
(Subject to the approval of the Trust Board on Wednesday 29 July 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
Malcolm Gandy	MG	Director of Informatics
Elsie Hayford	EH	Shadow Non-Executive Director (via MS Teams)
Gareth Lawrence	GL	Chief Finance Officer
Lisa Knight	LK	Non-Executive Director
Lesley Neary	LN	Chief Operating Officer
Sarah O'Brien	SO	Chief Nursing Officer
Simon Regan	SRe	Director of Corporate Services
Mini Singh	MSi	Non-Executive Director
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer

In Attendance

Name	Initials	Title
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
No apologies received		

Agenda Item	Description
Preliminary Business	
1.	**Chair's Welcome and Note of Apologies**
	1.1. SR welcomed all to the meeting and in particular welcomed SRe who was attending his first Board meeting in his role as Director of Corporate Services. 1.2. The following awards and recognitions were noted: 1.2.1. In the latest national NHS performance rankings (published as part of the NHS Oversight Framework), MWL had climbed 27 places, making the Trust the fourth most improved Trust in the country. SR acknowledged the sustained day-to-day work undertaken by the staff as well as the work of the Executive Team in maintaining momentum and ensuring that the improvement journey continued. 1.2.2. Heather Skelland, Clinical Practice Educator, has won a Cavell Clinical Procurement Rising Star Award. 1.2.3. Miss Leena Chagla, Consultant Surgeon and Lead Clinician for Breast Services, was invited to attend The King's Garden Party at Buckingham Palace in recognition of her outstanding career in the NHS. Apologies for absence were **noted** as detailed above
2.	**Employee of the Month**
	2.1. The Employee of the Month for June 2026 was Lisa Shaw (LS), Complaints Co-ordinator, Whiston Hospital. 2.2. SR read out the citation for LS and RC presented the Employee of the Month certificate and pin badge. **RESOLVED:** The Board **noted** Employee of the Month for June 2026 and congratulated the winner.
3.	**Declaration of Interests**
	3.1. There were no new declarations of interests made in relation to the meeting agenda items.
4.	**TB26/042 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 27 May 2026 and approved them as a correct and accurate record of proceedings subject to the following amendments: 4.1.1. 1.2 to be amended to read *'SR read out the citation for MD and RC presented the Employee of the Month certificate and pin badge.'* 4.1.2. 5.1.1 to be amended to read *'The Meeting Attendance 2026/27 table to be updated to include NFr'*

	RESOLVED: The Board **approved** the minutes from the meeting held on 27 May subject to the amendments detailed above
5.	**TB26/043 Matters Arising and Action Logs**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. The following actions were closed: 5.2.1. Action Log number 21 (TB25/072 Statutory Pay Gap Annual Declaration 2024/25– An action has been included on the Strategic People Committee action log, and any concerns would be alerted to the Board via the Assurance Report. **Action closed.** 5.3. There were no other outstanding actions. **RESOLVED:** The Board **approved** the action log
Performance Reports	
6.	**TB26/044 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for May 2026 was presented.
6.1.	**Quality Indicators**
	6.1.1. SO and SD presented the Quality Indicators. SO highlighted the following: • There had been an increase in Clostridioides difficile (C.Diff) infections, particularly at Whiston Hospital, when compared to the same period last year. Targeted interventions were ongoing in affected areas, and a Trust-wide awareness campaign was being launched. Additionally, a Quality Improvement (QI) initiative with a focus on C.Diff would be launched in July 2026. A detailed update had been received at Quality Committee. • Complaints responses within 60 days performance had reduced in month to 59.3% (target 80%) and SO advised that work was ongoing with the Clinical Divisions to ensure timely responses. Additionally, the lessons learnt from previous months when performance had been improved were being applied. The main reason for the delay in responses was the time required for clinical reviews, which was dependent on clinicians reviewing notes and outcomes. 6.1.2. RC asked whether the complexity of complaints, multiple services or cross-organisational issues were contributing to delays in responding to complaints. SO responded that the main issue was the availability of key staff, including clinical staff, for responses. RC reflected on the use of technology, for example the use of ambient voice technology (AVT) in clinics to streamline the documentation and artificial intelligence (AI) tools to search

	notes and whether this would improve the processes. SO commented that work with AI in relation to policy searches could be extended to the complaints process, and this would be explored. 6.1.3. GB reflected on a Parliamentary and Health Service Ombudsman (PHSO) report which had recommended the use of AI to analyse complaints for emerging themes and trends. GB noted that this approach could generate more detailed and actionable insights than broad categories such as communication or clinical diagnosis, enabling more targeted improvement activities and service interventions. 6.1.4. MSi asked whether summer leave had impacted complaints performance. SO confirmed that this had been a contributing factor; however, performance had remained challenging over the preceding two months. GB noted that complaints performance had continued to present a challenge over a sustained period. 6.1.5. MG advised that the Trust was piloting AVT in clinics and exploring the use of AI to support policy and procedure searches and this could extend to trend analysis within complaints. AMS noted the potential risk that the use of AVT and AI could detract from clinical communication with patients and potentially contribute to an increase in complaints. SD commented that AVT could also support complaints handling by providing a more comprehensive record of consultations.
6.2.	**Operational Indicators**
	6.2.1. LN presented the operational indicators and highlighted the following: <u>Urgent and Emergency Activity</u> 6.2.2. The Trust 4-hour mapped waiting time performance for May 2026 was 77.3% which was a slight decrease from 77.9% in April 2026 (target 82%). This compared to 75.7% nationally and 73.8% for Cheshire and Merseyside (C&M). During May there had been a 3.5% increase in attendance. It was noted that the four-hour performance masked ongoing challenges, including long waits in the Emergency Departments (EDs), delays with ambulance handovers and corridor care. 6.2.3. In May 2026, a quarter of all patients arriving by ambulance had exceeded the 45-minute handover target and whilst this had improved, it remained an area of focus. LN reported that there had also been a 4% increase in the number of patients arriving by ambulance. 6.2.4. The Trust had started to report under the new national definitions for corridor care from 09 June 2026 and the Trust's systems and processes had been aligned to the national guidance. Previously, the Trust had averaged around 100 patients per day being cared for in a corridor during winter, however, this had reduced to an average of 63 in April 2026 and 30 in June 2026. LN highlighted that there had recently been an eight-day period with no corridor

	care over 45 minutes on either site. Additionally, the back corridor at Whiston Hospital had been closed and the use of the Same Day Elective Care (SDEC) corridor at Southport Hospital had been avoided. Escalation plans had been amended and senior sign-off was required by LN, SO or SD to use these areas. 6.2.5. Bed occupancy in May 2026 was 105% (equating to an average of an additional 93 patients above the number of available beds). This included patients in General and Acute (G&A) beds, escalation areas and those waiting for admission in the ED. 6.2.6. 22.2% of patients in May 2026 did not meet the Criteria to Reside (NCTR) in hospital (20.1% in April 2026) (YTD 23.2%) which equated to about 260 patients, or eight wards. Additionally, there had been bed closures at care homes in St Helens following visits by the Care Quality Commission (CQC) as well as unrelated closures in Sefton, which had further impacted capacity. It was noted that work was underway on system-wide improvement plans, and this included a C&M single point of access, and standardisation of the urgent treatment centre (UTC) options in the region. There was also a focus on mental health patient flow planning ahead of winter and LN noted that some of the long waits in the ED were for patients awaiting a mental health bed. 6.2.7. SD commented that the number of patients receiving care on a corridor would become a key metric and that there would be increased scrutiny. SD noted that sustained improvement would require system-wide change and advised that initial conversations had been positive but that sustained focus and consistency would be important to ensure changes become embedded. 6.2.8. SD advised that the Trust had a transformation programme which focused on areas within the Trust's direct ability to effect change, alongside continued work with external partners at both ends of the pathway, and that further assurance would be included in future reports. 6.2.9. It was noted that, with effect from July 2026, the Committee Performance Report (CPR) and the Integrated Performance Report (IPR) would be updated to include data relating to corridor care. Additionally, corridor care would also be discussed at Quality Committee, and Finance and Performance Committee, and this would provide routes for oversight and assurance. GB highlighted the importance of the narrative that would be included in the CPR and IPR reports. 6.2.10. GB commented that recent interviews with acute physicians had shown a shift in mindset as there had been a recognition that corridor care was a Trust-wide and system issue, and not just an ED one. The Acute physicians had discussed practical improvements, such as not keeping patients in the Acute Medical Unit (AMU) for blood tests and using virtual wards.

	6.2.11. SO agreed that reducing corridor care required a whole-Trust response and this included raising awareness amongst ward staff about the impact of timely discharges and length of stay, which contributed to corridor care pressures. 6.2.12. SD commented that discussions with clinicians had highlighted the level of clinical risk being held at the front end of the pathway. There was a need to ensure that those managing patient flow had a clear understanding of where the risk was being held, so that the overall position could be managed more effectively, across the whole system. 6.2.13. SRe provided feedback on the recent NHS Alliance workshop: Understanding acute Trust metrics in the NHS Oversight Framework (NOF) 2026/27, that he had attended, and noted that corridor care was currently being treated as a contextual measure, reflecting the current level of confidence in the available data, but that the intention was for corridor care to become a scoring metric later in the year. 6.2.14. MSi reflected on the impact of corridor care and peak-season pressures on staff wellbeing, including the potential for them to experience moral injury where operational pressures led to providing care on the corridor, and asked what support was available for staff when pressures were at their highest. LN responded that health and wellbeing support was offered to staff in the significantly challenged areas and reported that there had been discussion at a recent event in London regarding moral injury amongst staff and the impact of sustained operational pressures on how staff were feeling. LN commented that visits to departments had highlighted the relief felt by teams when pressure eased, and that this had provided a powerful reminder of the emotional impact experienced by staff working in challenging conditions. It was noted that, while arrangements might not yet be fully developed, efforts were being made to provide support to staff experiencing such challenges. MS advised that wellbeing teams and mental health first aiders were based in the high-pressure areas to provide support. It was noted that the ED teams at Whiston and Southport Hospitals had demonstrated strong teamwork and mutual support. The matrons also supported the teams which promoted resilience and helped to maintain a positive and collaborative working environment. Additionally, psychological support was offered, but this was limited. 6.2.15. MS highlighted that workforce mental health support remained an area that the organisation wished to grow and develop, particularly as this continued to be a leading reason for sickness absence. However, existing capacity was already stretched, and any expansion of support would need to be carefully considered. 6.2.16. RC commented that delivery of support needed to be consistent and available on a 24-hour basis. Another important feature of providing wellbeing support at times of pressure, highlighted at a recent national event, was the visibility of executive leadership to support delivery. RC commented

that LN, SD and SO had been consistently visible in relation to this work, and that their visibility had contributed positively to the progress being made.

6.2.17. RC reflected on the recent acute physician interviews and noted that the discussions had focused on how corridor care could be eradicated. This represented a significant shift in perspective and demonstrated broader recognition by the acute physicians, as a collective group, that corridor care was a Trust-wide issue requiring coordinated action.

6.2.18. SR commented that corridor care was a whole-hospital and whole-system issue linked to wider urgent and emergency care pressures, including performance, discharge and patient flow.

6.2.19. GB commented that she understood that corridor care also included adapted or additional bed spaces in inappropriate environments, and that it would be important to monitor the impact of their usage. LN responded that this information would be included in monthly reporting, with further detail being provided to Quality Committee and in future reports to Board.

6.2.20. SR asked whether the bed spaces referred to by GB were currently included as corridor care in the reported metrics. LN responded that if the bed met the relevant criteria, then they were included. LN reported that escalation areas on the Whiston site did not meet the criteria, however, some of the boarded areas on Southport site met the criteria to be declared as corridor care. SD commented that the term corridor care could be misleading and that further work was being undertaken to identify this within reporting and assurance processes.

<u>Elective Care</u>

6.2.21. The 18-week Referral to Treatment (RTT) performance was 67.2% in May 2026 and this was above plan (63.9%) and the national average (64.9%) compared to 66.8% in April 2026. MWL was the best performing Trust in C&M.

6.2.22. 52-weeks wait performance was 1.6% in May 2026, which was below the planned target of 1.7%. The elective waiting list had increased due to the transfer of between 1,500 to 1,800 patients in the plastics speciality from Wrightington, Wigan, and Leigh (WWL) NHS Foundation Trust (NHSFT) as well as the opening of gynaecology referrals at the Whiston and St Helens sites. Additionally, an increase in demand had been noted in dermatology and gastroenterology.

6.2.23. LN reported that the same processes that were in place for the urgent and emergency care transformation programme were in place for elective care and these included optimising pre-operative processes, aligning procedures to appropriate settings (e.g. moving some theatre activity to procedure rooms), and running high-volume, low-complexity (HVLC) lists, which improved patient flow and satisfaction, as well as theatre utilisation.

6.2.24. LN reported that, as part of the planning for the resident doctors' industrial action in June 2026, 39 outpatient clinics had been stood down. However, following the cancellation of the planned industrial action, 34 of these clinics had been reinstated within the same week. It was noted that no cancer patients had been affected.

Diagnostics

6.2.25. Diagnostics performance in May 2026 was 80.6% (target 95%) compared to 82.5% in April 2026. This compared to 87% for C&M and 75.1% nationally. There were two main underperforming specialities: Non-Obstetric Ultrasound (NOUS) and endoscopy. Performance was challenged due to workforce shortages of sonographers which reflected the national picture. A business case was being developed to expand sonographer training, and it was anticipated that the benefits of this would be seen in 18 months. Additionally, there had been a 38% increase in demand.

6.2.26. Challenges in Endoscopy at Whiston Hospital were mainly attributable to staff absence. A range of options to provide additional support had been explored, including the potential use of a room at St Helens Hospital during weekends to help manage demand. Work had also been undertaken to utilise the Endoscopy Hub at Halton; however, the associated administrative processes remained burdensome, and discussions were taking place with the C&M Director of Diagnostic Services to identify opportunities to streamline these arrangements.

Cancer Performance

6.2.27. Performance against the 28-day cancer target had deteriorated to 76% in April 2026 (target 77%) compared to 80.4% in March 2026. This compared to 75.9% nationally and 77.2% for C&M.

6.2.28. Performance against the 62-day performance had also deteriorated to 80.4% in April 2026 (target 85%) compared to 86.3% in March 2026. This compared to 76.9% for C&M and 70% nationally.

6.2.29. The two challenged specialities were skin and lower gastrointestinal (GI). LN reported that the Trust had maintained just over 85% performance for the 28-day skin cancer pathways, however, the continued increase in demand remained challenging. It was anticipated that the recruitment of four skin analytics support workers would improve triage. Additionally, the Trust was working with the Cancer Alliance to develop recovery plans.

6.2.30. MSi advised that the Integrated Care Board (ICB) had planned work to support and educate the primary care workforce in relation to suspected skin cancer pathways. This was due to be introduced in September 2026 and was intended to help address the increased demand, which had been identified as a key pressure point. LN reported that discussions at a recent skin cancer conference had focused on pathway improvements, system-wide responses and the importance of system thinking. It was noted that the use

	of skin analytics had supported the Trust in prioritising patients more effectively and in understanding the level of risk associated with patients being managed through the pathway. LN advised that as a regional plastic centre, the Trust continued to receive a number of complex cases, and it remained important to balance overall demand management with ensuring that clinically urgent patients were seen in a timely manner. 6.2.31. GB commented that at the recent Acute Physicians interviews there had been a discussion around the use of point-of-care ultrasound and noted that some medical staff had the relevant training. This would provide an opportunity for an initial assessment at the point of presentation, with further diagnostic imaging being undertaken where clinically indicated.
6.3.	**Workforce Indicators**
	6.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for mandatory training was 89.5% in May 2026 (target 85%). • The appraisal compliance rate was 79.5% in May 2026 against a target of 85%. This was the first month of the annual appraisal window for Agenda for Change staff, which was due to close in September 2026. Performance was ahead of the position reported for the same period in 2025, indicating that compliance was being achieved more quickly, and it was anticipated that the target would be reached sooner. • Sickness absence had reduced to 6.4% in May 2026 from 6.5% in April 2026 (target 5%). This was a reduction from a high point of 7.8% in December 2025 but was still higher than neighbouring Trusts. The Executive Committee continued to monitor absence support and long-term sickness, and a paper was due to be presented to review long term sickness. There was improved compliance with the Welcome Back conversations and MS noted the importance of these discussions in supporting staff to return to work. An absence calendar to support managers in identifying when staff reached absence trigger points had been introduced recently to provide managers with practical support in monitoring absence more effectively. Additionally, an investment had also been made in absence management training for managers and feedback received was positive, particularly on the support provided to managers in managing sickness absence consistently. • In month staff turnover remained stable at 0.8% (target 1.1%). • The average Time to Hire metric had decreased to 50.2 days in May 2026 from 52 days in April 2026, however, this remained above the target of 50 days. This was mainly due to a 14% increase in resident doctor headcount, and this would impact on occupational health capacity. MS reported that the Strategic People Committee would continue to closely monitor the recovery of this metric.
6.4.	**Financial Indicators**

	6.4.1. GL presented the financial performance indicators and reminded the Board that the Trust had set a deficit plan of £16.7m for 2026/27 which would enable access to £16.7m deficit support funding. This was supported by the delivery of a recurrent Cost Improvement Programme (CIP) of £49.7m as well as the delivery of activity in line with an agreed contract. 6.4.2. At month 2, the Trust was reporting an adjusted position of £6.1m and, if deficit support funding was excluded the adjusted position was an £8.9m deficit, which was in line with the plan. 6.4.3. GL highlighted the following: • Agency spend was 1.1% against a cap of 1.2% of total pay spend. • Bank spend was currently above the 6.1% cap at 7.8%. This included the impact of the resident doctors' industrial action in April 2026; however, this had not been taken into consideration. • The Trust had identified schemes in excess of the total target for the financial year, and this was in line with NHS England's (NHSE) directive and the requirement to access Q2 deficit support funding. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB26/044 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. RC presented the Executive Committee Assurance report for the four meetings held in May 2026. 7.1.2. 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. 7.1.3. The Committee had received the regular monthly assurance reports for: • Nurse Safer Staffing • Procedural Documents Update • Vacancy Control Panel (VCP) activity • CIP Update • Risk Management Council 7.1.4. RC highlighted the following items from the report: • The Committee received the Newton Hospital Estates work update following the security incident at Newton Hospital in December 2025, which had prompted a review of staff safety measures. It was noted that some previously approved security improvements had not yet been

implemented. Assurance was provided that these actions were progressing and the Committee would continue to monitor progress.

- The Committee had received the Acute Medical Rapid Assessment Unit (AMRU) Progress report. This pilot was one of the key initiatives in the Trust's efforts to eradicate corridor care and formed part of the wider Trust plan with various departments contributing to this. The effectiveness of the pilot would be reviewed post-implementation, and the Committee would consider whether to continue, adapt, or replace the approach based on outcomes. RC noted that this had formed part of the discussions at the recent acute physicians' interviews.
- The Committee received an update on the Neighbourhood Health Pioneer Programme and emphasised the need for the programme to progress beyond discussion to deliver tangible impact. It was noted that the Committee expected to see increased action and demonstrable results during the current year, and progress would be closely monitored.
- The Committee had received an update on the Electronic Prescribing and Medicines Administration (EPMA) licences and discussed the need to increase the number of licences to support the move to a single instance across MWL. The Committee had requested additional information.
- The Committee had received a verbal update on corridor care, and a report would be presented at a future meeting.

7.1.5. The Committee had approved the following investments during May 2026:

- Gastrointestinal (GI) Bleed Rota - the appointment of a locum to cover the gap in the GI bleed rota from August 2026 onwards to ensure continuity of care and compliance with clinical standards on the Southport and Ormskirk sites. RC advised that the existing service level agreement (SLA) with NHS University Hospitals of Liverpool Group (UHLG) would end in August 2026.
- A four month extension for clinical coding service provision to ensure that the Trust maintained accurate coding and data quality while longer-term arrangements were being finalised.

7.1.6. GB reflected on the appointment of locums to cover the gap in the GI Bleed rota and commented that this had addressed the perceived inequity between the Trust's two main hospital sites, however, continued focus would be required to support equitable service development across MWL's footprint.

7.1.7. GB reflected on Southport Hospital's reliance on SLAs with UHLG and commented that, where appropriate, services should be provided within the Trust's own footprint to support resilience, consistency and equity of access. RC commented that service development and integration had been among the intended benefits of bringing the two legacy organisations together, and that progress was beginning to be seen across several areas. Additionally, RC noted that there had been 16 applicants for consultant posts at Southport ED, which was an improvement compared with previous recruitment experience, with several strong candidates identified.

	7.1.8. KA requested additional information around the Neighbourhood Health Pioneer Programme including any timeframes for presentation to Board. RC responded that both St Helens and Sefton were national pioneer areas and members of the Executive team were engaged in work in both areas. The responsibility for neighbourhood delivery sat with the ICB who were currently undergoing an organisational restructure. There were relatively mature programmes in place in Sefton and St Helens, and the Trust would continue to contribute where possible to influence delivery. Additionally, Sefton had identified a neighbourhood health hub site and MWL would be part of the delivery, particularly from a diagnostics perspective. RC advised that the overall neighbourhood strategy was expected around September 2026; however, a draft had been shared, and this would support a more consistent approach across places and neighbourhoods. KA reflected on the current ad-hoc, and disconnected nature of the programme and that a clear strategy would support alignment with the wider left shift as well as the Trust's strategic objectives. The remainder of the report was **noted.**
7.2.	**Audit Committee**
	7.2.1. SC presented a verbal assurance report following the Audit Committee meeting that had been held on 23 June 2026 due to the timing of the Committee and proximity to the Board meeting. SC advised that he, GB and CS had attended a private session with the internal and external auditors prior to the meeting. This had allowed for more detailed discussion of certain topics as well as an opportunity to benchmark the Trust against peers. SC reported that both the internal and external audit teams had emphasised the Trust's positive culture and robust governance and highlighted strong delivery in financial management and CIP achievement. 7.2.2. SC highlighted the following: • The Committee had received the External Auditors draft Findings report for 2025/26 which confirmed that the audit had proceeded smoothly with effective collaboration between auditors and the finance team. The audit was substantially complete, and the auditors expected to issue an unqualified opinion. • The Committee had received the External Auditors' Annual Report for 2025/26 which had assessed the arrangements for value for money, financial sustainability, governance, and efficiency. The report had been positive, and no significant weaknesses had been identified. The Trust's performance, relative to other organisations, had been commended. • The Committee had formally approved the submission of the 2025/26 financial statements and the letter of representation, which confirmed that the accounts provided a true and fair view. • The Committee had received the Head of Internal Audit's Opinion, which had provided a summary of the work undertaken during 2025/26. The Trust had received substantial assurance overall, which was considered a

	strong result. The report had also highlighted the Trust's constructive approach to audit as well as the effectiveness of its review processes. • The Committee had received the 2025/26 Anti-Fraud Annual Report. • The Committee had approved submission of the 2025/26 Annual Report, and Annual Governance Statement. • The Committee had received the Annual Meeting Effectiveness Assurance report, which provided a summary of all committee assurance and checked for consistency and trends, and no major issues had been identified. 7.2.3. SC reflected on the value of the private meetings with the auditors in providing objective feedback and wider context regarding the Trust's performance, noting that this had provided assurance to the NEDs. CS reported that the auditors had advised that the Trust's internal audit programme was appropriately challenging, and that no further areas for improvement had been identified beyond those already being progressed. 7.2.4. GB commented that the External Auditors had been particularly impressed by the Trust's delivery of the CIP target, which had been a challenging one. The positive attitude toward audit and the finance team's performance had been commended. The Board **noted** the verbal update.
7.3.	**Quality Committee**
	7.3.1. GB, on behalf of MSi, presented the Quality Committee Assurance Report for the meeting held on 16 June 2026, noting the key quality performance indicators had already been discussed earlier in the meeting. 7.3.2. GB highlighted the following points from the report: <u>Quality Committee Performance Report</u> 7.3.3. GB reported that there had been two neonatal deaths relating to premature births and assured that the Committee had not identified any concerns with the care provided to the babies or their families. Additionally, GB highlighted the Committee's commitment to recognising issues and implementing improvement actions, however, sustaining these remained a challenge. It was anticipated that the ongoing quality improvement work would provide stability, however, this would need to be an area of focus going forward. <u>Clinical Effectiveness Council</u> 7.3.4. The rollout of My Kit Check, an electronic process to help staff maintain and monitor equipment for the resuscitation trollies in ED, had been highlighted. 7.3.5. Sepsis performance required improvement and a Sepsis Group was being established to address variation in provision across MWL. A Sepsis Lead had been appointed for Southport Hospital.

7.3.6. The Committee had received assurance on the Maternity triage process, which included the implementation of the new recommendations for telephone triage.

Mandatory Training Report

7.3.7. The Committee had reviewed the report, and it was noted that overall compliance with core mandatory and compulsory skills remained above target. However, some specific skills and work areas, such as nasogastric tube competency and sepsis, were identified as high-risk and required targeted intervention and fast-tracked training needs assessments.

7.3.8. A new NHS England (NHSE) competency-based framework would be introduced in April 2027, and the Trust would integrate this into ongoing training projects.

7.3.9. Medical and dental staff, as well as estates and facilities staff were identified as groups needing further support to achieve compliance, especially for the Oliver McGowan training and a deep dive would highlight any subject areas for escalation.

Patient Safety Council

7.3.10. Five incidents of severe harm had been reported in April 2026, and the Committee had received information on the incidents, the actions taken and shared learning. The importance of sustaining these improvements had been highlighted.

Patient Experience Council Report

7.3.11. The Committee had received the report and the scale of the work being undertaken across the Trust was noted.

7.3.12. There had been an improvement in compliance with the provision of the Trust's discharge information booklet, however, continued focus was required to ensure patients received appropriate discharge information. Additionally, the importance of patients having clear information following discharge, particularly where they needed to understand how to access support or raise concerns once they had returned home, was noted.

7.3.13. Improvements in feedback relating to whether relatives and friends felt that their concerns had been listened to and responded to with dignity and respect had been noted, however, further targeted work in this area could support improvements in the management and prevention of complaints.

7.3.14. There had been a decrease in the Maternity Patient Experience survey score relating to the information provided about options for where to have a baby, including site choice. Work was ongoing to support the recent pathway changes and to improve information provided to women and families.

7.3.15. The development of the new Friends and Family Test platform was progressing and the go-live was planned for August 2026.

7.3.16. The final draft Healthwatch reports following the visits to the EDs were awaited. GB commented that it was anticipated that the reports would provide further insight to inform ongoing improvement work within urgent and emergency care.

	7.3.17. The Council's Terms of Reference (ToR) had been approved subject to several minor amendments. <u>Annual Safeguarding Report</u> 7.3.18. The Committee had received the annual report for 2025/26. 7.3.19. GB reflected on the value of safeguarding case studies received by the Quality Committee, which provided insight into the breadth, depth and complexity of safeguarding activity supporting patients and staff and suggested that this were circulated to Board members. **Action:** The Safeguarding cases studies included in the 2025/26 Safeguarding Annual Report to be circulated to Board members. **BY:** Immediate 7.3.20. SO reported that two national maternity reviews, namely the National Maternity and Neonatal Investigation (led by Baroness Amos) and the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (led by Donna Ockenden), were due to be published shortly with potentially significant findings. SO advised that the Trust would await national guidance before undertaking benchmarking or immediate changes but would act on any urgent learning as needed and this would be reported through the Quality Committee. 7.3.21. MS commented on the challenges in relation to mandatory training compliance for Estates and Facilities (E&F), which had been identified as an area of risk at the recent Divisional Performance Review (DPR) meeting. This related primarily to Oliver McGowan training and fire safety training. It was noted that plans had been developed to improve access to Oliver McGowan training, which had previously been delivered as a one-off requirement and was now repeated on a three-yearly cycle. Further enhancements to the training offer were also being progressed. 7.3.22. MS advised that mandatory training compliance for medical and dental staff had been challenging for some time and she would be working with subject matter experts (SMEs) and medical and dental colleagues to develop a recovery plan to support improvement in mandatory training compliance to be presented to a future Executive Committee. The remainder of the report was **noted**.
7.4.	**Strategic People Committee**
	7.4.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 17 June 2026 and noted that some of the points noted had already been discussed in earlier reports to the Board and would not be repeated. 7.4.2. LK highlighted the following: • The Committee had received the annual update on the Staff Survey which had focused on the four targeted areas, namely strengthening leadership,

creating opportunities to listen and learn, improving everyday behaviours and supporting each other. Additionally, the Committee had also received an update on the targeted 90-day improvement plan for Southport and Ormskirk sites.

- The Committee had discussed the Time to Hire metric, and it was noted that whilst improvements had been made, the back end of the process around the clearance and occupational health stages continued to present challenges. This would be monitored to determine whether the recent interventions had the desired impact on reducing this.
- The Committee had received an update on the Mutually Agreed Resignation Scheme (MARS).
- The Committee had discussed the National Education and Training Survey (NETS) results and additional information; action planning and updates had been requested from the Valuing Our People Council. Key priorities raised in the survey included workload, facilities, supervision, quality of care, and variations in learning experience, and these were similar to preceding years. It was noted that the sample size of responders had been low and this had made meaningful analysis difficult.
- The Committee had received an update on Improving Working Lives (IWL) Resident Doctor (10-point plan) and the progress against the plan had been noted.
- The Committee had received the annual Volunteers Operational Plan update and noted the enthusiasm for increasing the volunteer workforce. The Volunteer Service Manager for Whiston, St Helens and Newton sites would be leaving the Trust at the end of June 2026, and the Committee had thanked her for her service and support.

7.4.3. MSi asked for clarification on the distinction between a Senior Resident Doctor Lead and a Resident Doctor Lead. MS explained that Resident Doctor Leads were resident doctors, while she and LK, as NED Lead, fulfilled the Senior Resident Doctor Lead roles as Board representatives.

7.4.4. CS recognised the work being undertaken by the SPC to provide ongoing triangulation of the People Plan into finance and performance, as required by the Trust's Plan, external auditors, and PricewaterhouseCoopers International Limited (PWC). The Deputy Director of Human Resources (HR) continued to work with MS to ensure rigorous monthly reviews and continuous improvement.

7.4.5. MS reported that she and SD had met in person with the resident doctor leads at Southport Hospital. Additionally, meetings were held monthly at Whiston Hospital via MS Teams. The value of having four engaged leads instead of the minimum one and the positive impact of this engagement on unblocking issues and improving experience was noted. The forum allowed for better understanding of existing support and the opportunity to enhance the resident doctor experience. MS advised that, in her absence, SD would continue to provide oversight to ensure continuity. MS reported that there was a new national requirement for Board Assurance Framework and a draft

	would be presented at Executive Committee and SPC for review before being presented at Board for discussion. MS noted that the Trust was well placed as a large lead employer, with existing infrastructure to support the resident doctors, and it was anticipated that there would be further enhancements to the resident doctor experience and survey outcomes as the 10-point plan was embedded. The remainder of the report was **noted**.
7.5.	**Finance and Performance Committee**
	7.5.1. CS presented the Finance and Performance (F&P) Committee Assurance report for the meeting held on 18 June 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. 7.5.2. CS reported that the M2 position had continued the positive trend established in M1 and noted that the Trust's performance remained ahead of other organisations across the ICB and nationally. This was attributed to the robust approach to CIP development across the Trust. 7.5.3. Other points to highlight from the report were: • The new NHS Oversight Framework had been received, and it was noted that new metrics were being introduced. These included community metrics and a combination of productivity and outcome measures and it was expected that these would evolve during the year as organisations responded to their feasibility and implementation. • CS highlighted the importance of integrating the new metrics into MWL's existing productivity and performance measurement processes, rather than managing them separately. This approach would also be applied to transformation programmes to ensure consistency in tracking improvement and performance. • The Committee had discussed what future reporting suites might look like and noted a focus on productivity and performance would be key. There would also be a need to assess the resilience of productivity and performance levels across specialties or transformation pathways, for example diagnostics performance had fluctuated and recovery plans had been required. • The Committee had discussed overlaying reporting with resilience measures, which would inform investment decisions and ensure that areas critical to sustained performance received appropriate attention. This approach would help identify vulnerabilities and guide the allocation of resources. **RESOLVED:** The Board **noted** the Committee Assurance Reports

Other Board Reports	
8.	**TB26/046 Fit and Proper Person Chair's Annual Declaration**
	8.1. SR presented the Fit and Proper Person Chair's Annual Declaration which provided assurance to the Board that the Trust met the requirements of the NHSE Fit and Proper Person Test Framework for Board members and was compliant with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 8.2. It was noted that as part of the annual process, the Chair had ratified the declarations and checks for all Board members, and the Deputy Chair had ratified the declarations and checks for the Chair. **RESOLVED:** The Board **noted** the Corporate Risk Register Fit and Proper Person Chair's Annual Declaration
9.	**TB26/047 2025/26 Safeguarding Annual Report (Adults and Children)**
	9.1. SO presented the 2025/26 Safeguarding Annual Report (Adults and Children) which provided an overview of safeguarding activity across the Trust, and assurance that the Trust fulfilled statutory requirements. 9.2. The report provided assurance that the Trust's safeguarding systems and processes were compliant with the statutory functions and CQC standards as well as the legal frameworks governing safeguarding. Additionally, the report detailed the extensive oversight that was received from the Commissioners and the ICB, and this was overseen by NHSE. There were numerous Key Performance Indicators (KPIs) that the Trust had to submit quarterly to the ICB. 9.3. The Trust had received significant assurance from the ICB, with only occasional performance below target in relation to Level 3 adult safeguarding training. The Trust had maintained strong safeguarding performance, supported by external assurance and positive feedback from the ICB. SO referred to correspondence received by RC from the ICB, which had commended the Trust's safeguarding arrangements, including the strength of the safeguarding teams. 9.4. The report provided a detailed breakdown of safeguarding activity and referrals and, whilst the number of overall referrals were slightly down, there had been an increase in the number of deprivation of liberty safeguards (DoLS). It was noted that the complexity of these cases had increased and this had affected patients and staff. SO acknowledged the safeguarding and legal teams for their expertise in managing these cases. 9.5. SO reported that NHS guidance was awaited following a new ruling that meant that DoLS applications would no longer be applied as a blanket

	requirement for all hospital admissions lacking capacity. Instead, more complex assessments would be required at ward level to determine necessity, potentially reducing the volume of applications to local authorities but increasing complexity for Trust staff. This was based on a recent Supreme Court judgment (2026) that overturned the previous Cheshire West "acid test" from 2014. The Trust would need to assess the impact of the new judgment on frontline staff, the safeguarding team, and the organisation. SO advised that the Department of Health and Social Care and NHSE had advised Trusts to wait for the new guidance before implementing any changes. **RESOLVED:** The Board **noted** the 2025/26 Safeguarding Annual Report (Adults and Children)
10.	**TB26/048 Freedom to Speak Up Annual Report 2025/26**
	10.1. SO presented the 2025/26 Freedom to Speak Up Annual Report which provided a summary of Freedom to Speak Up (FTSU) activity during the year and highlighted the main themes and trends. The report provided assurance that the Trust's processes were robust and compliant with national guidance. 10.2. SO reported that Estates and Facilities and administration staff were the two primary groups who had raised concerns. It was noted that, whilst these groups often raised concerns collectively, national guidance required concerns to be raised individually, and this approach had resulted in a higher number of concerns being raised as each collective theme was counted as multiple individual cases. SO assured that all concerns raised had been listened to and addressed and, if any issues were more appropriate for HR or were in line with other Trust policies, these were managed accordingly. Both staff groups had provided feedback that improvements had been made following their input. 10.3. SO reported that there had been an increase in FTSU activity, however, this was viewed as positive as it reflected greater awareness following increased engagement around FTSU. Additionally, the number of FTSU champions had increased to 41 during 2025/26 and this had supported the embedding of a speaking-up culture within the organisation. 10.4. NFr asked how the Trust compared to other Trusts in terms of the number of FTSU champions. SO responded that she was not aware of any issues regarding the number of FTSU Champions but agreed to check this against comparative data for other Trusts. 10.5. NFr reflected on the number of consultants that were FTSU Champions and asked whether this was normal and whether additional consultants should be encouraged to become Champions. SO responded that, whilst this was not unusual, it might be good to have more balance across the workforce by increasing the number of champions from the medical workforce not just at

	consultant level. AMS explained that the concept of FTSU Champions was not universal across all Trusts and for MWL this had originated at the legacy Southport and Ormskirk Hospitals NHS Trust. MWL had adopted the model and continued to expand champion numbers, aiming for representation across all staff groups and levels. SR commented that it would therefore not be possible to provide benchmarking for the FTSU Champions. **RESOLVED:** The Board **noted** the Freedom to Speak Up Annual Report 2025/26
Concluding Business	
11.	**Effectiveness of Meeting**
	11.1. Board members agreed that meeting had been effective.
12.	**Any Other Business**
	12.1. There being no other business, the Chair thanked all for attending and brought the meeting to a close 11.11 The next Board meeting would be held on **Wednesday 29 July 2026 at 09:30**.

Meeting Attendance 2026/27												
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	✓	✓	✓									
Simon Regan			✓									
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 24 July 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
29	26/11/2025	**TB25/093 Research and Development Annual Report and Capability Statement**	SD to develop a new MWL Research Strategy. Update (19/06/2026) The new MWL Research Strategy to be developed in line with the Clinical Strategy following Clincial Director (CD) development.	SD	~~Jun 2026~~ Oct 2026		
31	25/03/2026	**TB26/019 Committee Assurance Reports** 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. Update (24/07/2026) The Digitising Documentation Paper is currently progressing through the appropriate governance approval processes. The paper will set out the strategic approach, implementation plan, and proposed timeline for reducing paper-based processes across the Trust. Subject to governance approval, the paper is scheduled to be presented to the Closed Board in September.	MG	~~May 26~~ ~~Jun 26~~ ~~Jul 26~~ Sept-26		**Delegated to Closed Board in Septement 2026**

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
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. Update (24/07/2026) CRR reviewed and updated. Risk Register reviewed and relevant risks streamlined. **Action completed.** Update (22/05/2026) Risk on corridor care on CRR, but three on RR. Risks being reviewed and consolidated.	SO	Jul-26		**Completed**
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		**Included on agenda**
4	24/06/2026	**TB26/044 Committee Assurance Reports** 7.3 Quality Committee	The Safeguarding cases studies included in the 2025/26 Safeguarding Annual Report to be circulated to Board members. Update (14/07/2026) The 2025/26 Safeguarding Annual Report (including case studies) that was presented at Quality Committee was circulated to Board members. Action completed.	SO	Immediate		**Completed**

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	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.	MS / SD	~~Jan-26~~ ~~Apr-26~~ Jun-26	**19/06/2026** - Action added to the Strategic People Committee (SPC) action log and any concerns will be alerted to Board via the Assurance Report. **ACTION CLOSED**. **24/04/2026** - Recruitment was ongoing and planned into May 2026. An update would be provided at the Strategic People Committee in June 2026. **20/02/2026** - The medical leadership structure recruitment is underway and an update will be presented to SPC in April. **23/01/2026** - The CMO is about to commence recruitment to the new integrated medical leadership structure, and as part of this work the Trust had considered whether aspects of the current medical leadership structure or role design may be perceived as more attractive to male colleagues. This has included reviewing role expectations, the recruitment approach and any potential barriers or unintended impacts to ensure that our leadership opportunities are equitable, inclusive, and accessible to all. A further update once the process has concluded and if any recommendations have been identified will be shared with the Strategic People Committee (SPC).	**Action closed**

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/051**			
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 47 key metrics. Quality has 18 metrics, Operations 17 metrics, Workforce 6 metrics and Finance 6 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 18 metrics for Quality provide an overview for summary across MWL.

Recommendations

The Trust Board is asked to note performance for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
	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

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
Never Events	Jun-26	0	0	0	
Falls ≥ moderate harm per 1000 bed days	Jun-26	0.19	0.00	0.16	
Nurse Fill Rates	Jun-26	94.6%	90.0%	94.5%	
NEWS Obs on Time or Within Tolerance (A&E)	Jun-26	70.2%	80.0%	68.8%	
% Screened using the MUST tool	Jun-26	79.1%	95.0%	79.7%	
Fluid balance chart in place and accurately completed	May-26	51.2%	90.0%	52.7%	
MRSA	Jun-26	0	0	0	
C.difficile	Jun-26	10	97	30	
MSSA	Jun-26	12	0	23	
E.coli	Jun-26	18	151	53	
Complaints Responded In 60 Days	Jun-26	73.0%	80.0%	69.2%	
FFT - Inpatients % Recommended	Jun-26	93.2%	90.0%	93.6%	Worst 40%
Mortality - HSMR	Mar-26	116.2	100	97.4	Best 50%
Mortality - SHMI	Feb-26	1.00	1.00		
Mortality - SMR - Sepsis	Mar-26	83.6	100	83.3	
Neonatal Deaths	Jun-26	4	0	7	
Stillbirths (intrapartum)	Jun-26	0	0	0	
Sepsis: Administration of Antibiotics within agreed time	May-26	70.3%		69.2%	

Operations	Period	Score	Target	YTD	Benchmark
Average instances of Corridor Care (ED)	Jun-26	49.6	0	58.0	
Average instances of Corridor Care in (G&A) (IP)	Jun-26	0.6	0	0.8	
A&E Triage: % < 15 mins	Jun-26	74.4%	95.0%	72.7%	
A&E Standard (Mapped)	Jun-26	76.7%	82.0%	77.3%	Best 40%
% of patients spending more than 12 hours in A&E	Jun-26	19.1%	15.6%	18.9%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Jun-26	83.5%	100.0%	79.4%	
RTT % less than 18 weeks	Jun-26		70.6%		Best 40%
18 weeks: % 52+ RTT waits	Jun-26		1.0%		Worst 30%
Diagnostic Waits: % <6 weeks	Jun-26	80.6%	95.0%	80.6%	
G&A Bed Occupancy	Jun-26	96.9%	92.0%	97.0%	Worst 10%
Discharges Before Noon	Jun-26	18.7%	25.0%	19.3%	
% of Patients With No Criteria to Reside	Jun-26	20.6%	15.0%	22.3%	
Cancer Faster Diagnosis Standard	May-26	76.8%	80.0%	76.4%	Worst 40%
Cancer 31 Days	May-26	94.9%	94.0%	95.2%	
Cancer 62 Days	May-26	81.7%	80.0%	81.0%	Best 20%
Elective Actual Utilisation: Capped Orm & St.H	Jun-26	73.5%	78.7%	74.2%	
Elective Actual Utilisation: Capped S'port & Whist	Jun-26	81.1%	84.5%	80.6%	

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.

Workforce	Period	Score	Target	YTD	Benchmark
Mandatory Training	Jun-26	89.9%	85.0%	89.9%	
Appraisals	Jun-26	70.5%	85.0%	70.5%	
Sickness: All Staff Sickness Rate	Jun-26	6.7%	5.0%	6.5%	
Sickness Rate - All Staff (Rolling 12 months)	Jun-26	6.9%	5.0%		
Average time to recruit (days) - All Staff	Jun-26	50	40	51	
Staffing: Turnover rate	Jun-26	0.7%	1.1%	0.7%	

Finance	Period	Score	Target	YTD	Benchmark
Reported Surplus/Deficit (000's)	Jun-26		-6,812	-6,783	
Forecast outturn surplus/(deficit) (£000)	Jun-26		16	16	
Delivery of CIP savings (000's)	Jun-26		9,939	9,939	
Cash Balances - Days to Cover Operating Expenses	Jun-26	0.9	1.5		
Capital Spend £ 000's	Jun-26		7,883	2,519	
Value of aged debt >90days overdue £000's	Jun-26		11,000	15,536	

Board Summary - Quality

Quality

Never Events: No Never Events were reported in June 2026.

