Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 27 November 2024
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (November 2024)** *Purpose: To **note** the Employee of the Month presentations for November 2024*	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.	**TB24/080 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 30 October 2024*	Report	
	6.	**TB24/081 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.	**TB24/082 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	L Barnes L Neary M Szpakowska G Lawrence *(30 mins)*

Committee Assurance Reports				
11.10	8.	**TB24/083 Committee Assurance Reports** 8.1. Executive Committee 8.2. Charitable Funds Committee 8.3. Quality Committee 8.4. Strategic People Committee 8.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	A Marr S Connor obo H Scott G Brown L Knight S Connor *(40 mins)*
Other Board Reports				
11.50	9.	**TB24/084 2024/25 Trust Objectives Mid-Year Review** *Purpose: To **note** the 2024/25 Trust Objectives Mid-Year Review*	Report	A Marr *(20 mins)*
12.10	10.	**TB24/085 Digital Strategy Update** *Purpose: To **note** the Informatics Report and Strategy Update*	Report	M Gandy *(15 mins)*
12.25	11.	**TB24/086 Research and Development Capability Statement** *Purpose: To **approve** the MWL Research and Capability Statement*	Report	P Williams *(10 mins)*
12.35	12.	**TB24/087 Biennial Review of NHS Constitution** *Purpose: To **note** the Biennial Review of the NHS Constitution*	Report	N Bunce *(10 mins)*
12.45	13.	**TB24/088 Trust Board Meeting Arrangements** *Purpose: To **approve** the Trust Board Meeting Arrangements for 2025/26*	Report	N Bunce *(10 mins)*
Concluding Business				
12.55	14.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.00	15.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*

		Date and time of next meeting: Wednesday 29 January 2024 at 09:30		**13.15 close**
30 minutes lunch break				

Chair: Richard Fraser

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**	27 November 2024
Agenda Item	**TB24/000**		
Report Title	Patient Story		
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance.		
Presenting Officer	Yvonne Mahambrey; Quality Matron Patient Experience Helen Morear; Inpatient Smokefree Service Lead		

Action Required		**To Approve**	X	**To Note**

Purpose

To provide an overview of feedback shared by a patient who received help and support from the smoke free service to stop smoking whilst in Hospital on the Intensive Care Unit (ICU).

Executive Summary

The NHS Long Term Plan (LTP) has set out a commitment for the NHS to deliver NHS funded tobacco dependence treatment services across inpatient, maternity and outpatient/community settings. These services are intended to increase the numbers of people engaging in tobacco dependence treatment and to reduce the total number of smokers in the general population. To assist with this goal all inpatients should be screened for their smoking status on admission into hospital. When a patient is screened as a current smoker, they will be visited by a Tobacco Dependency Advisor (TDA) within 24 hours. The patient can then choose to 'opt out' of the service if they so wish.

The story below highlights how intervention can provide a teachable moment for patients whilst in hospital and help them to stop smoking regardless of the amount of time they have been a smoker. It also highlights the importance to screen patients for smoking status in a timely manner at the beginning of their journey.

A patient experience.
Eileen is 79 years old and has smoked for 64 years. Eileen described the reason she smoked was to help relieve stress. Eilleen smoked 20 cigarettes a day and has previously tried to give up twice but has always reverted to smoking.

Eileen was admitted into Whiston Hospital in July onto critical care due to pneumonia, she was extremely poorly. On transfer to an in-patient ward Eileen was screened for her smoking status, visited by the Tobacco dependency advisor (TDA) offered support to stop and accepted. During these health promotion conversations, Eileen was counselled about her smoking behaviour and provided with information about what chemicals were in cigarettes, a conversation that nobody had ever had with Eileen before. Working with her to devise a plan of personalised Nicotine Replacement Therapy (NRT) can help her to stop permanently.

A referral was also sent to her local stop smoking service (St Helen's Wellbeing) who would continue her NRT and behavioural support for a further 12 weeks. Eileen thought this was wonderful how everything was taken care of for her and how the two services worked together. Although Eileen had been really frightened during her admission and had already decided that she was going to stop smoking, however the Tobacco dependency team had given her the confidence, management plan and support she needed to see it through.

When Eileen was discharged from hospital, the St Helen's Wellbeing service contacted Eileen immediately after she was discharged. Eileen expressed how lovely and supportive the telephone

calls she received were and how efficient the service was. Her NRT continued and Eilleen noticed she was using her Nicorette Inhalator less as the weeks went by.

Since stopping smoking, Eileen has felt so much better and noticed her breathing has improved significantly. Eileen was shown a previous chest x-ray by her doctor in comparison to a more recent one since she stopped smoking. Eileen was astonished when these changes were explained to her by a doctor in addition to the improvements in Eileen's health, she had also noticed the impact of quitting smoking had on her finances, Eileen managed to save £250 in just over one month.

Lessons Learned:

- The health and financial benefits for someone who stops smoking are huge.
- Accessibility to the smoke free service is beneficial to all patients regardless of age and length of time the patient has smoked.
- Over 1,700 patients have been offered the service since it was launched in April 2024, 60% of those patients visited have engaged with the service, with 40% stopping completely 28-days after leaving hospital meaning they are five times more likely to stay smokefree for good.
- There is a cohort of patients admitted and discharged over the same weekend that are not visited by the team - a "sorry we missed you" letter has been devised to signpost to community teams.

Next Steps:

- The smoke free team have been invited to present at the Trust Patient Participation Group in December.
- The service will start looking at different ways to improve screening. We are currently piloting a process to improve screening of inpatients who have had a decision to be admitted into hospital from the Emergency Department.

Financial Implications
None as a direct result of this paper.
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
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 30 October 2024
(Approved at Trust Board on Wednesday 27 November 2024)

Name	Initials	Title
Richard Fraser	RF	Chair
Gill Brown	GB	Non-Executive Director & Deputy Chair
Ann Marr	AM	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Lynne Barnes	LB	Acting Director of Nursing, Midwifery & Governance
Nicola Bunce	NB	Director of Corporate Services
Ian Clayton	IC	Non-Executive Director (via MS Teams)
Steve Connor	SC	Non-Executive Director
Rob Cooper	RC	Managing Director
Malcolm Gandy	MG	Director of Informatics
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	Non-Executive Director
Carole Spencer	CS	Non-Executive Director
Rani Thind	RT	Associate Non-Executive Director
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Dr Marion Ashe	MA	Senior Anaesthetic Trainee (Observer) (via MS Teams)
Angela Ball	AB	Halton Council Representative (Stakeholder Representative) (via MS Teams)
Dr Awais Rauf	AR	Ophthalmologist (Observer) (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Sue Redfern	SR	Director of Nursing, Midwifery and Governance
Malise Szpakowska	MS	Acting Director of Human Resources

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for October 2024 was Julie Woosey, Bereavement Officer, Clinical Support and Community Services Division and the Board watched the film of PW reading the citation and presenting the award to Julie

	RESOLVED: The Board **noted** Employee of the Month for October 2024 and congratulated the winner.
2.	**Chair's Welcome and Note of Apologies**
	2.1. RF welcomed all to the meeting including AB, MA and RA who were attending the meeting as observers. 2.2. RF noted the apologies of MS and SR. 2.3. RF acknowledged the following awards and recognition that the Trust had recently received: 2.3.1. Angie Westwood, Matron for Critical Care Outreach, Pain Team & Cardiac Rehabilitation, received the Cavell Star for her dedication, commitment and support to staff. 2.3.2. Anne Potter, HR Business Partner for Lead Employer won a KPMG Star Award at the HPMA Excellence in People Awards. 2.3.3. Rebecca Crooke, Digital Midwife, Ormskirk Hospital and Christine Rhall, Macmillan Acute Oncology Lead Nurse, St Helens Hospital recently completed a prestigious 18-month Leadership Scholarship with the Florence Nightingale Foundation. 2.3.4. MWL had supported the development of a Clinical Skills Hub at Southport College, which will create a new learning environment for students. 2.3.5. Over £1,700 was raised for MWL's NHS Charity by a group of staff who took part in abseiling off Liverpool Cathedral. 2.3.6. LB recently completed a five kilometre memory walk with her niece to raise funds for the Alzheimer's Society Apologies for absence were **noted** as detailed above
3.	**Declaration of Interests**
	3.1. There were no declarations of interests in relation to the agenda items.
4.	**TB24/069 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 25 September 2024 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 25 September 2024
5.	**TB24/070 Matters Arising and Action Log**
	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 confirmed as closed: 5.2.1. Agenda Ref 12 (MWL TB24/010 Learning from Deaths Annual Report) – the annual report was presented under Agenda Item TB24/064 at the meeting held on 28 September. **Action closed.** 5.2.2. Agenda Ref 7 (TB24/051 Executive Committee Assurance Report, Quality Ward Rounds) – LB had circulated further information and guidance about the new MWL Quality Ward Rounds process to Board members. **Action closed.** 5.2.3. Agenda Ref 8 (TB24/052 Integrated Performance Report) - LN circulated the presentation to Board members. **Action closed** **RESOLVED:** The Board **approved** the action log.
Performance Reports	
6.	**TB24/071 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for September 2024 was presented.
6.1.	**Quality Indicators**
	6.1.1. LB and PW presented the Quality Indicators. 6.1.2. LB highlighted the following: 6.1.2.1. The inpatient Family and Friends Test (FFT) recommendation rate in September 2024 was 94.7% (94.8% YTD) against a target of 90.0% despite some lower recommendation rates from the maternity areas. The Trust continued to benchmark well with peers. 6.1.2.2. The Nurse fill rate was 97.0% against a target of 90.0% and LB advised that the work to align the way in which the two legacy organisations reported the nurse fill rates had now been aligned. 6.1.2.3. The 2024/25 thresholds for Clostridioides difficile (C.diff) (no more than 113 cases) and Escherichia coli (E.coli) (no more than 171 cases) were received from NHSE and year to date (YTD), the Trust was within the tolerance levels. Work continued on all elements around infection, prevention and control (IPC) and this formed a big part of the ward accreditation work. One case of Meticillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) had been reported in month on the maternity unit and LB reported that no lapses in care had been identified when this was investigated. 6.1.2.4. There had been an increase, in the number of pressure ulcers compared to recent months, and this would be closely monitored. 6.1.2.5. Falls remained within the normal variation, and it was noted that the numbers were starting to align between the legacy organisations. LB reported that work had been undertaken to review the impact of supplementary care on falls. Additionally, the Trust was working with NHSE on the development of the enhanced therapeutic observation of

	care. LB reported that bay nursing was being implemented, so both qualified and unqualified staff would be based in the bay. 6.1.2.6. There had been no still births, neonatal deaths or never events reported in September 2024. 6.1.2.7. The number of complaints responded to within 60 days in September was 55.8% against a target of 80%, with work ongoing to reduce the backlog. LB reported that more complaints had been closed during September 2024 than any month in 2024/25. Additionally, there were less open or overdue complaints and less new complaints had been received in month. LB noted that there had been an increase in the number of complaints received during the summer months, and a backlog from the Patient Advise and Liaison Service (PALS) concerns on one of the MWL sites but recovery actions were now in place. 6.1.3. PW noted the following: 6.1.3.1. The Trust had received the Hospital Standardised Mortality Ratio (HSMR) data up to March 2024. The final 2023/24 HSMR remained low at 92.7 with both sites below 100 (legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) sites at 90.7 and legacy Southport and Ormskirk Hospital NHS Trust (S&O) sites at 97.5). PW reminded the meeting about the work undertaken to gain a better understanding of why the HSMR was potentially inaccurate for legacy S&O due to coding issues and PW assured that these had now been rectified. Work was ongoing with the Mortality Outcomes Group and specific diagnosis groups were being reviewed to ensure that there were no red flags that required further investigation. 6.1.3.2. The Summary Hospital-level Mortality Indicator - Deaths associated with hospitalisation (SHMI) remained unchanged at 1.06 and was within normal levels.
6.2.	**Operational Indicators**
	6.2.1. LN presented the operational indicators and highlighted the following: 6.2.1.1. Urgent and Emergency Care performance remained pressured. 6.2.1.2. The 4-hour performance (mapped) in September was 79.4% against a target of 78%, national performance was 74.2% and Cheshire and Merseyside (C&M) performance was 72.9%. Bed occupancy remained high and there were long waits for admission in the Emergency Departments as well as increased ambulance handover times. 6.2.1.3. Bed occupancy across all sites was 105.4% in September (133 additional patients) and patient flow had been further impacted by several IPC challenges on the wards. 6.2.1.4. There had been a reduction in the proportion of Non-Criteria to Reside (NCTR) patients from 22% in August to 19.1% in September. 6.2.1.5. There was a continued focus on the Urgent and Emergency Care (UEC) Recovery Programme and LN advised that the Trust had been identified as one that required additional support for winter which would be provided by the Emergency Care Improvement Support Team (ECIST) as part of a 12-week programme. The programme had been running for four weeks