Falls: There was 7 Falls with Harm (moderate and above) in May 2026 (3 moderate and 4 severe). June data is yet to be validated for harm and learning reviews are currently underway for all falls with harm.

Safe Staffing: Staffing fill rates above threshold - Trust wide overall fill rates: Registered Nurse and Midwife - 94.60%, Care staff - 104.72%.

NEWS: Southport ED has continued its positive trajectory, achieving a further 3.12% improvement in compliance, increasing from 79.53% in May to 82.65% in June.
Whiston ED reported a further increase in compliance in June, rising from 61.13% to 62.93%.

MUST: MUST screening on admission - The importance of MUST screening for patients on admission has been re-highlighted to all areas and discussed at the ward managers and matrons July meeting.

Fluid Balance: Highest risk patients (with an AKI Stage 2 or above) have a fluid balance chart in place and accurately completed- This a new measure for 26/27.

MRSA: A zero-tolerance approach is still in place to support no MRSA bacteraemia. There were no MRSA bacteraemia YTD.

Clostridium difficile infection: There were 10 healthcare-associated CDT cases at MWL in June, and the Trust is 6 cases above threshold. A number of actions continue, aimed at improving diarrhoea management, IPC practices and the cleanliness of equipment and the environment.

MSSA: There were 12 healthcare-associated MSSA bacteraemia. The Bloodstream Infection Improvement Plan remains in progress, and improvements have been achieved in timely blood culture collection within the sepsis pathway.

Gram-negative bloodstream infections, E coli: There were 18 healthcare-associated E coli bacteraemia in June, compared to 24 in May. The Trust is 16 cases above threshold, which is a notable increase compared to Q1 2025/26.

Complaints: 64 first stage complaints were closed in June. 47 were closed in time and 17 were closed out of time, resulting in an improved compliance of 72% for the agreed Trust 60 working day target.

FFT: June positive score 93.16%, 0.84% below internal target of 94% (Most recent national average score April 2026 - 95%).

HSMR: The final HSMR for financial year 2025-26 was 97.4 for MWL (93.8 for STHK and 107.0 for S&O).

SHMI: The latest SHMI data for 12 months ending Feb-26 is 1.00 (1.01 for STHK and 0.98 for S&O).

Neonatal Deaths: 1 NND before 28 weeks born at MWL, 3 babies born before 28 weeks that died at another Trust.

Sepsis: The performance is better for moderate-risk patients with sepsis (80% within 3 hours) than for high-risk patients (66.7% within 1 hour).

Sepsis SMR: Noted that the Trust's sepsis mortality ratio is well below the target of 100, indicating better-than-expected survival rates for patients with sepsis.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
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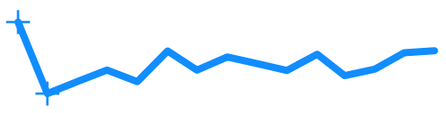
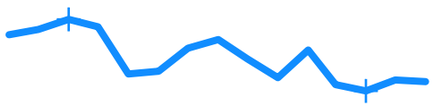
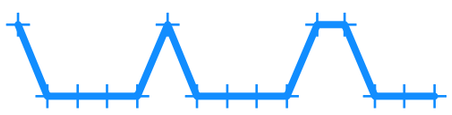
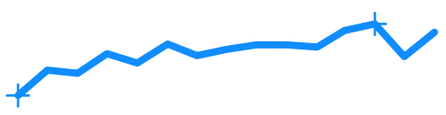
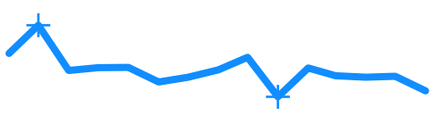
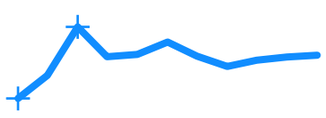
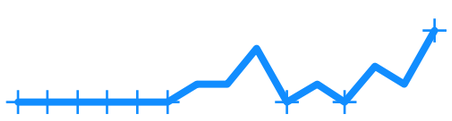
Board Summary - Quality

Quality	Period	Score	Target	YTD	Bench...	Trend
Never Events	Jun-26	0	0	0		
Falls ≥ moderate harm per 1000 bed days	Jun-26	0.19	0.00	0.16		
Nurse Fill Rates	Jun-26	94.6%	90.0%	94.5%		
NEWS Obs on Time or Within Tolerance (A&E)	Jun-26	70.2%	80.0%	68.8%		
% Screened using the MUST tool	Jun-26	79.1%	95.0%	79.7%		
Fluid balance chart in place and accurately completed	May-26	51.2%	90.0%	52.7%		
MRSA	Jun-26	0	0	0		
C.difficile	Jun-26	10	97	30		
MSSA	Jun-26	12	0	23		
E.coli	Jun-26	18	151	53		
Complaints Responded In 60 Days	Jun-26	73.0%	80.0%	69.2%		
FFT - Inpatients % Recommended	Jun-26	93.2%	90.0%	93.6%	Worst 40%	
Mortality - HSMR	Mar-26	116.2	100	97.4	Best 50%	
Mortality - SHMI	Feb-26	1.0	1.00			
Mortality - SMR - Sepsis	Mar-26	83.6	100	83.3		
Neonatal Deaths	Jun-26	4	0	7		
Stillbirths (intrapartum)	Jun-26	0	0	0		
Sepsis: Administration of Antibiotics within agreed	May-26	70.3%		69.2%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E
4-Hour performance decreased again in June, achieving 72.6% (all types). Trust performance is below National (75.0%) and C&M (73.2%). The Trusts mapped 4-Hour performance achieved 76.7%.

Patient Flow
Bed occupancy across MWL averaged 103.4% in June equating to 77.2 patients - an ongoing trend of high occupancy. There was a peak of 128 patients (45 at S&O, 83 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 8% higher than last June, with a 3% increase in 1+ day LOS activity and a 13% increase in 0 day LOS activity. St Helens had a 5% increase in 0 day and 1+ day LOS activity from June 25 to June 26, however Southport had a 26% increase in 0 day and a 1% reduction in 1+ day LOS activity. Average length of stay for emergency admissions remains high, at 9.3 at S&O and 7.7 at StHK, with an overall average of 8.2 days, the impact of non CTR patients being 20.6% at Organisation level, 1.6% lower than May and 0.6% lower than June 25 (22.6% S&O and 19.4% StHK for June 26).

Cancer
Cancer performance for MWL in May improved to 76.8% for the 28 day standard (target 80%), with Southport achieving 75.1% and St Helens performance being 77.9%. Latest published data (May) shows national performance of 79.0% and C&M regional performance of 78.9%. Performance for 62-day also improved, achieving 81.7% (target 80%), with Southport achieving 76.1% and St Helens 83.5%. C&M performance was 74.4% and National 69.6%. 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.

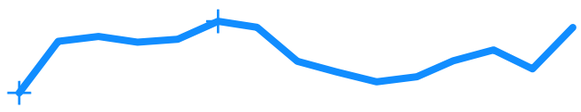
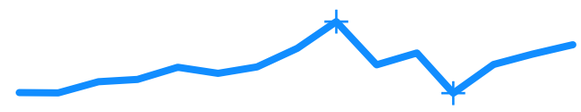
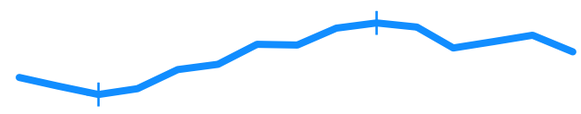
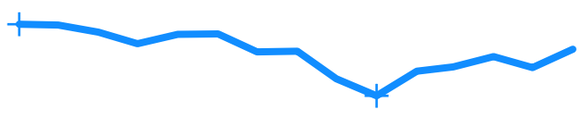
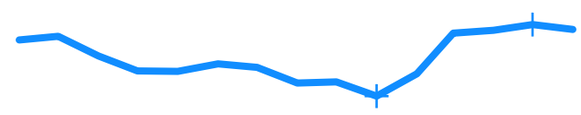
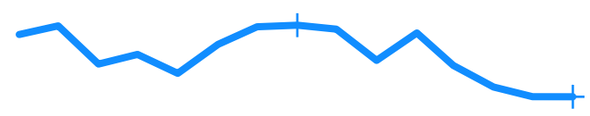
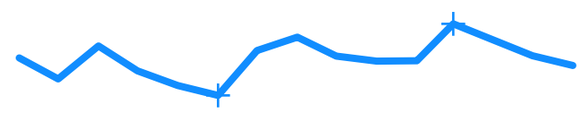
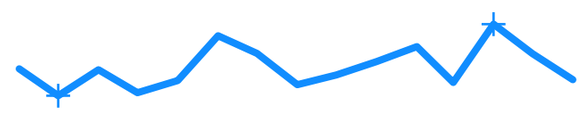
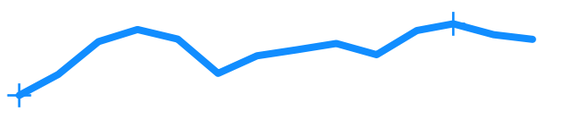
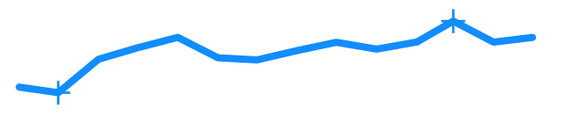
Diagnostics
Diagnostic performance in June remained at 80.6% for MWL, failing to achieve the 95% target, with S&O achieving 71.4% and StHK 88.6%. MWL performance is ahead of national performance (latest month May) of 76.0% and below C&M regional performance of 87.6%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
A&E Triage: % < 15 mins	Jun-26	74.4%	95.0%	72.7%		
A&E Standard (Mapped)	Jun-26	76.7%	82.0%	77.3%	Best 40%	
% of patients spending more than 12 hours in A&E	Jun-26	19.1%	15.6%	18.9%		
Ambulance Arrival to Vehicle Handover: % <45 mins	Jun-26	83.5%	100.0%	79.4%		
RTT % less than 18 weeks	Jun-26		70.6%		Best 40%	
18 weeks: % 52+ RTT waits	Jun-26		1.0%		Worst 30%	
Diagnostic Waits: % <6 weeks	Jun-26	80.6%	95.0%	80.6%		
G&A Bed Occupancy	Jun-26	96.9%	92.0%	97.0%	Worst 10%	
Discharges Before Noon	Jun-26	18.7%	25.0%	19.3%		
% of Patients With No Criteria to Reside	Jun-26	20.6%	15.0%	22.3%		
Cancer Faster Diagnosis Standard	May-26	76.8%	80.0%	76.4%	Worst 40%	
Cancer 31 Days	May-26	94.9%	94.0%	95.2%		
Cancer 62 Days	May-26	81.7%	80.0%	81.0%	Best 20%	
Elective Actual Utilisation: Capped Orm & St.H	Jun-26	73.5%	78.7%	74.2%		
Elective Actual Utilisation: Capped S'port & Whist	Jun-26	81.1%	84.5%	80.6%		

Board Summary - Workforce

Workforce

Mandatory Training

The Trust continues to exceed its mandatory training target, achieving 89.9% compliance in June 2026, above the 85% target. The Learning and Organisational Development team continues to work with areas below the required compliance level, particularly within Corporate Services (Estates and Facilities) and Medical and Dental staff groups. Targeted support remains in place to ensure staff can access training and sustain compliance across all staff groups.

Appraisals

Appraisal compliance reduced further to 70.5% in June 2026, against the Trust target of 85%. This decrease was anticipated following the opening of the 2026/27 appraisal window on 1 May. Updated appraisal documentation, incorporating the Trust Behavioural Framework, is available and managers are being supported through training, targeted communications and one-to-one assistance to improve completion rates.

Sickness Absence

Sickness absence increased to 6.7% in June 2026, above the Trust target of 5%, with the rolling 12-month absence rate standing at 6.9%. Following a review of the data, increases have been observed across most staff groups. While improvements in long-term sickness absence have been noted in some targeted areas, short-term absence continues to fluctuate across services. The Absence Support Team and Absence Taskforce Group continue to provide focused support to high-risk areas, alongside audits of Welcome Back Conversations, manager coaching and attendance management training. Sickness absence remains a key workforce priority for the Trust.

Turnover

In-month turnover for June 2026 reduced to 0.7%, compared to 0.8% in May, and remains below the target of 1.1%. This demonstrates continued workforce stability and positive staff retention despite ongoing operational pressures.

Time to Hire

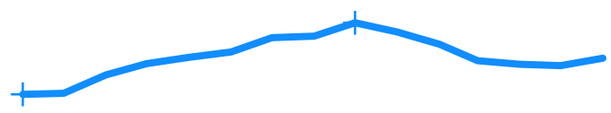
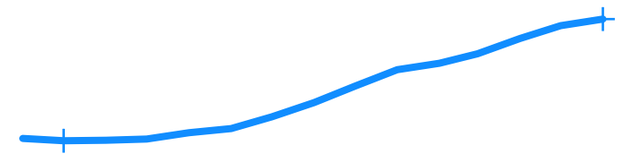
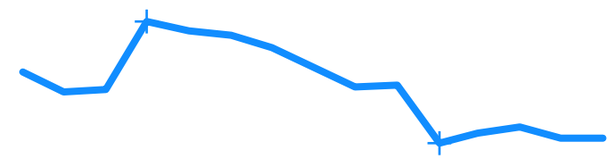
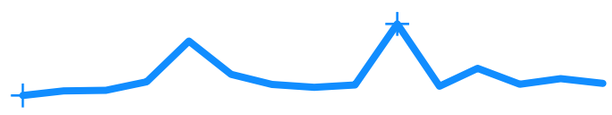
The average time to recruit in June was 50 days, compared to the Trust target of 40 days, with a year-to-date average of 51 days. Whilst remaining above target, performance has remained stable despite recruitment activity running at significantly higher levels than the same period last year. Increased demand associated with substantive re Recovery actions remain in place and the current trajectory indicates progressive improvement over the coming months, although performance remains above the Trust target at present. Recovery actions remain in place and the current trajectory indicates progressive improvement over the coming months.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Mandatory Training	Jun-26	89.9%	85.0%	89.9%		
Appraisals	Jun-26	70.5%	85.0%	70.5%		
Sickness: All Staff Sickness Rate	Jun-26	6.7%	5.0%	6.5%		
Sickness Rate - All Staff (Rolling 12 months)	Jun-26	6.9%	5.0%			
Average time to recruit (days) - All Staff	Jun-26	50	40	51		
Staffing: Turnover rate	Jun-26	0.7%	1.1%	0.7%		

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 3, the Trust is reporting an adjusted position of £6.8m deficit. Excluding deficit support funding, the adjusted position is £11.0m deficit, in line with plan. This includes the impact of the 2026/27 pay awards 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 3, the Trust has successfully transacted CIP of £9.9m year to date, in line with plan.

Cash - At the end of M3, the Trust's cash balance was £2.9m. 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 £2.5m, which is £5.4m below plan.

Integrated Performance Report

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NHS
Mersey and West Lancashire Teaching Hospitals
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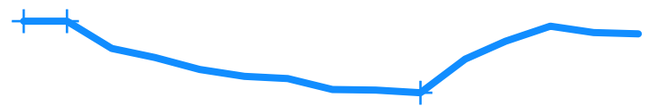
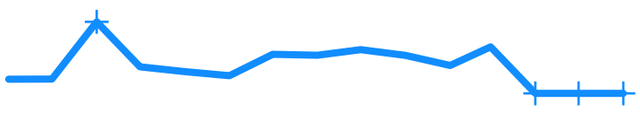
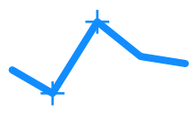
Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Reported Surplus/Deficit (000's)	Jun-26		-6,812	-6,783		
Forecast outturn surplus/(deficit) (£000)	Jun-26		16	16		
Delivery of CIP savings (000's)	Jun-26		9,939	9,939		
Cash Balances - Days to Cover Operating Expenses	Jun-26	0.9	1.5			
Capital Spend £ 000's	Jun-26		7,883	2,519		
Value of aged debt >90days overdue £000's	Jun-26		11,000	15,536		

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**	29 July 2026
Agenda Item	**TB26/052 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in June 2026		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
The Executive Committee met on four occasions during June 2026. At each meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The weekly vacancy control panel decisions were also reported at each Committee meeting.		
04 June 2026		

Corridor Care Update	• The Chief Finance Officer, on behalf of the Chief Operating Officer, introduced the update which summarised the position and opportunities in relation to the time patients spent in the Emergency Department (ED), resulting in corridors being used as a clinical area.
	• The MWL month 1 position by site against national metrics was:
	  ○ 77.9% (Whiston 58.7%, Southport 54.9%, Ormskirk 95.1%) of patients discharged or admitted from ED within 4 Hours against a target of 82%.
	  ○ 18.8% (Whiston 22.6%, Southport 13.7%) of patients held in ED for over 12 hours against a target of 2%
	  ○ 80% (Whiston 73.7%, Southport 90.5%) of ambulances handed over within 45 minutes against a target of 100%.
	• Data was collated and being validated in relation to instances of corridor care using national definitions.
	• Patients awaiting admission was identified as one of the key drivers for patients waiting in the ED, resulting in patients remaining in the department for over 12 hours.
		Assurance

	• The report highlighted the suite of actions that had been undertaken to improve patient flow since 2024 including Urgent and Emergency Care (UEC) Recovery Programme (2024-present), Emergency Care Intensive Support Team (ECIST) (Oct 2024-Feb 2025), MWL Transformation Programme (ongoing), MWL Winter Summit (March 2026) and the RESET event (May 2026). • A range of additional internal and external high impact actions were presented, with the aim of reducing the length of stay for patients, which would support the ability to close corridors within the ED. • The actions were supported by the Chief Medical Officer as the Executive Lead. • The Committee noted the report and actions and requested that a range of further potential actions were explored to support improvements by the end of the month.	
Community Diagnostic Centre (CDC) Development Case for Southport	• The Chief Finance Officer introduced a paper that proposed the development of a MWL-led CDC in Southport. • A site had been identified, and the proposal was supported by capital funding from NHS England (NHSE), which would be in keeping with the Trust's objectives, and national objectives in relation to care in the community. • The Executive Committee approved the proposal.	Approval
Digitising Documentation	• The Director of Informatics presented the report, which summarised the proposed phased programme of transition from paper-based to digital clinical documentation. • The proposed programme would establish digital clinical documentation; to allow information to be recorded at the point of care, this would then be immediately available on the system and be fully auditable. • The proposal had been provided as an initial overview, and a strategic transformation plan would be developed and brought back to the Committee for approval. • The Committee noted the report.	Assurance
Specialist Palliative Care Consultant Briefing	• The Chief Medical Officer presented the report which outlined risks and proposals relating to the fragility of the medical workforce in the Palliative Care Service.	Assurance

	• Approval was given for short term recruitment to a locum position to provide medical cover, and for the Deputy Chief Medical Officer to provide medical oversight in addition. • It was noted that a further proposal was required to provide options for the continued sustainability of the service. • The Committee noted the report and approved the recruitment of a locum to the service.	

Appraisals and Mandatory Training Assurance Reports	• The Chief People Officer presented the Agenda for Change (AfC) Appraisal Compliance Report and noted the following:
	  ○ The 2026 appraisal window had opened compliance as of April 2026 was 89.6%.
	  ○ Measures had been put in place to improve the Appraisal experience following low scores in the staff survey, including the introduction of appraisal ambassadors and appraisal guidance documentation.
	• In terms of Mandatory Training:
	  ○ On 30 April 2026 Mandatory Training Compliance was reported at 89.6%.
	  ○ There were areas of lower compliance when this was split by professional groups and noting the importance of mandatory training, a range of options were discussed.
	• A plan with targeted key actions was to be developed and presented at the next update.
	• The Committee noted the report.
		Assurance

Safe Staffing Report	• The Chief Nursing Officer presented an update on Safe Staffing for April 2026. • Fill rates were noted to be steady at ~90%, however, there were some pockets below target and actions for these had been put in place. • Some wards had reported high sickness rates and some further triangulation against red flags is required. • Incidents in relation to staffing were reviewed, with no associated harm identified. • A discussion took place in relation to vacancies for Health Care Assistants (HCAs) and the associated bank spend. • The Chief Nursing Officer discussed the staffing model and the potential to use the vacancies in a different way, which may provide additional benefits, but this would require further analysis	Assurance

	before proposals could be made to the Committee. • The Executive Committee noted the report.	
Electronic Patient Record (EPR) Executive Steering Group (ESG) Assurance Report	• The Director of Informatics introduced the assurance report which gave an update on ongoing programmes of work overseen by the steering group. • An apparent delay in the implementation of Badgernet was discussed with a request for an update to be brought back to the Committee. • The Executive Committee noted the report.	Assurance
Summary from Vacancy Control Panel (VCP)	• The Chief People Officer presented the summary from VCP held on 01 June 2026 and noted the following: ○ 25 vacancies had been approved, six posts required further information and one post had been declined. • The Executive Committee noted the report.	Assurance
11 June 2026		
Equality Delivery System (EDS) Annual Report 2026	• The Chief Nursing Officer introduced the report which sought approval for the publication of the EDS Annual Report 2026 on the Trust website and submission to the Integrated Care Board (ICB). • Following internal assessment and review by stakeholder groups, the scoring for each domain was noted as Domain 1 (commissioned and provided services)- Excelling, Domain 2 (workforce, health & wellbeing)- Achieving, Domain 3 (Inclusive Leadership)- Achieving. Overall, the Trust is assessed as Achieving against the framework. • An action plan was in place and would be shared with Quality Committee (for patient-focused elements) and Strategic People Committee (for workforce elements). • The Executive Committee approved the report for publication on the Trust website and for submission to the ICB.	Approval
Strategic Transformation / Programme Management Office (PMO) Update	• The Chief Executive introduced the report which provided an overview of the Strategic Transformation Programmes which had been developed to support continuous improvement in the delivery of 5 Star Patient Care across six workstreams. • An update was also provided on the PMO function being mobilised to support focused delivery of the programmes.	Assurance

	• The report outlined progress to date, along with next steps. Prioritisation workshops had been completed, and the programmes would now move into the delivery phase. Project Initiation Documents (PIDs) were being developed. • The Executive Committee noted the report.	
Maternity & Neonatal Report Review	• The Chief Nursing Officer presented the report following a review of the MWL reported metrics for Maternity and Neonatal Services, against external reporting requirements. • The report highlighted the metrics that were required for external reporting and those which had been added based on internal requests; it was noted that most metrics were externally required. • It was noted that Cheshire & Mersey Local Maternity and Neonatal Service (LMNS) had requested other units use the MWL reporting methodology and therefore, it was considered that the reporting was well validated. • The Committee discussed several options to improve internal reporting including developing a dashboard using a RAG (red, amber, green) methodology to support the Quality Committee and Board in understanding areas that may require more focus. • It was agreed this would be explored, whilst noting that the anticipated outcome of inquiries and national reviews may include some recommendations that would need to be taken into consideration. • The Executive Committee noted the report.	Assurance
Cyber Report	• The Director of Informatics introduced the quarterly report which provided assurance around the management of Trust infrastructure from a cyber security perspective. • The Trust continues to maintain robust data security, key controls continue to operate effectively, and the overall cyber risk profile continues to improve. • Overall, the report provided significant assurance that cyber security remains robust; there were no matters requiring escalation or intervention. • The Executive Committee noted the report.	Assurance
Finance Improvement Group (FIG) Update	• The report and content was reviewed and noted. • The Committee discussed some potential duplication with the Divisional Performance	Assurance

	Review (DPR) meetings. A review of the report format was requested. • The Committee noted the report.	
Risk Management Council (RMC) Assurance Report – June 2026	• The Director of Corporate Services presented the report and noted the following: o There had been 36 new risks added to the Risk Register and 45 risks had been closed. o There had been an increase in the number of risks overdue for review, which required action. o 23 risks had been escalated to the Corporate Risk Register (CRR). o The Trust Escalation Policy had been reviewed and approved at the meeting. • The Executive Committee noted the report.	Assurance
Integrated Performance Report (IPR)	• The Chief Operating Officer presented the report and noted the need for narrative to be reviewed. • There had been a deterioration in cancer performance and trajectories were under review and would be reported through Finance and Performance Committee. • The Executive Committee noted the report.	Assurance
Summary from Vacancy Control Panel (VCP)	• The Chief Medical Officer presented the summary from VCP held on 08 June 2026 and noted the following: o 19 vacancies had been approved and three posts required further information. • The Executive Committee noted the report.	Assurance
18 June 2026		
ED/Frailty Whiston Consultant Business Case	• The Chief Operating Officer introduced the report which proposed the recruitment of an ED Consultant with a special interest in Frailty. • It was outlined that the post was expected to be cost-neutral due to reallocation of funding following a review of job planning and virtual ward reconfiguration. • The post would support training and enhance the interface with community services with an implementation date in Q2. • The Committee noted the predicted reduction in length of stay (LOS) included in the report but felt a future projection of benefits to quantify the impact of the post would be useful. • The Executive Committee did not approve the proposal but agreed this could be progressed and approved outside of the meeting once the benefits had been clarified.	Approval

	• The Committee requested a Benefits Realisation Report to be presented to the Committee in 12 months' time.	
Temporary Workforce Quarterly Update	• The Chief People Officer introduced the report which provided an overview of bank and agency usage during April and May 2026. • Bank use at the end of May was equivalent to 50 whole time equivalents (WTE) over plan; highest usage was noted for supplementary care, sickness, and vacancies. • Bank fill rates were 77% in May; there was an increase of unfilled hours from 17 to 21% across MWL. • There had been a 30% increase in unfilled hours at Southport and Ormskirk sites, this was likely due to the move from NHSP to One Bank Model. A deep dive with a focus on registered nurses (RNs) and HCAs was planned. • It was noted that changes to rules relating to zero-hour contracts may impact the existing bank model; further insight was expected in the next report. • The average bank spend was less than at the same period in the previous year. • There had been a reduction in the overall use of agency, however, use of agency remains high for the Medical workforce. There had been some challenges with the implementation of Patchwork related to the migration of data from the Allocate system, which were expected to resolve. • The Chief Medical Officer advised there had recently been an increase in the number of escalations for approval, particularly from ED. The Committee discussed the recruitment programme for ED. • The Executive Committee noted the report	Assurance
Impact of Introducing the Cheshire & Mersey (C&M) Rate Card	• The Chief People Officer introduced the report which provided an overview of the impact of introducing the C&M Bank Rate Card for Resident and SAS Doctors in November 2025. • The Committee queried if data from the previous year was available as comparative reports were from quite different times of the year and may not be directly comparable. It was agreed this would be reviewed and considered in future reporting. • The Committee noted the report included several recommendations, one of which related to	Assurance

	focussed intervention in ED due to the number of escalated shifts. It was commented that a high number of the escalation requests related to the same staff and were related to times of pressure. • There was also a recommendation related to addressing vacancy gaps which was planned, in conjunction with Divisional Teams. • There has been a request that Trusts discuss regionally to understand the wider position. • The Committee requested a further update on the impact of implementing the rate card in six months' time, as this would provide a 12-month overview, to be followed by a Quality Impact Assessment (QIA). • The Executive Committee noted the report	
Freedom of Information (FOI) Report	• The Chief Finance Officer presented the report. • Compliance with responses in the timeframe had reduced to 60% for May 2026 and the Committee requested a review of the approach. • The Executive Committee noted the report.	Assurance
Proposal for the Management of Community Services	• The Chief Operating Officer presented the report which sought approval for the establishment of a standalone Community Division, given the growth of community provision following the planned transfer of West Lancashire Community Services. • This would involve the Community services being split from the current Clinical Support Services (CSS) Division. • To support the proposed changes, an investment of c.£386k against budget, c.£695k against run rate, would be required. • Workforce change processes would need to be followed as part of the proposed changes. • The Committee agreed with the principles of the new Community Division but noted that final sign-off from the Chief Executive would be required as he was not at the meeting. • The Committee did not approve the establishment of the Community Division but noted this would be considered outside of the meeting by the Chief Executive.	Approval
Developmental Well-Led Review	• The Director of Corporate Services presented the report which sought endorsement for the commissioning of an independent, external Well-Led Review. • The Committee noted it had been almost three years since the formation of MWL, and the Trust	Noting

	had yet to have a Care Quality Commission (CQC) Well-Led inspection; it was therefore felt that a Trust-initiated review would be useful at this point to assess the progress and maturity of the structures within the Trust. • The Executive Committee noted the report and endorsed the approach, and that this would be shared with the Board of Directors for consideration.	
Summary from Vacancy Control Panel (VCP)	• The Chief Medical Officer presented the summary from VCP held on 15 June 2026 and noted the following: o 25 vacancies had been approved. • The Executive Committee noted the report.	Assurance
25 June 2026		
Laboratory Information System (LIMS) Support Extension	• The Director of Informatics introduced the report which outlined that the current vendor LIMS support for the system is approaching expiry. • The Committee was advised that the original intention was to transition when the new LIMS was implemented, but this had been delayed. • An outline of options considered was presented and the Committee were advised that there was no viable option to not extend. It was noted that the extension would present a cost pressure for the Trust. • Four options were considered, and the recommended option was Option 3, which was to upgrade the current system and extend the system support until May 2028. The estimated financial requirement was £278,000, including the platform upgrade and additional support costs but it was noted that this option would not provide any additional operational functionality, but is required to maintain continuity of service. • It was also noted that the current LIMS provider would not extend their support beyond May 2028, creating a risk if the Trust has not transitioned to the new LIMS system by that point. • The updated LIMS timeline was outlined and advised that the original timeline was considered ambitious. A revised plan had been submitted for review, proposing a nine-month extension into 2028 and the team were comfortable with the revised timeline, and that a proposal for additional programme resource was due to be considered by the Partnership Board.	Approval

	• The Committee discussed how the extension would be funded, and it was confirmed that this would be a cost pressure with no associated operational efficiencies or benefits identified to support the funding at the time of presenting the report. • It was agreed that the Trust cannot operate without a laboratory system and therefore would need to proceed but requested that further work be undertaken on how the cost pressure would be offset. • The Chief Executive requested that an update on the LIMS system rollout and progress with implementation be built into the cycle of business for further updates at the Committee to monitor progress. • The Executive Committee approved Option 3, noting the need for further work on how the cost pressure will be managed and offset.	
High Absences Report	• The Chief People Officer introduced the report which had been requested following the creation of the Sickness Absence Taskforce and following feedback about managing long-term sickness. • The report provided an overview of current cases along with the support provided to staff who are absent from work. • It was noted that mental health, and musculoskeletal conditions were the highest causes of sickness absence which is consistent with national trends, and that stress, anxiety and depression all feature within the top ten secondary absence reasons. • Mental health absences were reportedly increasing nationally, although national categorisation made detailed comparison difficult. It was agreed that mental health requires further consideration and suggested that the Trust could consider further work around resilience for staff. • It was agreed that a follow up report would be reviewed in the HR Divisional Performance Review (DPR). • The Executive Committee noted the report.	Assurance
Financial Improvement Group (FIG) Update	• The Director of Strategic Resourcing presented the report which reported on meetings of the groups since the last update.	Assurance

	• The Committee were advised on recent changes to the FIG process including data being shared to divisions earlier. • Divisions were being sent queries on their performance packs in advance and being asked to provide their action logs ahead of meetings, but feedback suggested some duplication and overlap with other meetings. • It was suggested that that the FIG meetings could be more closely aligned with the transformation agenda and noted the need for further training and guidance for divisional teams on what data should be reviewed and how it should be used. • The Committee welcomed the level of detail in the report but asked if future reports could provide early sight of business cases being developed, to aid in managing expectations and maintaining Executive oversight. • The Committee noted the report.	
Corporate Benchmarking	• The Chief Finance Officer introduced the corporate benchmarking submission and advised that it had been shared with relevant Directors over recent weeks and was due for submission by 08 July 2026. • The Committee were advised on the background to the submission and summarised the position by corporate area. The Committee noted that the Trust's relative position had improved despite inflation pressures. • It was highlighted that pay costs and whole-time equivalents had reduced, while non-pay costs and costs per whole-time had increased. • Further updates were requested in relation to comparison with the previous year where there were outlying areas and it was noted these would come to the meeting next week to support final approval for the submission. • The Committee noted the report.	Assurance
Trust Board Agendas – July 2026	• The Director of Corporate Services presented the Trust Board agendas for the meeting on Wednesday 29 July 2026 from the annual workplan and outstanding actions. The Trust Board in July was a public Board, followed by a Closed Board session. • The Committee selected the Employee of the Month for July, from the nominations received.	Assurance

Summary from the Vacancy Control Panel (VCP)	• The Chief People Officer presented the Summary from the VCP held on 19 and 22 June 2026. • The VCP had approved 56 vacancies. Five vacancies had been held awaiting further information. • The Executive Committee noted the report.	Assurance

Alerts:

The extension of the support contract for the current Laboratory Information System (LIMS) due to a delay in implementing the new LIMS.

Decisions and Recommendations:

New investment decisions taken by the Committee during June 2026 were:

- Specialist Palliative Care – Recruitment of a locum.
- LIMS extension – £278k funding for the extension of the support contract for the existing LIMS system was approved.

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	29 July 2026
Agenda Item	**TB26/052 (8.2)**		
Committee being reported	Audit Committee		
Date of Meeting	23 June 2026		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
External Audit Reports	Grant Thornton (GT) provided an overview of the external audit findings to date and shared the draft Audit Findings Report (ISA 260) and draft Annual Auditors Report. The Audit Findings Report identified one breach regarding the Trust's statutory breakeven duty, three non-trivial audit adjustments, two unadjusted non-material misstatements and four new recommendations along with associated management responses. At the time of the Committee, GT expected to issue an unmodified opinion at the end of June 2026. The Annual Auditors report contained one improvement recommendation along with associated management responses. At the time of the Committee, GT did not identify any significant weaknesses in any of the Trust's arrangements for 2025/26. At the time of the Committee, the Audit team expected to complete their audit and for the Trust to submit its audited Annual Report and Accounts by the deadline of the 26 June 2026.	Assurance
Adoption of Mersey and West Lancashire Teaching Hospital NHS Trust Accounts	The Committee reviewed and approved the annual accounts and letter of representation (LoR) for the Trust for 2025/26.	Approval
Head of Internal Audit Opinion	Overall substantial assurance opinion provided by MIAA for 2025/26.	Assurance

Anti-Fraud Annual Report	MIAA presented the Anti-Fraud Annual Report for 2025/26.	Assurance
Draft Annual Report and Draft Annual Governance Statement	Committee reviewed and approved the Trust's draft Annual Report and draft Annual Governance Statement for 2025/26.	Approval
Annual Meeting Effectiveness Review Assurance Report	Committee received a summary of the findings from all annual effectiveness reviews undertaken in March and April 2026 for all Trust Committees.	Assurance
Annual Review of Register of Interests	Committee received and reviewed a summary of the Trust's register of interests as of June 2026.	Assurance

Alerts:

None

Decisions and Recommendation(s):

MWL Accounts adoption
Head of Internal Audit Opinion (HoIAO)
MWL Annual Report and Annual Governance Statement

- The final 2025/26 accounts, annual report and annual governance statement were approved by the Committee subject to satisfactory conclusion to the external audit. Approval of the final accounts will be concluded outside of the meeting following the release of final external audit reports.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	29 June 2026
Agenda Item	**TB26/052 (8.3)**		
Committee being reported	Charitable Funds Committee		
Date of Meeting	29 June 2026		
Committee Chair	Neil French, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Head of Charity Report	Updates were provided on the Charity teams activity between March 2026 and June 2026 key points included: • An update on legacy income • Spinal appeal progress • 2026 event calendar including the Whiston Hospital Abseil and the Southport 10km run • A patient engagement story	Assurance
Finance Report (including Treasury Matters)	An update of MWL NHS Charity's financial performance and financial position (fund balances) as at 31 May 2026. MWL NHS Charity balance was £1.466m at 31 May 2026.	Assurance
Review of Charity Risk Register	No risks were presented to the Committee.	Assurance
Summary of Applications received since March 2026	A list of all applications MWL NHS Charity has received since March 2026. A total of eight projects has been granted with a combined value of £22,600 including: • Cold cap comforters to support patients during their chemotherapy treatment • Neonatal patient milestones signage	Assurance
Project spotlight – Butterfly project	An update was provided on the impact the Charity funded Butterfly project which supports end of life patients and their loved ones.	Assurance

Alerts:
None.
Decisions and Recommendation(s):
None.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 July 2026
Agenda Item	**TB26/052 (8.4)**		
Committee being reported	Quality Committee		
Date of Meeting	21 July 2026		
Committee Chair	Minal Singh, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes and Action Log	• The minutes of the Quality Committee meeting held in June 2026 were approved and the actions due for update in June were all reviewed and updated.	Assurance
Quality Committee Corporate Performance Report (CPR).	• Zero Never Events in June. • Improvements in Venous Thromboembolism (VTE) risk assessments and National Early Warning Score (NEWS) assessments in Emergency Department (ED). • Nutritional metrics remain an area of focus through Nutrition and Hydration working group. • Clostridioides difficile (C Diff) remains main Infection Prevention and Control (IPC) indicator of concern. Gloves off campaign focus noted and the potential benefits. • Complaints performance against 60-day target shows improved performance. • Corridor care data reported for the first time. Renewed commitment to eradicating this in line with trust action plan. Whiston back corridor not utilised in escalation process for a number of weeks now and Southport Same Day Emergency Care (SDEC) corridor also not being escalated into other 'corridor care' areas continue to be intermittently utilised at times of escalation. • Four Neonatal deaths (three at less than 28 weeks) all required processes being followed and none attributed directly to patient care. • Hospital Standardised Mortality Ratio (HSMR) 116.2. Deep dive instigated immediately by Executives and will report at next Quality Committee.	Assurance

Patient Safety Report Inc assurance and further detail in relation to actions 219 and 220.	• Overall reporting levels increased in May, reflecting continued positive reporting culture. • One new Patient Safety Incident Review (PSIR) reviewed by Patient Safety Panel in May. • 2,841 incidents reported on InPhase most resulting in low harm. • 0.91% of patient affecting incidents were graded as moderate or above harm with the majority of incidents graded as no or low harm (99.09%). Severe and above harm incidents accounted for 0.38% of reported incidents. • 249 inpatient falls recorded in May compared to 234 in April of these three moderate harms, four severe, and nil fatal. • Falls per 1,000 bed days for May 6.602. • Patient Safety Council Assurance report received by the Committee for July 2026. • Update on Marthas rule noted with future request for update in two months. • InPhase development group reviewing further functionalities to improve reporting.	Assurance
Infection Prevention and Control Annual Report	• Annual statutory report received to committee. • During 2025/26 MWL exceeded the thresholds as set out in the NHS Standard Contract for Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, Escherichia coli (E. Coli), Pseudomonas bacteraemia, and (C.diff). This reflects the national picture across acute trusts, with all adult acute Trusts in the region exceeding the thresholds for C.diff. • Klebsiella bacteraemia - MWL reported 46 cases and below the threshold set. • MRSA bacteraemia –four cases (target zero) two with no lapses in care. • Clostridioides difficile (CDI) – 109 cases (12 cases above threshold) a reduction from114 cases in 2024-25. • E.Coli bacteraemia – 163 cases (12 cases above threshold). • Pseudomonas bacteraemia – 15 cases (one case above threshold). • MSSA bacteraemia reduced from 90 to 79 cases. • No Carbapenemase-producing Enterobacteriaceae (CPE outbreaks). • No IPC risks currently exceed a risk score of 15. • Bloodstream infection reduction remains a Quality Account priority. Improvement plans	Assurance

	continue for: Peripheral intravenous cannula management (PIVC), Bloodstream infection prevention and C.diff reduction. • 129 outbreaks managed, affecting 1,149 patients, resulting in 1,838 lost bed days with an estimated operational impact of £827k. Most outbreaks attributed to: Norovirus, Covid-19 and Influenza. Mersey Internal Audit Agency (MIAA) review provided Significant Assurance for Norovirus outbreak management. • Committee requested additional reporting to be added aligned to infection impact on staff. • Successful management of Emerging and High Consequence Infections including Measles. Mpox, Tuberculosis, Covid-19, Influenza and Respiratory Syncytial Virus (RSV). • Improvement plans in place for surgical site infections (Hip and Knees) as Trust high outlier. • Key achievements noted providing assurance in Antimicrobial Stewardship, Education and Training Compliance with the exception of practical competency for Aseptic Non Touch Technique (ANTT), key progress against Estates and Facilities and Decontamination. • Key risks noted due to limited side room capacity (Southport site), ageing decontamination infrastructure and maintenance programmes. • IPC governance remains robust. The Committee noted the Terms of Reference for Hospital Infection Prevention Group (HIPG) for 2026/27. Divisional IPC meetings in place. • Harmonised 36 of 39 IPC procedural documents. • Robust discussion regarding underpinning IPC actions with improvement methodology to effect sustained change. • The Committee noted the annual work plan for2026/27.	
Never Events Deep Dive	• Update provided on the immediate work undertaken by the Surgical Division and Corporate Safety Team to identify any additional learning and recommendations from the two surgical Never Events in January and February 2026. • The review provided an objective evaluation of current theatre practice across MWL.	Assurance

	• Evidence from observational visits demonstrated a generally positive safety culture and reliable checking processes. • Absence of any immediate patient safety concerns and high overall compliance score. • Committee noted recommendations and priorities going forward to be taken through the Theatre Utilisation Group. • No Never Events reported at MWL since February 2026. • Action - assurance required going forward that learning and embed behaviour leads to required changes. Future reporting to be confirmed. • Committee advised on Health Innovation Northwest external review ongoing-future reporting to committee agreed.	
Lost to Follow Up	• Update provided on historical Lost to Follow Up (LTFU) recording, validation and review process aligned to extreme risk (2019) in Ophthalmology with review commenced in 2025. • Ophthalmology Task and Finish Group validated and risk stratified patients. • 2,037 patient impacted - 306 discharged,1609 required review of those 91% have been reviewed with no additional patient harms identified. • 144 going through active management with actions noted including face to face or telephone consultation. • Weekly updates continue for assurance through to executive committee. • External audit agency to review LTFU processes. • Assurance against capacity and having a process to flag capacity issues going forward to be determined. • Noted work with Patient Engagement Portal to maintain contact with patients recognising patients have multiple appointments via multiple specialities. • Action - update report to Committee in September.	Assurance
Maternity Update	• The Committee received a verbal update on the Trust's response to recent national maternity and neonatal reviews, including the Ockenden and Amos reports, the National	Assurance

	Maternity Triage Specification, and other emerging national requirements. • Assurance provided on co-ordinated programme of work including gap analysis review recommendations, and alignment with existing maternity improvement initiatives. • Committee recognised the significant scale of the programme of work, including 18 Immediate and Essential Actions and 68 associated actions arising from the Ockenden review, alongside further requirements relating to staffing, estates and audit. • A comprehensive update on compliance, implementation progress and any identified gaps will be presented to the Committee and Board in September.	
Clinical Effectiveness Report	• Committee noted report. • Concerns highlighted towards community service provision, including workforce recruitment, delays affecting service delivery, reduction of intermediate care bed capacity and progress related to district nursing business case. • Executive Team to undertake a review of the operationalisation, membership and integration of the Council within the Trust Governance structure, with recommendations to be brought back to future Committee meeting.	Assurance
Care Quality Commission (CQC) Quarterly Report Including Accreditation Report	• No CQC inspection activity to advise on in quarter 1 2026/27. • Positive engagement visit took place on 08 June 2026 at St Helen's Hospital site. • 11 enquiries received in quarter 1 (in line with quarter 4). Themes include patient care and/or experience. Noted reduction in concerns related to unsafe discharge. • Strategy Board in June received an update in relation to the Well Led framework. Noted opportunity to review progress against the eight quality statements, key activities and areas for development. • Ward Accreditation activity noted. • Action to include previous accreditation outcomes to show areas of improvement	Assurance

Equality Delivery System (EDS)-Patient Domain Assurance Report	• Update received against Domain 1: Commissioned or provided services achieved Excelling overall. • For 2025/26 Radiology, Diabetes and Interpreting services were assessed. • Action plan shared reflecting initial actions agreed in February 2026 with ongoing updates and bi-annual report through Patient Experience Council.	Assurance
Patient Experience Council Assurance Report	• July assurance report received. • Patient story noted citing a patient on a cancer pathway with carer responsibilities. The story strengthened staff awareness and training around carers and changes made in the Trust Patient Advise and Liaison Service (PALS) team to display carer information/resources to improve awareness. • Healthwatch reports were received. Halton advised on organisational change. • Clinical Support Services (CSS) and Community biannual report noted with a patient story reflected from the Urgent Treatment centre. • Estates and Facilities biannual report noted updating on progress across the Southport and Ormskirk sites. • Patient experience and Inclusion (PEI) Champions Terms of Reference and effectiveness review shared noting 107 PEI champions across the Trust with improvements required for engagement. • Personalisation of Care Quality update for quarter 2. • Patient Experience Council Terms of Reference updated against previous Quality Committee action.	Assurance
Any Other Business	• Nil	

Alerts:

- No alerts

Decisions and Recommendation(s):

The Trust Board is asked to note the report.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 July 2026
Agenda Item	**TB26/052 (8.5)**		
Committee being reported	Strategic People Committee		
Date of Meeting	22 July 2026		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Committee Performance Report (CPR)	Mandatory Training – manager training compliance exceeded target at 89.9% in June, with targeted support in place for areas below target and a mandatory training sanctions framework being finalised for Executive Committee consideration. Appraisals – appraisal compliance reduced to 70.5% in month and was slightly under the recovery trajectory, with sickness absence and operational pressures noted as contributing factors. Sickness Absence – all staff sickness increased slightly to 6.7% in June, with continued focus through the absence task force; early learning from the six high-risk areas will be reported back following Executive Committee review. Vacancy Rate – vacancies increased slightly, with the main gaps in admin and clerical services and senior healthcare assistant roles, the latter linked to the Band 2 to 3 organisational change process. Turnover – turnover remained stable. Health, Work & Wellbeing (HWWB) – pre-placement questionnaire receipt-to-clearance performance was 17 days and remained within Trust target; Did Not Attend (DNA) appointments increased slightly but remained within tolerated levels. The Committee noted the report.	Assurance
Workforce Operational Plan M3	The Committee received the Month 3 workforce operational plan update. The report provided a high-level summary of the Provider Workforce Return submission and noted that the overall position remained broadly in line with expectations, with workforce controls continuing to be effective.	Assurance

	The Committee noted the increased detail within the paper, including detail on confirmed service changes, outgoing changes, future growth and innovation, and staff group-level narrative to support triangulation. In response to a query, assurance was provided that the headline numbers were in line with plan and that this position reflected planning and triangulation with finance colleagues. The Committee noted the report.	
Time-to-hire Recovery Plan	The Committee reviewed the time-to-hire recovery plan and noted that performance remained 16 days above the 40-day target. The Recruitment team expected volumes to be back towards normal capacity by the end of August/beginning of September, subject to potential further pressures such as Band 2 to 3 recruitment. The report broke down delays across stages of the recruitment pathway. The conditional offer stage was seven days against a one-day Key Performance Indicator (KPI), with actions including use of strategic recruitment resource, targeted work with managers and review of the quality-check process. The Committee noted the commitment to halve this stage by the end of August while retaining the value of fair and robust recruitment quality checks. Pre-employment checks were confirmed as 33 days against the corrected KPI of 24 days. HWWB remained under target at the time of the meeting but was predicted to go above target in August; additional bank resource had been approved to help with the surge owing to Lead Employer August Rotation. Robotics and automation were expected to support reminders, reporting and, in time, a near real-time time-to-hire dashboard. The Committee asked that future reporting more clearly links interventions to expected impact and trajectory, and that consideration is given to targeted actions for staff groups where vacancy levels and temporary workforce reliance are highest. The Committee noted the report.	Assurance
Board Assurance Framework / Resident Doctors Staff Story	The Committee received the Resident Doctors Board Assurance Framework self-assessment, supported by the Resident Doctor Leads. Assurance was positive overall, with compliance against 17 of the 21 standards and no areas of non-compliance. The four partially compliant areas primarily related to rota transparency, annual leave reform and payroll accuracy. The Committee noted the report.	Assurance

Trust Objectives Q1 Update	The Committee received the Q1 update against the Trust people objectives, covering management and leadership skills, wellbeing and sickness management, compassionate, inclusive and accountable leadership, staff network voice, and career development. Cohort one of the Operational Excellence Programme had concluded and evaluation was underway to inform cohort two. The Committee noted progress on absence-related work, including learning from the absence task and finish group, planned scaling of successful approaches, automation, enhanced manager training and focus on welcome-back conversations. The national management and leadership framework was being reviewed by a local task and finish group to support with the adoption, embedding, self-assessment and future leadership shaping. The Committee noted the report.	Assurance
HR Commercial Services Objectives	The Committee received an update on HR Commercial Services objectives following a previous request for more specific measurements. The objectives had not changed, but the paper provided more detail on measures. The Committee noted that the objectives remained operational in places and that further work was required to distinguish operational delivery and KPIs from service aspirations. It was agreed that this would be developed further through the next quarterly update so that year-end assessment is clearer and more easily measurable. The Committee noted the report.	Assurance
Guardian of Safe Working (GOSW) Annual Report – Trust	The Committee received the Trust's GOSW Annual report. The key issue highlighted was a significant increase in exception reports following the change to the exception reporting process from February onwards. Under the revised process, exception reports are reviewed through the medical workforce team, with reports under two hours approved directly and longer reports escalated to the Guardian for review. The Committee noted that the new process had resulted in more reports being submitted, with more reports received in just under two months than would usually be received in a 12-month period. The increase had prompted reviews of working practices and rotas in some areas, with positive impacts for trainees. The Committee noted the report.	Assurance

GOSW Annual Report – Lead Employer (LE)	The Committee received the LE GoSW annual reports, noting the separate guardian arrangements for GP trainees, palliative medicine trainees, public health trainees and hosts with fewer than ten trainees, and for specialty trainees. During the reporting period, LE employed 13,617 doctors and dentists under the 2016 contract and received 991 exception reports. The majority were resolved through payment, time off in lieu or required no further action. No fines were issued and no work schedule reviews were required. Both guardians confirmed they were assured regarding the robustness of exception reporting. The Committee noted that exception reporting may increase following the process changes, although overall numbers remained relatively low and issues were generally being addressed locally without formal escalation through LE. The Committee noted the report.	Assurance
Lord Mann Review Action Plan	The Committee received the gap analysis and action plan linked to the Lord Mann review and NHS England (NHSE) guidance on tackling Anti-Semitism and wider racism in the NHS. The paper had already been considered by Executive Committee and included the gap analysis against 36 recommendations. The Committee noted the Trust's position on definitions, including adoption of the full definition of anti-Muslim hostility and a locally adopted anti-Semitism statement which captures the essence of the International Holocaust Remembrance Alliance (IHRA) working definition. The gap analysis demonstrated a positive assurance position, setting out current activity, gaps and decisive action. Ongoing monitoring will take place through the Equality, Diversity, and Inclusion (ED&I) Council, with reporting to the Strategic People Committee as necessary. The Committee noted the report.	
Assurance Reports from Subgroup(s)	The following assurance reports were received and noted: • People Performance Council • Valuing Our People Council • Equality, Diversity & Inclusion Council The Committee noted the approval of two policies through People Performance Council: the Sick Certificate Policy and the Referral policy for Nursing and Midwifery Council Referrals. The Committee also noted the change in chairing arrangements for the Employee Relations Oversight Group (EROG), with the Chief People Officer	Assurance

	(CPO) to chair going forward and a bi-monthly assurance report to come to the Committee, increasing oversight and assurance around case management.	

Alerts:
None
Decisions and Recommendation(s):
The Board is asked to note the report

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	29 July 2026
Agenda Item	**TB26/052 (8.6)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	23 July 2026		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Chief Financial Officer (CFO) narrative update on emerging news.	• The Committee received an update on national and system developments, including the republished NHS 10-year capital plan, potential changes to Public Dividend Capital (PDC) charges, the resident doctor settlement, consultant ballot position, and emerging regulatory changes. • The Trust's productivity performance was highlighted positively, with MWL reported as achieving 6.3% productivity growth by March 2026, the highest in Cheshire and Merseyside (C&M), second highest in the North West (NW), and top quartile nationally.	Assurance
NHS England (NHSE) Regulatory Updates	• Updates shared with regards to updated performance measures and regulatory frameworks including: ○ Updated NHS Oversight Framework for 2026/27 ○ Patient Experience Standards released ○ NHS NW performance framework draft shared.	Assurance
Committee Performance Report Month 3 2026/27	**Urgent care** • Accident and Emergency (A&E) performance was 76.7% in June, ahead of C&M (73.2%) and national (75.0%) • Long waits in the Emergency Department (ED) continued to be a challenge – 19.1% waited over 12 hours in June, improvement plans have been developed. • Ambulance Handover 45 – improvement to 83.5% of patients arriving by ambulance being handed over within 45 minutes.	Assurance

	• No Criteria to Reside (NCTR) patients accounted for 20.6% of inpatients which was a decrease from May. • Reductions in corridor care alongside decreases in ambulance handover times. **Elective** • 18 Week performance in June was 66.8%, a slight decrease from May, ahead of C&M and National of 65.2% and 65.6% respectively. • The Trust had 1,472 52-week waiters at the end of June and 11 65-week waiters. • Diagnostic 6-week performance for June was 80.6% which remained ahead of national performance at 76.0% and below C&M performance at 87.6%. The target remains at 95% and work is ongoing to ensure future delivery of this in a sustainable way. • Cancer performance in May increased to 76.8% for the 28-day standard (target 77%) and to 81.7% for the 62-day standard (target 85%). • Bed occupancy averaged 96.9%	
Finance Report Month 3	• 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. • The Trust is reporting a M3 deficit of £11.0m (excluding deficit support funding) in line with plan. • Deficit support funding has been confirmed for Q1 and Q2, future funding will be confirmed based on delivery of plan on a quarterly basis. • Our position takes account of all variable activity subject to commissioner reconciliation. • The reported position includes a significant proportion of uncoded activity as the activity freeze date had not taken place. • The Trust's 2026/27 Cost Improvement Programme (CIP) target is £49.7m. At M3, the Trust has delivered £9.9m in line with plan. • At M3 agency costs equate to £2.0m (1.2% of total pay costs), which is a continued improvement on prior year. • The Trust had a closing cash balance of £2.9m. • Aged debt (debt greater than 90 days) has decreased at £15.5m in M3.	Assurance

	• The revised capital plan for the year totals £42.2m which includes PFI Lifecycle and IFRS16 Lease Remeasurement. M3 spend is £2.5m and plans are in place to deliver the programme for the year.	
CIP Programme and Medicine & Urgent Care CIP Update	• Trust CIP target for 2026/27 is £49.7m. To date £55.7m schemes have been identified in year, £65.9m recurrently with £49.7m implemented or fully developed. • Trust Project Management Office (PMO) supporting in aligning CIP plans with transformation workstreams to support further delivery of targets • Medicine and Urgent Care Division reported their progress on CIP delivery in 2026/27 schemes including work to further develop ideas. The Division have identified more than £12.4m recurrent schemes for 2026/27 and are continuing to add to this and convert to delivery.	Assurance
Contract Update	• The Committee received an update on the 2026/27 contract position with agreement being reached on contract wording and value. • The impact of the contracts is reported through the finance reports and reflected per final agreement in the forecast.	Assurance
Forecast	• Committee received an update on the M3 forecast outturn position including the forecast run rate and associated actions needed to meet the financial plan. • The MWL underlying financial position was also shared alongside future opportunities not currently included in the figures.	Assurance
Benchmarking Update	• Committee received the annual corporate benchmarking return. • Members noted that national outputs have not yet been received and that the return will be reviewed further once benchmarking information is available.	Assurance
Cancer Targets Review	• The Committee received an update on cancer performance and the associated diagnostic challenges. • Cancer performance has improved compared with the previous year, although further improvement is required to meet operational standards. • The Committee noted that the Trust is ahead of planning trajectory for the treatment standards	Assurance

	but remains slightly off plan for the 28-day faster diagnosis standard. • Improvement in 28-day performance is expected during Q3, and Q4 as additional diagnostic, triage and booking capacity is implemented, and backlog reduction measures take effect.	
Assurance Reports from Subgroups:	• CIP Council Update • Capital Planning Council Update • IM&T Council Update • 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**	29 July 2026
Agenda Item	**TB26/053**			
Report Title	Corporate Risk Register			
Executive Lead	Simon Regan, Director of Corporate Services			
Presenting Officer	Sarah O'Brien, Chief Nursing Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

1. Risk Management Systems

Following the introduction of a single electronic system for managing risks, incidents, claims and complaints that was implemented in March 2025 (InPhase), the Trust Risk Management Framework has been reviewed, and the updated version was approved by the Executive Committee in March 2026.

Work continues to support the consistent description, scoring and reporting of risks and the systems and processes in each Division/Service to maintain effective risk management.

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

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

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

2. Risk Registers and Corporate Risk Registers

This report is a snapshot of the risk registers on 08 July 2026 and reflects risks reported and reviewed during June 2026.

Risk Register Summary

The total number of risks on the MWL risk register was 979 compared to 1,015 in April 2026.

22 risks are escalated to the CRR compared to 23 in April. Of the 22 risks escalated to the CRR, all are within review dates.
Three new escalated risks are reported on the CRR in July compared to April and four risks have been closed or de-escalated from the CRR.

Financial Implications	
None as a direct result of this report.	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Corporate Risk Register.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

JULY 2026 – Corporate Risk Register Report

1. Risk Register Summary for the Reporting Period

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

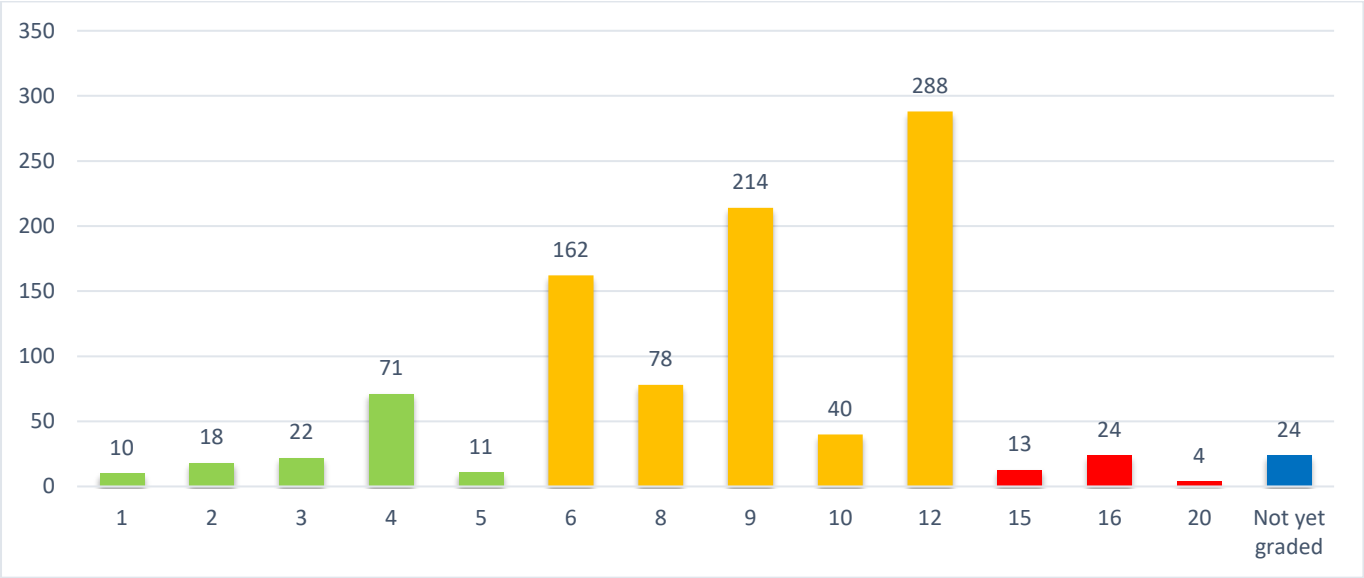
RISK REGISTER MWL SITES	Current Reporting Period (July 2026)	Reporting Period (June 2026)	Reporting Period (May 2026)
Number of new risks reported	38	36	22
Number of risks closed or removed	59	45	30
Number of risks overdue for review	216	201	261
Total Number of InPhase risks	**979**	**1001**	**1008**

*****includes new risks, not yet scored (**24**)*

2. Risk Profiles

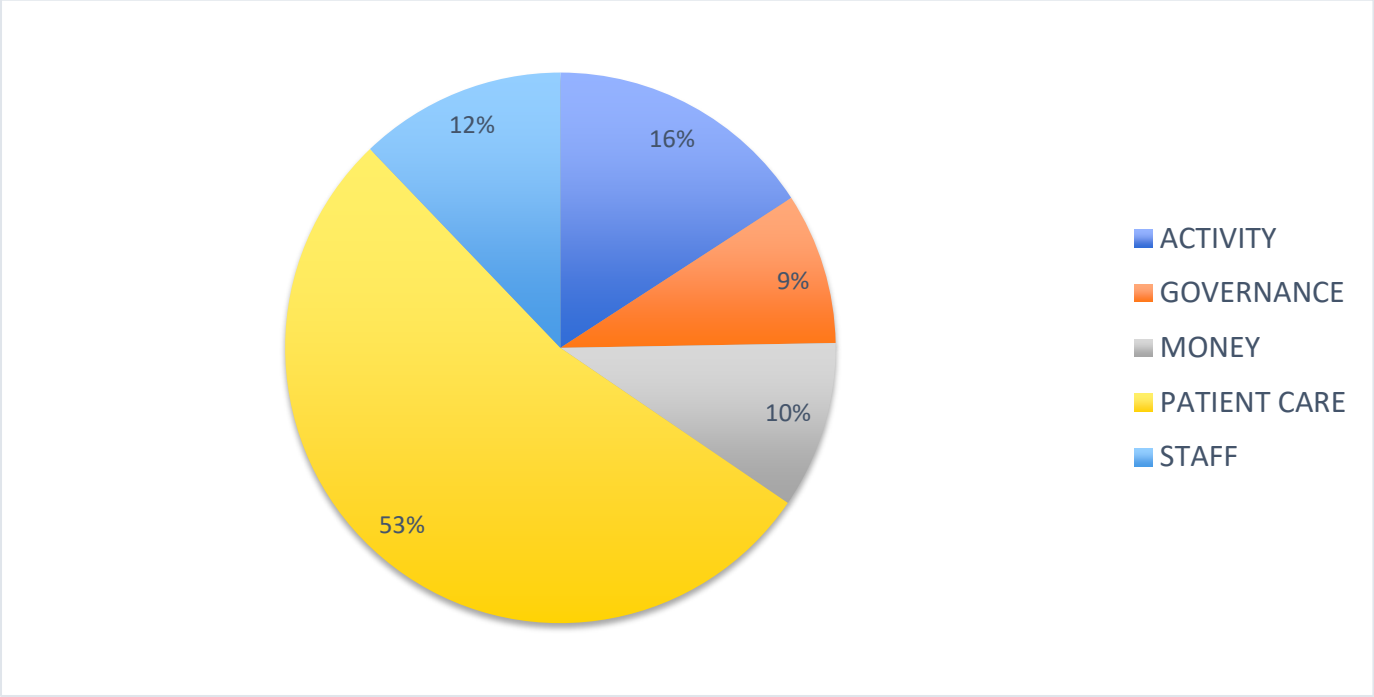
MWL Organisational Risk Profile

(Number of risks by risk score)

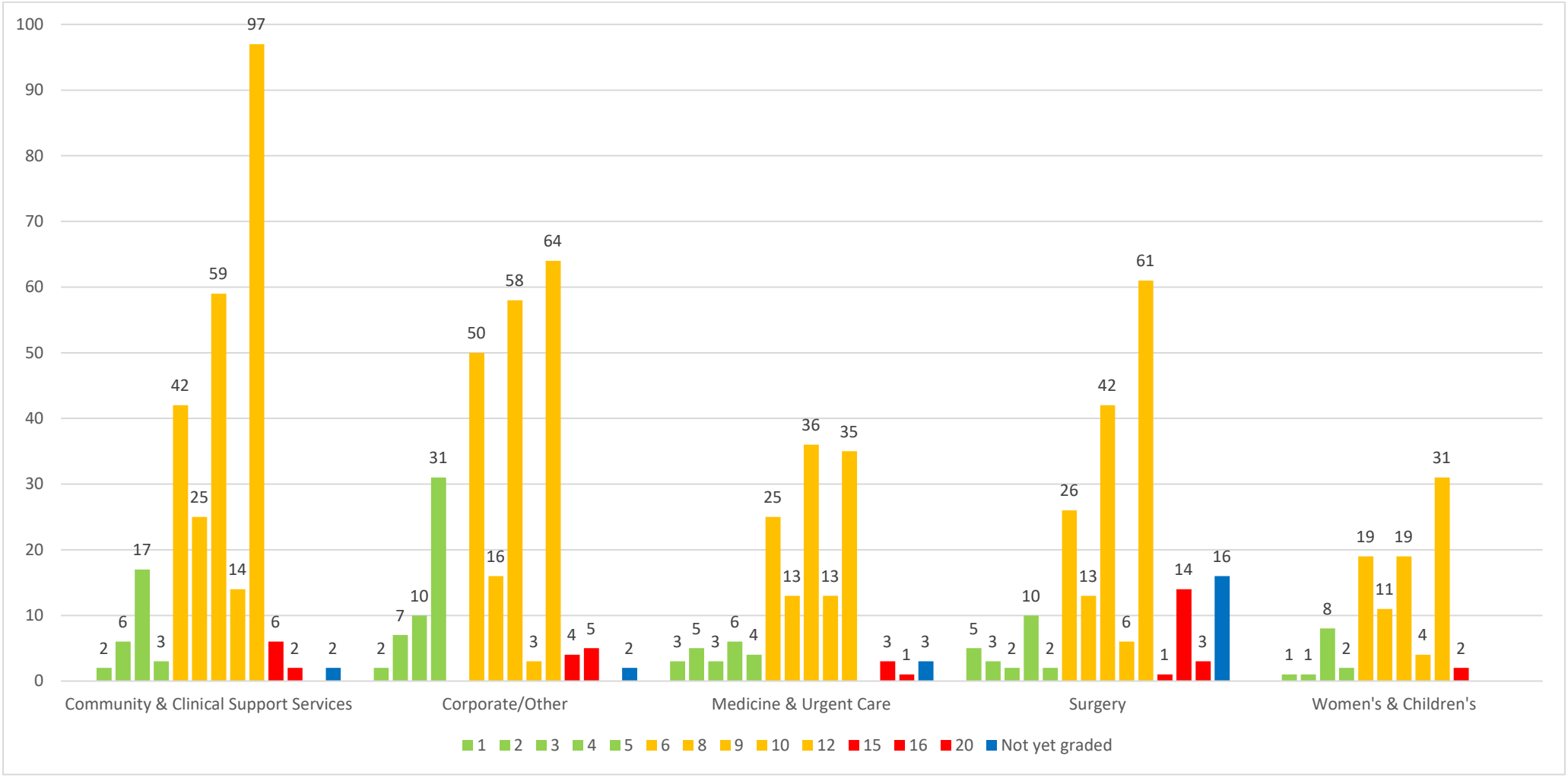


* *33 new risks awaiting review and control*

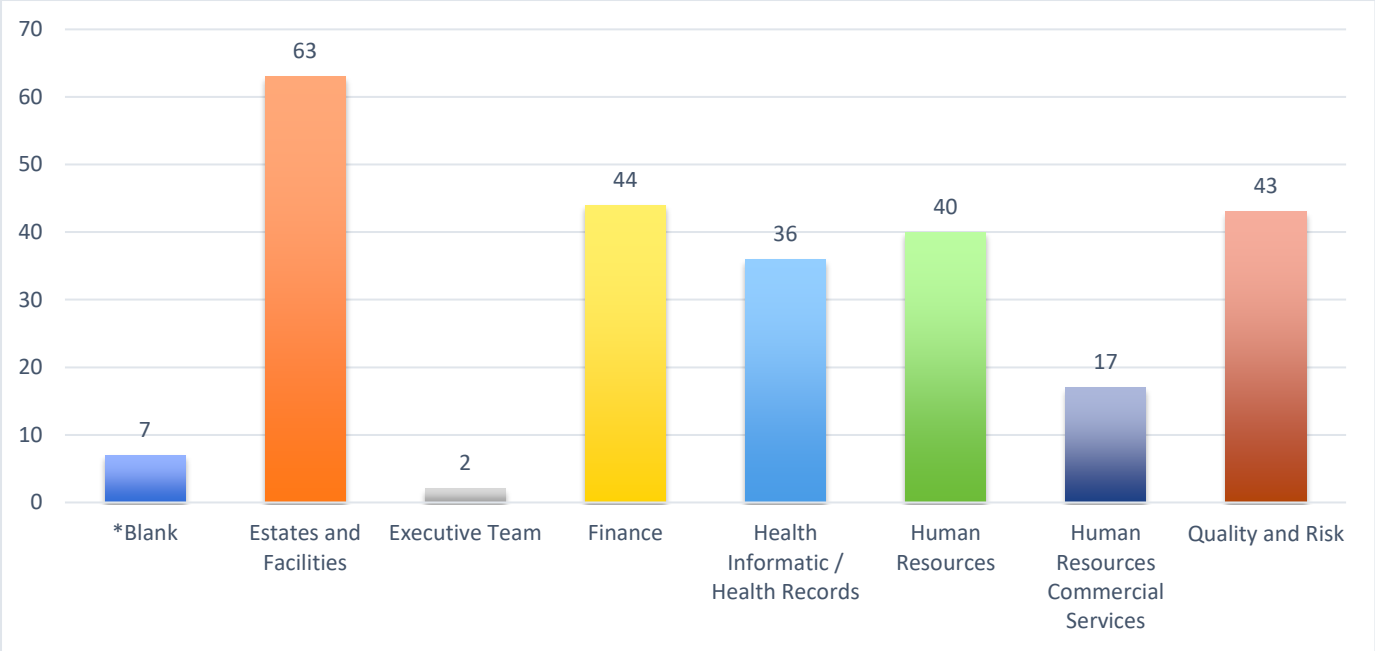
Risk Category Overview



The risk profiles for each of the Trust Divisions, and for the collective Corporate Services are:



The split of the risks across the corporate departments is:



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

No.	MWL Risk Id	Title	Risk Owner	Opened	Next review date	Grade	Specialty
1	30	If the Trust relies on bank and agency staffing then there is a risk to the quality of care, contract delivery and finance performance	Malise Szpakowska	29 Mar 2022	31 Jul 2026	16	Human Resources
2	47	If the trust cannot recruit and retain sufficient skilled staff, then there is a risk to safe staffing	Malise Szpakowska	07 May 2013	31 Jul 2026	16	Human Resources
3	80	If the critical estates infrastructure at the S&O hospital site fail, then there is a risk to delivery of services and the safety of staff and patients	Rob Cooper	25 Mar 2025	31 Jul 2026	15	Estates and Facilities
4	218	Lack of available Systemic Anti Cancer Treatment (SACT) treatment appointments	Sarah O'Brien	02 Apr 2025	15 Jul 2026	15	Cancer
5	361	If there is a malicious cyber attack that the Trust cannot block, then there is a risk to the delivery of services and patient / staff information	Malcolm Gandy	12 Oct 2016	31 Aug 2026	15	Health Informatic / Health Records
6	400	If obsolete audiology equipment is not replaced at Ormskirk Hospital, then there is a risk to continued service provision	Lesley Neary	04 Dec 2023	31 Jul 2026	15	Head and Neck
7	510	If obsolete, end of life HSDU equipment is not replaced, then there is a risk to the safe and sustainable delivery the elective surgical programme	Rob Cooper	21 Jul 2017	01 Jul 2026	16	Theatres
8	521	If the Trust cannot deliver sufficient out of hours anaesthetic support, then there is a risk to patients in a 2nd time critical maternity emergency at ODGH	Simon Dowson	25 May 2023	31 Jul 2026	20	Anaesthetics
9	587	If the Trust cannot recruit and retain Consultant ENT staff, then it would not be able to deliver the commissioned service	Lesley Neary	02 Nov 2023	31 Jul 2026	16	Head and Neck
10	591	If the Trust does not have effective booking and patient tracking systems in ophthalmology, then there is a risk of increased waiting times and patient harm	Lesley Neary	28 Apr 2025	31 Jul 2026	20	Head and Neck

No.	MWL Risk Id	Title	Risk Owner	Opened	Next review date	Grade	Specialty
11	630	If the Trust cannot move to a single EPR then there is a risk of duplication of effort, barriers to integrating clinical services and suboptimal use of available facilities	Malcolm Gandy	30 Apr 2025	30 Sep 2026	15	Health Informatic / Health Records
12	648	If the Trust under performs against the 2026/27 activity plan because of industrial action by the BMA, then it will not generate the expected income to deliver the agreed financial plan	Gareth Lawrence	24 Jul 2024	31 Jul 2026	16	Finance
13	663	If the Trust under performs against the 2026/27 variable activity plan, then it will not generate the expected income to deliver the agreed financial plan	Gareth Lawrence	17 Oct 2024	31 Aug 2026	16	Finance
14	758	If the Trust cannot achieve sustainable solutions for the clinical services assessed as fragile, then patient access and safety will be at risk	Kate Clark	07 Feb 2025	31 Jul 2026	16	Executive Team
15	914	If the Trust experiences increase demand and bed occupancy above planned capacity, then there will be reduced patient flow	Sarah O'Brien	13 Apr 2015	31 Jul 2026	20	General Medicine
16	978	If there is insufficient funding from NHS Wales, then there is a risk to the level of care MWL can deliver for plastic surgery patients in North Wales	Lesley Neary	15 Sep 2022	02 Oct 2026	16	Burns and Plastics
17	1125	If there are data quality errors and patient number mismatches due to legacy IT systems, then there is a risk to patient harm	Malcolm Gandy	04 Sep 2019	30 Jul 2026	15	Health Informatic / Health Records
18	1301	If there is a Lack of on site clinical services at MWL Ormskirk site then this will impact on the maternity service	Kate Clark	28 Sep 2025	31 Aug 2026	15	Maternity and Obstetrics
19	1513	Insufficient Administration Staffing Levels	Sarah O'Brien	09 Feb 2026	20 Jul 2026	15	Radiology
20	1349	Maternity emergency cases out of hours	Sarah O'Brien	18 Oct 2025	01 Sep 2026	16	Theatres
21	1501	Telepath Support Contract (Dedalus) & Powerterm	Malcolm Gandy	28 Jan 2026	15 Jul 2026	16	Pathology

No.	MWL Risk Id	Title	Risk Owner	Opened	Next review date	Grade	Specialty
22	1573	Absence of Occupational Therapy in Critical Care Therapy Service	Sarah O'Brien	09 Feb 2026	22 Jul 2026	15	Therapies

Blue Text = new CRR risks escalated since the April report

4. Risks closed or de-escalated from the CRR since the last report

No	MWL Risk Id	Title
1	319	If the trust cannot secure a sustainable interventional radiology service, then there is a risk of patient harm
2	791	If the Trust cannot agree a service specification with commissioners, then there is a risk to the delivery of a quality dietetic service for children and young people
3	1008	If commissioners do not agree contracts for 2025/26 there is a risk to Trust income
4	1351	If the existing MES contract for the Whiston and St Helens sites expires on 30/06/2026 with no agreement to extend or programme of re-procurement, then there would be a risk to the timely servicing and replacement of Radiology equipment at these sites

END

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/054**			
Report Title	Board Assurance Framework – July 2026			
Executive Lead	Rob Cooper, Chief Executive			
Presenting Officer	Rob Cooper, Chief Executive			
Action Required	X	**To Approve**		**To Note**

Purpose

For the Board to review and approve the proposed changes to the Board Assurance Framework (BAF).

Executive Summary

The MWL BAF is reviewed four times a year, the last review was in April 2026, and this review captures the changes that have occurred during Q1 (2026/27).

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

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

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

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

Proposed changes to risk scores
There are no proposed changes to the risk scores from Q1 2026/27

Financial Implications

None directly because of this report

Quality and/or Equality Impact

Not applicable

Recommendations

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

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

Board Assurance Framework Quarterly Review – Q1 2026/27

BOARD ASSURANCE FRAMEWORK 2026-27									
BAF	Risk Description	Exec Lead	Risk Score						
			Inherent	July 2025	Oct 2025	Jan 2026	April 2026	July 2026	Target
1	Systemic failures in the quality of care	Chief Medical Officer/Chief Nursing Officer	20	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	5
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Chief Finance Officer	20	20 ↔	20 ↔	20 ↔	15 ↓	15 ↔	10
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	16	20 ↔	20 ↔	20 ↔	16 ↓	16 ↔	12
4	Failure to maintain patient, partner and stakeholder confidence in the Trust	Deputy CEO	16	16 ↑	16 ↔	16 ↔	16 ↔	16 ↔	8
5	Failure to work in partnership with stakeholders	Chief People Officer	16	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	8
6	Failure to attract and retain staff with the skills required to deliver high quality services	Chief People Officer	20	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	10
7	Major and sustained failure of essential assets and infrastructure	Chief Executive	16	12 ↔	12 ↔	12 ↔	8 ↓	8 ↔	8
8	Major and sustained failure of essential IT systems	Director of Informatics	20	20 ↔	20 ↔	16 ↓	16 ↔	16 ↔	8

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

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

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Chief Medical Officer/Chief Nursing Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets. • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care. • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness, or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints. • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Midwifery Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • ~~CIP~~ Quality & Equality Impact Assessment Process • IG monitoring and audit • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • Maternity Incentive Scheme. • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family test scores • Quality Ward Rounds • Ward accreditation programme • Patient survey action plans **LEVEL 2** Board Assurance • IPR/CPR/DPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing & Midwifery Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework • Maternity High Risk Pathways Project Board **LEVEL 3** Independent Assurance • National clinical audits • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • Maternity Incentive Scheme/Saving Babies Lives	Complete implementation of post transaction corporate nursing and medical management structures (Revised to October 2026).	Routinely achieve 25% of discharges by midday 7 days a week to improve patient flow (By March 2027) Single set of key clinical and quality policies for MWL (Revised to March 2027) New ICB structure and operating model may impact the delivery of statutory functions such as CHC, Safeguarding and Medicines Management	Aim for response time of 60 days for complains and concerns, with month-on-month improvement (Revised to March 2027). Deliver the action plan to eliminate corridor care by March 2027

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

Exec Lead: Chief Finance Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty. • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders. • Failure to deliver strategic financial plans. • Failure to control costs or deliver CIP. • Failure to implement transformational change at sufficient pace. • Failure to continue to secure national PFI support. • Failure to respond to commissioner requirements. • Failure to respond to emerging market conditions. • Failure to secure sufficient capital to support additional equipment/bed capacity. • Failure to obtain sufficient cash balances. • Failure to obtain on going transaction support. • Failure to deliver financial plans. **Effect:** • Failure to meet statutory duties. • NHSE Single Oversight Framework rating. **Impact:** • Unable to deliver viable services. • Loss of market share External intervention	• Annual operational and financial plan • System financial plan • Annual Business Planning • Annual budget setting • CIP plans and quality impact assurances processes • Monthly financial reporting – with run rate and forecast • 3-year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • Provider Licence Conditions • Service Improvement Team capacity to support delivery of CIP and service transformation • Premium/agency payments approval and monitoring processes • Internal audit • Standards of business conduct • SFIs/SOs • Conflict of interest declarations • Benchmarking and reference cost group • Divisional ownership of finance and CIP plans • Productivity reviews and benchmarking • Underlying financial position review with NHSE/ICB	**LEVEL 1** Operational Assurance • Monthly divisional performance reviews (DPRs) • Finance Improvement Groups • CIP Council Meetings • Agency and locum spend approvals and reporting process. • Operational planning • Vacancy control panel **LEVEL 2** Board Assurance • Finance and Performance Committee and reporting Councils - run rate and forecast • Annual Financial Plan • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT, corporate benchmarking, ERIC) • Internal Audit Programme • Well Led finance self -assessment and peer review **LEVEL 3** Independent Assurance • Audit Committee • ICB & NHSE monthly reporting and MWL review meetings • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit/VFM reports • Head of Internal Audit Opinion • NHSE scrutiny of cash applications • NHSE oversight framework segmentation • NHSE support for deficit support funding • PWC Grip and Control Review	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, considering current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites and linked to the gradual taper of the agreed transaction support funding. Long term equipment replacement plans for key equipment (not included in the PFI agreement and for the non-PFI sites), inc. imaging, HSDU	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances. Development and delivery of the 3-year financial recovery plan, aligned to the ICB recovery plan (March 2028) Finalise contracts with the C&M ICB for 2026/27	Deliver the agreed 2026/27 operational and financial plans, including the CIP target (March 2027) Deliver the 2026/27 Capital Programme (March 2027)

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Failure of external parties to deliver required social care capacity **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Patients treated in ED or escalation beds. **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. • Negative impact on patient outcomes and experience	• NHS Constitutional Standards • Divisional activity profiles and work plans • System Winter Plan • Divisional Performance Review Meetings • ED RCA process for breaches • Tumour specific cancer waiting time recovery plans • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events • Bed occupancy rates • Number of super stranded /patients who no longer meet the criteria to reside	**LEVEL 1** Operational Assurance • Winter resilience plans • Financial Improvement Groups • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans • Monthly Executive Committee Divisional Performance Reviews **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance monthly oversight meetings	Implementation of CDCs at Southport and Ormskirk.	C&M UEC Improvement Programme for 2026/27 to enable MWL to eliminate corridor care, decrease escalation capacity and improve patient flow, achieve ambulance handover targets, reduce 12 hour breaches and improve ED waiting times by having appropriate alternatives to admission, supporting more timely discharge and reducing the number of patients who do not meet the criteria to reside (March 2027).	Deliver the 5 strategic transformation programmes to support improvements in access and waiting times, improved productivity and integration to support the stabilisation of fragile services. Deliver the 2026/27 elective recovery, and ED, diagnostic and cancer waiting time targets set out the national planning guidance (March 2027).

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

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff. • Increased external scrutiny/review. **Impact:** • Reduced financial viability and sustainability. • Reduced service safety and sustainability • Reduced operational performance. • Increased intervention	• Communication, Media and Public Engagement Strategy & action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Public Consultations • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR/FOI • Board media roundups and flash briefings • Work with ICB and NHSE communications teams • Communications, Media and Public Engagement Strategy	**LEVEL 1** Operational Assurance • Winter plans and awareness raising campaigns • Daily/weekly media briefings and board flash reports for urgent issues • Quarterly communications and media reports • Communications plans in relation to service change proposals • MWL UEC Recovery Programme **LEVEL 2** Board Assurance • Finance and Performance Committee • Patient Experience Council • Integrated Performance Report • Annual Operational Plan/objectives **LEVEL 3** Independent Assurance • NHSE & ICB monitoring and escalation returns/sit-reps • NHSE NOF Segmentation • Representation and participation across system forums – HWBB, Place and Neighbourhood • System winter resilience plan • CQC System Reviews/Reports • Provider Collaboratives/Alliance	Optimise opportunities for Neighbourhood Healthcare Hubs and Integrated Healthcare Organisations for the local population in partnership with Place/LA's and other key stakeholders	Creation of good working relationships with new Healthwatch/PBP areas post transaction.	~~Develop the MWL Communications, Media, and Public Engagement strategy for approval by the Trust Board (revised to June 2026)~~ Continue programme of CQC site visits to maintain understanding of the Trusts issues and responses (On-going) Demonstrate impact of Neighbourhood Health interventions for Wave 1 of NNHIO (December 2026)

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Chief People Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media. • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. **Effect:** • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff. **Impact:** • Unable to reach agreement on collaborations to secure sustainable services. • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff. • Failure to win new contracts. Increase in complaints and claims	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNC • Patient and Public Engagement and Involvement Strategy • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board/Neighbourhood Pilots • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Exec to Exec working • MWL Hospitals Charity annual objectives • Regular meetings with local MPs, OSCs etc. • Equality impact assessments • Anchor institution development plan • C&M/Alliance objectives and outcomes	**LEVEL 1** Operational Assurance • Shaping Care Together Programme • Membership of CMPC • Capital Planning Council • ED&I ~~Steering Group~~ Council • Staff Network Groups • Monitoring of NHS Choices comments and ratings • Review of digital media trends • Healthwatch feedback • Patient Experience Council • People Performance Council • HR Commercial Services Council • Valuing our People Council • CMPC Blueprint Delivery Board • System Partnerships Transformation Workstream **LEVEL 2** Board Assurance • Quality Committee • Strategic People Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • Quality Account • Annual staff engagement events programme • Staff survey results and action plan • Alliance Partnership Board • CMPC Blueprint Chairs & CEOs Group **LEVEL 3** Independent Assurance • NHSE review meetings • Participation in C&M ICB leadership and programme Boards • Collaborative working with Place Directors to develop plans for PBPs and Neighbourhood Health Prototypes with PCNs and LAs	Health inequalities improvement objectives to be agreed with each Place and the ICBs ~~Agree C&M /Alliance improvement objectives and outcomes~~	New **C**&M Integrated Care System performance and accountability framework ratings and reports Develop and maintain good working relationships with each Place Partnership, ICB and Primary Care Networks Work effectively with stakeholders to implement the NHS 10-year plan and develop neighbourhood model for the MWL footprint and our three shifts journey.	Continue to work with the SCT programme and other system partners to reduce the number of legacy S&O Trust fragile services (On-going) Engage with the transition of NHSE to DHSC and what this means for the local system infrastructure and responsibilities - including the impact on system engagement and decision making (March 2027) Demonstrate delivery of the three shifts for and impact of neighbourhood Health interventions for Wave 1 of NNHIP "Pioneers" (December 2026) ~~Agree priorities for C&M Blueprint Alliance~~ Implement System Partnerships Transformation workstream (July 2026) Develop System Partnerships Transformation workplan (September 2026)

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

Exec Lead: Chief People Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation Loss of market share	• Trust brief live • MWL News • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Workforce & Development Operational Plan • Learning and Organisational Development Operational Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Delivery plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • Trust Values • Medical Workforce Delivery plan • Talent Management action plan • Equality, Diversity, and Inclusion Delivery plan • Single temporary resourcing solution	**LEVEL 1** Operational Assurance • Finance and workforce Improvement Group • Monitoring of bank, agency and locum spend • Workforce operational plans and information dashboards • Vacancy control panel **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council, Equality, Diversity and Inclusions Council and HR Commercial Services Council • Finance and Performance Committee • Committee Performance Report • Staff Survey • Monitoring of vacancy rates/labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group • MWL People Plan 2025-2028 • Nurse safer staffing % fill rates **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report • Northwest BAME Assembly Anti-Racism Framework - bronze	Monthly Provider Workforce Returns (PWR) Delivery of MWL action plan for the NHSE 10 Point Plan to Improve the Working Lives of Resident Doctors (On-going).	Review of the MWL People Strategy to align with the MWL Strategy review and objectives (June 2026).	Continue to provide the necessary support for organisational change to implement the remaining management structure for the MWL integrated operating model (continues in 2026/27) Delivery of the 2025 staff survey action plan and engagement events (March 2027) Continue Healthcare Support Worker quarterly recruitment events for each hospital site for substantive and bank staff (on-going) Deliver the agreed Trust EDI priorities as outlined in the MWL People Plan 2025-28 and the High Impact Actions Delivery Plan (Revised to March 2027) ~~Implementation of single temporary resourcing solution (Revised to May 2026)~~ Time to Hire improvement plan monitored via Strategic People Committee (September 2026)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Chief Executive

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • Statutory safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data • Green Plan annual monitoring reports **LEVEL 3** Independent Assurance • Authorising Engineer Appointments and audits • Condition surveys • Premises Assurance Model (PAM) benchmarking • Model Hospital • PLACE Audit Results and benchmarking • Building Safety Act • ERIC/PAM benchmarking	Maintain up to date 10-year strategic estates development plans for MWL to support the Trusts service development and integration strategies. Development of an updated Trust Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	Compliance with the new Protect legislation for premises security (March 2027)	Deliver the agreed estates capital programme for 2026/27 (March 2027) Deliver the agreed backlog maintenance/critical infrastructure reduction programme for 2026/27 (March 2027) Deliver the PFI lifecycle programme for 2026/27 agreed with NewHospitals (March 2027) Develop the SCT preferred option capital business case and delivery plan (September 2026)

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Cyber Incident Response Plan (tested) • Information asset owner/administrator register • Service improvement plans • MWL Digital Strategy 2024-2027 • Microsoft Defender for Endpoints • Clinical & Digital Design Authority (CDDA) • MFA protection for confidential data – enforced on non-Trust devices • Annual DSPT self-assessments • C&M Major digital Incident planning exercises • Microsoft Secure Score / Exposure Management	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Comprehensive monitoring of systems and services • ~~Information security dashboard~~ • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring • Monthly cyber security operational meeting • Digital Transformation Steering Group • MMDA Strategy Board • Programme/Project Groups • Information Governance Group • Information Security Group • AI and RPA Group **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan • Audit Committee • Executive committee • Risk Management Council • IM&T Council • MMDA Service Operations Board • Quarterly Board Cyber Security Reports • Shared EPR Programme Executive Board **LEVEL 3** Independent Assurance • Internal/External Audits • Cyber Essentials Plus accreditation - MMDA. • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments • Data Security & Protection Toolkit	Annual IT Corporate Governance Structure review Technical Development of staff Joint EPR Programme Board Assurance Reports EPR Optimisation Council Assurance Reports	IT Communications Strategy Digital Maturity Assessment	Achieve HIMMS Level 5 2018 standards and core digital capabilities and WGLL standards (revised to September 2028 due to impact of extended EPR replacement programme) Windows Server 2016 are being retired and being replaced (Jan 2027) Delivery of the Frontline Productivity Programme to optimise Careflow EPR and implement new functionality to meet the core digital capability standards (full implementation will only be delivered when the new single EPR is in place – Feb 2029). Delivery of Community EPR (revised to March 2027) Implementation of Maternity Information System (revised to November 2026) following changes in service delivery model that have been reassessed and the implementation plan updated Implement EPMA at the Southport and Ormskirk Hospital sites (revised to June 2026) Deliver the 2026/27 IT Capital expenditure plan

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/055**			
Report Title	Incidents, Complaints, Concerns, Claims and Inquests Quarter 1 2026/27			
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 aim of this paper is to provide the Board with a closure report on the management of incidents, complaints, concerns and claims during Quarter 1 2026/27.