	and there was some good work taking place which included a focus on pre-admission processes and 'call before convey'. Additionally, there was work on the criteria to admit ensuring that the right patients were admitted, and this included the use of a national tool. Members of the Executive team were attending Board rounds to provide support to the staff and LN advised that several inconsistencies across the wards had been identified. Work on bed modelling was also part of the programme to establish if the Trust had sufficient beds to meet demand.
	6.2.1.6. For Elective Care LN advised that there were 144 65+week waiters (against a target of zero) at the end of September 2024 (third highest across C&M), which was mainly due to Plastics and LN reminded the meeting that the Trust was the regional centre for Plastics and the next nearest provider was Royal Stoke University Hospital. Royal Preston Hospital had recently opened a Plastics centre, and the Trust had discussed mutual aid, however, this had not been as forthcoming as anticipated. There also remained some long waits for vascular surgery that were delivered via a Service Level Agreement (SLA) with Liverpool University Hospitals NHS Foundation Trust.
	6.2.2. LN advised that AR had submitted the following question *'I would want to ask the Board what steps the Board is taking to reduce Ophthalmology wait lists?'* LN thanked AR for submitting the question and that Ophthalmology had been identified as a fragile service at Southport Hospital and this was one of the first services that had been amalgamated when MWL was formed and over the preceding 12 months there had been a focus on stabilising the workforce. There had been a number of vacancies at Southport Hospital, however, this had now been reduced. The Trust compared favourably from a long waits perspective and LN noted that there were only three patients who were waiting over 60 weeks for a corneal graft, and this was due to waiting for the delivery of the tissue. There was a focus on the follow-up patients and work was ongoing on the risk stratification of patients to ensure that those patients who were clinically more in need were being seen sooner. Patient initiated follow up was being introduced for suitable patients. A Paediatric Strategy for Ophthalmology was being developed and capacity being reviewed, with training of Advanced Clinical Practitioners (ACP). LN also summarised the estates development at Ormskirk Hospital and advised that there were plans for Ophthalmology to move into new accommodation. This would provide the Trust with an opportunity to expand the service to offer Age-related macular degeneration (AMD) and to be able to treat patients closer to home. LN noted that this would have a positive impact on service capacity across all MWL sites.
	6.2.3. RF thanked LN for her response and suggested that if AR required any further information regarding the Ophthalmology waiting times and plans for improvement, he contact JW to arrange a meeting with LN.
	6.2.4. GB commented on the reliance of the Trust on external partners for the discharge of NCTR patients and asked if there were any further actions the

	Trust could take. LN reported that the system partners had been attending the Executive led board rounds over the preceding two weeks, where NCRT patients were discussed. The UEC Improvement Recovery Programme, which was being led by PLACE, included three workstreams; admission avoidance, acute length of stay and discharge. Although there was currently a lot of focus on the discharge workstream, the capacity challenges remained and MWL continued to have similar levels of NCTR patients as similar trusts in C&M. However, for MWL who worked with different PLACES, each with different social work assessment criteria there were often inconsistencies in approach from the different Local Authorities. 6.2.5. LB advised that one of the benefits of the supplementary care work being undertaken was to maintain a patient's independence and prevent deconditioning. This may decrease the number of patients waiting for discharge to nursing homes or for packages of care. 6.2.6. CS asked if there was any significant variances in the attitudes of clinicians about a patient being ready for discharge between the different teams and wards during board rounds and, if this was observed, what action would be taken. PW responded that there were differences between specialties depending on the patient complexities, however, he had not observed any significant differences in attitude. PW had observed a difference in attitude amongst patients and relatives, with some who preferred to be discharged, while others felt safer remaining in hospital, even if this was not needed clinically. The teams had to work with patients and relatives to make them aware of the alternatives that would be more beneficial to the patient with specialist care and rehabilitation. LN commented that the multidisciplinary team (MDT) approach to board rounds with representatives from different organisations was beneficial as this allowed an opportunity for the different options for a patient's discharge to be considered. 6.2.7. RF commented that undertaking quality ward rounds was one of the favourite aspects of his role as a NED as it offered the opportunity to talk to patients, relatives and staff. *(AR left the meeting)*
6.3.	**Workforce Indicators**
	6.3.1. AMS, obo MS, presented the Workforce Indicators and highlighted the following: 6.3.1.1. The compliance rate for mandatory training was above the target of 85% at 88.8% and AMS advised that mandatory training was reviewed for each division on a monthly basis at Executive Committee to ensure compliance. Additionally, AMS advised that a wider review of mandatory training was being undertaken to ensure that the correct training for each role was identified and this was standardised across MWL. 6.3.1.2. The compliance rate for appraisals was 86.9% against a target of 85% and AMS noted that the appraisal window for 2024/25 had closed on 30

	September 2024, however, any outstanding appraisals would continue to be undertaken to ensure all staff had an annual appraisal with their manager. 6.3.1.3. September sickness absence was 5.68% against a target of 5% and this was similar to August 2024. AMS noted that this figure was slightly lower than the same period in 2023/24. The Task and Finish Group continued to explore the reasons for the higher Health Care Assistants (HCA) sickness and a report would be presented at a future Strategic People Committee (SPC). AMS advised that sickness management was overseen by managers, and it was important to ensure they felt supported to have the return-to-work conversations with staff. Training was ongoing and the conversations were audited to ensure that they were taking place between managers and staff. Additionally, bi-weekly reviews of long-term sickness cases were taking place between Health, Work and Well Being (HWWB) and HR. There was a particular focus on Musculoskeletal health (MSK) as this was the second highest reason for sickness absence. The provision of physiotherapy for staff was also being explored. 6.3.2. RT asked if risk assessments were undertaken in relation to MSK injuries. AMS responded that risk assessments were undertaken for all areas of work and if HWWB identified any trends in a particular area they would respond to that reactively. There were also various interventions in place to try and prevent staff from injuring themselves and this included completing the Moving and Handling mandatory training. Additionally, staff had access to call a 24-hour online Employee Assistance Programme who would undertake an initial assessment and, if appropriate, provide the individual with some exercises or signpost them to additional resources if required. AMS commented that risk assessments, from a HWWB perspective, was at the core of everything and if an injury resulted in a claim one of the first questions asked was whether a risk assessment had been completed.
6.4.	**Financial Indicators**
	6.4.1. GL presented the Financial Indicators and highlighted the following: 6.4.1.1. The final approved MWL financial plan for 2024/25 was a deficit of £26.7m which assumed: • Payment of £12m funds in line with the transaction business case • A Cost Improvement Programme (CIP) target of £48m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 activity plan including the step change in the elective recovery in activity following the completion of the new theatres at Whiston Hospital and the continued productivity gains 6.4.1.2. £250m additional deficit funding had been allocated to C&M to enable the system to deliver a breakeven plan and this had been allocated to all organisations based on the size of the deficit. MWL had received £15.8m additional funding which reduced the planned deficit for 2024/25 to £10.9m. This would be the new plan by which the Integrated Care Board (ICB) and NSHE would monitor for the rest of the year.

	6.4.1.3. At month 6 the Trust had reported a deficit of £10.3m. 6.4.1.4. The cash balance at month 6 was £3.7m 6.4.1.5. GL reported that the Trust had achieved £34.4m of the CIP target and this included £29.6m recurrent CIP. This differed to the reported position in the IPR following an update after papers were issued. 6.4.1.6. The YTD position was £2.9m better than the revised plan and this was as a result of the Trust receiving £4m transaction funding earlier than expected as well as £1m Industrial Action funding. GL noted that there was still a gap of circa £1m for industrial action funding. 6.4.1.7. The Trust continued to forecast the full delivery of the Capital Programme. 6.4.2. GL noted that the Trust continued to forecast delivery of the revised deficit plan of £10.9m, however, there were several risks to this, including delivery of elective activity for the second half of the financial year, and this was being closely monitored. Additionally, the resolution of the remaining adjustment for the cost of industrial action, and additional pressures as a result of the level of pay award funding allocation were also risks. 6.4.3. AM asked GL to explain how the Trust would go from reporting a £10.3m deficit currently to achieving a £10.9m deficit at the end of the financial year. GL responded that this was because income and expenditure had been profiled throughout the year, and this had assumed the full £12m transaction support would be received in month 12. As the Trust had already received £4m of the transaction funding in month 6, the organisation was currently above plan. GL noted that the year-to-date position would now deteriorate until the remaining transaction funding was received. AM asked why this funding had not been profiled over 12 months and the real financial position reported. GL responded that the ICB had stipulated that funding be reported in the month received. 6.4.4. LB commented on the incredible work being done by the divisions and corporate services to deliver the CIP targets. RF agreed with LB and commented that the divisions were not just looking at cost improvements but also ways to improve things for patients and staff. GL commented that CIP schemes for 2025/26 had already been reviewed at the recent Finance and Performance Committee to identify pipeline opportunities. 6.4.5. GB asked about the possible impact on employer's national insurance contributions following the budget. GL responded that his understanding was that this would be centrally funded, and the impact would be between 1 and 2% increase to the pay bill. 6.4.6. RF reflected on his recent discussions with volunteers at Whiston Hospital reception, where three generations of the same family gave up their time to support the Trust. These volunteers had asked for additional wheelchairs. NB reflected that 50 had been purchased at the end of the last financial year and the portering staff undertook daily rounds to collect wheelchairs from the wards and car parks.

	RESOLVED: The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB24/072 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. AM presented the Executive Committee Assurance report from the meetings held in September 2024 and noted that any bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The Committee also reviewed the decisions made by the weekly vacancy control panel at every meeting. 7.1.2. AM highlighted the following: 7.1.2.1. The Committee received a PLACE Partnership update which included an update on the Urgent and Emergency Care (UEC) Improvement Recovery Programme which was coterminous with the Trust's catchment area. However, the ICB was now reviewing its operating module. AM anticipated that there would be consolidation to reduce the number of PLACES. AM commented that from a patient flow perspective, Warrington and Halton Hospitals NHS Foundation Trust (WHH) belonged in Merseyside, and not Cheshire. 7.1.2.2. AM felt that the delivery and pace of the UEC Improvement Recovery Programme was not fast enough, and the main area of concern remained NCTR patients and, whilst there was some good work taking place, it was not making enough of an impact on the high number of NCTR patients in the Trust. LN commented that the target for C&M was to reduce NCTR patients to below 15% (the equivalent of two wards for MWL), however for many C&M trusts, including MWL it remained significantly above 15%. LN noted that she and the Director of Integration had now set PLACE a trajectory to achieve 15% with a stretch target of 10%, and this was being closely monitored. 7.1.2.3. GB reflected on the difficulty of discharging patients appropriately and the disappointing impact of the UEC Improvement Recovery Programme. RC agreed and reflected that the role of the PLACE Director and the Senior Responsible Owner (SRO) had been to lead the programme and bring the system together to improve patient flow, however, there had been marginal improvement in some areas and a deterioration in others. It was noted that the UEC Improvement Recovery Programme had been launched in April and confidence in a significant impact in winter 2024/25 was now extremely low. 7.1.2.4. AM reported that in a recent meeting the main focus of the lead Director of Social Services had been to contest the numbers, rather than look at overall trends and develop solutions. The recent attendance of the lead Director and SRO, with a different Director of Social Services had not provided any further assurance.

	7.1.2.5. RC commented that when the St Helens Director of Adult Social Services had attended a recent Executive led board round, the movement of patients had been significant and had resulted in 11 discharges from one ward that had not had any identified discharges at the start of the board round. RC noted that if Social Services from all boroughs were involved in the discharge planning this did result in significant increases. RC added that there was a need to constantly challenge the normalisation of delays, with each borough. GB questioned if the Local Authorities (LA) had the right people in place to be able to move things along. RC responded that the Director of Adult Social Services for St Helens believed that patients discharged earlier would reduce the cost of long-term care for the LA. Currently the average time to arrange for discharge was two to three days after a patient had been deemed medically fit for discharge for one borough, whilst for another it was eight to ten days, and in this time a patient could become deconditioned and their discharge needs change. 7.1.2.6. AMS asked if decisions taken at board rounds were monitored to ensure they took place. LN responded that the board rounds were capturing decisions taken via the ECIST discharge tool. 7.1.2.7. AB commented that, as far as she was aware, Halton had funded several posts to assist with discharges and she was not aware that delays were an issue. AB requested additional information so she could follow up with council officers. RC agreed to provide this information and thanked AB for agreeing to look into this and noted that the Halton delays were disproportionate to the amount of activity. Additionally, RC advised that it was possible that the posts that AB referred to were working more with WHH rather than MWL. 7.1.3. RT commented that there would be a cohort of patients who were waiting for tests before discharge and asked if there had been any exploration of other ways to manage their care including returning to hospital as an outpatient for any additional tests required. RT also asked if there was any evidence on the deconditioning of a patient whilst waiting for the additional tests. LN responded that this had been raised as part of the board rounds that she attended and noted that a morning huddle which included discharge coordinators as well as representatives from radiology and pharmacy had been setup to minimise delays for patients who could be discharged or could be discharged home to reattend for further tests. LN commented that the tool that ECIST has shared might provide data to help understand the impact of such delays. 7.1.4. RF reflected that the core element of the issue appeared to be that there had been a lack of investment in social and community services, who did not have capacity or funding to respond to the level of demand. AM agreed that the aging population meant there was an increase in the number of people requiring social care assistance and LA funding had not kept pace with this demand. RF asked if the funding received by the LA was ringfenced for social care and took account of health inequalities and social deprivation. AM agreed that it would be useful for the Board to have a