Executive Summary

Incidents

- A total of 8,247 incidents were reported across MWL in Q1 2026/27.
- Of these, 6,119 were patient safety incidents.
- 53 patient safety incidents were classified as moderate harm or above.
- The most frequently reported patient safety incidents in Q1 were:
  - Pressure Ulcers, including those not acquired under Trust care, were the highest reported Trust wide (819)
  - Accidents including slips, trips, falls, and collisions were the second highest reported incidents in Q1 (803)

  Data correct 16/07/2026

Complaints and Patient Advise and Liaison Service (PALS)

- The Trust received 156 first stage complaints in Q1.
- The Trust received 16 stage 2/reopened complaints in Q1.
- The Trust closed 156 complaints in Q1.
- Clinical treatment was the main theme for complaints, in line with previous quarters.
- Emergency Departments remained the main areas to receive complaints.
- The Trust received 1,028 PALS contacts in Q1 (not including Ask Rob or Compliments).

  Data correct 20/07/2026

Claims and Inquests

- In Q1 the Trust received 31 new claims; more than previous quarters. 25 were closed
- The Trust received 19 new inquests, and 13 inquests concluded
- No Prevention of Future Death (PFDs) were issued during that period

  Data correct 17/07/2026

Financial Implications

None as a direct consequence of this paper

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Incidents, Complaints, Concerns, Claims and Inquests Quarter 1 2026/27.

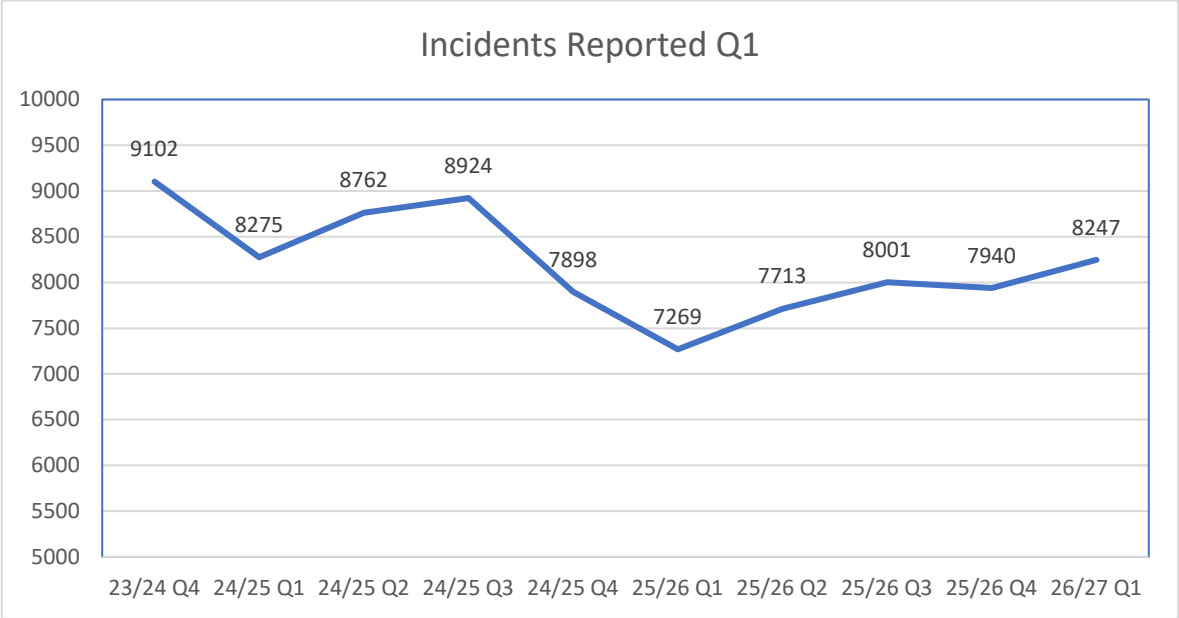
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational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

Incidents, Complaints, Concerns, Claims and Inquests Quarter 1 2026/27

1. Introduction

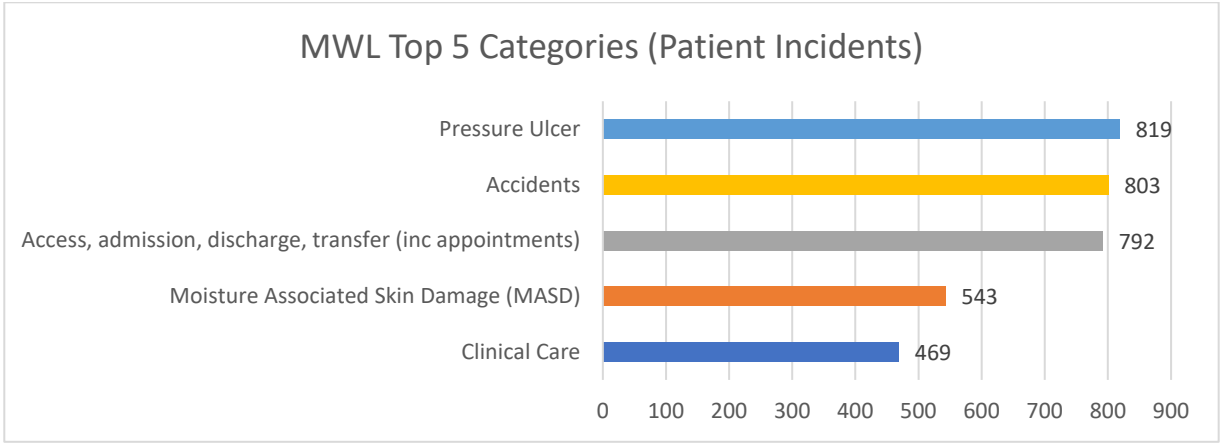
This paper includes reported incidents, complaints, PALS contacts, claims, and inquests during Quarter 1 2026/27, highlighting any trends, areas of concern and the learning that has taken place. In March 2025 the Trust moved to a new Incident Reporting System, InPhase, which brought all sites onto one reporting platform to record incidents, complaints, PALS, claims and inquests.

2. Incidents



MWL Q1 incidents reported	
6,119	**Incidents affecting patients**
722	**Incidents affecting staff**
1,348	**Incidents affecting the Trust or other organisation (examples include bed availability; notifications of staffing levels; delayed discharges; equipment issues and queries raised by system partners)**
40	**Incidents affecting visitors, contractors or members of the public**
18	**Martha's Rule / Call for Concern**

Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.



There were 8,247 incidents reported across MWL during Q1, which is a 3.9% increase on Q4 25/26 (7,940). Patient related incidents accounted for **74.2%** of these cases (6,119).

Among the highest categories for patient-related incidents:

- **Pressure ulcers** – including both those acquired while under MWL care and those acquired externally – were the most frequently reported in Q1, with 819 cases, which is a decrease compared with Q4 (950)
- **Accidents** – including slips, trips, falls, and collisions – were the second highest reported patient events (803) which is a decrease on the previous quarter (868 in Q4).

2.1 Incidents by harm category

The table below illustrates patient incidents by harm for Quarter 1 2026-27.

In Q1 there was one incident recorded as fatal severity across all sites which remains constant with the previous quarter. The percentage of severe and fatal incidents against the total of all patient incidents is **0.23%** for Q1 2026-27 compared with **0.12%** for Q4. This will continue to be monitored in the coming quarters.

The fatal incident reported in Q1 relates to a radiology discrepancy leading to a delay in medical care for a hepatic artery pseudoaneurysm. A PSIR has been completed and is due to be discussed at the Divisional Patient Safety Meeting to confirm harm.

MWL	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	26/27 Q1
Moderate	35	33	54	67	38	45	49	39
Severe	9	9	6	14	14	6	6	13
Death	2	4	2	4	4	7	1	1
Total	46	46	62	85	56	58	56	53

2.2 PSII incidents and Learning

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

Q1 2026/27 – Discussed at Patient Safety Panel	Total
Patient Safety Incident Reviews	16
Learning Reviews including Multi-Disciplinary Team (MDT) / After Action Review (AAR)	7
Patient Safety Incident Investigations (PSII) / (including Maternity and Newborn Safety Investigations (MNSI)	1

There was one Strategic Executive Information System (StEIS) reportable incident recorded for Q1 2026/27 which related to a Maternity and Newborn Safety Investigation (MNSI) accepted baby cooling incident. This was reported to StEIS and will be reviewed once the MNSI report has been received.

2.3 Duty of Candour

The duty of candour process has been commenced or completed for all incidents where harm has been confirmed as moderate or above. The investigation and validation of some Q1 reported incidents is still ongoing. In accordance with policy, Duty of Candour will be initiated following confirmation of harm.

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

3. Complaints

Closed Complaints	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
Not Upheld	22	17	20	16	12
Partially Upheld	89	86	127	90	120
Upheld	24	17	22	41	24
Total	**135**	**120**	**169**	**147**	**156**

Themes of Closed Complaints	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
Clinical Treatment	61	54	65	73	79
Patient Care (Nursing)	19	17	29	27	26
Values & Behaviours	2	5	8	13	9
Communication	14	21	26	20	14
Admission & Discharge	9	4	7	25	25

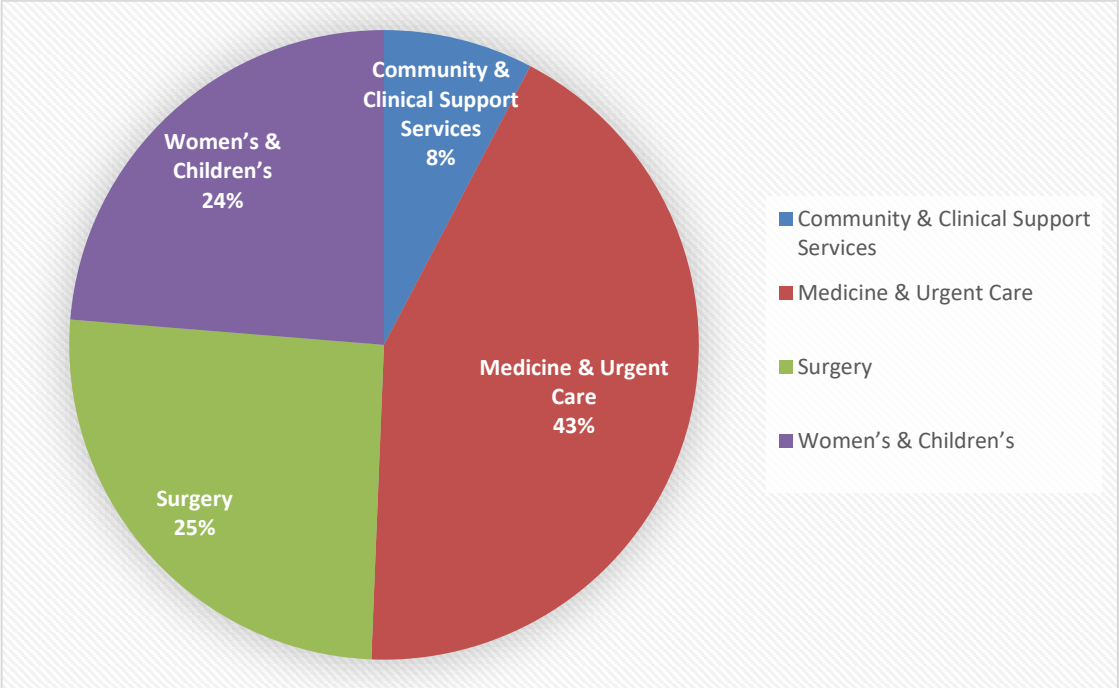
*Figures correct at time of reporting from InPhase

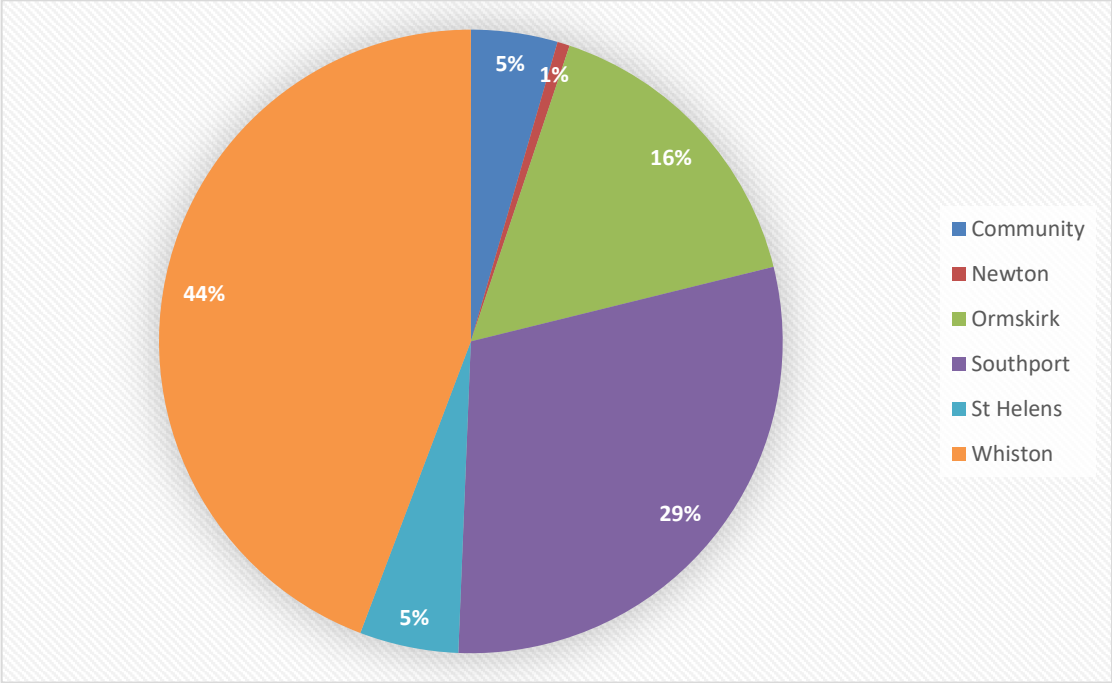
The Trust received 156 new complaints in Q1, likewise, there were 156 closed complaints that were upheld within the complaints process and four that were not supported through the complaints process in Q1. 60 aligned to complaints that had breached the 60-day target.

The Trust achieved a 69.2% compliance of complaints being responded to within 60 working days in Q1. This is an improvement on the figure from the previous two quarters, and the performance in Q1 2025/26

Quarterly comparison of 60 working day compliance	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4	2026/27 Q1
MWL First stage complaint	115	161	145	157	156
Second Response Trust Target Less than 12 per Q	16	16	18	20	15
Response Compliance Trust Target 80%	50.7%	71.6%	65%	64.8%	69.2%
MWL number of complaints breached 60 working timeframe	57	34	60	77	49

The charts below depict the specific Trust sites and divisional breakdown of the 156 first stage complaints received in Q1.





The Trust received 16 second stage/reopened complaints in Q1, which is generally consistent with the preceding three quarters.

Site	Total 2nd Stage/Reopened
Community	1
Ormskirk	0
Southport	4
St Helens	3
Whiston	8
Total	16

4. Patient Advice and Liaison Service (PALS), Askr Rob & Compliments

PALS Contacts	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
Number of contacts received	1131	1232	1112	1157	1028

*Figures at time of reporting from InPhase

PALS Contacts by Themes Q1

Q1 2026-27 PALS Themes by Division	C&CSS	Corporate / other /	M&UC	Surgery	W&C	Total
Communication	42	27	253	145	47	514
Appointments	36	5	37	65	23	166
Clinical Treatment	2	1	35	20	11	69
Admissions and Discharges	1	0	13	30	8	52
Patient Care/ Nursing Care	1	0	28	7	6	42
Access to Treatment or Drugs	2	4	8	7	4	25
Values & Behaviours	4	2	7	5	3	21
Waiting Times	1	0	2	12	1	16

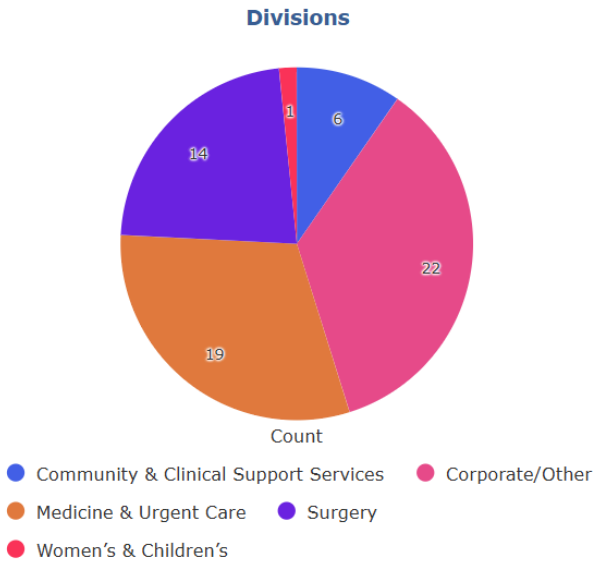
In Q1 there where 62 **Ask Rob** concerns received.

Ask Rob Contacts	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27
Number of contacts received	31	37	32	87	62

The top five themes for Ask Rob contact in Q1 were:

1. Communication (main theme)
2. Facilities
3. Appointments
4. Access to Drugs/Treatment / Patient/Nursing Care and Clinical Treatment.
5. Admissions and Discharge

The chart below displays the Ask Rob concerns received by division in Q1.



4.1 Compliments

Quarter 26/27	C &CSS	Corporate/Other	M&UC	Surgery	W&C	Total
1	426	11	187	145	33	803

4.2 Parliamentary and Health Service Ombudsman (PHSO)

The table below displays the number of PHSO case the Trust currently has ongoing in Q1 of 2026/27.

Current PHSO cases open to date

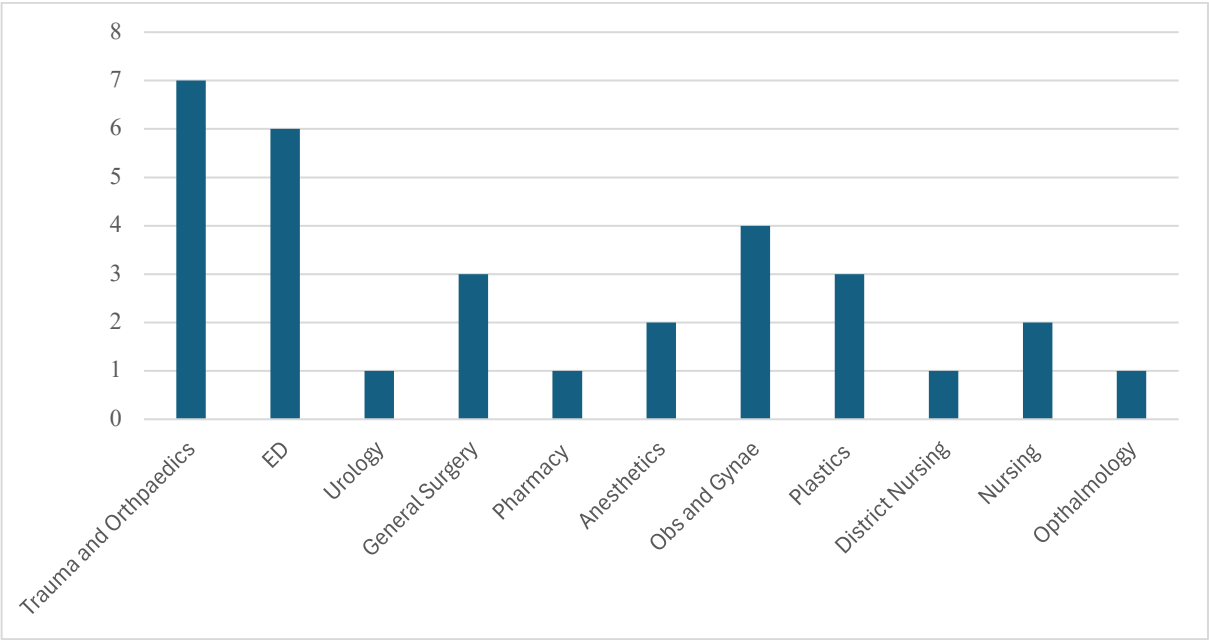
PHSO formal investigation	4
PHSO proposal to investigate	2
Primary investigation enquiry / Prelim enquiries open	10
Awaiting final outcome report	0
Total	16

No complaints were upheld by PHSO in Quarter 1 of 2026/27.

5. New Clinical Negligence Claims

The Trust received 31 new claims in Q1, which is substantially more than previous quarters, and the same quarter last year (18). Ten were received in April, ten in May, and 11 in June. This would also be well above the quarterly average for 2025/26, which was 20. We will monitor to see if this pattern is repeated in Q2.

5.1 New claims by speciality



The highest number of claims by speciality were Trauma and Orthopaedics. They also received three in the previous quarter. General Surgery, which had been the highest in a number of the previous quarters, only received three claims.

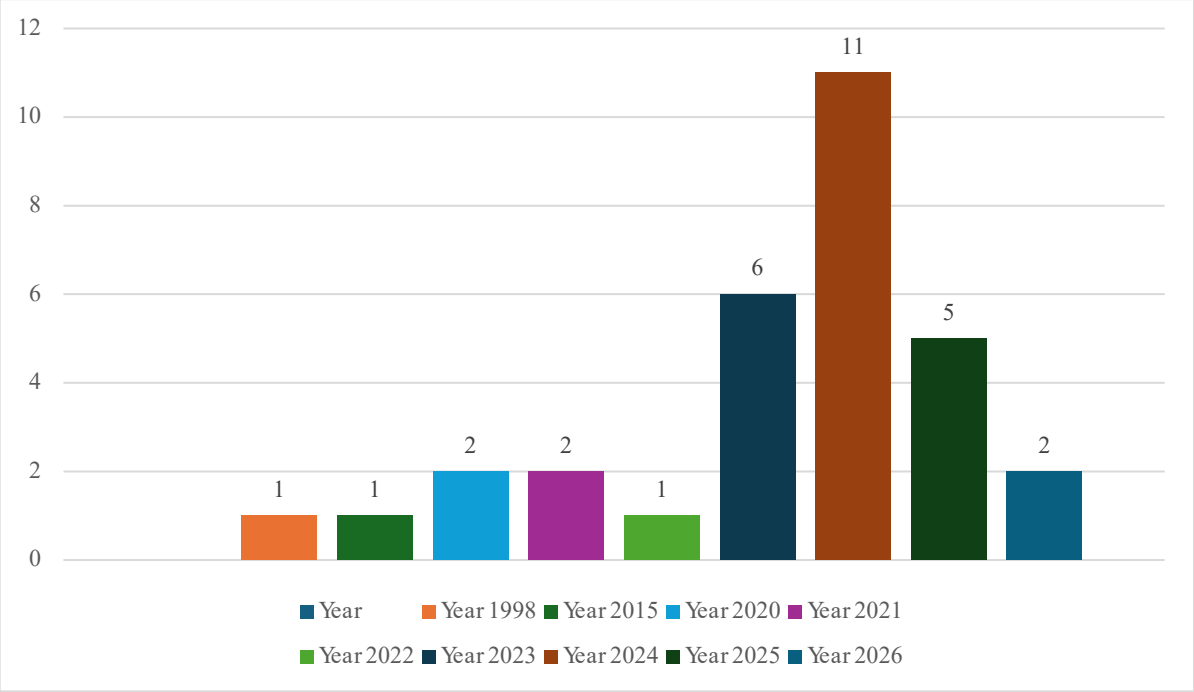
5.2 New claims by main reason

Failure/Delay in diagnosis and Failure/Delay in treatment are the largest causes of claims. Both nursing claims relate to falls. There is one never event which has led to a claim, which involved anaesthetics.

The cause codes used to identify reason are provided by NHS Resolution (NHSR), and the two main ones are quite broad. NHSR have introduced a new case management tool which, when it is fully operational, should allow for greater specificity in terms of the causes of claims. We will look to adopt any new cause codes from NHSR as part of our local data collection.

5.3 Year to which claims relate

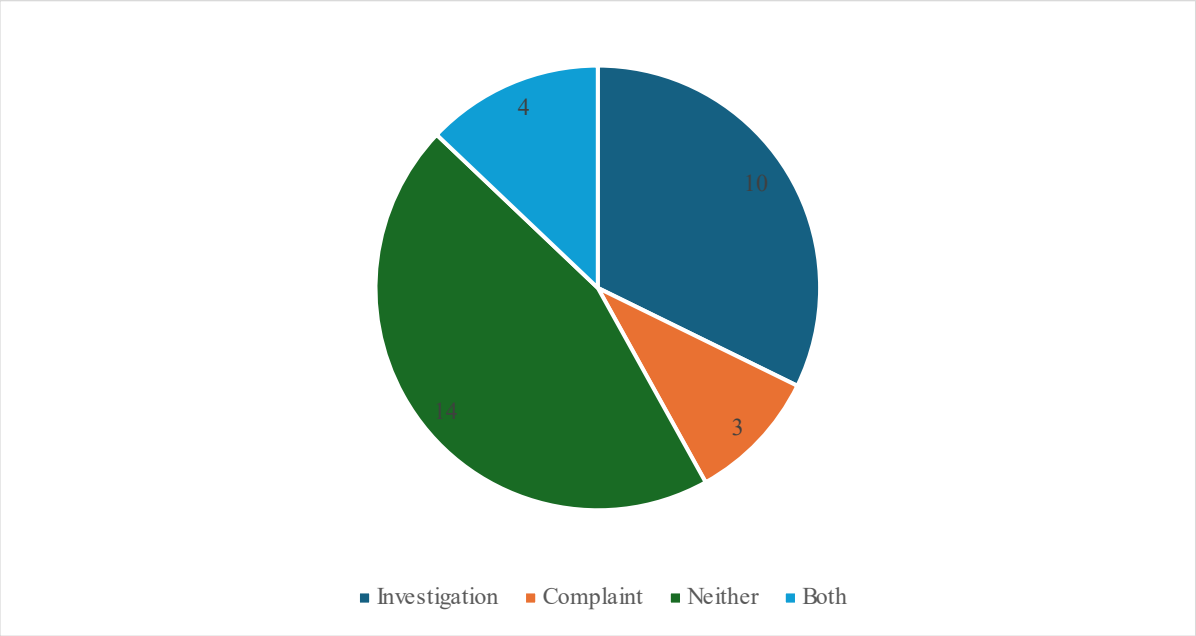
Although these claims were formally notified in Q1, the date of the incidents to which the claim relates can vary significantly. The graph shows the year in which the incident took place – where there is more than one incident the earliest that relates to this Trust is used.



The claim from 1998 relates to a birth injury claim.

5.4 Prior knowledge of issues causing claims

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



45.2% of the claims received had no previous investigation, which is less than the previous two quarters. The same percentage underwent a formal investigation, and 9.7% went through some type on concern/complaint process.

All claims that have not been investigated at all are reviewed at Claims Governance Group to see if an investigation should take place. Three claims so far from Q1 have been referred back to the Patient Safety team for a further investigation, with the June claims to be reviewed at the August Claims Governance meeting.

5.5 Lessons Learned/Actions taken from Closed Claims

The Trust closed 25 claims in Q1. 7 of these concluded due to inactivity, but a number were settled, or the claimant has chosen not to pursue them. No matters reached trial in Q1.

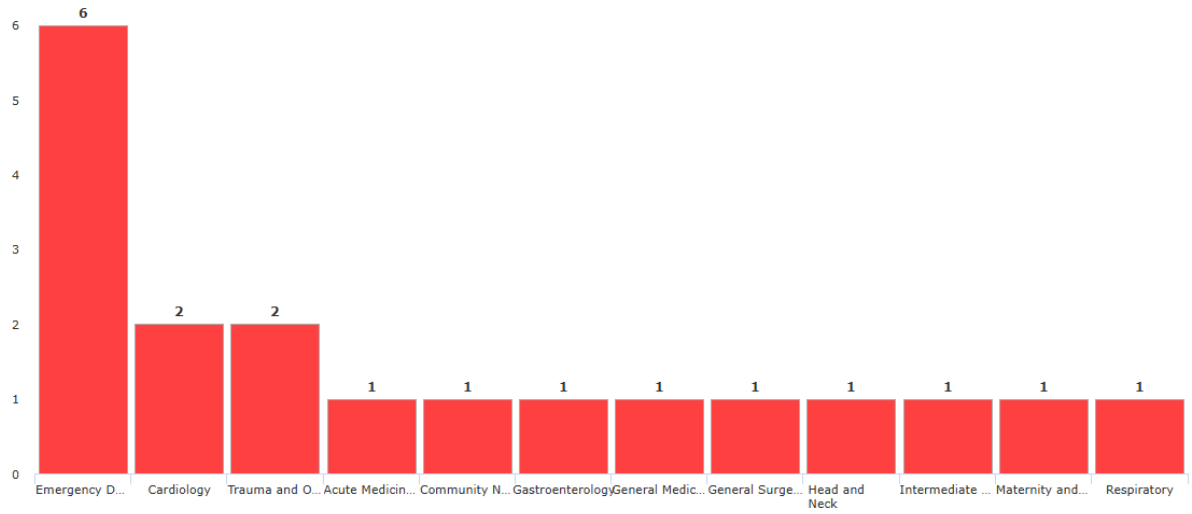
There were no claims closed in Q1 with learning specifically identified as a result of the claim process. Anecdotally this indicates that, where there were errors in care that caused harm for which the claimant received compensation, the Trust was aware and had taken steps to address them outside of/prior to the claim process. This is reassuring, given the length of time it takes a claim to reach conclusion.

6. Inquests

6.1 New Inquests

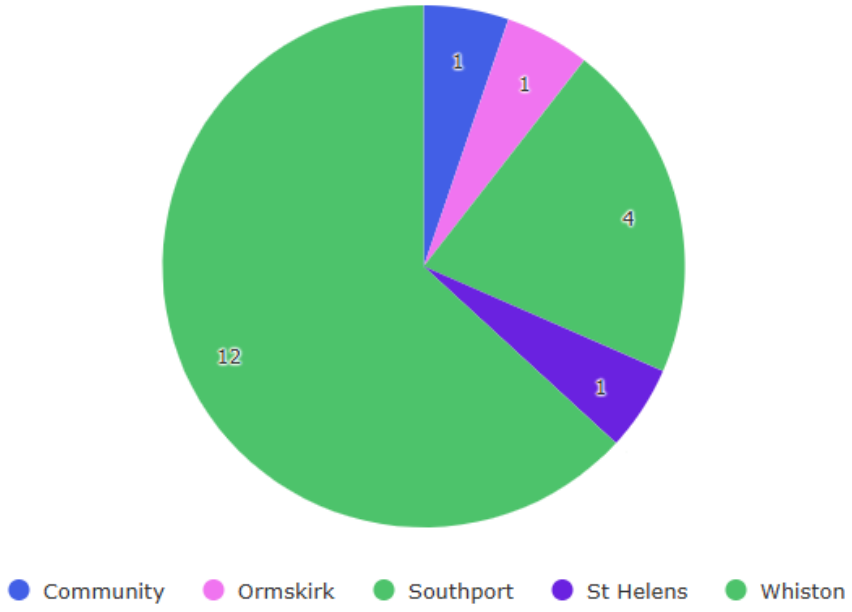
19 new inquests were opened in Q1. This is broadly consistent with the previous three quarters and would appear to reflect an overall downward trend in inquests received by the Trust.

These inquests are broken down by department as follows:



The Emergency Department (ED) received the most inquests, which is not unexpected and is consistent with previous quarters. No other department received more than two new inquests.

These inquests are broken down by site as follows:

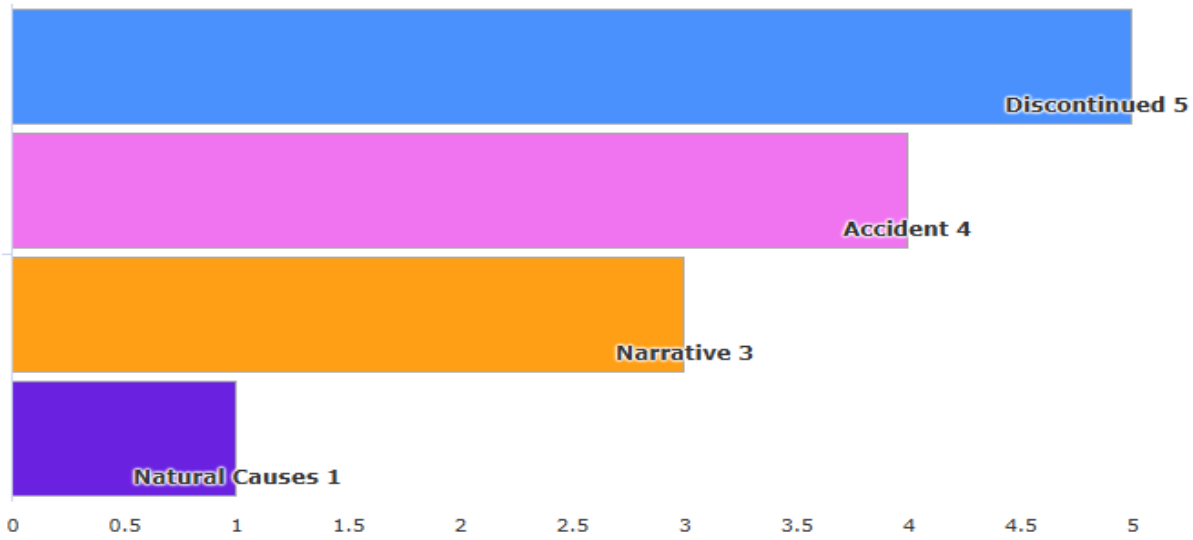


6.2 Closed inquests

We have endeavoured to improve the data and information provided in relation to closed inquests.

The Trust closed a total of 13 inquests in Quarter 1. This is less than would normally conclude, and may reflect the fact that the new Senior Coroner for Sefton has worked through a backlog of inquests following her appointment in September 2025. We will keep this under review.

The graph below shows the outcome of those inquests:



A narrative conclusion is given by the coroner when they do not feel a short form conclusion is sufficient to record how the deceased came by their death. Inquests can be discontinued when the coroner feels the medical cause of death provided is sufficient.

Of those 13 inquests:

- Seven involved surgery, and six involved medicine and urgent care.
- Six proceeded to a formal hearing; seven did not.
- None involved in a jury.
- The coroner did not find any neglect in any of them.
- 1 matter attracted some press interest.
- No Prevention of Future Death (PFD) notices were issued.
- The coroner did not require further assurance/information in any of them.

6.3 Other news

The Public Office Accountability Bill ("the Hillsborough law") has passed its final reading in the House of Commons. This will have significant impact for the Trust in terms of Duty of Candour and how it approaches inquests and other public enquiries.

7. Recommendations

It is recommended that the Board note the report and the learning and actions from recently concluded inquests and claims.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/056 (12.1)**			
Report Title	**Data Security and Protection Toolkit (DSPT) 2025/26**			
Executive Lead	Malcolm Gandy, Director of Informatics			
Presenting Officer	Malcolm Gandy, Director of Informatics			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

This report summarises MWL's status of the DSPT for its 2025/26 submission. The DSPT is an online self-assessment tool that allows organisations to evaluate their data security and protection practices.

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

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

The submission date for the DSPT was the end of June.

MWL submitted the DSPT assessment at the end of June 2026 for the 2025/26 submission and was able to submit evidence items for all the 'outcomes.' MWL has achieved a "**standards met**" rating for the submission.

Mersey Internal Audit Agency (MIAA) have audited a number of the outcomes and evidence items. The Trust has achieved a 'Low Risk' rating using the NHS England (NHSE) prescribed methodology in which they agreed that the Trust has met the minimum expected profile level across the outcomes that were selected for review. Please note this is equivalent to '**Substantial Assurance**' – MIAA have adapted their wording.

Financial Implications

None directly from this report.

Quality and/or Equality Impact

Not applicable.

Recommendations	
The Board is asked to note the Data Security and Protection Toolkit (DSPT) 2025/26	
Strategic Objectives	
	SO1 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Data Security and Protection Toolkit (DSPT) 2025/26

Introduction

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

In September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. This has led to NHS Trusts, Commissioning Support Units (CSUs), Arms Length Bodies (ALBs) and Integrated Care Boards (ICBs) seeing a different interface, which sets out CAF-aligned requirements in terms of objectives, principles and outcomes. This year has seen no change and the scope of the 2025/26 DSPT continues to include additional cyber requirements, reducing the information governance requirements compared to the 2023/24 DSPT.

This is the second year of completing the CAF-aligned DSPT.

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

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

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

The new CAF-aligned DSPT consists of five main objectives, which are split into 47 contributing outcomes, these are further unpinned by approximately 140 control expectations, each requiring multiple, robust pieces of evidence to demonstrate how they have been achieved. Each outcome is supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'.

The DSPT submission date remains the end of June.

It has been recognised that the move to a CAF-aligned DSPT is a significant change and will be a considerable challenge for many NHS organisations as it represents an increase in the data security requirements for organisations. The main areas of uplift are in the requirements to protect your organisation from cyber risk. There is understanding that this may take some time to meet all the requirements and NHSE are not expecting organisations this year to have achieved for each of the 47 outcomes.

There are five main Objectives:
A – Managing Risk
B - Protecting against cyber attack and data breaches

C - Detecting cyber security events
D - Minimising the impact of incidents
E - Using and sharing information appropriately

These objectives are then broken down into 'principles.' The number of principles vary per objective. These principles are broken down further into 'outcomes' which again vary per principle. Each outcome details what is expected for that particular one and evidence is expected to be provided here.

An example is:

- Objective A – Managing Risk
  - Principle A1 – Governance (polices & procedures)
  - Outcome A1a – Board Direction
  - Outcome A1b – Roles and Responsibilities
  - Outcome A1c – Decision Making and approval
  - Principle A2 – Risk Management
  - Outcome A2a – Risk Management Process
  - Outcome A2b – Assurance
  - Principle A3 – Asset Management
  - Outcome A3a – Asset Management
  - Principle A4 – Supply Chain
  - Outcome A4a – Supply Chain

Larger organisations, such as Acute Trusts, are also required to have their DSPT submission externally audited to ensure the accuracy of their submission. The objective of this exercise is to provide independent assurance over a nationally determined sample of evidence items and to highlight areas for improvement to inform the following year's DSPT submission.

To achieve 'standards met,' NHS organisations must meet the expected achievement level set by NHSE for each outcome and have achieved a successful independent audit.

Failure to complete the DSPT can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact MWL's ability to bid for new services in the future. In addition, could place MWL's reputation at risk. The Information Commissioner has also indicated that satisfactory completion of the DSPT can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of 2025/26 Submission

Evidence has been provided for the self-assessment against the CAF aligned DSPT. These items are recorded under 'outcomes' and this represents an indicator of maturity in that area. There are 47 outcomes that require evidence.

In order for MWL to have achieved "standards met", **all** of the outcomes must be evidenced.

MWL have completed the DSPT in time for the end of June 2026 submission date. The Trust has submitted '**standards met**.'

The table below shows the number of outcomes to be answered for each overarching Objective:

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

Evidence was required from MWL's IT Security, Information Governance (IG) and Data Quality (DQ) teams. The table above showing that IT Security were required to answer 32 outcomes, IG – 14 and finally DQ providing one evidence for one outcome.

DSPT Approval

The Senior Information Risk Owner (SIRO) has approved the submission of the DSPT for 2025/26 with the Trust at 'standards met.'

Internal Audit

Mersey Internal Audit Agency (MIAA) carried out an audit of MWL's DSPT submission (as required of larger NHS organisations) during two visits in February and May 2026 to assess the Trust's compliance against the new CAF aligned DSPT. MIAA reviewed 12 outcomes across the five objectives in the Cyber Assessment Framework. NHSE mandated nine outcomes to be audited for 2025/2026, the organisation was required to select and formally approve a further three outcomes to be audited standards.

A selection of outcomes were chosen from each of the five objectives.