	greater understanding of LA finance and statutory obligations and would explore this with the Executive Committee to inform a future discussion at Board. 7.1.5. AM continued with the report and advised that: 7.1.5.1. The Committee received the 2023 National Inpatient Survey report and advised that there was a concern that the perception of inpatients was impacted by the long waits and corridor care in the Emergency Department (ED) before being admitted to a ward. 7.1.5.2. Norovirus had been detected on the stroke unit at Whiston Hospital and stroke patients were cared for in other areas. Additionally, mutual aid had been requested from other local stroke units in case diverts had been required for new stroke patients, whilst the outbreak was managed. 7.1.5.3. The Committee had received an update on the plans to create three Pathology Hubs across C&M. 7.1.5.4. The C&M Laboratory Information Managements System (LIMS) contract had been signed. 7.1.6. The Committee had approved the appointment of temporary Acute Paediatric Consultant to support the eating disorders service and noted that this would be refunded to the Trust by Mersey Care NHS Foundation Trust. The remainder of the report was **noted.**
7.2.	**Audit Committee**
	7.2.1. SC, on behalf of IC, presented the assurance report following the Audit Committee that had been held on 16 October 2024 and advised that the Committee had received an update on the approval process and sign-off of the Trust's Annual Report and Accounts for 2023/24. SC reported that the Trust's external Auditors, Grant Thornton (GT) confirmed that an unqualified opinion had been issued and that the normal audit cycle would resume for 2024/25. 7.2.2. SC highlighted the following: 7.2.2.1. The Committee had received an update on the new Engagement Lead (EL) for GT as the current EL was time barred as he had been part of the external audit team for several years. It was noted that the current Audit manager and Audit team would probably remain in place to ensure continuity. 7.2.2.2. GT would hold a briefing session following the 2023/24 audit and the audit plan for 2024/25 would be issued in March 2025. 7.2.2.3. MIAA had issued four audit reviews during the period April to September 2024 and substantial assurance had been received for Mandatory Training, IT Housekeeping and Data Security and Protection Toolkit (DSPT). The Board reporting review had received high assurance. 7.2.2.4. The Committee had received the MWL Audit Log, which listed all the recommendations from previous Internal audits and provided assurance

	that the agreed management actions had been implemented in the planned timescales. 7.2.2.5. The Committee received the Anti-Fraud Progress Report and discussed the Conflict of Interest completion rate (50% against a target of 80%). 7.2.2.6. The Committee received the reports relating to Losses and Special Payments, Aged Debt and Tenders and Quotation Waivers and no issues were raised. 7.2.3. SC advised that the Committee considered that the Conflict of Interest declaration completion should be brought to the attention of the Board, although it had been recognised that a significant amount of work had already been undertaken to harmonise the Standards of Business Conduct Policy, making reporting easier and reminding relevant staff of the need to record any conflicts of interest (including nil returns). The Committee had asked if there was anything else that could be done to improve the declaration rate. 7.2.4. RF asked if there were any suggestions on actions that could be taken to improve the return rate. NB responded that the compliance rate was now 52% and following approval of the Standards of Business Conduct Policy by the Audit Committee in July 2024, reminders had been sent to relevant staff (budget holders and decision makers). The compliance rate for budget holders was at 72%. NB advised that all staff who had an outstanding return had been contacted again and the Lead Director would be advised of any outstanding returns for their areas of responsibility. PW would discuss the Conflict of Interests at the Clinical Leadership Team meeting to raise awareness, and a communication would be sent to all Clinical Directors explaining the importance of the completing a return. Additionally, there would be a reminder included within all appraisals and this would be discussed with the Medical Revalidation Team in respect of medical appraisals. 7.2.5. NB confirmed that the Board was fully compliant, and the Register of Interest for Board members published. AM requested that this was noted by the Audit Committee so that the minutes were clear. 7.2.6. RF asked if there was a trajectory in place to achieve the target of 80%. NB responded that the policy was in place to protect the individual staff member and needed to be built into the culture that staff were aware of their responsibilities as a custodian of NHS resources. NB added that she was not aware of any Trust that had achieved the 80% target and noted that this was a target that had been set by the Anti-Fraud team. GL commented that educating staff of the importance of completing a declaration was important as regular reminders were sent and instructions of how to complete the declaration via the Electronic Staff Record (ESR) were provided. Going forward an additional reminder could be linked to issuing budgets at the start of the financial year.

	7.2.7. AMS commented that for the majority of staff the declaration would be a nil return and that it was important to explain why these still needed to be completed. LK asked if the completion of declarations could be linked to the appraisals and NB responded that this was being investigated. 7.2.8. SC commented that the education piece of work would be important going forward. SC advised that the reason for escalating the Conflict of Interest return rate to the Board was to create a broader awareness of the issue. The remainder of the report was **noted.**
7.3.	**Quality Committee**
	7.3.1. GB presented the Quality Committee Assurance Report for the meeting held on 22 October 2024 and highlighted the following: 7.3.1.1. The Committee received the quarterly review of the 2024/25 Trust objectives aligned to the Quality Committee and partial assurance in all areas was noted. 7.3.1.2. The Committee received the provisional Trust results from the Maternity Patient Survey 2024, and it was noted that a full report would be presented once the national results had been published. 7.3.1.3. The Committee approved the Terms of Reference (ToR) for the Clinical Effectiveness, Clinical Engagement and Patient Safety Councils. <u>Clinical Effectiveness Council</u> 7.3.1.4. The Committee reviewed the bi-monthly Clinical Effectiveness Council (CEC) assurance report. 7.3.1.5. Work had continued on the harmonisation of policies and a number of new Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) clinical policies had been approved. GB noted that there were currently 24 outstanding policies aligned to CEC. 7.3.1.6. Resuscitation Services had carried out focused work on the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy and there had been positive audit outcomes reported. Additionally, the MWL wide Deteriorating Patient project had made good progress in supporting the early identification of deteriorating patients. 7.3.1.7. The Research, Development and Innovation (RDI) Annual Report had been presented at CEC and GB highlighted that new research hubs had been opened at Whiston Hospital as well as Marshalls Cross GP Practice. There was also increased collaboration with Liverpool and Edge Hill Universities. 7.3.1.8. There had been a slight increase in mortality in Orthopaedic emergency surgery and the Learning from Deaths team were reviewing the information to identify any rapid access actions for sharing. 7.3.1.9. CEC had received the Stroke Service performance report . <u>Care Quality Commission (CQC) Quarterly Report</u> 7.3.1.10. The Committee had been informed that the draft CQC report following the inspection of the Emergency Department at Whiston Hospital in March