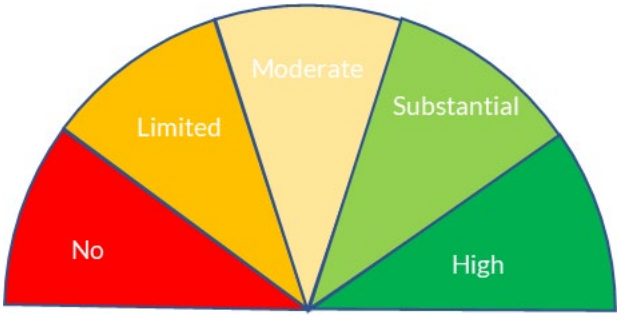
Area	Description
A1.a	Board Direction You have effective organisational information assurance management led at Board level and articulated clearly in corresponding policies.
A1.b*	Roles and responsibilities Your organisation has established roles and responsibilities for the security and governance of information, systems and networks at all levels, with clear and well-understood channels for communicating and escalating risks.
B1.a	Policy, process and procedure Development You have developed and continue to improve a set of information assurance and resilience policies, processes and procedures that manage and mitigate the risk of adverse impact on your essential function(s).
B4.a	Secure by design You design security into the network and information systems that support the operation of your essential function(s). You minimise their attack surface and ensure that the operation of your essential function(s) should not be impacted by the exploitation of any single vulnerability.
B5.a	Resilience preparation “You are prepared to restore the operation of your essential function(s) following adverse impact.”
B5.c	Backups “You hold accessible and secured current backups of data and information needed to recover operation of your essential function(s).”
C1.b	Securing logs You hold log data securely and grant appropriate access only to accounts with business need. No system or user should ever need to modify or delete master copies of log data within an agreed retention period, after which it should be deleted.”
C1.a	The data sources that you include in your monitoring allow for timely identification of security events which might affect the operation of your essential function(s).
C1.c*	Generating alerts “Evidence of potential security incidents contained in your monitoring data is reliably identified and triggers alerts.”
D2.a	Incident root cause analysis When an incident or near miss occurs, steps must be taken to understand its root causes and ensure appropriate remediating action is taken.
E1.a*	Privacy and transparency information You follow best practice for providing privacy and transparency information to ensure that all individuals have a reasonable understanding of their rights and how their information is being used.
E2.a	Managing data subject rights under UK GDPR You appropriately assess and manage information rights requests such as subject access, rectification and objections.
E2.c	National data opt-out policy “A robust policy and system is in place to ensure opt-outs are correctly applied to the information being used and shared by your organisation.”

*a further three outcomes approved by the SIRO for audit.

The Trust received the audit report from MIAA in June which has rated the organisation as '**Low Risk**.'

Please note that this is equivalent to the former rating known as 'Substantial Assurance.'

2025 Rating Model:



2026 Rating Model:

Overall Risk Rating across all tested outcomes	
Very High	More than four outcomes are rated as not meeting minimum achievement levels required and/or the organisation cannot comply with mandatory policy requirements.
High	Between two and four outcomes are rated as not meeting minimum achievement levels required.
Moderate	No more than one outcome is rated as not meeting minimum achievement levels required.
Low	All minimum achievement levels have been met.
Very Low	All minimum achievement levels have been met and achievement levels have been exceeded for at least one outcome.

Rating Achieved 2025/26:

LOW RISK

Objective	Overall Assurance
A – Managing Risk	Met
B - Protecting against cyber attack and data breaches	Met
C - Detecting cyber security events	Met
D - Minimising the impact of incidents	Met
E - Using and sharing information appropriately	Met

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

High Confidence

Confidence levels are Low, Medium and High.

Recommendations received from MIAA Audit Report

MIAA have identified the areas that will require further attention in 2026-27, these areas do not affect the rating of each outcome but allows the Trust to strengthen their processes. An action plan is in place with assigned owners and dates to ensure these areas are completed. The action plan will be presented to the SIRO at the next Information Governance Steering Group.

Conclusion

MWL continue to build and improve on the Information Governance and IT Security foundations which have been embedded. After last year's disappointing rating of 'standards not met' due one area not being met, 'Multi-Factor Authentication'(MFA) MWL has demonstrated how they can work hard to ensure areas that require improvement are captured and focused on; showing an organisation that recognises where it needs to strengthen. The '**Low Risk**' rating and '**High Confidence**' in the evidence that has been provided highlight that MWL has excellent IG and IT Security processes in place.

END

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/056 (12.2)**			
Report Title	Information Governance Annual Report			
Executive Lead	Malcolm Gandy, Director of Informatics			
Presenting Officer	Malcolm Gandy, Director of Informatics			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

This report is designed to inform and give assurance to the Board of progress made against the Information Governance (IG) work programme for 2025/26.

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

IG has four fundamental aims:

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

MWL has a duty to ensure that it complies with its legal and regulatory obligations, for IG this is data protection legislation, more specifically the UK GDPR, Data Protection Act 2018 and the Data and Use Access Act 2025. MWL is committed to conducting frequent reviews and improvements of its services; this includes Information Governance (IG).

This report details the progress that has been made against the IG work programme for 2025/26 and provides a ‘year ahead’ programme of work on areas that are necessary to achieve IG compliancy and to further embed IG within MWL.

Financial Implications

None directly from this report.

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board to note the Information Governance Annual Report (including Freedom of Information Annual Report).	
Strategic Objectives	
	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Information Governance Annual Report

Introduction

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

MWL has a duty to comply with data protection legislation such as the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA 2018), Data and Use Access Act 2025 (DUAA), the Freedom of Information Act 2000 (FOIA 2000), and to meet IG / Information Security / NHS specifications and requirements to support the assurance standards of the Data Security and Protection Toolkit (DSPT).

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

MWL will complete and submit the Data Security and Protection Toolkit (DSPT) on an annual basis. The DSPT enables organisations to measure their performance against Data Security and IG requirements set out in legislation and Department of Health policy. In September 2024 NHS England (NHSE) published a new DSPT which has moved away from assessing organisations against the National Data Guardian's 10 Data Security Standards and is now aligned with the National Cyber Security Centre's Cyber Assessment Framework. MWL have completed the DSPT for 2025/26 and to provide assurance that the evidence provided was of a good standard it was audited by Mersey Internal Audit Agency. For 2025/26 MWL received the rating of 'Low Risk' equivalent to 'Substantial Assurance.'

Senior Information Risk Owner Update (SIRO)
This section of the paper is designed to inform and give assurance to the Board of progress made against the IG work programme for 2025/26.
This section will provide assurance, from the SIRO, that MWL:

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

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

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

The key responsibilities of the SIRO are to:

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

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

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

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

A – Managing Risk
B - Protecting against cyber-attack and data breaches
C - Detecting cyber security events
D - Minimising the impact of incidents
E - Using and sharing information appropriately

The Role of the Caldicott Guardian

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

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHSE. The Caldicott Guardian has a key role in ensuring that all NHS organisations achieve the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

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

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

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

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

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

The named DPO must be:

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

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

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

Camilla Bhondoo reports into the Director of Informatics/SIRO.

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

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

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

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

- Implementation and completion of an IG work plan for 2025/26 that detailed the IG tasks / actions that were required for the year, this IG work plan was even more imperative to have in place with the DSPT focussing on cyber security. The aim was to provide assurance to the Group (including the SIRO, Caldicott Guardian and DPO) that all areas of data protection laws were being addressed and therefore MWL were complying with these laws. For this IG work plan 22 workstreams were listed. A new 'IG Task' was added, named 'Quality Control' – the aim was to demonstrate that IG reviews are in place so the processes, actions, standards that are being used meet specific IG requirements and standards. Outputs have been inspected, measured and tested. There were 81 individual tasks / actions within the IG work plan – all requiring completing before DSPT submission (end of June).
- Annual review of the Terms of Reference and membership for the IG Steering Group to ensure it is still being inclusive and receives representation from the departments across the Trust; enabling key IG messages to be filtered to the right places. Ensuring that the purpose of the group and the responsibilities of the Group is adequately detailed and being adhered to, which ultimately monitors the Trust's Information Governance agenda. The review saw minor amendments and confirmed the Group's purpose is still valid and on track - approved Terms of Reference for the group.
- Approval of the following IG policies / key documents:
    - Information Governance Strategy – a key document that sets out the approach MWL takes to develop and implement a robust Information Governance Framework for the future management and protection of organisational and personal information.
    - IG Training Needs Analysis – this outlines the key roles within the Trust and the Information Governance training they are required to undertaken to support the Trust's Information Governance Framework and compliance with the Data Security and Protection Toolkit. This document requires an annual review.
    - Privacy Notices – documents required by law (UK GDPR, specifically UK GDPR Principle (a): Lawfulness, fairness and transparency and under the 'right to be informed') where MWL must inform individuals (in our case the public and patients and staff) when we collect personal data from them and how we intend to use it. This has been made accessible to the public via the Trust website. Privacy Notices must be reviewed annually as a minimum. This year:

      Public / Patient Privacy Notice saw the following changes:
        - Introduction of the Data Use and Access Act 2025 (DUAA 2025) – this act is designed to strengthen the UK GDPR and DPA 2018, it will amend some areas (not all) to strengthen, provide clarity while simplifying areas that have been open to interpretation.
        - Caldicott Guardian updated to Dr Simon Dowson.
        - 'How we protect Children and Young people's personal data?' section – sentence added to highlight that DUAA 2025 states for children that the needs of these users must be taken into account when processing their personal data especially for online services.
        - New section on Robotic Processing Automation (RPA), describing what is it and that where it is used the privacy and security risks are assessed before implementation.

To note, last year's review saw the section on 'Artificial Intelligence (AI)' being added. Important to distinguish between RPA and AI as they are different processes.

- 'How to access your personal data' section updated, the Access Team now operate as one, using one email address and contact phone number – previously they were separate for STHK requests and S&O requests.
- 'Accessing a deceased person's record' section updated to make it clear under the act only medical records can be requested – the Trust in the past year have received requests for deceased persons complaints, investigation which is not permitted.

Not approved at the review as this occurred in March 2026, however for information, the Data Security Protection Toolkit section has now been updated to reflect the recent June 2026 submission is – 'standards met' has been rated as 'low risk' formerly known as 'substantial assurance following an independent audit.

- Staff Privacy Notice – As above, a must for MWL to have in place. This Staff Privacy Notice is not only useful for staff who work within the Trust but as a Lead Employer and a Payroll provider often organisations the Trust is linked to will ask for a Staff Privacy Notice to see how we are protecting their staff's data. This is made available on the Trusts website and intranet. This year:

    - Addition of the Data Use and Access Act 2025 (DUAA 2025) in Background section.
    - Caldicott Guardian updated to Dr Simon Dowson.
    - 'Right of access to your personal data' section updated, the Access Team now operate as one, using one email address and contact phone number – previously they were separate for STHK requests and S&O requests.

- A Young Person's Privacy Notice - Patients of all ages need to be able to understand how the Trust looks after and protects their data. The Public / Patient Privacy Notice is extremely detailed and maybe seen as difficult to understand for all of our patients, particularly the younger ones, hence the need for a more simplified version.
    - Review saw no changes were needed.
- Individual Rights Policy and supporting Standard Operating Procedures (SOPs) - the updated policy was required due to the introduction of the DUAA which has introduced clearer statutory duties around clarification, proportionality and the handling of complex or high-volume data retrievals for subject access requests. The Act confirms the Trust's ability to pause statutory deadlines while waiting for clarification from a requester and emphasises the need to record why certain searches, particularly across email systems, may be disproportionate. The updated policy and introduction of SOPs provides explicit guidance on when extensions may be applied, how exemptions should be interpreted and what constitutes a reasonable and proportionate search.

    - Registration Authority (RA) Policy - the RA is responsible for putting arrangements in place that will ensure tight control over the issuing and maintenance of Smartcards, whilst providing an efficient and responsive service that meets the needs of the users. The review saw minor amendments and did not change the context of the policy.

    - IT Asset Management Policy - The aim of the policy is to provide a framework within which an accurate record of IT Assets (Hardware – workstations, servers, laptops, network, tablets, etc. & Software – Windows, Adobe Professional etc.) can be created and

maintained. The review saw minor amendments and did not change the context of the policy.

- MWL Record Keeping Documentation Policy – A new policy introduced by the Head of Clinical Audit. This policy relates to all clinical records including electronic and those manual records filed in the patients' case notes or kept separately within individual departments.

- Data Protection Impact Assessment (DPIA) Procedure - This document outlines what a DPIA is and its importance, when a DPIA is required (when personal data is being processed) and the approval process. This procedure was not due for review until 2027 (having been in place since February 2024) however, following a review by the IG Management Team there has been a review of the process, and this now needs to be reflected in this DPIA Procedure. The main changes included: IAO approval role (IAO i.e. Executive Lead to approve processing before DPIA is completed), introduction of a DPIA Risk Assessment Form 'mini DPIA' and DPO approval.

- Data Protection Impact Assessment (DPIA) Template – IT Security Section Revision - The existing DPIA template, in particular the IT Security section was updated by the IT Security team to ensure the documentation now reflects current security standards, emerging threats, and operational practices. Providing clearer guidance on assessing IT-related risks, including unauthorised access, account lifecycle management, and system-level controls. It will also streamline the review process by aligning with the latest internal security protocols and audit requirements. This change follows collaborative input from the IT Security team and reflects feedback gathered during recent DPIA reviews and IT Security meetings.

- Data Protection Impact Assessments (DPIAs) – a standing agenda item. A DPIA is a data protection and IT security assessment form which is mandated by the UK GDPR, it helps the Trust to identify, analyse, and minimise data protection risks of a project, IT system, process or initiatives, specifically where personal data is being processed. These can be new or changes to existing processes. It ensures processing is necessary and proportionate, acting as a crucial tool for demonstrating legal compliance and protecting individual's rights and privacy.
  Where suppliers are contracted to work on behalf of the Trust, they are 'checked' out to ensure they have the right IT/Cyber securities and data protection policies in place; Due Diligence Questionnaires (DDQs) are requested and completed.

  Additionally, this past year the IG team have started to review DPIAs and DDQs which are over a year old. This is to see whether they are still in use or if any there have been any changes to how the initiative / system is being used. 45 DPIAs were reviewed by the Project Lead and 22 DDQs. The IG team also identified where contracts were missing.

  43 DPIAs have been approved in the last year. Examples include:
  - The NHS National Uniform Project - introducing a standardised uniform for clinical staff across NHS trusts in England.
  - Federated Data Platform (FDP) – further use of the FDP – Patient-Level Information and Costing Systems (PLICS), Virtual Wards and Cancer 360.
  - EPMA (Automation Anywhere Robotic) Data Cleanse – Pharmacy – use of Robotic Process Automation (RPA / Bots) to assist with data quality.

- Transfer of the Knowsley Urgent Community Response contract from Mersey Care to MWL.
- Transfer of Sexual Health Services Sefton to Brook.
- Cheshire and Merseyside Pathology Network Laboratory Management Information System (LIMS) Implementation. Please note due the enormity of the LIMS project work is ongoing, DPIAs have been completed, further DPIAs may be required so this workstream remains open.
- West Lancashire Community Services into MWL from HCRG.

DPIAs are being completed in support of Artificial Intelligence (AI) and Robotic Processing Automation (RPA), and the Trust has seen a rise in use. The Trust have set up an AI/ RPA Steering Group, whereby all initiatives are presented, discussed and approved. Once approved where the AI or RPA is processing personal data, it is identified that a DPIA is required. These DPIAs feature as part of the IGSG's DPIA Standing Agenda Item.

- Monitor IG Training – standing item. IG training is mandatory particularly for members of staff who process personal data and those may come into contact with personal data. It is not only required by the law but also for the completion of the Trust's Data Security and Protection Toolkit (DSPT). If a member of staff is involved in a serious data breach it is likely that the supervisory body that is the Information Commissioner's Office (ICO) will ask if they have attended their IG training and when that was. Staff are required to complete their training once a year. The Trust's target is 85% which has been agreed by NHS England via the DSPT. The IG team actively monitor training compliance, sending reminders where necessary, in addition they offer a range of training modes – face to face, virtual (teams) or completion of a workbook (to support staff who do not have regular access to a computer). The Trust in the last year has met the compliance rate of 85% and continues to hover around the 86% mark – the highest having been 89%.

- Provide updates on the Subject Access Request (SAR) compliance. A Subject Access Request (SAR) is a legal right enabling individuals to request access to the personal data the Trust holds about them, including medical records and personnel files. In accordance with UK GDPR and the Data (Use and Access) Act 2025 (DUAA 2025), the Trust is required to respond to SARs within one calendar month. During the reporting period, compliance has reduced due to a significant increase in demand, driven largely by national maternity investigations and the Infected Blood Inquiry, resulting in a backlog of requests. A recovery plan has been implemented, with the service now operating at its planned establishment and enhanced management oversight in place to restore compliance. Performance is improving incrementally, with compliance continuing to increase as the backlog is reduced. Since transferring into the Information Governance service in January 2024, the SAR function has continued to strengthen governance arrangements, standardise processes and improve the overall service provided to requestors. Improvements in the last year include:
  - Sending requests via secure email (Egress) rather than printing the paperwork and posting out to the requestor. Saving not only on paper but posting fees. Notification of how requests will be sent out feature on the application forms, warning in advance of the process.

  - Adapting the application forms to be clearer on what documentation is needed and what personal data can be supplied i.e. requests from patients for email interaction regarding their care will not be provided as pertinent information is saved in the clinical record.

- The previous issues concerning IT and system access across sites has been largely resolved in the last year meaning the team can start to operate as one, previously the members of the team based at Southport and Ormskirk would only handle requests for those sites and vice a versa with St Helens and Knowsley.
- The team now use one central system (InPhase) to manage all requests, previously each side had two separate systems.
- Instructing the SAR team to only log a SAR once all documentation has been received, clarified and verified. Previously the team would log a request while still waiting for further information, the SAR 'clock' as confirmed by UK GDPR only starts once all information has been received.
- Previously when email search requests were received the team would ask the IT Security team to conduct the search, the search results would retrieve thousands of pages of which the SAR team would work through, often these were emails which featured the person in the distribution list i.e. global daily emails, newsletters. The IG team have taken over conducting these searches and with their knowledge are able to streamline the results, often from thousands of pages to 30 actual pages that need reviewing.
- IG Leads continue to provide SAR training to provide the team with confidence in redacting and continue to provide support for the more detailed requests that require further review and expert redaction before disclosure.
- SAR Working Group established – looking at better ways of working i.e. introducing a webform, moving to a more intuitive system where a completed webform is submitted and automatically creates a request within the system (saving on logging the request manually) and sends out an acknowledgement email to the requestor. Potential use of RPA to retrieve the data.

- Within the last 18 months all departments within MWL have received an initial audit by the IG team, with 79% of areas receiving an audit within the last 12 months, which equates to just over 100 departments. The IG team assess whether staff are acting in accordance with Information Governance principles when on-site. This includes ensuring identification badges are worn, clear desk policies are adhered to, secure areas are kept locked when unoccupied, etc. Key concerns have been discussed at the Group and actions assigned.

- Last year the IG team established Information Asset Registers for each department. This enabled the team to understand what key information assets each department had especially where they contained personal data i.e. personnel files, check that they legally can have them and ensure that whether they are held electronically or in paper format that they are held securely, with appropriate limited access. This year the team have built on this and ensured all of the registers that were completed have been subject to a review to identify any changes. Identified risks, such as paper files being stored in a broken filing cabinet, are escalated to the IG Steering Group for action.

- Monitoring of the IG incidents that are reported on the Trust's Incident Reporting System, InPhase. Each data breach has followed the IG Incident Reporting process and been investigated by the IG Team. Where data breaches have been classed as near miss data breaches or where key actions have been required the IG Officers have completed an IG Incident Proforma which details the data breach, score, findings and an action plan. These are

reviewed by the Directorate Manager and sent to the DPO for approval. Where data breaches are classed as serious there is a process in place to escalate to the SIRO and Caldicott Guardian (if patient data involved) via the DPO. A report is presented to the Group which also provides assurance that the Trust has a robust data breach procedure and policy in place. During the financial year 2025/26 720 incidents were reported to IG, at the time of writing 25 remain open – any incident causing alarm was discussed at the IG Steering Group.

Reportable Incidents
The Trust has a statutory duty to report personal data breaches to the Information Commissioner's Office (ICO) where they meet the reporting threshold under UK GDPR and the Data (Use and Access) Act 2025 (DUAA 2025).

During the 2025/26 reporting period, four breaches met the threshold for notification to the ICO.
The reported incidents reflected a range of information governance risks, including inappropriate access to or disclosure of personal information, human error and system configuration issues. In each case, the Trust responded in accordance with its Information Governance Incident Management procedures, including immediate containment of the incident, investigation, assessment of risk to individuals, implementation of Duty of Candour where appropriate, and notification to the ICO where required.

For each incident, comprehensive action plans were developed and monitored to completion through the Trust's IG governance arrangements. Actions included, where appropriate:

- Immediate containment of the incident and mitigation of further risk.
- Formal investigation and root cause analysis.
- Appropriate HR processes and professional regulatory referrals where applicable.
- Notification and support for affected individuals in line with Duty of Candour principles.
- Review and strengthening of policies, procedures and technical controls.
- Targeted staff training and organisational learning.
- Enhanced auditing, monitoring and assurance processes to reduce the likelihood of recurrence.

All reportable incidents were notified to the ICO in accordance with regulatory requirements. Where ICO reviews remain ongoing, the Trust continues to engage openly with the regulator and has not delayed implementation of corrective actions pending the outcome of those reviews.

At the time of publication, no financial penalties or enforcement action had been issued by the ICO in respect of the reportable incidents notified during 2025/26.

Learning from all reportable incidents has been incorporated into the Trust's wider Information Governance improvement programme and continues to inform staff awareness, policy development and system control enhancements.

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

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

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

The Year Ahead

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

This year the following areas will be of primary focus:

- **To create and implement an MWL IG work plan for 2026/27** – A new IG work plan for 2026727 for MWL will be in place as of July. The IG work plan details what work the Trust will need to carry out during the course of this next year to ensure it remains on track with its compliancy. It will also keep the Trust in line with the components of the DSPT (aligned to the Cyber Assessment Framework) and focus on key data protection legislations that are compulsory. The former IG work plan contained 22 workstreams, the new IG work plan will contain 23 as it will include the continued implementation of the Data Use and Access Act 2025 (DUAA). The IG team will ensure there is a continuous review of the IG work plan throughout the next year and provide assurance via the IG Steering Group.

- **Continue to implement Data Use and Access Act 2025 (DUAA)** – This new act received Royal Assent on the 19 June 2025; introducing a series of updates to the UK GDPR, the Data Protection Act 2018 and the Privacy and Electronic Communications Regulations. A reminder that these changes are seen as evolutionary rather than revolutionary, a supplementary law, not a replacement. Over the past year the ICO have been gradually updating key guidance which is still in progress. The ICO translate the legislation into meaningful chunks of advice and guidance, providing organisations with information on what they should be aiming for and adhering to in order to comply with the law. DUAA is providing clarity to areas that were seen as 'grey'. For example, Subject Access Requests and Reasonable and Proportionate Searches: Organisations are no longer legally required to undertake exhaustive, costly hunts across all systems if a request is overly broad.

  As the ICO guidance is released where changes are required to current practices and policies the IG team will do so via the IG Steering Group. It is envisaged that the clarification DUAA 2025 provides is for IG professionals to rely upon when providing support to Trust. In essence the changes will not directly affect staff members.

- **Continue to support Artificial Intelligence (AI) and Robotic Processing Automation (RPA)** – The Trust now have an established AI / RPA Steering Group and over the past year it has benefited from the use of such technologies to save on staff time, reduce repetitive burden, in some areas relieve financial pressures and produce outputs at a much quicker rate i.e. Ambient Voice Technology. The vision is that these technologies grow within the Trust, supporting its staff and patients where possible, and therefore the IG team will remain a prominent support, ensuring privacy and security risks are identified, assessed and mitigated before implementation. Any AI / RPA processing will be reported to the IG Steering Group via the DPIA standing agenda item.

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

- **To improve Subject Access Request process** – The SAR working group has been established to analyse the current working model and improve where needed. The focus for this year will be the implementation of a webform, which will replace the application forms that the team send out, receive in. The webform will sit on the Trust's internet and requestors will be directed to use the webform and will not be able to submit until all the fields have been completed and relevant ID / documentation has been provided. The team currently spend an enormous amount of 'admin' time, going back and forth with requestors. This will cut out this, once completed the webform will be submitted and a request within the system will automatically be created (saving on logging the request manually) and will also send out an acknowledgement email to the requestor. The team will need to move from using InPhase (that doesn't have this functionality) to Sostenuto. All progress will be reported to the IG Steering Group. It is hoped with less time being spent on 'admin' tasks the SAR team will be able to direct their attention on processing requests which will result in higher compliance.

  The group will also look at the use of RPA to locate and retrieve medical information from medical records. At present a medical records officer collates this information. With the introduction of RPA the medical records officer can be released from this task which can be onerous when the requests are high. The AI/RPA Steering Group have noted this as a future project.

- **To continue with Face-to-Face IG Mandatory Training Sessions** – In the last couple of years the requests for face to face has increased significantly. Staff are benefiting from the IG Officers bringing to life data protection, which has been providing more food for thought that the online module and even the MS Teams session. The team are able to provide information on recent data breaches close to home, making the training more relatable. From April 2025 – March 2026, 547 staff members received this type of training. Feedback continues to be extremely positive.

  Comments received from delegates:
  'I like how they provided different real life scenarios of information errors.'
  'Informative, Easy to follow, Interesting.'
  'I had an idea about the topic but I got to learn the details of what it entails'
  'It was informative, the information given was useful and was put into real life situations that made the importance of the data protection good to understand.'

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

- **Introduction of '2 model' walk around audit** – The team proactively visit each department, unannounced to gain a better picture of the team's information governance processes and are able to identify areas of improvement. This model will continue. The second additional model will be a more in-depth audit, liaising with service leads in advance to book a slot, contacting the Governance Matrons looking at areas of concerns, deep dive into whether paper records are complete, interview with the service lead and / or team to discuss areas of improvement, recent

data breaches (if applicable). Both models of audits will be scheduled in throughout the year. Reports will be provided to the IG Steering Group.

- **Improve on the Data Breach Investigation Process** – The Trust have a robust and detailed data breach policy in place and it is important to note the Trusts excellent culture in reporting all types of incidents via the Incident Management System (InPhase). Any IG related incidents are acknowledged by the team and an investigation then commences. The IG team have seen a rise in the past year of failing to close all 'open' incidents in a timely manner, meaning they are often left 'open' for months. It is important that any incident is investigated, lessons are learned, action plan is put in place and the incident is closed as soon as possible. Failure to do so could result in missing a reportable data breach to the ICO and / or complaints from individuals who have asked for an outcome. The IG team will work with line managers, service leads, directorate managers to ensure all incidents are managed and closed. Information Asset Owners (Exec Leads) will be notified where incidents continue to be left unmanaged. The IG Steering Group will monitor both open and closed incidents that are investigated by the team.

- **Introduction of Data Flow Mapping** – The Trust through the IG team have established Information Asset Registers that are reviewed on an annual basis. The registers enable the Trust to understand where in MWL personal data is processed and to ensure this data can be processed legally, is being held as securely as possible and to identify any risks. Alongside this it is important to understand if any teams / departments have regular 'Data Flows' to external organisations that contain personal data. It is therefore important that a Data Flow Mapping exercise is conducted for each department making sure any outflows of personal data are done via a secure manner, i.e., secure email. Required by the DSPT.

Conclusion

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

With the completion of the tasks listed in the IG work plan for 2025-26, completing the IG focused objectives within the DSPT, and having an established IG Steering Group which has addressed a significant number of topics in the last year, the Trust has not only implemented the key IG foundations which are required to ensure it is meeting its data protection obligations and IG Framework and Strategy, but are actively monitoring, reporting and consistently looking at ways to improve.

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

The excellent IG engagement by the Trust is further supported by the number of enquires received into the IG mailbox or via phone; for the financial year 2025/26 the IG team received 603 enquiries from various teams across the Trust.

This past year also has seen vast improvements in the Trust's Subject Access Request process and further developments have been identified to assist the SAR team in providing requests within the calendar month.

This year, the team will continue to build on the achievements from the past year, working to raise awareness of IG and reiterate its importance especially through training and audits, and will look forward to the objectives set for coming year.

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	29 July 2026
Agenda Item	**TB26/056 (13.3)**			
Report Title	Freedom of Information Act Annual Report 2025/26			
Executive Lead	Malcolm Gandy, Director of Informatics			
Presenting Officer	Malcolm Gandy, Director of Informatics			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide the Trust Board assurance that Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) strived to comply with the Freedom of Information Act.

Executive Summary

Summary: This report is designed to give the Trust Board assurances that MWL was compliant with the Freedom of Information Act. This report summarises the key points of Freedom of Information (FOI) compliance for 2025/26.

From April 2024 till the end of March 2025 838 requests were received, the previous years totalled 822, a very similar number. The 838 requests contained 7,152 questions and this was 1,487 from up for the 5,665 questions from the previous year.

99.28% of the requests received were completed, of those completed requests, 67.5% were completed within the 20-working daytime frame which is an improvement of last year's 63.6% compliance rate.

	April 2025 / March 2026
Requests received	838
Number of Questions contained within the total FOIs received	7,152
Requests completed	832 (99.4%)
20 working day compliance	523 (67.5%)

The 2025/26 reporting period saw a modest increase in the number of FOI requests received from the 2024/25 period, but a substantial rise in the number of questions contained within those requests, indicating a significant increase in the complexity and breadth of information being sought from the Trust. Despite this additional demand, the Trust maintained an exceptionally high completion rate, with over 99% of requests processed, and achieved an improvement in statutory compliance from 63.6% to 67.5%. This demonstrates the continued commitment of teams across the organisation to meeting FOI obligations and responding effectively to increasingly complex requests. While there remains further work to do to improve compliance with the 20-working-day requirement, the year-on-year improvement provides assurance that the Trust is moving in the right direction and continues to strengthen its FOI performance.

Financial Implications	
None directly from this report.	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board to note the Freedom of Information Act Annual Report 2025/26.	
Strategic Objectives	
	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Introduction

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

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

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

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

This report is designed to provide the Board with assurance that MWL is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for April 2025 – March 2026 will be shown here.

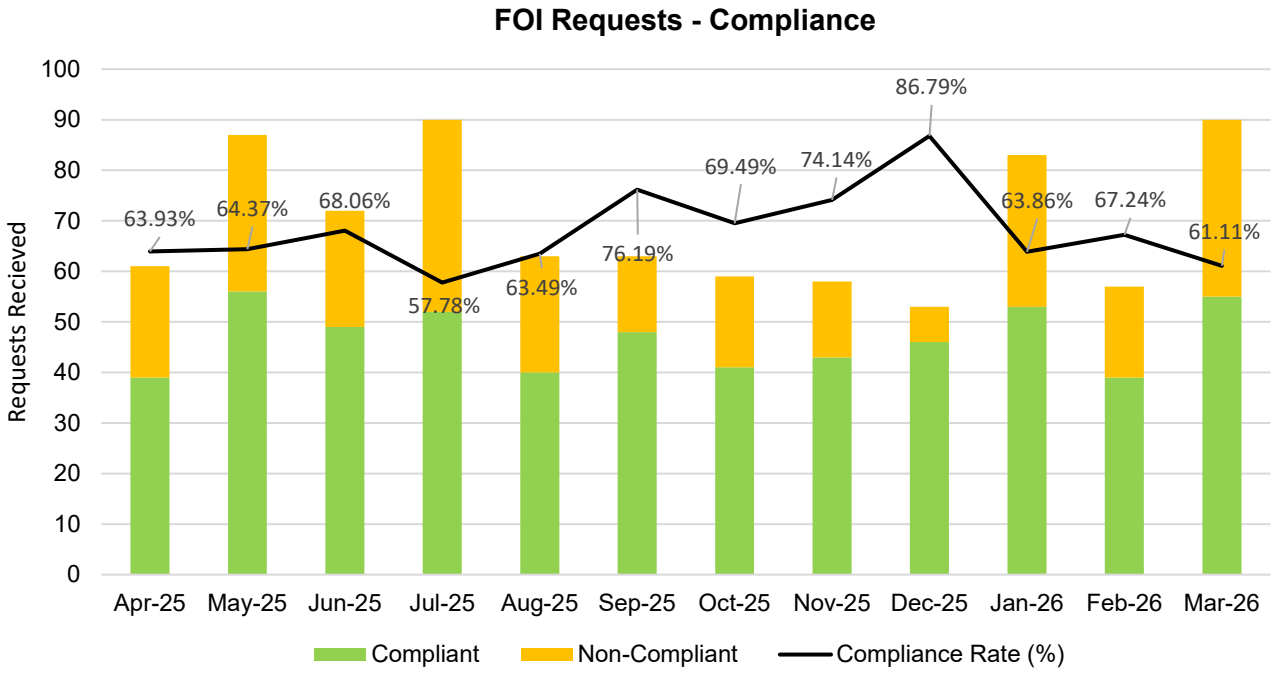
Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

FOI Performance Overview

During the 2025/26 reporting period, the Trust received 838 Freedom of Information requests containing 7,152 individual questions, demonstrating a significant level of information access activity across the organisation.

A total of 832 requests were closed during the year, with five requests remaining open at year-end, resulting in an overall closure rate of approximately 99.4%.
The Trust received three Internal Reviews during the reporting period and one Information Commissioner's Office (ICO) appeal**.**

Table 1 – April 2025 – March 2026



The overall FOI compliance rate for 2025/26 was 67.9%, representing an improvement on the previous year's reported compliance rate of 63.6%, although performance remains below the ICO's expectation that public authorities should respond to the majority of requests within statutory timescales.

The breakdown of requests handled by Executive Directorate during the period was:

- Chief Operations Officer Directorate – 230 requests
- Finance and Business Intelligence – 215 requests
- Human Resources – 151 requests
- Nursing and Midwifery – 96 requests
- Informatics – 73 requests
- Corporate Services – 52 requests
- Chief Medical Officer – five requests

Compliance Performance

Across the reporting period:

- 561 requests were completed within statutory timescales.
- 270 requests were completed outside statutory timescales.
- 5 requests remained outstanding at year-end.
- Overall compliance rate: 67.9%.

Monthly compliance rates ranged from:

- 57.78% in July 2025 (lowest performing month)
- 86.79% in December 2025 (highest performing month)

Several months achieved compliance above 70%, including September, November and December, demonstrating that higher levels of compliance are achievable when workloads and directorate response times are effectively managed.

Request Volumes and Complexity

The Trust received 838 requests comprising 7,152 individual questions throughout the year.
This equates to an average of approximately 8.5 questions per request.

Demand remained consistently high throughout the year:

- Highest monthly volume of requests: 90 requests (July 2025 and March 2026)
- Highest monthly volume of questions: 934 questions (January 2026)
- Lowest monthly volume of requests: 53 requests (December 2025)

The data demonstrates that request complexity continues to increase, with many requests containing multiple questions requiring input from several departments. This complexity has a direct impact on information gathering, review, approval and response preparation times.

Internal Reviews and ICO Appeals

The Trust received:

- three Internal Reviews
- one ICO Appeals

This represents a very low challenge rate in relation to the volume of requests received and may indicate that requestors were generally satisfied with the quality of responses provided, even where statutory timescales were not always met.

The having only one ICO appeal throughout the reporting period is a positive indicator and suggests that the Trust's decision-making and application of exemptions remain largely robust**.**

Request Sources

Requests originated from a variety of stakeholder groups.

Requester Type	Total
Commercial Organisations	531
Public	118
Press	90
Research	70
Other	53
Not Given	5
Staff	5

MPs	4
Service Users	0

Key observations include:

- Commercial organisations accounted for approximately 63% of all requests received and continue to represent the largest requester group.
- Members of the public generated the second highest number of requests.
- Press and Research requests remained relatively consistent throughout the year.
- There were no recorded requests from service users during the reporting period.
- Requests from Members of Parliament remained very low.

The predominance of commercial requests is consistent with wider NHS trends, where procurement activity, contract opportunities and market intelligence enquiries frequently account for a significant proportion of FOI activity.

Categories of Information Requested

The largest categories of requests received were:

Category	Total
Lists & Registers	288
About the Trust	265
What & How We Spend	101
Our Services	130
Policies & Procedures	48
Decision Making	6
Priorities & Progress	0

The continued dominance of Lists & Registers and About the Trust requests suggests opportunities exist to expand proactive publication and reduce the need for formal FOI requests.

Areas to Note

Increasing Complexity of Requests

The Trust continues to experience increasingly complex FOI requests, often containing multiple questions requiring contributions from several departments.

Whilst the number of requests received remains relatively stable, the amount of work required to coordinate responses continues to grow. Many requests require information from Finance, HR, Operational Services and Informatics simultaneously, resulting in longer internal approval and review processes.

Directorate Ownership and Response Times

The FOI Team coordinates and administers the FOI process but does not hold the information requested. Statutory compliance therefore remains dependent on departments identifying information, drafting responses and obtaining approvals in a timely manner.

Performance variation across directorates continues to be a significant factor affecting overall Trust compliance. Areas with well-established local processes continue to achieve higher compliance levels than those experiencing capacity or process challenges.

FOI Service Resilience
The FOI function continues to be delivered by a dedicated FOI Officer, supported by the wider Information Governance Team.

All members of the Information Governance Team have received FOI training and are able to provide cover when required. This ensures ongoing monitoring of requests during periods of annual leave or absence and provides continuity of service.

Internal Approval Processes
Directorates continue to utilise Executive Lead approval for FOI responses. This arrangement provides assurance regarding information released under FOI and ensures Executive visibility of disclosure activity.

Whilst this control strengthens governance, delays can arise where information retrieval, drafting or approval processes are not completed within agreed timescales.

Areas of Improvement during 2025/26

Strengthening Directorate Engagement
The Information Governance Team has continued working closely with directorates to identify appropriate contacts responsible for coordinating responses and obtaining approvals.

This has helped improve communication, clarify accountability and increase awareness of statutory obligations across departments.

FOI Guidance and Support
The FOI Team has continued providing advice, guidance and support to departments responding to requests. This has included assistance with exemption considerations, cost limit assessments, drafting responses and ensuring compliance with legislative requirements.

Publication and Transparency
Work has continued with several departments to identify information suitable for proactive publication.

The aim remains to reduce repeat requests for frequently requested information and allow requestors to access information directly without the need to submit formal FOI requests.

Monitoring and Escalation
Regular monitoring and escalation processes remain in place, enabling the FOI Team to identify requests approaching statutory deadlines and escalate matters where responses are delayed.

Suggested Areas of Focus for 2026/27

Improving Directorate Compliance

Executive Leads are continuing to reinforce the importance of responding promptly to FOI requests and ensuring that statutory deadlines are treated as a priority.

Particular focus should be placed on areas experiencing higher levels of non-compliance or increasing backlogs.

Review of Local FOI Processes

Directorates operating local coordination arrangements should review whether current processes remain effective and support achievement of statutory timescales.

Opportunities to simplify approval pathways and reduce internal delays should be explored.

Expansion of Publication Schemes

Further work should be undertaken to proactively publish information that is routinely requested through FOI.

This is particularly relevant for Lists & Registers, workforce information, expenditure information and operational performance data.

Performance Analytics

Further analysis of request handling times, directorate performance, recurring themes and publication opportunities should be developed to support more targeted improvement activity.

Capacity and Resilience

Directorates should ensure adequate resilience exists within teams responsible for responding to FOI requests, particularly during periods of annual leave, sickness absence or organisational change.

Conclusion

The 2025/26 reporting period demonstrates the continued high demand placed on the Trust's Freedom of Information service, with 838 requests and over 7,000 individual questions received during the year.

The Trust successfully responded to over 99% of requests received and achieved an overall compliance rate of 67.9%, representing an improvement on the previous reporting period.
However, performance remains below the level expected by the ICO and further improvement is required.

Encouragingly, the Trust received only three Internal Reviews and one ICO appeals, suggesting that the quality of responses and decision-making remains strong despite ongoing compliance challenges.

The FOI Team continues to provide effective coordination, monitoring and support; however, statutory compliance remains dependent upon timely engagement from departments that hold the requested information. Continued focus on ownership, proactive publication, directorate accountability and process improvement will be essential if the Trust is to further improve compliance performance during 2026/27.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	29 July 2026
Agenda Item	**TB26/057**				
Report Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/2026				
Executive Lead	Lesley Neary, Chief Operating Officer				
Presenting Officer	Lesley Neary, Chief Operating Officer				
Action Required	X	**To Approve**		**To Note**	

Purpose

To approve the Emergency Preparedness, Resilience and Response (EPRR) Annual Report for 2025/2026.

Executive Summary

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be presented to the governing committee and then to Trust Board.

This paper provides assurance that Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) have maintained effective emergency preparedness, resilience and response (EPRR) arrangements throughout 2025/26.

The Trust has demonstrated a mature and improving approach to EPRR, achieving a 97% compliance score against NHS England (NHSE) Core Standards and responding effectively to a broad range of incidents and operational disruptions during the year

Financial Implications

No new financial implications as a direct result of this paper

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the Emergency Preparedness, Resilience and Response (EPRR) Annual Report for 2025/2026.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance

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

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) MWL ANNUAL REPORT 2025/2026.

1. EXECUTIVE SUMMARY

The Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Business Continuity Management and Emergency Preparedness arrangements in place. Within the scheme of delegation, an annual report must be produced for the Trust Board to assure them that the organisation is meeting its obligations.

This report will cover the period 1 April 2025 to 31 March 2026.

Responsibility for resilience in the UK is delivered through a multi-agency system led by central government and local responders. National coordination sits within the Cabinet Office, working across departments to strengthen resilience. Organisations with statutory duties within the CCA 2004, are required to comply with the Act, and failure to meet these obligations may result in regulatory or enforcement action through appropriate oversight bodies. Within the health sector, NHS England provides national policy, guidance and assurance frameworks for this body of work, known as Emergency Preparedness, Resilience and Response (EPRR).

The role of NHS England relates to potentially disruptive threats and the need to take command of the NHS, as required, during emergency situations. These are wide ranging and may be anything from extreme weather conditions to outbreak of an infectious disease, a major transport accident or a terrorist incident. There continues to be a considerable amount of work in developing the Trust's EPRR arrangements due to the continuously changing risk and hazard landscape. Nationally, there is a high level of focus with the increasing amount of guidance and expanding range of threats the Trust must be prepared for. It is essential that there is a continued focus on the Trust's EPRR and business continuity arrangements and that the Trust maintains and continues to contribute towards the region's preparedness.

The Trust must be able to continue to deliver key services during times of disruption as part of the wider health economy. In doing so it must ensure patient and staff safety and consider stakeholder considerations.

This report aims to update the Board on progress in this matter and sets out how the Trust meets its obligations. The Trust is required to have an up-to-date Incident Response Plan and Business Continuity Plan. These must be updated following a major incident, exercises and/or other learning.

The Trust has a suite of plans to deal with major incidents and business continuity issues. These conform to the CCA (2004) and current NHS-wide guidance. All plans have been developed in consultation with stakeholders to ensure cohesion with the plans.

Throughout the year the plans have been reviewed, any changes to plans must be tested/exercised to ensure they are fit for purpose.

The responsibility for EPRR sits within the portfolio of the Chief Operating Officer. The work is managed on a daily basis by the Head of Emergency Preparedness and supported by a designated Consultant within the Whiston and Southport Emergency Departments. The work programme is managed through the EPRR Group, which is chaired by the Chief Operating Officer. The group meets quarterly with representatives from across the organisation and reports directly into Risk Management Council (RMC).

2. LEGAL OBLIGATIONS

As a Category 1 responder, the Trust has the following statutory duties:

a) Risk Assessment
b) Emergency Planning
c) Business Continuity Management
d) Warning and informing
e) Co-operation
f) Information Sharing

Ways that the Trust is meeting these obligations are listed below:

a) Risk Assessment

Under the CCA (2004), the Trust, as a Category 1 responder, is required to assess risks associated with emergencies. This includes evaluating potential impacts on patients, staff, and facilities.

EPRR risk assessments are conducted based on the UK National Risk Register (NRR) and Community Risk Registers (CRR). These assessments help identify and mitigate risks to the Trust's operations. Currently, key national risks identified within the NRR include pandemics and emerging infectious diseases, cyber-attacks, failure of critical infrastructure, terrorism, chemical, biological, radiological and nuclear (CBRN) incidents, geopolitical instability and state-based threats, and the impacts of climate change such as flooding, heatwaves and space weather. The Local Resilience Forum (LRF) CRR reflects similar priorities.

Any identified concerns or risks are reviewed at EPRR meetings and may be added to the Trust Risk Register if necessary. These risks are then discussed at RMC to ensure appropriate oversight and action.

EPRR considerations are integrated into the Trust's Board Assurance Framework (BAF) to provide oversight and ensure that preparedness measures align with the organisation's overall risk management strategy.

b) Emergency Planning

EPRR are responsible for the development and maintenance of a suite of emergency plans including (but not limited to):

- Incident Response Plan
- Major Incident Action Cards
- Mass Casualty Plan
- CBRN Plan
- Adverse Weather and Health Plan
- Shelter and Evacuation Plan
- Crisis Communications Plan
- New and Emerging Pandemic Plan
- Energy and Utility Resilience Plan
- Protected Individuals Plan
- Business Continuity Policy
- EPRR Policy

All of these plans and policies are essential documents that require formal approval from the Board.

To ensure their continued effectiveness and relevance, these emergency plans undergo a comprehensive review at least annually and are shared with multi-agency partners. Following development or updates, the plans are rigorously tested through exercises to assess their practicality and effectiveness.

Lessons identified from these exercises, as well as from real-life incidents, are carefully documented during debrief sessions. These lessons are subsequently monitored by the EPRR Group and RMC until all action items are addressed and the situation returns to a new business as usual (BAU) state.

Capturing and acting on these lessons is crucial for continuous improvement in our emergency planning arrangements, ensuring that our strategies adapt effectively to emerging challenges and opportunities.

c) Business Continuity Management

The Trust's Business Continuity Policy is reviewed and updated at least every three years. This policy outlines the framework for responding to disruptions in accordance with legal obligations and EPRR guidance. It is the responsibility of each ward and department to develop and maintain their own continuity plans, which must be updated annually and immediately following an incident or service change. Support for these plans is available from the EPRR Team as needed.

Throughout the year, the Trust has responded to a range of disruptions, including industrial action, local incidents, significant operational pressures, communication failures, power outages and IT downtime. In an ongoing effort to enhance resilience, the Trust conducts debriefs following each incident to capture key learnings and inform action plans for improvement. These incidents and the corresponding actions are reviewed and documented through the EPRR Group meetings

The Trust has activated its Business Continuity Plans (BCPs) on multiple occasions in response to both planned and unplanned outages. Planned downtimes were managed in coordination with the EPRR Group or Senior Operational meetings, while unplanned outages across hospital sites necessitated the activation of BCPs by affected wards and departments (Appendix 1).

d) Warning and Informing

The Trust continues to strengthen its arrangements for warning and informing the public. Social media provides significant opportunities to reach patients, service users and communities who may not engage with traditional communication channels. During the year, the Trust has utilised a range of platforms to support timely and effective communication, including television, press, social media channels such as Facebook and Twitter, and a public-facing Trust website.

e) Co-operation with other responders

The Trust is represented by the Chief Operating Officer and Head of Emergency Preparedness at the Local Health Resilience Partnership (LHRP) Strategic and Tactical meetings and relevant subgroups.

The Trust has actively participated in multi-agency exercises and engagement forums with partner organisations, including NHS England, Cheshire and Merseyside Integrated Care Board (ICB), neighbouring provider Trusts, commissioners, and emergency services partners such as Police, Mersey Fire and Rescue Service (MFRS) and North West Ambulance Service (NWAS).
The Trust continues to work collaboratively with multi-agency partners to support effective co-ordination, joint planning and a joined-up response to incidents.

f) Information Sharing

Under the Civil Contingencies Act (2004), Category 1 responders have a statutory duty to share information with partner organisations to support effective co-operation and co-ordination.

The Trust fulfils this duty through active engagement with multi-agency partners and the use of Resilience Direct, a secure Cabinet Office managed platform, that enables information sharing and collaboration across organisational and geographical boundaries. This supports joint working during the preparedness, response and recovery phases of incidents, ensuring timely information exchange and co-ordinated multi-agency action.

3. ASSURANCE

In line with the EPRR 2025-2026 Assurance Process requirements, compliance is assessed based on the percentage of Core Standards fully met against established rating thresholds. The Trust was compliant with 60 out of 62 Core Standards, 97%, an overall EPRR assurance rating of 'substantially compliant' for 2025/2026 (Appendix 2). This was an increase of 16% from the previous year.

Summary position for Cheshire and Merseyside ICB

	Compliance Percentage from 2023/2024	Compliance percentage from 2024/2025	Compliance percentage from 2025/2026
Alder Hey	8%	68%	81%
Countess of Chester	8%	81%	90%
East Cheshire	29%	79%	79%
Liverpool University	18%	94%	94%
Mersey and West Lancashire	44%	81%	97%
Mid Cheshire	37%	76%	97%
Warrington and Halton	5%	68%	85%
Wirral University	2%	84%	95%
Clatterbridge	17%	97%	97%
LHCH	15%	86%	95%
Liverpool Womens	Non-compliant	73%	86%
Walton	Non-compliant	78%	63%
Bridgewater	0%	83%	83%
CWP	Non-compliant	84%	91%
Merseycare	33%	98%	98%
Wirral Community	Non-compliant	86%	97%
NHS C&M	19%	87%	91%

The Trust's 'Substantially Compliant' rating has led to the development and implementation of targeted action plans to address identified gaps. These actions have been incorporated into the 2026/2027 EPRR Workplan.

The primary factors contributing to the partial compliance rating were:

- **Business Continuity Management**: Greater focus is needed on developing and governing ward and service-level business continuity plans to ensure organisational resilience and preparedness.

In addition to the annual Core Standards assurance process, the Trust undertook a MIAA Audit to evaluate the existing control environment in respect of emergency planning in which the Trust scored 'Substantial'. 1 low risk was identified and resolved at the time of the report, 1 low risk has a target completion date of 31st December 2026, and 1 medium risk was completed on 1st April 2026 following approval at RMC in February 2026.

4. TRAINING

The EPRR Team has organised a range of training and awareness sessions for staff, including those responsible for on-call duties at Strategic and Tactical levels. The training programs offered include:

- **PHC Strategic Commander Training**
- **PHC Tactical Commander Training**
- **Legal Awareness for EPRR Training**
- **Media Awareness Training**

Compliance with training requirements for senior managers is monitored and reported through the EPRR Group and RMC, in alignment with the Minimum Occupational Standards (MOS) and the EPRR Training Needs Analysis.

In addition to senior manager training, EPRR Awareness eLearning has been developed and was launched Trust-wide in January 2026. Compliance with this awareness training is continually monitored and reported through the governance groups mentioned above.

5. EXERCISES

In accordance with NHS England's EPRR Core Standards, Acute Trusts are required to engage in planned exercises with external partner organisations.

During this reporting period, the Trust conducted a Trust-wide National Power Outage exercise, named Exercise Black Sky, on 3rd September 2025.

This exercise aimed to support the development of a new Energy and Utility Resilience Plan across the Trust footprint.

The exercise was attended by representatives from the Strategic, Tactical, and Operational Teams, including key participants from acute care areas. Feedback was positive, and all lessons identified were captured during the debrief session.

The EPRR Team also supported a capacity modelling exercise, Exercise Bedlock, on 27 July 2025, enabling Trust divisions to test internal escalation arrangements for managing capacity and patient flow. Lessons identified were captured and disseminated through governance processes.

6. COMMUNICATIONS

Effective communication is crucial in managing adverse incidents. To ensure preparedness, the Trust conducts regular communication exercises designed to test and enhance our incident response capabilities.

A full communications cascade exercise is conducted twice yearly across Whiston, Southport, St Helens and Ormskirk Hospitals. These exercises simulate a major incident communications cascade and are intended to assess and validate the Trust's ability to alert staff and initiate incident response processes effectively.

Lessons learned from the exercise cascades are captured in response plans.

7. GOVERNANCE AND OVERSIGHT

The EPRR Workplan is overseen by the EPRR Group, which is responsible for managing progress and actions. The EPRR Group reports on its activities and the status of the workplan to RMC, where ongoing actions and progress are reviewed and managed.

As a Category 1 responder, the Trust is required to report on progress and provide assurance regarding emergency planning directly to the Trust Board. This ensures that the Board is informed of the Trust's preparedness and compliance with emergency planning requirements.

8. PARTNERSHIP WORKING

The Trust actively collaborates with a variety of partner agencies through both formal and ad hoc arrangements. This collaboration is facilitated through formal standing meetings and committees.

Notably, the Trust is a member of the LHRP, among other formal committees. These partnerships are integral to ensuring effective coordination and resilience in our emergency preparedness and response efforts.

9. RECOMMENDATIONS

In accordance with our legal obligations as a Category 1 responder, it is crucial to maintain robust Business Continuity Management and Emergency Preparedness arrangements. The Trust Board is therefore requested to acknowledge and review this Annual Report on EPRR.

The arrangements detailed in this report align with our legal responsibilities under the CCA (2004) and NHS England EPRR guidance, ensuring that the Trust meets its statutory obligations and maintains effective emergency preparedness.

Appendix 1: EPRR – Incident/System Escalation/Exercises 2025 – 2026

INCIDENTS	
25-30/07/25	NWAS Major Incident - Road Traffic Accident in Liverpool
02/06/2025	NWAS Major Incident - Fire in Warrington
25/06-04/07/25	Merseyside Police Major Incident - St Helens Explosives and Bomb
14/07/2025	Formalin Spillage at Southport
25-30/07/25	Resident Doctors' Industrial Action
22/07/2025	Multitone (RF) Pages Out of Range
22-23/08/25	Telephone Outage at S&O
25-28/08/2025	SBS Oracle Downtime
25/08/2025	Flooding Incident in ED at Southport
15/09/2025	Power Interruptions at Whiston resulting in going to full generator use
27/09/2025	Power Outage - St Helens Urgent Care Treatment Centre
20/10/2025	Telephone Outage at S&O
21/10/2025	Wirral University Hopsital Critical Incident - Sterile Services (mutual aid provided)
18-21/12/2025	CT Scanner Downtime at Southport
30/12/2025	Newton Attack
17/03/2026	Ormskirk Burst Water Pipe
27/03/2026	Power Outage at Ormskirk
FULL TO CAPACITY (OPEL 4)	
22/04/2025	MWL escalated to Opel 4
06/02/2026	Whiston System Escalation
15/01/2026	Southport System Escalation
INDUSTRIAL ACTION	
14-19/11/25	Resident Doctors' Industrial Action
17-22/12/25	Resident Doctors' Industrial Action
07-13/04.26	Resident Doctors' Industrial Action
TRAINING AND EXERCISES	
06/05/2025	Exercise Alert - Comms Cascade
21/07/2025	Exercise Bedlock
03/09/2025	Exercise Black Sky
04/09/2025	Exercise Mayday

Appendix 2: EPRR Statement of Compliance

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

STATEMENT OF COMPLIANCE

Mersey and West Lancashire Teaching Hospitals NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Mersey and West Lancashire Teaching Hospitals NHS Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

24/09/2025
Date signed

24/09/2025	24/09/2025	
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix 3: Core Standards Self-Assessment

Mersey and West Lancashire Teaching Hospitals NHS Trust

Please select type of organisati: **Acute Providers**

Click button to format the workbo: Format Workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	60	2	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so.
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 6: In the Action Plan tab, click on the 'Format Action Plan' button.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	29 July 2025
Agenda Item	**TB26/058**				
Report Title	Infection, Prevention and Control Annual Report 2025/26				
Executive Lead	Sarah O'Brien, Chief Nursing Officer				
Presenting Officer	Sarah O'Brien, Chief Nursing Officer				
Action Required	X	**To Approve**		**To Note**	

Purpose

To present the 2025/26 Infection Prevention and Control (IPC) Annual Report for approval following presentation to the Quality Committee on 21 July 2026. The report provides assurance that the Trust is taking the necessary action to monitor and prevent hospital acquired infections.

Executive Summary

This is the third Infection Prevention and Control (IPC) Annual report for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).

Infection prevention and control is a statutory duty of the Trust Board, and an annual report must be made annually on performance in the previous year The previous IPC annual was reported to Trust Board in July 2025.

The report is a two-part document; Part 1 outlines the developments and performance related to Infection Prevention (IP) activities during 2025/26 and Part 2 (Appendix 2) is the annual work plan for 2026/27 which aims to reduce the risk of healthcare associated infections (HCAIs). The report identifies the achievements and challenges faced in-year and the Trust's approach to reducing the risk of Healthcare Associated Infections (HCAI) for patients. The IPC programme is based around compliance with the Health and Social Care Act 2008 – Code of Practice on the prevention and control of infections and related guidance (also known as the Hygiene Code), the Infection Prevention & Control Board Assurance Framework and effective Antimicrobial Stewardship.

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

As outlined in the report other services have contributed to the report in relation to the services they provide

IPC is everyone business is key message, the Team has a "Teams without walls approach" when interacting with others utilising a shared leadership and learning approach which is delivered across multiple systems, both internal and external, and services with focus on patients' quality and safe care delivery.

The report highlights the important work that we have done over the past year to keep our patients safe from infection and to use antibiotics in the most responsible way. Infection prevention and control (IPC) and antimicrobial stewardship (AMS) are at the heart of safe, high-quality care. Over the past year, our teams have worked together to strengthen the basics, like hand hygiene, safe use of invasive devices, and regular cleaning, all of which make a real difference to patient safety.

Key Summary points to highlight:

- The Trust has remained compliant with infection prevention and control (IPC) standards and has maintained its Outstanding Care Quality Commission (CQC) rating. IPC and antimicrobial stewardship continue to be fundamental components of delivering safe, high-quality patient care.

- During 2025/26, the Trust strengthened IPC governance, surveillance, education, outbreak management and antimicrobial stewardship arrangements. Significant progress was achieved through collaborative working across clinical divisions, estates and facilities, microbiology, pharmacy and external system partners.

- There are national annual contractual reduction objectives for Clostridioides difficile (C.diff) infections and gram-negative blood steam infections (GNBSIs). Zero tolerance to Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia remains in place. These are included in the six infections that are subject to mandatory reporting to United Kingdom Health and Security Agency (UKHSA). Whilst positive improvements were seen in several areas, the Trust did not achieve all national HCAI reduction thresholds. This is consistent with other regional Trusts.
- Performance against national objectives remains a key priority for 2026/27.

MWL Performance Against National Targets**.**

- MRSA bacteraemia: disappointingly there were four cases (target: zero) two cases no lapse and one lapse in antibiotics prescribing and screening one in progress.
- C.Diff: 109 cases (12 above threshold, but a reduction from previous year)
- E. coli bacteraemia: 163 cases (12 above threshold).
- Pseudomonas bacteraemia: 15 cases (one above threshold).
- Klebsiella bacteraemia: 46 cases (below threshold).
- MSSA bacteraemia: There is no external objective, the Trust for 2025/26 set an internal reduction objective of 10% on the 2024/25 data. There was 11 case reduction i.e. 79 cases compared to 90 cases in 2025/26. Reduced from 90 cases in 2024/25 to 79 cases in 2025/2626.
- There were no Carbapenemase-producing Enterobacteriaceae (CPE) outbreaks in the reporting period
- Outbreaks: 129 outbreaks managed, affecting 1,149 patients and resulting in 1,838 lost bed days (mainly Norovirus, Covid-19 and Influenza) with an estimated operational impact of £827k. This has been the biggest challenge throughout the year.
- Throughout the year, we have also responded to infections like measles, chicken pox, meningitis, respiratory viruses and norovirus, as well as some of the rarer infections such as Mpox and Tuberculosis
- The Infection Prevention Team (IPT) has worked closely with local and national partners to make sure we have up to date evidence-based policies and guidance in place. We have made our information clearer and accessible to staff supported by education and training and communicating any changes to national guidance or preparing for emerging infections.

Key Achievements

- IPC governance arrangements remain robust through Hospital Infection Prevention Group (HIPG), Board reporting and divisional oversight. HCAIs are reported every month via the Corporate Performance Report (CPR) and the Board, via the Quality Committee, also gains assurance via regular in-depth reports of the actions taken and lessons learnt.
- Effective collaboration has continued and developed cross-divisional with IPC divisional meeting implemented and holding to account and with external partnership working.
- The IPC Board Assurance Framework demonstrated that the Trust was 83% Green compliant and 17% partially compliant with the indictors, with no red-rated areas.
- There is no IPC risks currently exceed a risk score of 15.

- Six Freedom of Information (FOI) requests related to policies.
- Bloodstream infection reduction remains a Quality Account priority. Improvement plans continue for: Peripheral intravenous cannula management (PIVC), Bloodstream infection prevention and C.Diff reduction.
- A Mersey Internal Audit Agency (MIAA) review provided Significant Assurance for Norovirus outbreak management.
- The Trust successfully managed Emerging and High Consequence Infections including Measles, Mpox, Tuberculosis, Covid-19, Influenza and Respiratory Syncytial Virus (RSV).
- MWL was a high outlier for rates of surgical site infections (HIP and Knees) in two out of four quarters. Improvements plans in place.
- An MWL PIVC Improvement Plan has continued since 2024/25. This was superseded by the blood stream improvement plan in 2025/26. This included the implementation of a single Trust system and process for Aseptic Non-Touch Technique (ANTT), cannula insertion and ongoing PIVC monitoring documentation, and the development of effective audit processes to support peer review of IPC standards.
- Hand hygiene continues to be strongly promoted throughout the Trust. Monthly audits of hand hygiene were undertaken on all wards throughout the year.
- Antimicrobial Stewardship (AMS**)** Key achievements included: Development and expansion of Outpatient (OPAT) services, Implementation of Eolas antimicrobial prescribing application, development of Trust-wide antimicrobial policies, introduction of IV-to-oral antibiotic decision support tools and the continued maintenance of low usage of Watch and Reserve antibiotics across the region.
- Education and Training Compliance achieved: IPC Level 1 Training: 90.7% and IPC Level 2 Training: 85.1%. ANTT: Theory training achieved target. Practical competency remains below the required standard in some areas and continues as a focus for improvement.
- Estates, Facilities and Decontamination: Key progress includes National Standards of Healthcare Cleanliness implementation, Digital environmental monitoring, Water safety and ventilation assurance and enhanced environmental cleaning programmes.
- Key risks remain: Limited side-room capacity, particularly at Southport, ageing decontamination and sterile services infrastructure, Estates constraints affecting isolation capacity and maintenance programmes.

Improvement Actions and Learning.

- Extended After Action Review for all C.Diff cases for timely learning.
- Ongoing improvement plans for bloodstream infection reduction, PIVC management, and C.Diff reduction.
- Enhanced outbreak management and early-warning systems.
- Harmonisation of IPC policies across the Trust (35/37 completed).
- Monthly audits and targeted training are used to address compliance gaps in hand hygiene and ANTT.

IPC Priorities for 2026/27.

- Deliver Bloodstream Infection Improvement Plan.
- Reduce MRSA, CDI and Gram-negative bacteraemia's to NHS England (NSHE) thresholds.
- Improve PIVC care and achieve:
    - 90% VIP monitoring compliance.
    - 85% ANTT compliance.
- Enhance outbreak early-warning and response systems.
- Complete harmonisation of remaining IPC policies.
- Continue antimicrobial stewardship and AMR reduction initiatives.

- Improve environmental cleanliness and National Standards of Cleanliness compliance.
- Strengthen preparedness for emerging infectious diseases.
- Improve surgical site infection performance and reduce orthopaedic Surgical Site Infection (SSI) rates.

The IPC annual report provides assurance that the Trust has effective IPC systems, governance arrangements, surveillance programmes and improvement plans in place. Whilst national HCAI performance targets were not achieved in all areas, clear improvement programmes are established, risks are actively managed, and IPC remains a strategic priority supporting delivery of safe, high-quality patient care across Mersey and West Lancashire Teaching Hospitals NHS Trust.

Part 2 - The MWL IPC forward plan for 2026/27.

Financial Implications
None as a direct consequence of this paper.

Quality and/or Equality Impact
Not applicable

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

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

Mersey and West Lancashire Teaching Hospitals

Infection Prevention Annual Report

2025-26

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1. Introduction

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

The Board of Directors and ultimately the Chief Executive, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC). Managers and clinicians within the divisions ensure that the management of IPC risks is one of their fundamental duties. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and our patients, visitors and the people who live within our local area and beyond. The Director of Infection Prevention and Control (DIPC) is required to produce an annual report on the compliance with healthcare associated infections in the organisation. The Health and Social Care Act 2008: 'Code of Practice on the prevention and control of infections and related guidance' requires the IPC annual report to be publicly available on the Trust website to demonstrate effective governance and public accountability.

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

This third MWL IPC annual report provides assurance that the Trust is in line with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance, the Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(h) regulation 15(2), regulation 17(2)(b), and the National Infection Prevention and Control Manual for England (2022).

The report highlights the important work that we have done over the past year (April 2025 to March 2026) to keep our patients safe from infection and to use antibiotics in the most responsible way. Infection prevention and control (IPC) and antimicrobial stewardship (AMS) are at the heart of safe, high-quality care. They help to stop the spread of harmful microorganisms and make sure antibiotics continue to work when people need them most. Over the past year, our teams have worked hard together to strengthen the basics, like hand hygiene, safe use of invasive devices, and regular cleaning, all of which make a real difference to patient safety.

This report consists of two parts: the performance related to Infection Prevention and Control (IPC) and exception reporting during 2025/26, and the broad plan of work for 2026/27 to reduce the risk of HCAIs. The IPC Forward Plan relates to the 10 criteria outlined in the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

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

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

Throughout the year, we have also responded to infections like measles, chickenpox, meningitis, respiratory viruses and norovirus, as well as other infections such as Mpox and Tuberculosis. Our Infection Prevention Team (IPT) work closely with local and national partners to make sure we have up to date evidence-based policies and guidance in place that will keep patients safe. We have made our information clearer and accessible to staff supported by education and training and communicating any changes to national guidance or preparing for emerging infections.

New digital systems have supported reporting, monitoring and auditing of IPC practice and prescribing. We also launched a new electronic system and app (Eolas Medical, software platform that digitizes antimicrobial prescribing guidelines.) to support doctors to choose the right antibiotics for their patients, which helps fight antimicrobial resistance. Of course, we still have challenges, some infections are proving harder to reduce, and some surgeries are becoming more complex to treat however, through collaborative working within the Trust and the regional IPC collaborative, ICB, NHSE and UKHSA, we are developing standardised strategies to collectively address this.

Infection prevention is everyone's business, supported by the IPT, Medical Microbiology, and antimicrobial pharmacist team. Staff play a key role in keeping patients safe through good IPC and antimicrobial stewardship (AMS) practice.

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

2. Context

In July 2023, the integration of St Helens and Knowsley Teaching Hospitals and Southport and Ormskirk Hospitals was transacted forming a single larger organisation, Mersey and West Lancashire NHS Teaching Hospitals Trust, which provides acute, intermediate, community and specialist healthcare to over 4 million people a year with a combined workforce of around 11,000 dedicated and skilled staff.

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

The Trust has continued to focus on Improvement plans for Peripheral cannula care, blood stream infections, and C. difficile reduction. The E coli Improvement Plan was closed in 2024/25 following more than a year of sustained improvement, while the other improvement plans continue. Reducing blood stream infection including Staphylococcus aureus (MRSA/MSSA) bacteraemia is a Trust Quality objective in the 2025/206 and 2026/27 Quality Account.

3. Governance and Monitoring

3.1 Governance

During 2025/26, the Trust maintained its compliance with the criteria set out in the Health and Social Care Act Code of Practice (2008) and maintained its outstanding rating with the Care Quality Commission (CQC).

The annual plan for IPC for 2025/26 sets out the proposed activities for the IPT ensuring that we continued to meet the expected requirements and standards outlined by regulation and legislation. The plan also accounts for locally agreed actions, as well as internal programmes of work that we planned to deliver throughout the year. We have on-going action plans focusing on the prevention and management of HCAIs and Antimicrobial stewardship (AMS) across our hospitals, and these underpin the programmes of work referenced in this report. The plan is formally reviewed annually through the quality governance framework to assess impact and provide assurance. Progress on actions is also monitored and reported through regular operational meetings. While the Trust has many examples of excellent work and high-quality care, it recognises that there is more to do to achieve its goals and ambitions. The IPC annual plan and associated action plans support the Trust to deliver its strategic objectives.

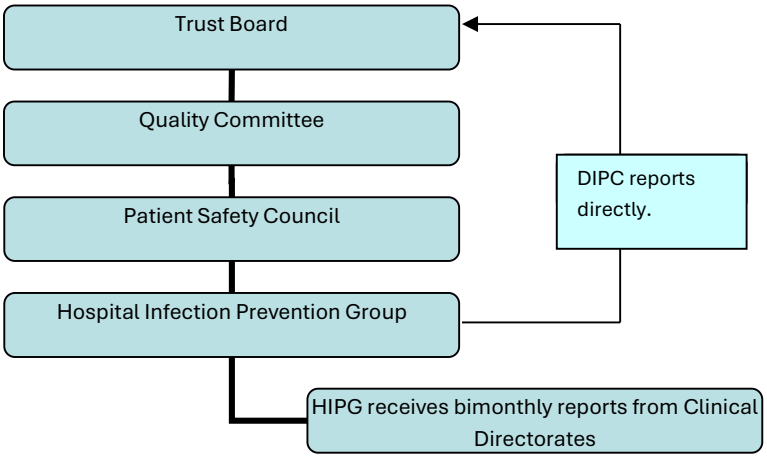
The Board of Directors has collective responsibility for keeping the risk of infection to a minimum and recognises its responsibility for overseeing IPC arrangements in the Trust.

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

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

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

Figure 1 outlines the IPC governance structure at MWL.



3.2 External agency support and oversight

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

3.3 Risk register

The IPC risk register identifies risks to the organisation in relation to IPC measures and practices. As in previous years the key risks in 2025/26 included the lack of side room capacity (Southport site), limitations of the estates structure, risk of suboptimal practice relating to vascular access, fragility of antimicrobial supply chain to support effective treatment plans, staffing, new and emerging infections and outbreak management. Risks are monitored monthly and reviewed at the Trust's Hospital Infection Group meeting on a bimonthly basis and risks are escalated via the Risk Management Council to Executive committee and Trust board. There are no IPC related risks scoring 15 and above.

3.4 Freedom of information (FOI) requests

There were 6 FOI requests related to IPC during 2025-26, all were responded to within the agreed time frame.

3.5 IPC Board Assurance Framework (IPC BAF)

NHS England updated the IPC Board Assurance framework (BAF)[1] in August 2023, which was developed to support healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control Manual (NIPCM)[2] and other related infection prevention and control guidance. The IPC BAF is structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection[3] which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[4]. The Trust's IPC BAF has been aligned across the organisation to provide assurance against these requirements. This was last presented to the Executive Committee in February 2026.

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

The review of the IPC BAF indicated that 43 of the 52 (83%) key lines of enquiry are rated green, with 9 (17%) rated partially compliant. This included harmonisation of policies and leaflets, ANTT and IPC training being just below 85%, compliance with National Standards of Healthcare Cleanliness standards, estates and preventative planned maintenance due to spatial constraints and financial investment. The Trust is sighted on the gaps and there are no indicators that are non-compliant (red rated).

4. Infection Prevention Team

The IPT works primarily on a site-based model with matrix working responsibilities across the sites. The current total MWL IPT establishment including ICNs, administration and audit support is 13.4 WTE (inclusive of 1 WTE band 4 admin vacancy).

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

STHK sites:

- 1.0 WTE Band 8B Lead Nurse
- 2.0 WTE Band 7 Specialist Nurse IPC
- 2.0 WTE Band 6 Infection Prevention Nurse
- 1.0 WTE Band 4 Infection Prevention Secretary
- 0.6 WTE Band 3 Surveillance Assistant

Southport and Ormskirk sites:

- 1.0 WTE Band 8A Matron
- 2.8 WTE Band 7 Specialist Nurse IPC
- 1.0 WTE Band 3 Support Worker
- 1.0 WTE Band 4 Administrator (Vacancy since December 2025)

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

5. Health Economy Engagement

The Consultant Nurse IPC continues to represent MWL at the Cheshire and Merseyside, Integrated Care board (ICB) Infection Prevention and Control and Antimicrobial Resistance meetings to drive forward the ambition to support a reduction in healthcare associated Gram-negative bloodstream infections (GNBSI) and a reduction in antimicrobial resistance to antibiotics.

The Lead Nurse Infection Prevention continues to attend the Halton and Warrington System-wide Collaborative, Infection Prevention Group, with GNBSI reduction as a priority. The group aims to provide the opportunity for the Health and Local Authority partners across the North Mersey place to enter constructive dialogue with regards to the IPC and AMR improvement plan.

The Consultant Nurse IPC represents the Trust at an NHSE-led Cheshire and Merseyside IPC provider collaborative. The purpose of this efficiency at scale IPC Collaboration Group is to:

- Ensure consistency of IPC reporting across providers in Cheshire and Merseyside (C&M), including provider performance, adherence to national guidance and best practice identified.
- Support the levelling-up agenda of IPC provision across providers in C&M and identify

the consequences of gaps in IPC provision.
- Support the mitigation of risks relating to IPC provision across C&M.
- Bring together IPC subject matter experts across providers in C&M.
- Ensure lessons learned from Covid-19 pandemic are captured, reflected upon and built into business as usual, together with ensuring the C&M system is prepared for future IPC challenges.

Improvement projects included the production of a C difficile Toolkit covering diarrhoea management, antimicrobial stewardship, CPE screening, and alignment of cleaning protocols and products.

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

The Consultant Nurse IPC is an expert member of the national NHS Supply Chain Infection Prevention & Control (IPC) Clinical Council, to advise on product specifications and support clinical engagement for products and services that require specific clinical input from an IPC perspective. In 2025/26 this included wipes for surface cleaning and disinfection and the Hand Hygiene Framework and associated products and services.

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

The DIPC and Consultant Nurse IPC participate in the NHSE DIPC development programme. The IPT attended and participated in the One Together conference during 2025-26.

6. Surveillance

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

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

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

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

7. Achievements against the National HCAI thresholds

The NHS Standard Contract 2025/26 includes quality requirements for NHS trusts to minimise rates of both C. difficile and GNBSIs to threshold levels set by NHS England[5]. They are inclusive of all healthcare associated infections (community onset healthcare associated, and hospital onset healthcare associated).

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

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

The NHS Standard Contract for 2025/26 in respect of reportable healthcare associated infections and thresholds for the Trust are as follows.

- C. difficile </=97
- E coli </=151
- Klebsiella </=49
- Pseudomonas </=14
- Zero tolerance to MRSA bacteraemia

Figure 2. Trust performance against NHSE annual HCAI thresholds 2025/26

MWL YTD	HOHA	COHA	Total	
MRSA	3	1	4	Above threshold
MSSA	57	22	79	No threshold set
CDT	70	39	109	Above threshold (x 12 cases)
E coli	84	79	163	Above threshold (x 12 cases)
Klebsiella	26	20	46	Below threshold (x 3 cases)
Pseudomonas	10	5	15	Above threshold (x 1 cases)

The Trust ended the year above NHSE threshold for all HCAI objectives except for Klebsiella. There were four MRSA bacteraemia in year, a reduction from 6 in 2024-25 and a reduction of MSSA bacteraemia cases by 11 cases in year.

8. Mandatory Reporting

Disappointingly, the Trust reported 4 healthcare-associated MRSA bacteraemia (MRSAb) cases during 2025-26 (Figure 3).

[5] https://www.england.nhs.uk/wp-content/uploads/2021/08/PRN00150-NHS-Standard-Contract-2025-26-Minimising-Clostridioides-difficile-and-Gram-negative-bloodstream-infect-1.pdf

Figure 3. Healthcare-associated MRSA bacteraemia 2025/26

Case	Date	Attribution	Dept	Site	Source	Avoidable
1	22/04/25	HOHA	7B	Southport	Shoulder joint	No
2	04/09/25	HOHA	3B	Whiston	Prosthetic hip	Yes
3	08/02/26	COHA	ED	Whiston	Contaminant	No
4	17/03/26	HOHA	1D	Whiston	Intra-abdominal	TBC

This is a reduction of 2 cases compared to 2024-25 when the trust reported 6 MRSA cases.

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

Two of the four MRSA blood stream infection cases were considered to have had no lapse in care that contributed to the infection, with several good practice points identified on IPLR. However, there was wider Trust learning, such as the adequacy of ward stock of MRSA suppression treatment to support timely commencement of therapy, timely specimen collection and body mapping of wounds and skin breaks, and the reliability of wound care.

One was deemed avoidable due to contributory gaps and lapses in care including antimicrobial prescribing for a patient with known MRSA.

The fourth case is in progress

From April 2026, the IPLR process will be enhanced by the introduction of After Action Reviews (AAR) which is an MDT investigation with the clinical team which is undertaken as near as possible to the date of the positive sample.

A zero-tolerance approach to reduction in avoidable (no lapses or gaps in care) bloodstream infections remain a Trust priority within the Trust Objectives and Quality Account 2026/27. The measures that will be used to support this ambition are:

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

The Peripheral Intravenous Vascular Cannula (PIVC) Improvement Plan was incorporated into the Bloodstream Infection Improvement Plan for 2025/26.

Prompt identification and management of sepsis is a key action, with measures of NEWS and Sepsis 6 monitored to provide assurance. The compliance data for 2025-26; demonstrates:

- improvement with clinical assessment within 30 minutes of severe diagnosis and an hour for moderate diagnosis 30 mins.

- Senior review by Critical Care within 1 hour of sepsis diagnosis
- Microbiology tests within 1 hour for severe diagnosis and 3 hours for moderate diagnosis (timely blood cultures).

There are two measures which are receiving increased focus for improvement are timely antibiotic treatment, and IV fluids given within 1 hour of sepsis diagnosis.

Figure 4. MWL Sepsis Pathway compliance February 2026 (latest data available)

Clinical Process Measure	
SEPSIS-21: National Early Warning Score (NEWS/NEWS2) recorded within 1 hour of hospital arrival	92%
SEPSIS-22: Clinical assessment done within 30 minutes of severe diagnosis and an hour for moderate diagnosis	86.2%
SEPSIS-23: Senior Review by Critical Care within 1 hour of sepsis diagnosis	83.3%
SEPSIS-24: Microbiology tests within 1 hour for severe diagnosis and 3 hours for moderate diagnosis	81.5%
SEPSIS-25: Antimicrobials given within 1 hour of severe diagnosis and 3 hours for moderate diagnosis	40.7%
SEPSIS-26: IV fluids given within 1 hour of sepsis diagnosis	62.5%

The Sepsis Team analyse the data to identify any themes and disseminate this in the governance meeting. The Chief Medical Officer reports improvement actions and sepsis training compliance corporately.

The Trust agreed that due to the transition from AQUA (Q) to Audit Management and Tracking system (AMaT: a comprehensive digital governance platform used widely cross the NHS which is designed to help healthcare teams manage clinical audits, quality improvement projects, NICE compliance, and mortality reviews). March data would not be available and reporting via AMaT data would commence from April 2026.

The IPC Team continue to undertake the monthly PIVC spot check audit of inpatient areas at Whiston, Southport and Ormskirk sites, with timely feedback to clinical and divisional teams, to support improvement. A target of minimum 90% compliance with VIP monitoring has been set. Ward managers and matrons also undertake monthly Nursing Care Indicator audits to provide assurance regarding cannula care and IPC indicators as part of the monthly Tendable audit programme. This also contributes to the outcome of the ward accreditation ratings.

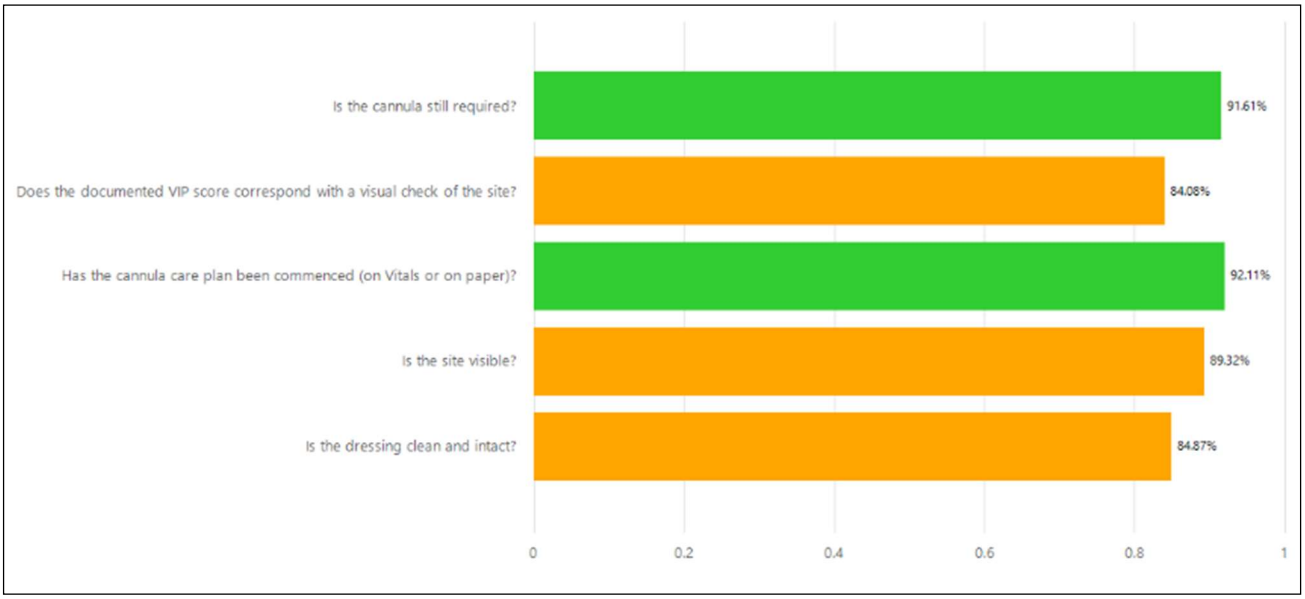
Figure 5. outlines overall compliance across the Trust by month. The average in Q4 was 83.6%, and the Trust did not meet the Trust target of 90%.

Measurement Quality Account		MWL Compliance rate
90% compliance with visual infusion phlebitis (VIP) monitoring	April	90.2%
	May	85.8%
	June	81.2%

Measurement Quality Account		MWL Compliance rate
	July	83.9%
	August	87.8%
	September	87.5%
	October	83.7%
	November	87%
	December	83.5%
	January	86.8%
	February	84.8%
	March	78.3%

Figure 6. PIVC Spot Check compliance by question – March 2026

This data provides a breakdown by PIVC spot check questions and highlights that the same themes have continued during the year, Further improvement is required regarding accurate VIP monitoring, visibility of the cannula site, and the dressing being clean and intact. This is comparable to the findings in previous quarters.



IPC Level 1 e-learning compliance was 90.7% Level 2 e-learning compliance for clinical staff was 85.1% at the end of Q4 which meets the Trust target of 85% minimum.

ANTT compliance is monitored within the divisional IPC meetings and any need for improvement in compliance is discussed at the weekly IPLR meetings, as individual cases are discussed.

Figure 7. ANTT Compliance 2025/26

Measurement Quality Account		April %	May %	June %	July %	Aug %	Sept %	Oct %	Nov %	Dec %	Jan %	Feb %	Mar %
Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for Level 2 across MWL (practical)	Level 1	92.8	67	78.7	82.7	84.6	86.2	87.2	87.6	88.5	88.9	88.9	89.3
	Level 2	68.8	68.5	73.6	77.5	79.8	80.9	82.8	83.2	83.6	84%	83.2	82.6

MRSA screening compliance

Compliance with MRSA screening was >94% for emergency admissions at end of 2025-26.

Figure 8. MRSA Screening Compliance Apr-Mar 2025/26

Measurement Quality Account		S&O			STHK		
Achievement of 95% for MRSA screening		Emergency admissions	Elective admissions	**Total Compliance**	Emergency admissions	Elective admissions	**Total Compliance**
	April	93%	98.6%	**95.8%**	98.6%	-	**98.6%**
	May	89.7%	98.8%	**94.2%**	99%	-	**99%**
	June	90.9%	98.9%	**95%**	95.1%	-	**95.1%**
	July	93.1%	98.1%	**95.6%**	95%	-	**95%**
	Aug	92.3%	96.6%	**94.5%**	94.2%	-	**94.2%**
	Sept	90.7%	99.5%	**95.1%**	95.4%	-	**95.4%**
	Oct	89%	99.4%	**94.2%**	96.6%	-	**96.6%**
	Nov	91.9%	97.9%	**94.9%**	94.9%	-	**94.9%**
	Dec	88%	98%	**92.5%**	94.4%	-	**94.4%**

Measurement Quality Account		S&O			STHK		
	Jan	89.1%	97%	**93%**	94.6%	-	**94.6%**
	Feb	81.9%	94.7%	**88.3%**	94.6%	-	**94.6%**
	Mar	90.3%	95.2%	**92.7%**	94%	-	**94%**

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

The Trust has a policy in place which is aligned to best practice for MRSA screening and suppression guidance and continues to use a robust approach to screening most patients, either preoperatively or on admission and patients who have a length of stay for 30 days or more are also screened. MRSA admission screening compliance is monitored monthly and reported within the Trust Quality objective. The target for MRSA screening is 95% of eligible patients requiring screening, STHK compliance was >94% for emergency admissions in Q4, however elective screening compliance will be reported retrospectively, when the work to clarify screening requirements within the Surgical Division is completed.

At Southport and Ormskirk sites Q4 compliance for emergency and elective admissions was 92.7%, which is below the Trust target of minimum 95% admission screening for all inpatients. Screening of emergency admissions improved to 90.3% while elective screening was 95.2% in Q4.

The relaunch of the One Together Programme and updated NHSE GIRFT guidance: Preoperative decolonisation interventions and washes before elective surgery will be used to inform the elective screening policy going forward, will help to guide the MWL approach. These meetings were reconvened in April 2026, with reviews of specific specialty pathways (Orthopaedics, Plastics and Sanderson Suite) requested by the IPC Team, to inform the MRSA screening requirements going forward. Work remains ongoing in relation to elective screening within the Surgical Division. The relaunch of the One Together Programme and updated NHSE GIRFT guidance: Preoperative decolonisation interventions and washes before elective surgery will be used to inform the elective screening policy going forward and will help to guide the MWL approach.

MSSA bacteraemia

There is no external objective for MSSA bacteraemia. However, for 2025-26 an internal reduction objective of 10% on the 2024/25 outturn of cases with lapses in care was set, the Trust had 79 healthcare-associated MSSAb (57 HOHA, 22 COHA), which is a reduction of 11 cases compared to the 90 cases 2024/25, This follows the implementation of the Bloodstream Infection Improvement Plan.

Figure 8. MSSA bacteraemia cases by legacy sites 2024/25 and 2025/26

Financial Year	Attribution	STHK	S&O	Total MWL cases
2024-25	HOHA	32	20	52
	COHA	25	13	38
Total		**57**	**33**	**90**
2025-26	HOHA	32	25	57
	COHA	18	4	22
Total		**40**	**39**	**79**

Figure 9: MWL for MSSA rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 25	Jul-Sep 25	Oct – Dec 25	Jan-Mar 26
Cheshire & Merseyside	**18.3**	**15.3**	**16.8**	**17.4**
MWL	**17.8**	**18.1**	**19.9**	**17.2**

The Trust was below C&M rate for MSSA in Q4, after being above in Q2/3 (Figure 9). The, with Infection Prevention Learning Reviews(IPLR) indicated that further improvement in sepsis identification and management is required.

The HOHA cases are subject to the IPLR process to clarify the sources of infection (e.g. cannula, wounds) and to identify lessons for improvement.