	2024 had been received for factual accuracy checking and the final agreed report and any actions being taken by the Trust in response would be presented at a future meeting. 7.3.1.11. The Committee had received positive feedback from staff regarding the Ward Accreditation Programme and wards were taking responsibility and accountability for making improvements. GB congratulated the 4 Star accredited awards across the Trust and noted the new structure of the Quality Ward Rounds (QWR) linked to the ward accreditation scheme which were also a positive step. <u>Patient Safety Council Report</u> 7.3.1.12. The Committee had reviewed the report and noted that a deep dive into Hospital Acquired Pressure Ulcers (HAPU) had been undertaken and several lapses in recording had been identified, however, improvement work was taking place with specific targeted work in the Emergency Departments (ED). 7.3.1.13. There was also specific targeted work taking place in the ED in relation to falls. 7.3.1.14. There had been one neonatal death reported. The baby had died at another Trust, but the mother had received care at MWL. An initial investigation has identified no actions that would have changed the outcome but there was learning in relation to supporting women to have their first trimester screening within the advised timescales to identify any foetal abnormalities. <u>Maternity and Neonatal Services Report – Quarter 2 2024/25</u> 7.3.1.15. The Committee had reviewed the report, and it was noted that the Trust was on track to deliver on all the 2024 Maternity Incentive Scheme (MIS) Safety Actions, however, GB advised that there were several actions that required additional evidence and work to meet the deadlines. 7.3.1.16. Safety Action 3 (Transitional Care), Whiston site - LB advised that this related to keeping mothers and babies together and noted that the Trust did not have a dedicated transitional unit at either the Whiston or Ormskirk Maternity units. Mothers and babies were kept on the maternity unit and babies would receive any additional support required, for example oxygen therapy. LB noted that there were two different nursing models currently in place at the two maternity units mainly because the maternity unit at Whiston was a bigger centre. It was noted that this had been discussed at a recent Operating Delivery Network (ODN) meeting and that following this meeting, LB had reviewed the staffing model to ensure it was suitable based on the activity and acuity of the babies being cared for. At Ormskirk the neonatal service identified a member of their team to outreach into the maternity unit to deliver any specialist care to the baby, whilst Whiston was sufficiently large to have dedicated Maternity Support Workers (MSW). This would be reported back to the Neonatal ODN who were part of the check and challenge for the Clinical Negligence Scheme for Trusts (CNST) to assure them that the current staffing models were suitable.

	7.3.1.17. Safety Action 8 (Training) – GB advised that compliance was being scrutinised in detail by the Committee and further work was still required in this area to achieve the targets by the end of November 2024, due to staff turnover, but the Committee was assured that all the necessary staff had been booked on to training dates. 7.3.1.18. The Maternity Clinical Outcomes Dashboard - Whiston Maternity Unit had achieved 100% compliance for advice to women during pregnancy to help them stop smoking. Additional focus is required at Ormskirk Maternity Unit to meet the target. The rates for third-and fourth-degree tears were below the national average. MWL is also below the national average for severe post-partum haemorrhage (PPH). 7.3.1.19. Perinatal mortality – there were five reportable deaths recorded in quarter 2 and it was noted that these had been reviewed and no concerns about care had been identified. Any lessons learnt had been shared across the maternity service. There had been one Maternity and Neonatal Serious Incident (MNSI) reported in quarter 1, which found no issues with the care provided. There were no other open MNSI investigations. There had been zero never events or serious incidents reported in quarter 2 and no other on-going investigations. 7.3.1.20. Neonatal Unit Medications Monitoring – GB noted that this had been reported to Quality Committee in the preceding six months and had now been incorporated into the quarterly Maternity and Neonatal Services Report. The Committee had requested additional assurance about the impact of errors, any trends and the rates per 1,000 bed days to allow the Trust to benchmark against other organisations in C&M. A deep dive into the Critical Medications storage and administration across MWL was to be undertaken by the Medicines Management team. 7.3.1.21. Saving Babies Lives (Safety Action 6) – The Trust was working towards full compliance. Quarterly meetings were taking place with the Local Maternity and Neonatal System (LMNS). This safety action is externally validated by the LMNS. 7.3.1.22. CQC Action Plan – work continued to deliver the 'Should' and 'Must Do' actions from the 2023 inspections and the Committee had requested a full update on the action plan to ensure timely progress was being made against all the actions. 7.3.1.23. Complaints and Claims – Maternity and neonatal safety incidents had decreased since 2019, which was positive assurance about the service. 7.3.1.24. Maternity Red Flag Incidents – there had been an increase in incidents reported in September 2024 at Ormskirk Maternity Unit, related to increased activity but with no harms reported. 7.3.1.25. Workforce – There had been 100% compliance with the provision of one-on-one care in labour as well as the availability of a supernumerary Delivery Suite Shift Coordinator in quarter 2. 7.3.1.26. There had been no maternity service diverts in quarter 2. Closures were noted to external admissions in neonatal services.

	7.3.2. RT reflected on the QWR and ward accreditation process and acknowledged the work and effort that had gone into getting this right for MWL. 7.3.3. LB referred to Safety Action 8 (Training) and assured the Board that all staff had allocated dates for training and noted that a high number of these staff were newly appointed, either as newly qualified midwives or as part of the doctor's training placement rotation that took place in August. LB reported, that as some of the training had to be multi-disciplinary it could not all be covered as part of the induction. 7.3.4. LB noted that the first ward had now achieved 5 stars in the ward accreditation scheme. This was G Ward at Ormskirk Hospital. The Board congratulated the staff of G ward on this achievement. 7.3.5. GB also reflected on a recent QWR she had attended at Southport Hospital and commented that the new format had allowed her more time to interact with patients and their family members. One of the patients had given positive feedback about one of the doctors on the ward, which GB was able to feedback to the individual in real time. 7.3.6. The remainder of the report was **noted**.
7.4.	**Strategic People Committee**
	7.4.1. LK presented the Strategic People Committee Assurance report for the meeting held on 21 October and advised that work was ongoing to better understand the reasons for HCA sickness absence. 7.4.2. The Committee received the updates on the People Plan and Workforce Development Operational Plan and LK highlighted the following: 7.4.2.1. The Trust was currently recruiting the next group of Nursing Degree Apprentices and Trainee Advanced Practitioners. 7.4.2.2. It was anticipated that the legacy S&O Work Experience Programme would be replicated across MWL for students interested in both clinical and non-clinical roles. 7.4.2.3. The Lead Employer Collaborative Bank has been rebranded to the NHS Collaborative Bank (MWL) to assist with fill rates, agency spend and variations in pay. 7.4.3. RT reflected positively on the low turnover and vacancy rates for a Trust that has recently merged. RT was also pleased to note that, as part of the new ways of working, training had been provided for radiology assistants to recognise the early warning signs of patient deterioration. In the Learning from Deaths reports it had been highlighted that earlier identification of deteriorating patients was needed and asked if there were any plans to roll this training out to other support staff. LB advised that the Trust offered the Bedside Emergency Assessment Course (BEACH) training for HCAs and other staff groups. RT asked if the training could also be offered to volunteers.