The main themes identified through Infection Prevention Learning Reviews (IPLRs) were:

- Peripheral intravenous cannula (PIVC) management
    - Ongoing focus on insertion, maintenance and timely removal of cannulas.
    - Need to improve compliance with Visual Infusion Phlebitis (VIP) monitoring.
- Sepsis recognition and management
    - Delays in recognition and escalation of deteriorating patients.
    - Opportunities to improve compliance with sepsis pathways and timely intervention.
- Timely microbiology investigations

    - Prompt collection of blood cultures and other diagnostic specimens to support early diagnosis and treatment.

- Antimicrobial prescribing
    - Ensuring timely, appropriate and targeted antibiotic prescribing in line with stewardship principles.
    - Need to reduce delays in antibiotic administration.
- Aseptic Non-Touch Technique (ANTT)
    - Continued emphasis on ANTT training, competency assessment and compliance during invasive procedures.
- Vascular access care
    - Improving standards of line and device management to reduce infection risks associated with invasive devices.

Key Actions for 2026/27

To address these themes, the Trust will continue to:

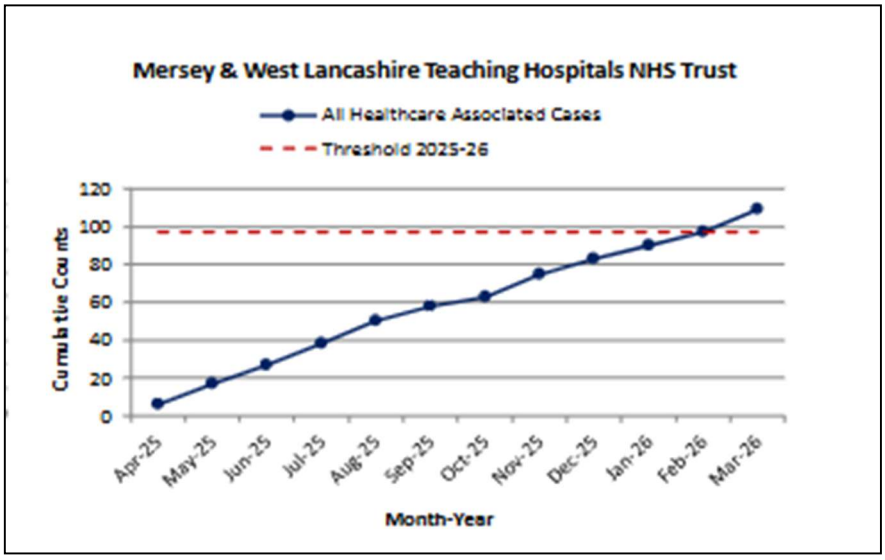
- Deliver the Bloodstream Infection Improvement Plan.
- Achieve 90% VIP monitoring compliance.
- Maintain minimum 85% ANTT training compliance.
- Strengthen sepsis identification and treatment.
- Improve blood culture collection and diagnostic practice.
- Continue targeted learning from IPLRs and the introduction of After Action Reviews (AARs) to support faster learning and improvement.

Clostridioides difficile infection

The C. difficile NHSE threshold for MWL was no more than 97 cases in year.

During 2025-26, there were 109 healthcare-associated cases which was 12 cases above NHSE threshold, however, this was a reduction of 5 cases compared to 2024/25.

Figure 10. MWL healthcare-associated C. difficile 2025/26



UKHSA data indicates that MWL remained below the C&M rate for C difficile infection throughout 2025/26 (Figure 11), the only large acute Trust in C&M below the rate.

Comparable Trusts had rates of C difficile between 34.3-74.4 per 100,000 bed days, while MWL was 23.5 per 100,000 bed days in Q4.

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

Rate per 100,000 bed days	Apr-June 25	Jul-Sept 25	Oct-Dec 25	Jan-Mar 26
Cheshire & Merseyside	**32.0**	**36.6**	**27.3**	**33.4**
MWL (combined)	**24.5**	**28.0**	**22.6**	**23.5**

In 2025/26, legacy STHK sites had 71 cases (43 HOHA, 28 COHA) which is an increase of 7 cases compared to the previous FY. This is predominantly related to an increase in COHA cases (Figure 12).

Legacy Southport and Ormskirk sites had 38 hospital-associated cases (27 HOHA, 11 COHA). There were 50 cases at these sites at the same time last year.

Figure 12. CDI cases Q1-Q4 by legacy sites 2023/24 and 2024/25

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

Financial Year	Attribution	STHK	S&O	Total MWL cases
	COHA	17	10	27
		64	**50**	**114**
2025-26	HOHA	43	27	70
	COHA	28	11	39
		71	**38**	**109**

Learning from IPLR reviews indicates that antibiotic prescribing and diarrhoea management (timely testing and isolation) are the most common themes requiring further improvement. The IPC Team continues to support wards and departments with improving diarrhoea management (Bristol Stool Chart monitoring, timely testing and isolation) across the Trust.

Matrons continue to undertake Nursing Care Indicator Bristol Stool Chart audits, and this supports IPT observations that improved documentation of BSC on admission (68.5%) and prompt isolation of patients (60%) is required. The IPT assesses commode and near patient equipment cleanliness monthly using ATP monitoring. Results are reported directly to the Nurse in Charge and discussed at divisional IPC meetings. Audit data indicates the need for further improvement in the cleanliness of commodes, blood pressure cuffs and oxygen saturation probes. The IPT support the teams with Trust wide education and training in relation to cleaning of patient's equipment.

Gram-negative bloodstream infections

E coli Bacteraemia

The NHS Standard Contract for 2025/26 outlined the E. coli threshold for MWL as no more than 151 cases in year.

There were 162 cases (84 HOHA, 78 COHA), which is 4 cases above the outturn in 2024/25. However, MWL has remained below the Cheshire and Merseyside rate for E coli bacteraemia throughout this, and the previous financial year.

Figure 13. MWL healthcare-associated *E. coli* 2025/26

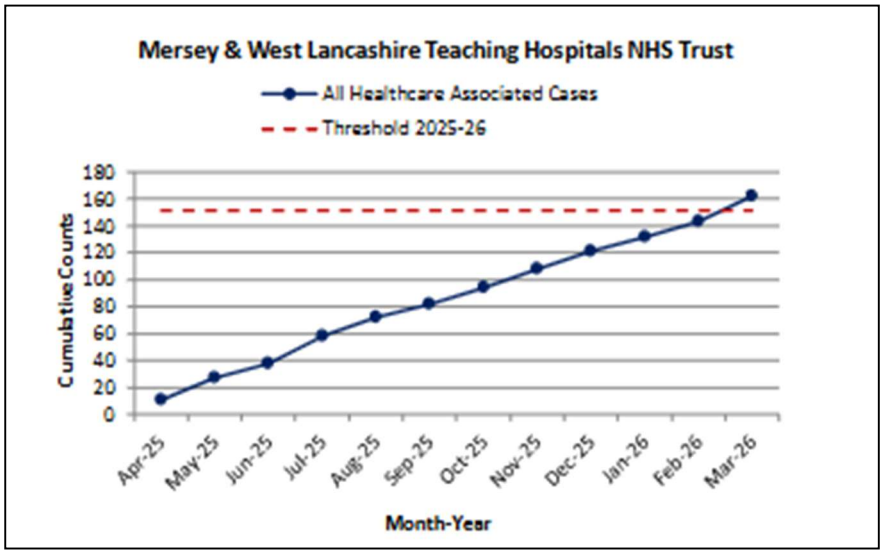


Figure 14. E coli rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun25	Jul-Sept 25	Oct-Dec 25	Jan-Mar 26
Cheshire & Merseyside	**36.2**	**40.7**	**39.9**	**37.8**
MWL Trust	**34.4**	**39.8**	**35.3**	**37.1**

HOHA cases continue to be investigated using the IPLR process with lessons learned including timely sepsis identification and management, such as blood culture and urine specimen collection, and appropriate antibiotic prescribing and administration.

Learning from Infection Prevention Learning Reviews (IPLRs) identified the following recurring themes:

- Timely recognition and management of sepsis
    - Delays in identifying deteriorating patients.
    - Need for earlier escalation and intervention in patients with suspected infection.
- Prompt collection of microbiology specimens
    - Delays or missed opportunities to obtain blood cultures and urine specimens before antibiotic administration.
    - Importance of obtaining appropriate samples to identify the source of infection.
- Urinary tract infections (UTIs) as a common source

    - Many cases were associated with urinary tract infections, highlighting the need for improved prevention, recognition and management.

- Antimicrobial prescribing
    - Ensuring appropriate antibiotic selection, timely administration and review in line with antimicrobial stewardship principles.
- Device-related infections
    - Ongoing focus on reducing risks associated with urinary catheters and vascular access devices through adherence to care bundles and prompt device removal where clinically appropriate.
- Clinical assessment and escalation
    - Need for consistent senior clinical review and adherence to sepsis pathways and treatment standards.

Actions to Support Improvement

Improvement work continues through:

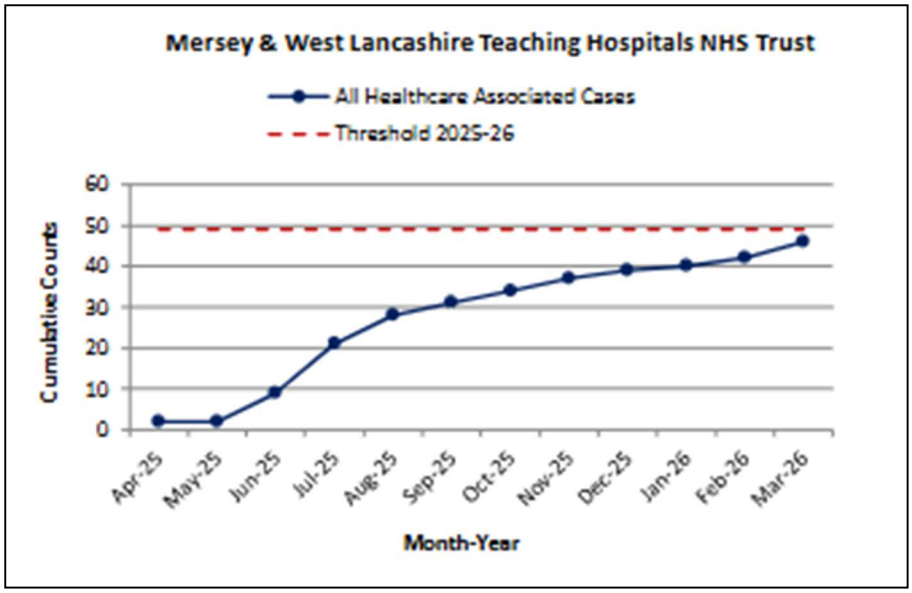
- The Bloodstream Infection Improvement Plan.
- Enhanced sepsis education and monitoring.
- Continued focus on blood culture and urine specimen collection.
- Reduction of avoidable urinary catheter use.
- Strengthening antimicrobial stewardship.
- Ongoing review of all hospital-onset cases through the IPLR process to identify lessons learned and share best practice.

Klebsiella Bacteraemia

The NHS Standard Contract for 2025/26 outlines the Klebsiella threshold for MWL for no more than 49 cases in year.

MWL was 3 cases below the NHSE threshold with 46 cases during 2025-26 which was an increase of one case compared to 2024/25.

Figure 15. MWL healthcare-associated *Klebsiella species* 2025/26.



In Q4, MWL remained a low outlier in Cheshire and Merseyside for rates of Klebsiella bacteraemia, with a rate of 6.3 per 100,000 bed days, compared to the C&M rate of 14.3 per 100,000 bed days. Prior to Q2 MWL was below the C&M rate for the last four quarters.

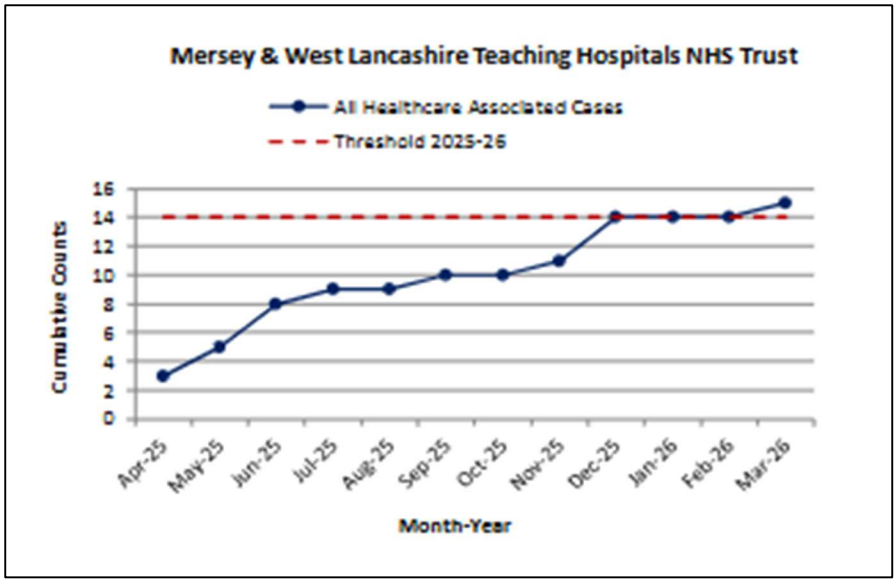
Figure 16. *Klebsiella spp*. rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 25	Jul-Sept 25	Oct-Dec 25	Jan-Mar 26
Cheshire & Merseyside	**14.6**	**15.7**	**15.3**	**14.3**
MWL Trust	**8.2**	**19.9**	**7.2**	**6.3**

Pseudomonas aeruginosa Bacteraemia

The NHS Standard Contract for 2025/26 outlines the Pseudomonas aeruginosa threshold for MWL was no more than 14 cases in year. The Trust was one case above threshold with 15 cases in 2025/26 (10 HOHA, 5 COHA).

Figure 17. MWL healthcare-associated Pseudomonas aeruginosa April 25-Mar 26.



The Trust was below the C&M rate for Q4 and Q3 as outlined in Figure 18.

Figure 18. Pseudomonas aeruginosa rates per 100,000 bed days

Rate per 100,000 bed days	Apr-Jun 25	Jul-Sept 25	Oct-Dec 25	Jan-Mar 26
Cheshire & Merseyside	**5.7**	**5.6**	**5.1**	**3.2**
MWL Trust	**7.2**	**1.8**	**3.6**	**0.9**

The key themes for Pseudomonas bacteraemia's were invasive device management, sepsis recognition, timely diagnostics, antimicrobial stewardship, environmental and water safety controls, and the management of complex, high-risk patients.

Improvement Actions include:

- Strengthening vascular access care and ANTT compliance.
- Ongoing water safety monitoring and environmental risk assessments.
- Enhanced sepsis management and early escalation.
- Continued review of all cases through the IPLR process to identify learning and reduce avoidable infections.

9. Carbapenemase Producing Enterobacterales (CPE)

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

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

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

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

The CPE business case for implementation of a single PCR test for the existing risk patient groups was approved in August 2025. The involved the transitioning from the current culture-based CPE screening method to a PCR-based approach.

The Trust had 3 hospital onsets, healthcare associated CPE bacteraemia's during 2025-26, one at Whiston Hospital and 2 at Southport Hospital. There were no CPE outbreaks within the Trust in 2025-2026

10. Respiratory Viruses

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

The IPT detected and supported with the respiratory virus cases and outbreaks in 2025/26, in line with the Trust's Outbreak Policy and UKHSA guidance.

10.1 Covid -19

The Covid-19 pandemic caused by the SARS-CoV2 virus, continues to present in waves of infection. In 2025/26 there was a total of 1259 patients with Covid-19, known as either community or hospital onset cases. Compared to 1414 in 2024/25. This included 628 cases diagnosed at St Helens and Knowsley sites and 631 cases at Southport and Ormskirk sites. 699 of the1259 (55%) cases were definite community onset.

UKHSA definitions of Covid are as follows.

- COVID-CO: Community Onset - First positive specimen date ≤ 2 days after admission to Trust
- COVID-HOIHA: Hospital Onset - Indeterminate Healthcare Associated - First positive specimen date 3-7 days after admission.

- COVID-HOPHA: Hospital Onset - Probable Healthcare Associated - First positive specimen date 8-14 days after admission.
- COVID-HODHA: Hospital Onset - Definite Healthcare Associated - First positive specimen date 15 or more days after admission.

Figure 19 and 20 outlines the attribution of cases.

Figure 19. Covid-19 STHK 2025/26

STHK Covid-19 cases					**Total**
Attribution	HO-dHA	HO-pHA	HO-iHA	Community	
April	6 (22%)	0 (0%)	3 (11%)	18 (67%)	27
May	9 (18%)	10 (20%)	3 (6%)	28 (56%)	50
June	5 (11%)	2 (4.5%)	7 (16%)	30 (68%)	44
July	1 (3.1%)	2 (6.3%)	0 (0%)	29 (91%)	32
August	10 (18.5%	3 (5.6%)	9 (16.7)	32 (59.3	54
Sept	33 (21.7%)	16 (10.5%)	15 (9.9%)	88 (57.9)	152
Oct	12 (11.2) %	9 (8.4%)	11 (10.3)	75 (70.1%)	107
Nov	1 (3.3) %	1 (3.3) %	1 (3.3) %	27 (90) %	30
Dec	1 (5.3%)	2 (10.5%)	1 (5.3%)	15 (78.9%)	18
Jan	8 (25.8%)	3 (9.7%)	3 (9.7%)	17 (54.8)	31
Feb	1 (2.7%)	3 (8.1%)	3 (8.1%)	30 (81.1)	35
Mar	1 (2.2%)	1 (2.2%)	3 (6.7%)	40 (88.9%)	45
Total	88(14%)	52(8.3%)	59(9,4%)	429 (68.3%)	628

Figure 20. Covid-19 S&O 2025/26

S&O Covid-19 cases					**Total**
Attribution	HO-dHA	HO-pHA	HO-iHA	Community	
April	17 (30%)	7 (13%)	5 (9%)	27 (48%)	56
May	5 (14%)	2 (5%)	4 (11%)	26 (70%)	37
June	23 (26%)	9 (10%)	12 (14%)	44 (50%)	88
July	31 (48%)	9 (14%)	9 (14%)	16 (24%)	65
August	15 (38%)	8 (20%)	1 (2%)	15 (38%)	39
Sept	10 (13%)	10 (13%)	3 (4%)	53 (69%)	76

Oct	19 (22%)	10 (11%)	18 (21%)	38 (44%)	85
Nov	28 (51%)	11 (20%)	7 (12%)	8 (14%)	54
Dec	14 (46%)	6 (20%)	4 (13%)	6 (20%)	30
Jan	11 (22%)	10 (20%)	12 (24%)	17(34%)	50
Feb	6 (25%)	2 (8.3%)	2 (8.3%)	14 (58%)	24
Mar	21 (77%)	0 (0%)	0 (0%)	6 (22%)	27
Total	190 (30.2%)	94 (14.9%)	77(12.2%)	270 (42.7%)	631

10.2 Influenza

There was a total of 1528 influenza A cases reported at MWL in 2025-26 compared to 1,777 cases reported during 2024-25.

The peak months were as expected, in October, November and December, cases reduced steeply across all MWL sites in January (Figures 21 and 22).1368 of 1528 (89.5%) cases were community onset with patients presenting to hospital with symptoms.

Figure 21. Flu cases STHK 2025/26

STHK Flu cases			
Attribution	Non HCAI	HCAI	Total
July	0	0	0
August	3	0	3
Sept	2	0	2
Oct	166	6	172
Nov	286	8	294
Dec	391	27	418
Jan	78	16	94
Feb	17	2	19
Mar	6	0	6
Total	949	59	1008

Figure 22. Flu cases S&O 2025/26

S&O Flu cases			
Attribution	Non HCAI	HCAI	Total
July	2	0	2
August	1	0	1
Sept	1	0	1
Oct	17	12	29
Nov	148	10	158
Dec	134	31	165
Jan	107	42	149
Feb	9	6	15
Mar	0	0	0
Total	419	101	520

10.3 Respiratory Syncytial Virus

RSV is one of the common viruses that cause coughs and colds in winter, although it usually causes a mild self-limiting respiratory infection in adults and children, it can be severe in infants and older adults who are at increased risk of acute lower respiratory tract infection.

At Southport and Ormskirk sites during 2025/26, there were 457 RSV cases of which 95.6% were community associated cases.

At STHK sites there were 753 cases of RSV detected in 2025/26, of which approximately 90% were community-associated cases.

11. Measles

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

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

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

Across MWL the IPT supported the management of positive cases and undertook contact tracing for patient contacts.

12. Mpox

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

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

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

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

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

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

During 2025-26, the IPT supported the clinical teams to manage suspected and confirmed cases, ensuring the appropriate contact tracing and screening isolation was undertaken and there was no onward transmission within the Trust.

On the 19 March 2025, The Advisory Committee on Dangerous Pathogens (ACDP) concluded that the evidence gathered by UKHSA for Clade I and 2 Mpox indicated that they no longer met the criteria of a high consequence infectious disease (HCID). Therefore, the Chief Medical Officers (CMOs) of the 4 nations have agreed that mpox will no longer be managed as an HCID within healthcare settings.

MWL have revised the Trust policy and guidance to reflect the changes and have incorporated this is the Emergency Preparedness, Resilience and Response plans.

13. Tuberculosis

The latest provisional data from the UK Health Security Agency (UKHSA) shows that tuberculosis (TB) notifications in England remained broadly stable in 2025, with 5,424 cases reported compared with 5,487 in 2024, a decrease of 1.1%. Despite this stabilisation, TB rates remain above pre-pandemic levels, highlighting that TB continues to be a significant public health concern in England. The notification rate in 2025 was 9.4 cases per 100,000 population.

Tuberculosis (TB) is a bacterial infection that most commonly affects the lungs, although it can affect other parts of the body. It spreads through the air when a person with active pulmonary TB coughs or sneezes. TB is preventable and curable with a course of specialist antibiotics, but it can cause serious illness if diagnosis and treatment are delayed. Symptoms may include a persistent cough lasting more than three weeks, fever, night sweats, loss of appetite and unexplained weight loss. The Bacillus Calmette-Guérin (BCG) vaccine provides protection against severe forms of TB and is offered to individuals at increased risk of infection.

During the period 2025-26 the IPT in conjunction with HWWB and TB nurses have coordinated the contact tracing for staff and patient contacts, following 5 confirmed and 4 suspected cases. The MWL TB Policy has been revised to support the management of related incidents.

14.Outbreaks/Incidents

There were 129 outbreaks at MWL during the period 1 April 2025 to 31 March 2026, this was widespread across the wards, including 1149 patients and resulted in 1838 lost bed days, at an estimated cost of £827,100 (calculated on £450 per day). This corresponded with severe

operational pressures, community transmission of Norovirus. Outbreak management was supported by the IPC team, Health Protection Unit and operational management teams.

All affected wards had terminal cleans.

Figure 23: Number of outbreaks per site

Number of outbreaks per site	
Southport	68
Ormskirk	6
Whiston	52
St. Helens	3
Newton	0

Figure 24: Organism affecting outbreak.

Organism	Southport	Whiston	Ormskirk	St. Helens	Total
Norovirus	32	13	1	1	47
COVID	19	19	2	1	41
Influenza	10	8	2	1	21
COVID & Influenza	5	0	0	0	5
RSV	0	1	0	0	1
CPE colonisation	1	0	1	0	2
MRSA Colonisation	0	1	0	0	1
Other	2	7	0	0	9

A Mersey internal Audit Agency (MIAA) assurance review of Norovirus Outbreak management processes was completed in March 2026 further details are in section 16.

15. Surgical Site Surveillance (SSI)

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

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

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

- Hip replacements

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

The Trust participates in the mandatory UKHSA surveillance of elective orthopaedic surgery and submits data for hip and knee replacements for each quarter of the year. The Trust was identified as a high outlier for SSI in both hip and knee during 2025-26 reporting period.

During 2025-26, the Trust performed a total of 1,472 hip and knee procedures.

Figure 25. SSI Rates Total Knee Replacement (TKR) & Total Hip Replacement (THR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2025	165	0	0%
July- September 2025	125	1	0.8%
October – December 2025	133	**3**	**2.3%**
January – March 2026	136	1	0.7%
Total	559	5	0.9%

STHK Total Hip Replacements (THR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2025	131	0	0%
July- September 2025	138	**2**	**1.4%**
October – December 2025	114	1	0.9%
January – March 2026	131	0	0%
Total	514	3	0.6%

S&O: Total Knee Replacement (TKR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2025	54	0	0%
July- September 2025	54	0	0%
October – December 2025	43	0.43	0.43%
January – March 2026	39	0	0%
Total	190	0.43	0.43%

S&O: Total Hip Replacements (THR)

Data per quarter	No procedures	No infections	Infection rate per 100 procedures
April – June 2025	53	0	0%

July- September 2025	54	0	0%
October – December 2025	57	0	0%
January – March 2026	45	0	0%
Total	209	0	0%

A task and finish group has been established with Service improvement team involvement to address the key actions required to ensure sustained reduced incidents of Surgical site infections. This is monitored within the surgical division and is reported to the Executive committee via the divisional performance review process.

The One Together Project relaunch

This is a national quality improvement programme focused on reducing healthcare-associated infections, particularly surgical site infections (SSIs) and bloodstream infections through the implementation of evidence-based infection prevention practices.

During 2025/26, MWL relaunched the One Together Programme to support improvements in:

- Surgical site infection prevention.
- MRSA screening and pre-operative decolonisation pathways.
- Standardisation of infection prevention practices across clinical specialties.
- Alignment with updated NHSE GIRFT guidance for elective surgery patients.

The programme has been used to inform reviews of Orthopaedic, surgical pathways, ensuring patients are appropriately screened, treated and prepared before surgery to reduce the risk of infection. It also supports multidisciplinary working across IPC, surgery, anaesthetics, theatre, nursing and pharmacy teams.

The One Together Programme forms an important part of the Trust's 2026/27 strategy to reduce surgical site infections, improve patient outcomes and strengthen compliance with national infection prevention standards.

16. IPC Audit

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

IPC practices and the clinical environments continued to be audited by the IPT. This includes hand hygiene, PPE, peripheral cannula and urinary catheter audits.

Contamination of hospital surfaces plays an important role in the transmission of healthcare-associated infections, such as *Clostridioides difficile*, MRSA and VRE. The risk from frequently touched surfaces has also gained more attention in recent years. Healthcare organisations need to provide assurance that they are meeting and maintaining safe standards

of cleanliness, thus supporting good IPC practice. The most common method used to assess the standard of cleaning is visual inspection and this is the overarching method promoted in previous and the most recent revised National Standards of Healthcare Cleanliness (2025).

ATP is an energy molecule present in all living cells, and all organic matter contains ATP, including blood, saliva, and bacteria. Its presence can be detected by a biochemical reaction which emits light, known as bioluminescence. The intensity of the light produced is in direct correlation to the amount of ATP present, which is a proxy of organic matter and, consequently, of microbial contamination. The technology works by taking a swab sample from a surface, placing it in a handheld machine, which gives a result within ten seconds of testing.

The IPC Team audit commode & near patient equipment cleanliness monthly using ATP monitoring. Results are reported directly to the Nurse in Charge and discussed at HIPG. Feedback is given directly to clinical teams and reported within divisions. Audit findings provide data that can be used to inform targeted interventions and staff training.

The infection prevention audit plan 2025/26 generates the data on a monthly, quarterly and yearly basis. The team has aligned the MWL IPC Audit programme, to address key priorities and lessons from infection and outbreak reviews. Clinical areas are required to submit hand hygiene, PPE, and cannula audits monthly via the Tendable app. Audit findings are presented within the divisional IPC reports. The IPT has worked on the harmonisation of these reports across the Trust to support divisional governance processes.

The IPC Team is supporting individual areas with IPC improvements, delivering training, engaging the wider MDT and support teams (e.g. Estates and Facilities), and considering human factors and ergonomics in driving improvement in clinical IPC. This information is presented at the Divisional Infection Prevention Governance Group and HIPG.

A separate monthly audit report outlining Trust wide compliance with the IPC Audit Plan is presented to Patient Safety Council monthly. IPC elements are also embedded in the Ward Accreditation Programme.

16.1 Mersey Internal Audit Agency (MIAA)

During 2025-26 MIAA conducted two audits in relation to IPC:

1. Spot check quality assurance audit: Moderate assurance

The overall objective of this review was to assess compliance with national infection prevention and control (IPC) standards ensuring safe, high-quality care and reducing the risk of healthcare-associated infections.

The review identified several areas of good practice in Infection Prevention and Control. The Trust demonstrated a commitment to Infection Prevention and Control (IPC) through active participation in regional collaboratives, robust hand hygiene promotion, evidence-based cleaning protocols, and effective outbreak management. IPC data is consistently shared at ward, Trust, and system levels. Collaborative engagement, targeted action plans, and transparent data sharing underpin the Trust's IPC approach.

The review identified that there were inconsistencies with infection prevention measures across clinical areas, Observations included a review of Standard Infection Control Precautions (SICPs), appropriateness of glove use, clinical and environmental cleaning and a review of documentation of bowel assessments. An improvement plan is in place which is monitored via Divisional IPC meetings, HIPG and Quality committee

2. MIAA audit to review Norovirus Outbreak management: Significant assurance

A MIAA audit to review Norovirus Outbreak management processes was completed in March 2026, to assess whether the Trust's arrangements for managing Norovirus outbreaks are clear, robust, and compliant with UKHSA guidance, ensuring timely identification, effective escalation, and rapid containment throughout the full outbreak lifecycle, supported by appropriate governance, roles, responsibilities, and decision-making processes.

Norovirus outbreak management is clear, robust, and compliant with UKHSA guidance, ensuring timely identification, effective escalation, and rapid containment throughout the full outbreak lifecycle, supported by appropriate governance, roles, responsibilities, and decision-making processes.

The review included the following sub-objectives:

- To review whether Trust policies and procedures supported the timely identification of suspected outbreak cases and appropriate escalation to the Outbreak Management Team (OMT).
- To assess the robustness of Trust outbreak policies in supporting effective escalation, containment, and control measures, using sample outbreak cases provided by the Infection Prevention and Control (IPC) team.
- To evaluate organisational outbreak management policies and procedures against current UKHSA guidance and local standards, ensuring they were accurate, up to date and fit for purpose.
- To review the policy framework for internal and external communication during outbreaks and assess whether sample outbreak cases demonstrated effective application of these arrangements.
- To examine the Trust's policy requirements for outbreak record
- keeping and evaluate sample outbreak documentation for
- completeness, clarity, and compliance.
- To review the Trust's arrangements for post-outbreak reviews and organisational learning and assess whether sample case reviews demonstrated that learning was captured, actioned, and shared effectively.

MIAA concluded that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

There was strong evidence of effective outbreak management and infection prevention practice. IPC teams demonstrated prompt, multidisciplinary working once notified, supporting timely escalation and decision-making. Rapid access to testing supported timely confirmation of cases, while escalation was appropriately guided by clinical judgement and dynamic risk assessment rather than rigid thresholds.

Governance and communication arrangements were clear and effective, underpinned by current policies aligned with national guidance, robust documentation, and visible executive oversight during periods of heightened pressure, collectively providing assurance of safe and coordinated outbreak management.

Areas for improvement relate to earlier identification, consistency, and organisational learning. While outbreak management was effective once escalated, there were instances where initial recognition and notification to Infection Prevention and Control (IPC) teams were delayed, indicating a need for more systematic early-warning triggers at ward level. Practice varied

across sites and clinical areas, particularly in the consistent use of outbreak management systems and precautionary measures prior to IPC involvement, creating a risk to uniform standards during emerging outbreaks.

Regular PIVC spot check audit of clinical areas was included in the IPC Team audit plan for 2025/26 for inpatient areas at Whiston, Southport and Ormskirk sites, with timely feedback to clinical and divisional teams, to support improvement. This is also an audit on Tendable that ward managers and matrons undertake peer reviews. A target of minimum 90% compliance with VIP monitoring was set.

Figure 26: VIP compliance 2025/26

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

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

17. Education & Training

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

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

17.1 IPC Mandatory Training

Infection prevention mandatory training e-learning is available on Moodle (STHK sites) or ESR (S&O sites).

Infection Prevention and Control – Level 1 is for non-clinical staff (to be completed every 3 years).

Infection Prevention and Control – Level 2 is for clinical staff (to be completed annually).

Level 1 e-learning compliance in March was 90.7%, Level 2 compliance for clinical staff increased to 85.1%**,** with both Levels 1 and 2 meeting the Trust target**.**

Figure 27: IPC Mandatory Training Compliance

MWL	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
IP level 1 (non-clinical)	94.1%	93.4%	95.5%	95.6%	95.2%	94.3%	95.4%	75.4%	82.9%	86.9%	89.2%	90.7%
IP level 2 (clinical)	81.2%	81.5%	81.5%	81.9%	81.2%	82.7%	82.9%	84.2%	85%	85.1%	85.3%	85.1%

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

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

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

Figure 28. ANTT compliance

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

Other Training Sessions/Courses included:

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

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

During 2025/26, there has been a rolling programme of infection prevention training aimed at the different nursing roles. These sessions have covered basic infection prevention principles, outbreak management, roles and responsibilities and cleaning. Sessions have been delivered on both Southport and Ormskirk sites with the aim of capturing as many staff as possible.

Ward based training has been delivered on various topics including diarrhoea management, outbreak management to wards across the Southport, Ormskirk and Whiston sites. Area specific training has been delivered on critical care as part of their monthly meetings. IPC link staff training also continues to be delivered on a bimonthly interval with 2 hours per session.

S7essions have included hand hygiene and hand hygiene audits, pathology department, environmental cleanliness, MRSA and VRE.

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

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

The IPT during the years have been supported to complete the following courses and qualifications:

- Consultant Nurse IPC: DIPC development programme, NETB: water safety training
- IPC lead Nurse: Master's degree in leadership, IPC development pathway and NETB: water safety training
- IPC Matron: Rosalind Franklin, NHSLA leadership course. IPC development pathway and NTEB water safety training
- IPN Band 7 (x2) completed Mary Seacole leadership course, IPC pathway development
- SSI: one together conference
- Addressing Health care inequalities in IPC - By HIS
- HCAID Assessment training
- Water and wastewater safety course - By HIS commenced in March 2026.

18. Infection Prevention Policies

An MWL policy harmonisation plan was developed in 2024-26, with a delivery plan to align more than thirty IPC policies across the new Trust. Two policies remain under development which relates to blood cultures and cleaning.

19. Estates & Facilities

At the heart of the team's objectives is ensuring safe, effective and efficient patient care. The team's work is close liaison with the Infection prevention team and clinical staff across the organisation.

The Estates and Facilities (E&F) team plays a key role in supporting infection prevention and control (IPC) by ensuring safe, clean, and compliant healthcare environments across MWL. Close partnership working with the IPC Team underpins all activities, supported by comprehensive staff training and robust governance arrangements.

The Estates and Facilities Senior Leadership team objectives have strong links to the IPC agenda, including a joint reporting arrangement for the E&F Matron to strengthen professional and operational oversight. To strengthen this partnership working approach the Estates and Facilities Matron who reports into the Deputy Director of Estates and Facilities from an operational perspective also reports into DIPC for clinical professional development. Forging closer working relationships across the teams.

Compliance with IPC training requirements is monitored through established governance structures.

The E&F Matron has introduced a digital daily environmental check list to address any immediate concerns with regards to the estates and cleanliness of the hospital corridors. In addition to this the E&F Matron is implementing a digital E&F 15 Step Challenge Quality assessing the environment from a patient's perspective using the NHSE toolkit. The E&F team & Matron continue to support IPC colleagues with the Environmental audits. Action planning and escalating where required.

New workstreams are triangulating ATP results with outbreak data to identify potential links between environmental contamination and infection outbreaks, enabling targeted improvements. This triangulated approach supports targeted interventions, improved escalation pathways, and enhanced assurance reporting to the IPC Group and operational leadership.

Domestic Team Leaders at Southport and Ormskirk have been aligned to divisional structures, strengthening local accountability for cleanliness standards and audit performance.

Collaborative programmes continue to support ward deep cleans maintenance, flooring and painting replacement initiatives.

Development of dementia-friendly ward environments in line with national standards and patient experience requirements.

19.1 Hospital Ventilation Group (VSG)

The MWL Ventilation Safety Group meets monthly covering all acute and community sites across the Trust. This group provides oversight and assurance regarding compliance with Health Technical Memoranda (HTMs). The Trust has an appointed Authorising Engineer (ventilation) to support the Ventilation Safety group. A gap analysis against revised HTM 03-01 standards has been completed at Whiston and St Helens sites. that the Trust is compliant with relevant legislation.

All specialist ventilation systems remain compliant following annual validation and planned preventative maintenance programmes.

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

All tasks are monitored via the VSG which meets on a quarterly basis. Any non-compliances or faults are tracked on an action plan and are rectified within a timely manner.

Key workstreams during the period 2025-26 include: -

Operating theatre ventilation is monitored with contracts in place to carry out planned preventative maintenance on all air conditioning systems. The Trust's in house team and Vinci FM maintain all ventilation systems including

The group also discusses any construction projects that are ongoing withing the Trust taking a collaborative approach with IPC colleagues, authorising engineers and persons agreeing works needed or derogations that require logging within the organisation.

Any items of concern raised by the groups are reported and discussed at the Estates and Facilities Governance Council with appropriate actions noted for assurance.

19.2 Water Safety Group (WSG)

The Water Safety Group reports to HIPG and meets in line with its terms of reference. Ther are robust water safety arrangements in place, supported by an Authorising Engineer and regular Water Safety Group oversight.

Weekly monitoring of underused water outlets and flushing programmes continue across all sites to minimise legionella and waterborne infection risks.

19.3 Cleaning Services

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

Key actions include:

- The National Standards of Cleanliness (NSOC) 2021 are being implemented across MWL
- investment in new cleaning technologies, including ultraviolet and hydrogen peroxide decontamination equipment.
- Introduction of a rolling equipment replacement programme to ensure all domestic equipment remains fit for purpose and supports IPC standards.
- Review of domestic service delivery at Southport and Ormskirk is improving cleaning schedules, accountability and consistency.
- A dedicated Cleanliness Trainer role has been approved to further support compliance with national cleaning standards.
- A Cleanliness Trainer post has been approved to provide support to the NSOC standards. Their involvement will strengthen adherence to national standards, enhance monitoring processes, and support frontline teams in sustaining high levels of cleanliness and infection prevention practice.

NSOC risk ratings: functional risks categorise different healthcare areas by infection threat levels (FR1 to FR6) to determine necessary cleaning frequencies, target audit scores, and safety control

Figure 29. identifies the 6 functional risk categories

2021 Risk rating and target
FR1 = 98%: Operating theatres and critical care units where vulnerability and infection risks are highest**.**
FR2 = 95%: Emergency departments and treatment rooms where invasive procedures occur.
FR3 = 90%: Outpatient clinics and long-term assessment or treatment areas.
FR4 = 85%: Public waiting spaces, main entrances, and non-invasive consultation rooms.
FR5 = 80%: Circulation corridors, stairwells, and lift lobbies
FR6 = 75%: General administrative offices, medical records, and storage rooms.

Figure 30. STHK NSOC Scores per Functional Area

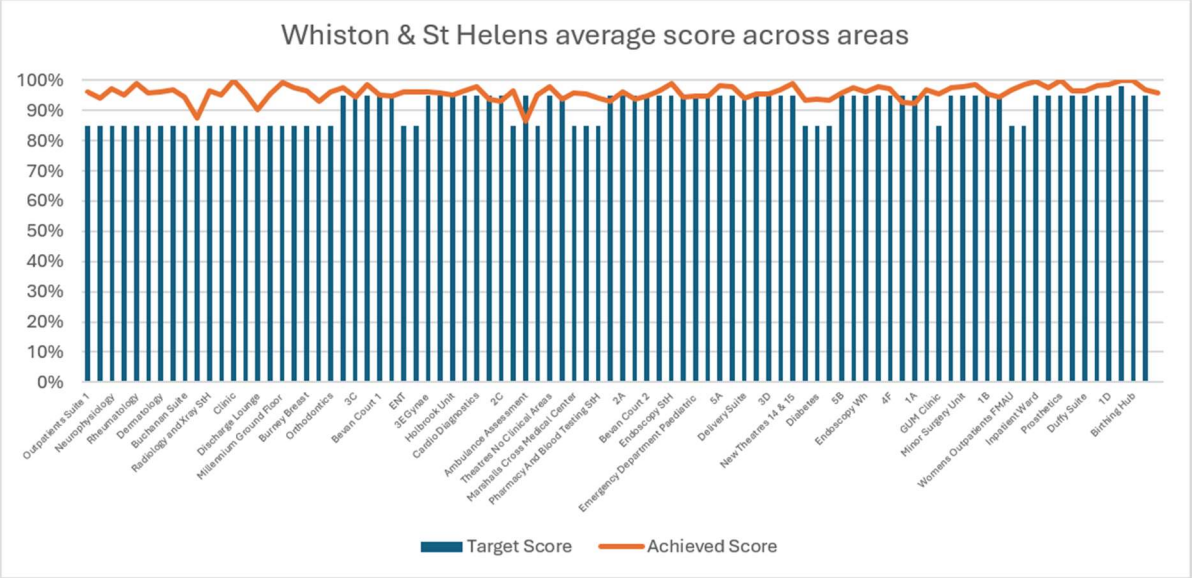
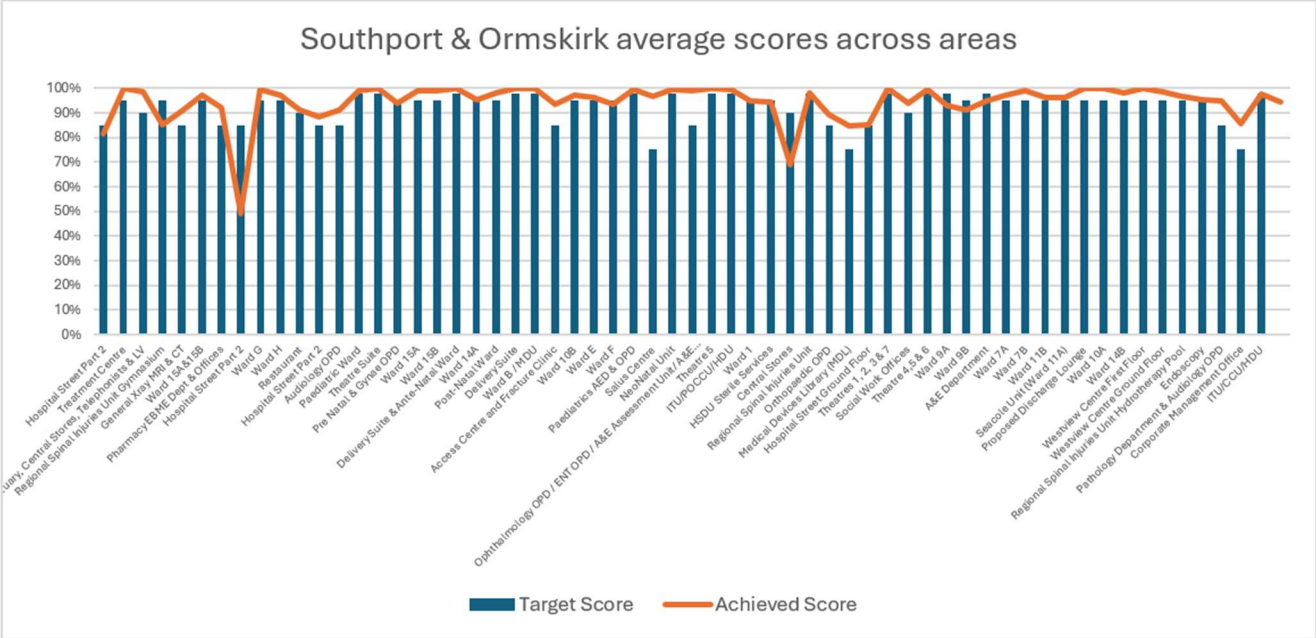


Figure 31. Southport and Ormskirk NSOC Scores per Functional Area



19.4 Waste Management

The Waste Group meets bimonthly and receives regular reports and compliance audits, this provides assurance that the Trust is compliant with relevant legislation. There is continued focus on sustainable waste management and reducing environmental impact.