	AMS responded that the Trust needed to be mindful of the role of volunteers and could not create a situation where they would be responsible of reacting, so careful thought would need to be given to this. 7.4.4. RT asked if the planned reduction in the time to hire target from 40 days to 30 days was achievable. AMS responded that the Trust has already achieved 34 days in some months and noted that when the target was not reached it was mainly due to specific posts, for example medical posts which took longer to finalise, however, these were already individually tracked to ensure that staff were able to take up post as quickly as possible. 7.4.5. RF commented that it should not be forgotten that the Trust was still in the process of integrating the two legacy organisations and working through many issues and processes to adopt best practice whilst at the same time continuing with business as usual delivery. The remainder of the report was **noted**.
7.5.	**Finance and Performance Committee**
	7.5.1. SC presented the Committee Assurance report for the meeting held on 24 October 2024 and noted that the Committee had reviewed the CPR and monthly finance report, but the key points had already been discussed in earlier reports so would not be repeated. Other points to highlight were: 7.5.1.1. The Director of Finance Report had provided an update on the position following the external financial reviews that had taken place. It was noted that the ICB had established a finance improvement command centre to closely monitor the financial position and to provide assurance on the delivery of plans. 7.5.1.2. The Trust had been allocated £15.8m additional funding and the Committee had approved the amendments to the 2024/25 finance plan, which was recommended to the Board. 7.5.1.3. The Committee had discussed Month 6 projections which included the actions to be undertaken to continue to deliver the 2024/25 plan. There was significant ongoing scrutiny and review to provide assurance of achieving the plan, as well as the establishment of the new Financial Improvement Groups which would sit alongside the CIP process . 7.5.1.4. The Committee had reviewed the results of the Corporate Benchmarking return, and it was noted that the Trust was lower than the ICB median but slightly higher than the national median and this was being reviewed by the Corporate Leads alongside peers in other organisations to identify any opportunities for further improvement. 7.5.1.5. CIP continued to make significant progress against plan and 75% of the £48m target had been achieved. This included £30.9m of recurrent CIP which was 85% of the £36.2m target. SC noted that an additional £10m would be required to achieve the targets by the end of the financial year. 7.5.1.6. The Committee received the Surgical Division CIP update which included an overview of the governance processes in place. SC noted that this was

	the first time the integration between CIP and the Financial Improvement Group had been evidenced. 7.5.1.7. The Committee received the Elective Care Recovery review which provided an overview of the latest position, including the national Further Faster 20 programme which was part of the Getting It Right First Time (GIRFT) programme. 7.5.2. The Committee received the assurance reports from the Procurement Council, the CIP Council, the Capital Planning Council, the Estates & Facilities Management Council, and the IM&T Council 7.5.3. RT asked for further information about the Further Faster 20 Programme and the elective pathways for patients in areas with high levels of economic inactivity. PW explained that the programme had been introduced by the new government and was designed to help people who were waiting for elective procedures to get back to work. The programme was being targeted in areas where there was financial, economic and social deprivation and was designed to maximise theatre efficiency and reduce waiting lists. LN reported that there was an expectation that patients on the waiting list would be reviewed if they were not receiving a wage, however this information was not always available to the NHS currently. The purpose of the programme was to get people fit and healthy and back to work but LN noted that it was also about balancing clinical priority. MWL was one of 20 trusts participating in the national programme. 7.5.4. GB asked if the Trust completed more elective activity than planned it would be paid. GL confirmed that activity above plan did generate additional income, however the CIP delivery relied on this income as to achieve the financial plan the Trust had built in assumptions to deliver higher levels of activity via the new theatres in the second half of the financial year. 7.5.5. AM noted that there had been recent national discussions about the costs of the elective recovery programme and advised that she had attended a meeting with the NHSE Deputy Chief Executive and Chief Financial Officer, where the Elective Recovery Fund (ERF) payments had been discussed. GL commented that elective activity was now circa 112 - 113% of the 2019/20 baseline nationally which was above the target and therefore costing more than anticipated but there had not yet been a corresponding reduction in the size of the waiting list. The remainder of the report was **noted**. **RESOLVED:** The Board **approved** the revised 2024/25 financial plan and **noted** the Committee Assurance Reports
Other Board Reports	

8.	**TB24/073 Corporate Risk Register**
	8.1. NB presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the MWL CRR via the Trust's risk management systems. NB noted that there were fewer risks included on the CRR and advised that work had been ongoing to remove any duplicated risks as well as to align the risks across sites. 8.2. NB reported that the main risks, for example patient flow and staffing, were still included on the CRR, however it might appear that several risks had been removed and NB assured that these had either been rescored to be managed by the divisions or combined with another existing risk. 8.3. NB advised that when a risk was raised on either the legacy STHK or legacy S&O system it could now apply to the whole of MWL. 8.4. The new integrated risk and incident management system for MWL and was due to be implemented in early 2025. The transition to the new system might cause a delay to the next quarterly report that was due in January. 8.5. RT reflected on Risk 20 (anaesthetic cover out of hours was not sufficient to support a second time critical emergency at Ormskirk Hospital) which had been escalated to the CRR some time ago and asked if there was now capacity across MWL to provide cover. PW responded that although it was now one organisation not all the clinical teams had been merged. There were particular issues with regards to critical care, and the anaesthesia rota at Southport Hospital and advised that Whiston Hospital was providing mutual support where possible, but two rotas still had to be maintained because of the distances involved. There were mitigations in place with specialist doctors who were primarily based at Ormskirk Hospital as well as the consultant who covered Southport Hospital, but the risk was still present, in a case where there were multiple emergencies. 8.6. RT asked if the neonatal and maternity units' closure were due to inadequate staffing levels. LB responded that the staffing at the units was appropriate for planned levels of activity but sometimes there were variations and spikes in acuity which meant the units appropriately followed the network escalation guidance to close to new admissions and make use of other capacity across the network. This issue was on the risk register but did not score above 15 so was not included on the CRR. **RESOLVED:** The Board **noted** the Corporate Risk Register
9.	**TB24/074 Board Assurance Framework**