During 2025/26:

- Cardboard recycling increased by 12%.
- Confidential waste reduced by 1%.
- Alternative treatment waste reduced by 8%.
- General waste increased by 11%.

Clinical waste services remained stable throughout the year, supported by contingency arrangements and regular contractor oversight.

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

Figure 32. The table below highlights the Waste Management 2025 / 26.

Waste Management 2025/26															
Waste Disposal Tonnage	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 24/25	Total 25/26	Trend
Total waste	187.4	184.4	186.5	203.8	188.3	190.5	210.1	196.5	222.6	232.7	231.5	266.1	2,267.1	2,500.3	
Clinical - incinerated (£847.50/ton)	24.1	25.8	25.4	27.7	25.4	26.5	27.4	23.1	28.6	24.5	23.9	27.4	262.4	309.8	
Clinical - alternative (£491.55/ton)	41.9	43.6	44.8	45.0	42.8	39.0	54.4	63.5	72.8	83.3	91.5	115.7	566.2	738.2	
Clinical - Offensive (£247.02/ton)	35.0	31.7	31.8	39.8	38.1	34.5	36.6	31.6	33.4	40.0	34.4	34.8	385.8	421.6	
Domestic - (£150/ton)	58.0	57.9	58.3	66.2	60.5	61.8	66.9	55.5	63.2	60.6	57.3	63.7	757.8	729.8	
Domestic - recycling (£180/ton)	1.3	0.5	0.8	0.6	2.4	0.7	1.0	0.6	0.9	0.6	0.9	1.0	14.5	11.1	
Special - confidential (£125/ton)	27.2	24.8	25.4	24.4	19.2	27.9	23.8	22.3	23.6	23.8	23.6	23.6	280.5	289.8	

The Estates and Facilities service continues to provide strong support to the Trust's IPC objectives through effective governance, environmental monitoring, water and ventilation safety management, improved cleaning standards, and robust waste management arrangements. Ongoing investment and service developments are helping to strengthen environmental safety, improve patient experience, and reduce infection risks across all MWL sites

20. Antimicrobial Stewardship

The AMS Pharmacy Team has continued to provide weekly stewardship ward rounds across multiple specialties at predominantly but not limited to general surgery, urology, orthopaedic, and plastics wards. Weekly Clostridium difficile and OPAT in-reach ward rounds are conducted alongside a weekly OPAT MDT. Regular stewardship ward rounds also take place to cover all other areas on a rotational basis according to identified areas of poor practice.

Key Achievements

- Weekly AMS ward rounds delivered across surgical, urology, orthopaedic, plastics and other clinical specialties, including dedicated C. difficile and OPAT reviews.
- Continued expansion of the Outpatient Parenteral Antimicrobial Therapy (OPAT) service, supported by the successful use of EMIS to manage patients in a virtual ward setting.
- Ongoing development of Eolas as the Trust's digital antimicrobial guidance platform, including new prescribing guidance for pregnancy and breastfeeding.
- Harmonisation and update of paediatric antimicrobial policies across MWL in line with national stewardship guidance.
- Introduction of an IV-to-Oral Switch (IVOST) decision support tool to promote timely transition from intravenous to oral antibiotics.
- Development of a 5-year Antimicrobial Stewardship Strategy aligned to national antimicrobial resistance (AMR) priorities.
- Enhanced audit capability through a new SharePoint data collection platform and 6-monthly antimicrobial point prevalence audits.
- Maintained one of the lowest levels of 'Watch' and 'Reserve' antibiotic use within the region.
- Approval of new treatment options including Rezafungin for selected patients.
- Funding secured for a Consultant Antimicrobial Pharmacist post.
- Continued contribution to regional education and training, including pharmacy student teaching.

Key Challenges

- Completion of a single harmonised antimicrobial policy for adult, neonatal and paediatric services.

- Rising demand for OPAT and increasing use of broad-spectrum antibiotics to treat resistant infections.
- Ongoing work to improve prescribing quality, therapeutic drug monitoring and reduce missed antimicrobial doses.
- Limited funding for elastomeric devices and capacity constraints within aseptic pharmacy services.
- National supply issues affecting some critical medications, particularly tuberculosis treatments.
- Continued need to improve data extraction and reporting through EPMA systems to support stewardship activities.

Priorities for 2026/27

- Publish harmonised adult and neonatal antimicrobial policies.
- Continue integration and enhancement of Eolas, including exploration of AI functionality.
- Roll out the Trust-wide penicillin de-labelling programme.
- Develop an antimicrobial dashboard and strengthen EPMA reporting.
- Deliver improvement plans targeting national AMR priorities:
    - IV-to-Oral Switch (IVOST)
    - Blood culture optimisation
    - Penicillin de-labelling
- Expand education and training for doctors, nurses and pharmacists.

21. Decontamination

The Trust maintains a robust Decontamination Policy aligned with national HTM standards (HTM 01-01 and HTM 01-06). Assurance is provided through the Hospital Infection Prevention Group (HIPG) and the Trust Decontamination Steering Group. The Authorised Persons (Decontamination) on each site undertake monthly reviews of service performance and technical issues.

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

21.1 Endoscopy Decontamination Services.

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

Whiston, Ormskirk and St Helens Hospitals have centralised endoscope decontamination units for their respective sites. In addition, Ormskirk provides endoscope decontamination for a limited number of Endoscopes used at the Southport site. Services support Endoscopy, Theatres, Urology and ENT, with additional out-of-hours provision at Whiston.

Southport and Ormskirk utilise ultraviolet decontamination technology for selected equipment including Nas endoscopes and ultrasound probes.

Endoscopy activity remained high across the Trust, with increased activity at St Helens and significant anticipated growth at Ormskirk following the opening of the new Southport Endoscopy Suite.

All decontamination equipment is maintained, tested and validated in accordance with national standards.

Weekly water testing, routine validation and annual independent audits are undertaken.

During 2025/26:

- St Helens achieved a green audit rating
- Whiston achieved an Amber/Green rating
- Ormskirk retained ISO 13485 accreditation

Monitoring arrangements remain in place to comply with updated manufacturer requirements for endoscope cleaning times.

Figure 33: Endoscopy Activity

Site	**2024/2025 Activity**	**2025/26 activity**	**Change**
St Helens	21228	21796	3%
Whiston	13549	11696	-14%
Ormskirk	N/A	11427	N/A

The decrease at Whiston is largely due to longer times the scopes can be stored in the storage cabinet times that has successfully reduced the amount of re-processing of scopes in storage cabinets that have expired.

The activity through the Ormskirk unit is expected to increase in the next year with the opening of the new Endoscopy Suite in Southport. The current decontamination services are currently managing the increase in activity expected on opening 1 room

Monitoring is in place and reported to each Decontamination steering group and performance is already very good and continues to improve.

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

The Trust Decontamination Policy has been reviewed and updated to ensure that it meets and interprets appropriately the guidance of Health Technical Memorandum (HTM) 01-01 and 01-06 (2016).

Risks and Challenges

- Increased future endoscopy activity may exceed current decontamination capacity, particularly when the second Southport Endoscopy Room opens in 2027.
- Whiston decontamination equipment is near end of life cycle resulting in increasing repairs and reduced efficiency.
- Replacement and refurbishment plans have been approved by Executive Committee and are awaiting capital funding allocation.
- Failure of key decontamination equipment remains a recognised risk on the Trust Risk Register.

21.2 Endoscope Tracking and Traceability

The Health Edge electronic tracking system provides full traceability for endoscope use and decontamination processes.

Work is underway to consolidate all site systems onto a single server to improve resilience, interoperability and mutual aid arrangements across the Trust.

The Trust continues to provide safe and compliant decontamination services supported by strong governance, external assurance, robust traceability systems and national accreditation. Key priorities are addressing ageing infrastructure at Whiston and planning capacity requirements to support future expansion of endoscopy services.

21.3 Sterile Services

The Trust outsources sterile services covering Whiston, St Helens and Newton Sites. HSDU services for Southport and Ormskirk sites and provides some services to external sites. The department is ISO 13685:2016 & MDR production Quality Certification Assurance registered and are audited annually by an external notified body to ensure compliance with guidance .

The Trust continues to provide safe and compliant decontamination services supported by strong governance, external assurance, robust traceability systems and national accreditation. Key priorities are addressing ageing infrastructure at Whiston and planning capacity requirements to support future expansion of endoscopy services.

22. Health Work and Well Being

Mersey and West Lancashire Teaching Hospitals NHS Trust's Occupational Health Service has continued to maintain the standards to meet the SEQOHS annual re-accreditation requirements. Regular clinical audits are undertaken, supplemented by ongoing management and worker feedback systems which are used to support service improvement. The Service maintains good governance, with the timely review of clinical policies, procedures and protocols helping to underpin clinical practice. The Service is encouraged to maintain its standards over the coming year.

22.1 Winter Vaccine Campaign 2025/26

Key Achievements:

- Key staff targeted by roving flu clinics, available on all shift patterns including weekends, evening, and early mornings
- Clinics were held across all sites.
- Additional training was provided to vaccinators by NHSE to support challenging attitudes and behaviours around receiving vaccinations.
- 43.85% uptake in frontline HCW groups which is a 5% increase from 2024/5 campaign percentage uptake. This is in line with National and Regional average uptake for the year.

22.2 Needlestick/ Body Fluid Exposure 2025/26

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

Key Achievements:

- More NSI/Body fluid exposure reported due to raising awareness 256 report to HWWB either via telephone or In Phase.
- Medicine and urgent care collective have had the highest incident overall and each month.

Figure 34 Needlestick injuries (NSI) by division

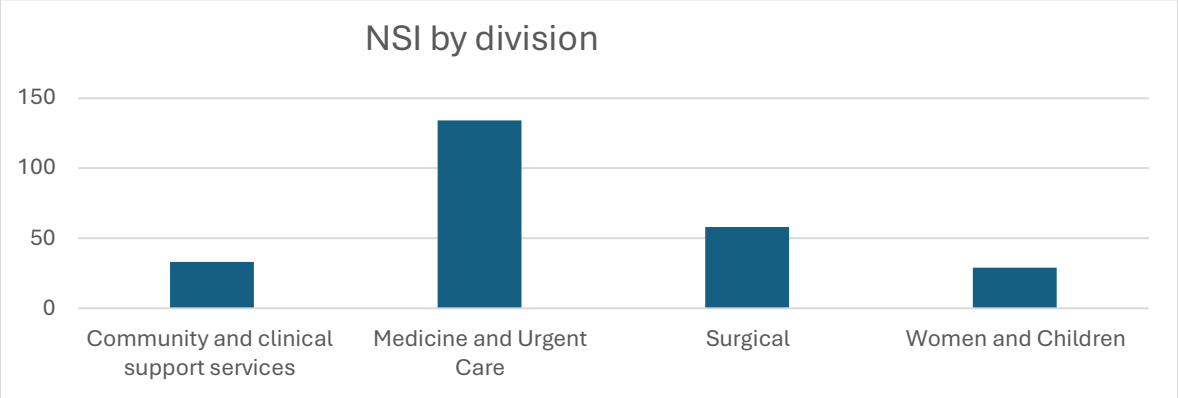
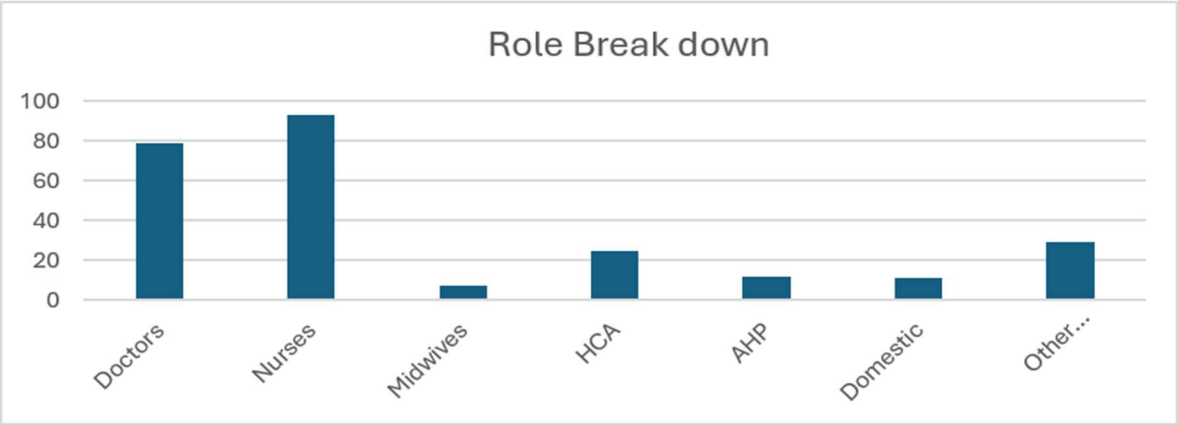


Figure 35: Needlestick injury sustained by role



- Needlestick injuries have an investigation review which HWWB report to Learning and development in relation to any user error and to Estates and facilities regarding any disposal errors.
- HWWB conduct bi-annual NSI audit on internal processes. 100% compliant.
- Re commence NSI group and work closely with H&S and procurement and estates and facilities on key themes from data.

22.3 Outbreaks

- HWWB have supported the swabbing of staff who were identified in any outbreaks.
- HWWB have worked closely with key stakeholders to support all staff involved in outbreaks.

23. IPC key priorities 2026/27

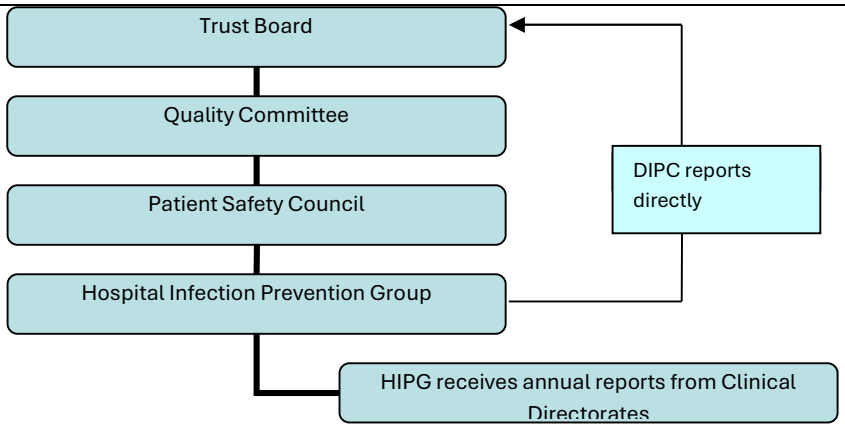
1. Deliver Bloodstream Infection Improvement Plan.
2. Reduce MRSA, CDI and Gram-negative bacteraemia's to NHSE thresholds.
3. Improve PIVC care and achieve:
    - 90% VIP monitoring compliance.
    - 85% ANTT compliance.
4. Enhance outbreak early-warning and response systems.
5. Complete harmonisation of remaining IPC policies.
6. Continue antimicrobial stewardship and AMR reduction initiatives.
7. Improve environmental cleanliness and National Standards of Cleanliness compliance.
8. Strengthen preparedness for emerging infectious diseases.
9. Improve surgical site infection performance and reduce orthopaedic SSI rates.
10. IPC support in outbreak management, decontamination, estates and infrastructure resilience.

ENDS.

Appendix 1: TOR HIPG

Terms of Reference	NAME: HOSPITAL INFECTION PREVENTION GROUP (HIPG) FINANCIAL YEAR: 2026-27
Authority	To ensure that Mersey and West Lancashire NHS Teaching Hospitals Trust have effective systems in place to prevent and control healthcare-associated infections and to provide assurance to the Trust Board. To maintain an overview of infection prevention priorities within the Trust, and link this into the clinical governance and risk management processes.
Terms of Reference	1.To oversee the delivery of the Trust's HCAI objectives and IPC-related indicators 2. To approve and oversee the implementation of the IPC Annual Plan 3. To receive reports and assurance from subgroups, including, decontamination, water safety, ventilation safety and antimicrobial stewardship. 4. To identify key standards for infection prevention as part of the Trust's clinical governance programme. 5. To ensure that programmes for the prevention and control of infection, including education, are in place and working effectively. 6. To ensure that appropriate infection prevention policies and procedures are in place, implemented and monitored. 7. To ensure that robust plans for the management of outbreaks of infection are in place and to monitor their effectiveness. 8. To monitor surveillance of infection results e.g. mandatory surveillance, post-operative infection rates. 9. To highlight priorities for action in infection prevention management. 10. To agree the annual infection prevention audit programme and monitor its implementation. 11. To approve the annual infection prevention report, prior to its submission to the Trust Board. 12. To ensure that national guidance and best practice in infection prevention is implemented within the Trust. 13. To ensure the delivery of national infection prevention objectives e.g. UKHSA alerts / NICE guidelines /CQC reports/ High Level Enquiries. 14. To appraise innovative products regarding infection prevention 15. To monitor antimicrobial/disinfectant usage & expenditure patterns.

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



Meeting Frequency

6 times a year

Agenda Setting and Minute Production and Distribution.

Agenda

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

Regular reports received by HIPG.

Quality indicator report	Frequency of report	Reported by
Mandatory surveillance: a. MRSA bacteraemia b. C difficile infection c. MSSA bacteraemia d. Gram negative (E coli/Klebsiella/Pseudomonas aeruginosa) bacteraemia e. SSI orthopaedics	At each meeting	Lead IPN/Consultant Nurse
Local surveillance results	As available.	Infection Prevention Nurses
External inspection reports and action plan progress (e.g. CQC)	As required (subject to reports being issued by external agencies)	Lead IPN/Consultant Nurse
Antimicrobial Management Team report (To include audit results and action plans, policy compliance and review)	At each meeting	Consultant Microbiologist and Antibiotic Pharmacist
Annual Report	Annual	DIPC or deputy
Reports from Medical & Urgent Care, Surgical, Women's & Children's and Community & Clinical	At each meeting	Divisional Directors of Nursing

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

Minute Production and Distribution.

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

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

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

Appendix 2: IPC Forward Plan

Mersey and West Lancashire Teaching Hospitals NHS Trust

1. Executive summary

The annual programme of the Infection Prevention and Control (IPC) Service for April 2026-March 2027 sets out the proposed activities which will ensure that the programme of work continues to focus on two main areas: raising awareness of IPC through education and training and reducing the incidence of Health Care Associated Infection (HCAI). It also supports the Trusts continuing registration with the Care Quality Commission (CQC).This programme is based around The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance, Care Quality Commission core standards (2014), and the National Standards of Healthcare Cleanliness (NHSE 2021). Learning from incidents, complaints, root cause analysis (LPR)) and observation of care audits have also contributed to this programme.

Infection Prevention and Control Annual Work Programme 2026-27

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

Infection Prevention Work Programme 2026/27							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/27**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
	1. Infection Prevention Team Staffing						
	DIPC - Director of Infection, Prevention and Control	Sue Redfern	Annual review of IPC establishment				
	Consultant Nurse IPC	Fionnuala Browne					
	IPC annual forward plan						
	Infection Control Doctor	Dr Kalani Mortimer					
	Lead Nurse IP	Claire Chalinor					
	Clinical Nurse Specialist Band 7	2.0 WTE					
	IP Staff Nurse Band 5	2.0 WTE					
	Audit and Surveillance Assistant	1.0 WTE					
	IP Secretary	1.0 WTE					
	Antimicrobial Stewardship Pharmacist	Andy Lewis, Elisha King, Jade Pickup					
	Southport & Ormskirk Sites						
	Infection Control Doctor	Vacant post	Locum Medical Microbiologist in post .				
	Clinical Nurse Specialist Band 7	2.8 WTE					
	Support Worker Band 3	1.0 WTE					
	IPC Administrator	1 WTE vacancy from Dec 2025					
	Antimicrobial Stewardship Pharmacist	Alex Priestman 0.5 WTE					
	Hospital IPC Group (HIPG)						
	The IPC Team via HIPG will report to the patient safety panel , Quality Committee and Trust board	DIPC. Consultant Nurse IPC . Infection Control Dr					
	HIPG meet six times per year	DIPC. Consultant Nurse IPC , Infection control Dr	TOR reviewed annually . Bimonthly report from key services , complinace against DH objectives				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4 and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**2. Surveillance**						
	Alert organisms	IPC Team, Microbiology	To maintain and alert Trust staff to risks associated with pathogenic organisms To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				
	Mandatory Reporting			**Q1**	**Q2**	**Q3**	**Q4**
	MRSA, MSSA, E. coli, Klebsiella, Pseudomonas aeruginosa bloodstream infection	IPC Team, Microbiology, Executive Review Panel	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases of all MRSA BSIs, MSSA and GNBSI HOHA cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG.				
	Clostridium difficile infection (CDI)	IPC Team, Microbiology	To identify, communicate and instigate investigations with clinical teams for Trust-associated cases. To ensure that lessons learnt are disseminated throughout the organisation and reported to HIPG. To undertake a weekly ward round to review patients with CDI.				
	Carbapenem resistant Enterobacterales (CPE)	IPC Team	To manage patients with CPE colonisation as per policy Harmonise policies across MWL IT screening and risk assessment form in to be included in new Careflow (which will support monitoring of compliance)				
	Surgical Site Surveillance (SSI) Total hip and knee replacements	Orthopaedic Surgery	To support the orthopaedic team to review any learning from surveillance. To consider revisiting the One Together SSI improvement toolkit.				
	Respiratory Viruses e.g. influenza, Covid-19, RSV	IPC Team	To provide IPC guidance to minimise the risks to patients, colleagues and visitors.				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/2027**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 5, 6 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**3. Hand Decontamination**						
	Continue to audit compliance with policy	IP Team	Report Trustwide Include in IPC Mandatory Training for all Trust staff Review potential approaches to undertake more objective audits, including the hand hygiene product provider, peer review and patients.				
	To undertake site survey for hand hygiene products with supplier of hand hygiene products, at MWL	IP Team	To optimise placement of products and standardisation of products. Site survey to be completed at STHK sites. Site surveys of all MWL sites to be reviewed and a plan established to refresh dispensers and signage.				
	Gloves Off campaign to commence July 2026 120 day improvement project	IP Team	To implement the Gloves Off campaign on the Critical Care Units. To further roll-out across other clinical areas following initial implementation, incorporating lessons learnt.				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**4. Policies and Patient Information Leaflets**						
	To agree plan for alignment of policies across MWL, prioritising harmonisation of high risk policies . (37)	DIPC	36/37 policies have been harmonised (2 pending in progress). All reflect the requirements of the National IPC manual . (NIPCM)				
	To provide advice and support on policies where IP is an integral component	IPT	IP review policies as part of the consultation process				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 4, 5 and 9 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**5. ANTT/Intravascular Access and Therapy**						
	Develop implementation plan for training	IPT/Training & OD	To establish frequency of training and and mode of delivery for key trainers and clinical staff.				
	Monitor Trust wide compliance	OD and subject matter expert (SME)	Provide updated compliance figures to the relevant care groups and for HIPG				
	Provide Key Trainer training at STHK sites	IPNs, Nurse Consultant ICU	Key trainer training sessions are provided at agreed intervals.				
	To act as an advisory role for vascular access and therapy related issues at STHK sites	Nurse Consultant : MET IV access. IPNs, Nurse Consultant ICU	To provide expert advice on matters relating to vascular access and therapy. Provide report to HIPG. Lead IP nurse to co-chair IV Access and therapy Group with Nurse Consultant ICU				
	Facilitate annual Trust PIVC audit	IPT	Provide report to HIPG and PSC. Produce an action plan that will be monitored at the IV Group. Ward PIVC audits completed monthly on Tendable				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2024/2025**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**6. Training**						
	IPC training to junior doctors, volunteers, student nurses, preceptors.	IPC Team	Ongoing				
	Mandatory training	IPT	12 month mandatory training is provided via an online video for clinical staff. 3 yearly mandatory training update for non-clinical staff is via e-learning. Induction training is online.				
	Link Personnel	IPT	Quarterly face to face meetings				
	Antibiotic Prescribing	Antimicrobial Management Pharmacists, Medical Microbiologists	Junior doctor training (medical and surgical twice yearly), medical student teaching, medical staff induction.	STHK S&O			
	Keep IP staff updated with evidence based practice	IPT	Attend North West/ national Infection Prevention Society/ infection control conferences. Undertake webinars by accredited IP organisation e.g. Hospital Infection Society				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/2027**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6 7, 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**7.Audit**						
	To provide assurance to the Board and relevant committes of adherence to high quality IP practices	IPT	Reported to quality leads, matrons, ward managers, supports services, HIPG and				
	Annual Programme revised annually	IPT	Divsional IPC meetings implemented monthly				
	Use Tendable platform for IPC audits	IPT	To work with MWL digital leads to optimise this platfrom for IPC audits				
	Further audits are undertaken by the IPT as the service requires	IPT	e.g. Commodes and dirty utility, flushing audit (augmented areas), Sharpsmart audit, ward kitchen audit, hand sanitiser placement, blood culture audit, deep clean audit.				
	Urinary Catheter care & maintenance point prevalence audit Q3-4	IPT	To undertake annually across all inpatient areas planned fo Sept 2026				
	Vascular access devices point prevalence audit		To undertake annual poiunt prevelenec in Q4 across al inpatient . Monthly spot checks				
	Vascular access devices	IPT	VIP audits are undertaken if issues are identified through RCA. Monthly reporting via IP audit indicators and Tendable				
	Compliance with IP precautions including isolation, careplans, PPE etc	IPNs	Quarterly				
	Mattresses	TK	Audited bi-monthly on the inpatient areas by clinical teams. Recorded on tendable Reporting included in Divisonal IPC meetings with assurance to HIPG.				
	Blood culture contamination rates below 5%	KM	ED rates reported weekly to clinical leads. Trust rates reported monthly in IP report at STHK sites. Further rollout of BC training competency	2-6%			

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/2027**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4, and 5 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**8. Antibiotic Prescribing**						
	Participate in IVOS audit (IV to oral switch)	AMT	Report bimonthly to HIPG				
	Undertake weekly AMT wardrounds on medical and surgical wards at STHK sites	AMT	Immediate feedback provided on wards, reported in IP monthly report				
	Undertake microbiology wardrounds on Critical Care, Orthopaedic Surgery, Spinal Unit and other ward rounds as staffing allows	Consultant Microbiologist, Southport Site	Immediate feedback provided on wards				
	Point prevalence audit of policy adherence, missed doses, antibiotic review and course lengths at STHK sites	Antimicrobial Management Pharmacists	Reported to Trust clincial leads and in IP monthly report				
	Antimicrobial expenditure information at MWL sites	Antimicrobial Management Pharmacists	Reported to HIPG and DTG				
	Penicillin delabelling	AMT	to audit baseline data				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/2027**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6, 7 9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**9. Communications**						
	IPC Monthly Data Report	IPT, AMT	Unified IP monthly report, combining monthly reports for the medical and nursing staff				
	Communication with other Trusts and agencies such as UKHSA	IPT	To share information, best practice and lessons from incidents				
	IPC intranet website	IPT	To maintain and update Trust intranet site(s) with relevant and up to date information with Trust staff				
	Administration	JD	To provide administrative support including coordination of meetings, dairy management, data collection, minutes, ICNet administration				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/2027**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 3, 4, 5, 8 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**10. Information Technology**						
	ICNet surveillance and case management system	IPT	Continue to use system to manage patients and to run reports. To introduce futher function to the system as they become available e.g. recent addition of outbreak module.				
	Tendable audit platfrom	IPT	To optimise the use of this digital platform for IPC audits, revised general IPC Team audit by in collaboration with Quality Matrons.approved June 2025				
	Electronic prescribing roll out on hold date to be confirmed	AMT	To optimise the functionality of the EPMA system				
	Careflow Connect	IPT	To optimise the IPC opportunities on this platform e.g. infection alerts and screening requirements.				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/2027**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code:							
1, 2, 3, 4, 5, 6, 9 and 10 **Trust Objectives:**	Continue IPC and environmental audits	IPC Team	Improvement in IPC audit indicators				
	IPC Link network with reps in all clinical depts	Matron IPC	bimonthly meeting and education events				

Infection Prevention Work Programme 2026/2027							
IP Code and Trust Objectives	**Plan and Priority Activities 2026/2027**	**Lead(s)**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**
IP Code: 1, 2, 3, 4, 5, 6,9 and 10 **Trust Objectives:** Care, Safety, Pathways, Systems and Communication	**12. Interface with relevant groups**						
	Care Group/Divisional meetings	ICNs	To provide expert advice and support as required				
	Decontamination	IPT	To attend quarterly scheduled decontamination meetings. To provide expert advice and support as required.				
	Water Safety	KM	Attend Water Safety Meeting				
	Ventilation Safety	KM	Attend Ventilation Safety Meeting				
	Waste Management	IPT	To provide expert advice and support as required				
	Medical Devices Group	IPT	To provide expert advice and support as required				
	Estates & Facilities	IPT	To provide expert advice and support as required, for capital schemes, linen, catering and other elements.				
	Health & Safety	IPNs	To provide expert advice and support as required				
	Emergency Planning	IPT	To provide expert advice and support as required				
	Health, Work and Wellbeing	IPT	To provide expert advice and support as required				
	ICB meetings	IPT	To attend and provde assurance to commissioners related to IPC				
	NW IPC Regional Meeting	IPT	To engage with and share best practice with peers				
	CMAST	IPT	To provide expert advice and support as required				

Appendix 3: MWL Outbreak data 2025/26

No.	Outbreak started	Outbreak closed	Ward	Organism	Days ward closed	Beds Lost	Patients affected
1	03/04/2025	09/04/2025	11A	COVID	6	0	4
2	04/04/2025	12/04/2025	3C	COVID	0	0	2
3	10/04/2025	25/04/2025	7B	COVID	15	5	3
4	18/04/2025	25/04/2025	15A	Norovirus	7	13	11
5	20/04/2025	03/05/2025	11B	Norovirus	13	60	12
6	28/04/2025	14/05/2025	7B	Norovirus	16	64	14
7	01/05/2025	12/05/2025	10A	Norovirus	10	36	20
8	02/05/2025	21/05/2025	7A	Norovirus	19	76	15
9	02/05/2025	09/05/2025	Ward 1	Norovirus	6	21	25
10	05/05/2025	15/05/2025	9B	Norovirus	4	50	3
11	06/05/2025	17/05/2025	G ward	CPE	12	10	23
12	06/05/2025	19/05/2025	9A	Norovirus	13	46	20
13	06/05/2025	13/05/2025	CDU	Norovirus	2	0	15
14	05/05/2025	23/05/2025	10B	CPE	4	4	6
15	07/05/2025	21/05/2025	Bevan 2	COVID	0	0	6
16	07/05/2025	13/05/2025	5C	COVID	0	0	3
17	09/05/2025	13/05/2025	14A	Norovirus	4	1	2
18	11/05/2025	20/05/2025	11A	Norovirus	9	9	9
19	12/05/2025	20/05/2025	11B	Norovirus	8	15	8
20	14/05/2025	25/05/2025	14B	Norovirus	11	22	14
21	15/05/2025	27/05/2025	5A	COVID	0	0	2
22	23/05/2025	01/06/2025	2B	COVID	0	0	2
23	24/05/2025	01/06/2025	10A	Norovirus	8	30	10
24	28/05/2025	04/06/2025	G ward	COVID	7	0	6
25	01/06/2025	16/06/2025	SIU	COVID	15	0	9
26	03/06/2025	16/06/2025	7A	COVID	13	21	6
27	08/06/2025	13/06/2025	Ward 1	COVID	5	7	12
28	09/06/2025	17/06/2025	7B	COVID	8	14	12
29	23/06/2025	26/08/2025	5C	CDI	0	0	3
30	07/07/2025	28/07/2025	5A	VRE	0	0	4
31	07/07/2025	13/07/2025	11A	COVID	8	28	10
32	13/07/2025	27/07/2025	11B	COVID	14	7	8
33	17/07/2025	26/07/2025	G ward	COVID	9	0	3
34	28/07/2025	01/09/2025	2B	MRSA Non BSI	0	0	5
35	12/08/2025	17/08/2025	10A	COVID	2	0	2
36	18/08/2025	26/08/2025	5A	COVID	0	0	5
37	20/08/2025	26/08/2025	5D	COVID	0	0	3

No.	Outbreak started	Outbreak closed	Ward	Organism	Days ward closed	Beds Lost	Patients affected
38	01/09/2025	17/09/2025	5D	COVID	0	0	7
39	03/09/2025	16/09/2025	Bevan 2	COVID	0	0	6
40	11/09/2025	27/09/2025	2C	COVID	0	0	4
41	13/09/2025	30/09/2025	5B	COVID	0	0	16
42	14/09/2025	20/10/2025	1D	COVID	36	0	15
43	15/09/2025	27/09/2025	7B	COVID	6	0	3
44	21/09/2025	03/10/2025	Duffy	COVID	0	0	2
45	27/09/2025	13/10/2025	SIU	COVID	16	24	5
46	28/09/2025	08/10/2025	3 Alpha	COVID	0	0	2
47	30/09/2025	21/10/2025	Bevan 1	COVID	22	0	5
48	02/10/2025	06/10/2025	9B	Flu/COVID	4	1	6
49	02/10/2025	09/10/2025	11B	COVID	0	0	4
50	04/10/2025	14/10/2025	14A	Flu	10	3	10
51	05/10/2025	13/10/2025	7A	COVID	8	7	8
52	06/10/2025	13/10/2025	2A	COVID	0	0	7
53	07/10/2025	14/10/2025	Bevan 2	COVID	0	0	4
54	10/10/2025	14/10/2025	10A	Flu	4	2	6
55	14/10/2025	25/10/2025	7B	COVID	11	3	6
56	20/10/2025	01/11/2025	G ward	Flu	12	3	6
57	02/11/2025	06/11/2025	Ward 1	Flu	5	3	6
58	02/11/2025	09/11/2025	15A	Flu	7	0	4
59	09/11/2025	19/11/2025	9A	COVID	11	3	5
60	14/11/2025	20/11/2025	9B	COVID	7	0	2
61	25/11/2025	02/12/2025	Bevan 2	Flu	0	0	2
62	27/11/2025	12/12/2025	7B	Flu	15	10	3
63	27/11/2025	15/12/2025	7A	Flu/Covid/RSV	19	3	13
64	28/11/2025	08/12/2025	1C	COVID	2	0	2
65	05/12/2025	07/12/2025	Ward 1	COVID	2	0	2
66	05/12/2025	10/12/2025	10B	Flu/COVID	5	1	3
67	07/12/2025	15/12/2025	Bevan 2	Flu	7	5	3
68	08/12/2025	15/12/2025	1E	Flu	10	5	4
69	10/12/2025	28/01/2026	3C	CDI	0	0	2
70	10/12/2025	19/12/2025	5D	Flu	9	0	2
71	11/12/2025	24/12/2025	1A	Norovirus	13	108	27
72	16/12/2025	29/01/2026	5A	VRE	0	0	2
73	16/12/2025	30/12/2025	2D	Norovirus	14	50	16
74	18/12/2025	02/01/2026	5B	Norovirus	15	60	27
75	22/12/2025	27/12/2025	7B	Flu	5	0	2
76	22/12/2025	03/01/2026	5C	Flu	11	0	3

No.	Outbreak started	Outbreak closed	Ward	Organism	Days ward closed	Beds Lost	Patients affected
77	24/12/2025	29/12/2025	G Ward	Flu	5	1	2
78	29/12/2025	11/01/2026	7A	Flu	13	0	4
79	29/12/2025	02/01/2026	2C	Norovirus	3	27	7
80	30/12/2025	05/01/2026	2C	Flu	5	7	7
81	31/12/2025	11/01/2026	3C	Norovirus	11	34	23
82	01/01/2026	03/01/2026	1A	Norovirus	2	20	16
83	05/01/2026	12/01/2026	5A	Flu	0	0	4
84	08/01/2026	21/01/2026	9A	Flu/COVID	13	11	5
85	09/01/2025	22/01/2026	5B	Norovirus	13	81	37
86	12/01/2026	18/01/2026	1D	Norovirus	6	32	21
87	13/01/2026	22/01/2026	3D	COVID	0	0	2
88	14/01/2026	19/01/2026	2D	COVID	0	0	2
89	16/01/2026	05/02/2026	7A	Flu/COVID/RSV	20	8	21
90	16/01/2026	31/01/2026	7B	Flu	0	0	5
91	19/01/2026	05/02/2026	5A	Norovirus	17	22	25
92	20/01/2026	27/01/2026	2D	Flu	7	0	3
93	20/01/2026	04/02/2026	2D	Norovirus	15	30	18
94	22/01/2026	24/02/2026	2B	?Norovirus	2	5	20
95	22/01/2026	06/02/2026	10A	Flu/COVID	0	0	4
96	23/01/2026	27/01/2026	1A	RSV	4	0	3
97	25/01/2026	02/02/2026	10A	COVID/Flu	8	0	6
98	26/01/2026	02/02/2026	2D	COVID	7	0	6
99	27/01/2026	04/02/2026	14B	Flu	0	0	3
100	01/02/2026	14/02/2026	10B	Norovirus	13	21	17
101	01/02/2026	03/03/2026	9A	Norovirus	31	115	31
102	02/02/2026	10/02/2026	9B	Norovirus	7	39	16
103	06/02/2026	14/02/2026	15B	Norovirus	8	24	8
104	08/02/2026	10/02/2026	7B	COVID	2	1	2
105	05/02/2026	10/02/2026	Duffy	Flu	5	0	2
106	10/02/2026	17/02/2026	Duffy	Norovirus	7	29	13
107	11/02/2026	20/02/2026	Ward 1	Norovirus	9	28	5
108	11/02/2026	17/02/2026	9B	Norovirus	6	42	9
109	13/02/2026	03/03/2026	7B	Norovirus	18	29	30
110	17/02/2026	01/03/2026	5B	Norovirus	12	48	20
111	19/02/2026	22/02/2026	3E Gynae	Norovirus	3	0	1
112	21/02/2026	04/03/2026	Ward 1	Norovirus	11	8	12
113	22/02/2026	24/02/2026	CDU	Norovirus	2	4	4
114	22/02/2026	26/02/2026	9B	Norovirus	4	3	7

No.	Outbreak started	Outbreak closed	Ward	Organism	Days ward closed	Beds Lost	Patients affected
115	22/02/2026	03/03/2026	15A	Norovirus	9	7	16
116	22/02/2026	06/03/2026	14B	Norovirus	12	64	23
117	22/02/2026	14/03/2026	10A	Norovirus	20	20	22
118	23/02/2026	01/03/2026	2D	Norovirus	6	25	15
119	24/02/2026	08/04/2026	3B	VRE	43	0	2
120	25/02/2026	02/03/2026	G ward	Norovirus	5	3	7
121	26/02/2026	01/03/2026	14A	Norovirus	3	8	7
122	27/02/2026	02/03/2026	1A	Norovirus	3	6	10
123	07/03/2026	13/03/2026	SIU	Flu	6	0	4
124	15/03/2026	18/03/2026	14B	Norovirus	3	0	2
125	16/03/2026	31/03/2026	9B	Norovirus	15	93	25
126	20/03/2026	24/03/2026	Ward 1	Norovirus	4	9	3
127	24/03/2026	02/04/2026	SIU	Norovirus	9	34	5
128	02/03/2026	06/03/2026	3C	Norovirus	3	4	2
129	03/03/2026	15/03/2026	2D	Norovirus	11	66	16
				Total	975	1838	1149

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	29 July 2026
Agenda Item	**TB26/059**				
Report Title	Revised Trust Board Meeting Arrangements 2026/27				
Executive Lead	Simon Regan, Director of Corporate Services				
Presenting Officer	Anne-Marie Stretch, Deputy Chief Executive				
Action Required	X	**To Approve**		**To Note**	

Purpose

To advise Board members of the proposed amendments to the location of Trust Board meetings for 2026/27.

Executive Summary

This paper seeks approval for a revised schedule of Trust Board meetings for the remainder of 2026/27, introducing the rotation of meetings across MWL sites where operationally feasible. The proposal supports the Chairman's and Chief Executive's ambition to increase Board visibility, strengthen engagement with colleagues across the Trust, and reinforce organisational cohesion.

Venue assessments have identified Southport Hospital as suitable to host Board meetings, while Ormskirk Hospital is considered suitable subject to a formal site assessment and confirmation of governance, capacity and technology requirements.

Corporate Governance and operational support arrangements will remain unchanged and be coordinated through the Corporate Services Team.

Financial Implications

There may be some minor cost implications in relation to travel and subsistence associated with the change in venues. However, the potential benefits are considered to outweigh any potential cost increases.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the proposed rotation of Board meetings across Trust sites for the remainder of 2026/27.

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

REVISED SCHEDULE OF TRUST BOARD MEETINGS (2026/27)

1. Purpose

1.1. To seek the Board's endorsement of a proposal to hold Trust Board meetings across MWL sites, where operationally feasible, to enhance Board visibility, staff engagement, and organisational connectivity.

2. Background

2.1. Since the formation of Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), Trust Board meetings have traditionally been held on the Whiston Hospital site. Whilst this arrangement has provided consistency and administrative efficiency, it is considered that holding Board meetings on other MWL sites offers opportunities for Board members to engage directly with colleagues based at other Trust locations.

2.2. The Chairman and Chief Executive have requested that consideration be given to rotating the location of Trust Board meetings across sites where this can logistically be achieved.

3. Rotation of Board Meetings

3.1. Initial assessments have been made in relation to the suitability of venues to hold Board meetings. From the initial review:

- Southport Hospital is able to support a Board meeting in the Corporate Management Office (CMO), which historically supported Southport and Ormskirk NHS Trust Board meetings. This includes the operational requirements, such as IT facilities and provision of refreshments.
- Initial assessments indicate that Ormskirk Hospital can accommodate a Board meeting within either the Hilldale Building or Clinical Education Centre. However, a formal site visit will be undertaken in August 2026 to confirm suitability.
- St Helens Hospital does not have a suitable venue to host a Board meeting currently.
- Newton Community Hospital does not have a suitable venue to host a Board meeting currently.

3.2. Subject to operational requirements and venue suitability, it is proposed that Board meetings rotate across Trust sites according to the schedule below.

Board Meeting	Current Location	Proposed Location
August 2026	No Board Meeting	N/A
September 2026	Whiston Hospital	Southport Hospital
October 2026	Whiston Hospital	Ormskirk Hospital*
November 2026	Whiston Hospital	No change
December 2026	No Board Meeting	N/A
January 2027	Whiston Hospital	Southport Hospital
February 2027	Whiston Hospital	Ormskirk Hospital*
March 2027	Whiston Hospital	No change

**Subject to validation and vetting of the proposed Board meeting venue to ensure it is suitable for Board attendance requirements including capacity, technology and governance arrangements.*

4. Trust Board meeting arrangements and workplan

4.1. Administrative support will continue to be coordinated through the Corporate Services Team, who will work alongside operational leads at the relevant sites to ensure appropriate logistical access and support arrangements are in place.

4.2. No other changes are proposed in relation to meeting arrangements or the approved workplan for the Board of Directors.

5. Arrangements for 2027/28

5.1. The Trust Board meeting arrangements for 2027/28 will be considered in November 2026 in line with the usual Trust Board workplan.

6. Recommendations

6.1. It is recommended that that the Board of Directors:

I. Approve the proposed rotation of Board meetings across Trust sites for the remainder of 2026/27.