	9.1. NB presented the quarterly review of the Board Assurance Framework (BAF) and noted that each BAF risk has been reviewed by the lead Executive and updates provided in relation to closed and new actions. 9.2. NB advised that BAF risk 5 (Failure to work effectively with stakeholders) had been updated to reflect the comment made by SC regarding the current relationships with Place. 9.3. It was recommended that the risk score for Risk 3 (Sustained failure to maintain operational performance/deliver contracts) be increased to a score of 20 given the challenges to maintain operational performance and the concerns over the impact over the coming winter. 9.4. RF commented that the BAF was an easy document to follow and provided an overview of a wide range of issues for the board. **RESOLVED:** The Board **approved** the increased risk score and changes to the Board Assurance Framework
10.	**TB24/075 Learning from Deaths Quarterly Report (Quarter 4 2023/24)**
	10.1. PW presented the Learning from Deaths Quarterly Report and highlighted the following: 10.1.1. There had been 76 deaths that met the criteria for a Structured Judgement Review (SJR) in Q4 at legacy STHK, 66 of which had been completed. Of the cases reviewed, one was graded amber, the remaining were green, and none were graded as red. 10.1.2. At legacy S&O, 177 deaths had been reviewed by the Medical Examiners Team, of which four had been referred to the coroner. 13 SJR had been completed, and one case was graded as amber. 10.2. PW noted that all cases graded as red, or amber were further reviewed by the Mortality Groups with learning and any additional actions being shared with the relevant divisions. PW noted that following these reviews cases were often downgraded with a greater understanding of the case. Any cases referred to the coroner were automatically be flagged as red, but the SJR might be downgraded following the outcome of the coroner's inquest. 10.3. PW highlighted that the amber case related to a patient who had been admitted to a ward and had issues with translation services was a different issue to the case reported in Q3 where there had been difficulties accessing translation services for a patient in the Emergency Department (ED). Having reviewed the more recent case PW could assure the Board there had been no lapses in care but further work to standardise access to translation services was being undertaken, with a new task and finish group established.

	10.4. The second amber case had been downgraded from red when it had been found there had been no lapses in case, however, there was learning in relation to documenting the clinical decision to offer no further active treatment. 10.5. Both the red cases reported in Q4 had been referred to the coroner. The first case was also subject to an ongoing internal Patient Safety Incident Investigation (PSII). The second case related to an accidental opiate overdose external to the hospital. Learning about the process for managing the use of naloxone and morphine at the end of life would be feedback. 10.6. RT asked for more information about what would be done to prevent accidental overdose going forward. PW responded that the inquest had recorded the death was by natural causes, but the full report had not yet been received, however a review of the end-of-life pathways and liaison with primary care. **RESOLVED:** The Board **noted** the Learning from Deaths Quarterly Report
11.	**TB24/076 Aggregated Incidents, Complaints and Claims Report**
	11.1. LB presented the Aggregated Incidents, Complaints and Claims Report for quarter (Q)1 and quarter (Q)2 of 2024/25 and noted that there had been an increase in reporting for both legacy organisations in Q2. LB advised that a single MWL format report would be presented in January 2025. 11.2. LB highlighted the following: 11.2.1. The reporting categories differed across the legacy trusts which had made it difficult to analyse the data, however, this would be aligned once the new incident reporting system was implemented. The highest number of clinical incidents related to pressure ulcers, falls, slips, trips and long waits for beds. 11.2.2. There were Divisional level daily reviews of incidents, and reviews by the patient safety review team with immediate escalation if required. 11.2.3. Duty of Candour had been completed for all cases reported in Q1 and Q2. 11.2.4. The report included the overview of complaints by Divisional and the Urgent and Emergency Care Division continued to receive the highest number of complaints. 11.2.5. The Trust had closed 42 claims in Q1 and 65 in Q2. No significant trends had been identified from these claims, but an increase in orthopaedic claims in Q1 and general surgery claims in Q2 had been noted. 11.2.6. The Trust had closed 35 inquests during Q1 and 31 in Q2 and no future prevention death notices had been received from the coroner. 11.3. LB noted work was taking place to improve trust wide learning from incidents, complaints and claims, to supplement local service learning.

	RESOLVED: The Board **noted** Aggregated Incidents, Complaints and Claims Report
12.	**TB24/077 Workforce Reports**
12.1.	Workforce Race Equality Standard Report (WRES) and Workforce Disability Equality Standard Report (WDES)
	12.1.1. AMS, on behalf of MS, presented the Workforce Race Equality Standard Report (WRES) and the Workforce Disability Equality Standard Report (WDES) for the period ending 31 March 2024 and noted that these were statutory reports that must be published. 12.1.2. AMS noted that the reports reviewed a number of metrics which related to either race of disability and included responses from the staff survey and other data. <u>Workforce Race Equality Standard Report (WRES)</u> 12.1.3. AMS advised that, as part of the Board development programme, members would be working on the Trust's anti-racism framework accreditation. 12.1.4. A programme of Career Development Workshops for Band 5 Black, Asian and Minority Ethnic (BME) staff had been launched and the Trust continued to develop a reverse mentoring programme. 12.1.5. There had been an overall increase in the number of BME staff within the workforce across all bands (from 9.0% in 2020 to 15.1% in 2024), however there was still some challenges in the senior bands. AMS highlighted the following metrics: • 17.7% of BME staff had reported experiencing bullying and harassment by colleagues and managers, which, whilst not acceptable, was lower than the national figure at 24.9%. • 52.2% of BME staff believed that the Trust offered equality of opportunity in career progression compared to 48.9% nationally. • 12% of BME staff stated that they had experienced discrimination from a manager or other colleague compared to 15.5% nationally. 12.1.6. RT reflected on the improved metrics and commented that, whilst there was still more work to be done, this was the first time that a downward trend had been presented. AMS agreed that there was a long lead in time before improvements were seen but the actions taken by the Trust were now bearing fruit and she was particularly pleased to see that BME staff were now less likely to enter into the disciplinary process, which was a significant improvement over preceding years.
12.2.	Workforce Disability Equality Standard Report (WDES) (including action plan)
	12.2.1. AMS, on behalf of MS, Workforce Disability Equality Standard Report (WDES) and highlighted the following: 12.2.1.1. The number of staff who were confident to advise via ESR that they considered themselves to be disabled had increased to 5.6%, which was 2.5% more than for non-clinical staff this had improved to 6.9%.

	Additionally, there had been an increase in the number of disabled staff in all bands. 12.2.1.2. Additional work was required based on the staff survey responses as 26.5% of disabled staff considered that they would be more likely to experience harassment from patients, as well as from managers and colleagues. AMS noted that there has been several discussions at preceding Board meetings about the work and support required to ensure that managers were comfortable to engage with a member of staff on the subject of disability, and their needs. It was noted that three quarters of disabled staff had advised that they required some work place adjustments and that these had been put in place, which was an improvement. 12.2.2. LK commented that once a staff member had been through the assessment for reasonable adjustments they should be made and queried why this was not 100%. AMS responded that incremental improvements were being made and advised that the Disability Passport was now in place which allowed adjustments to move with the member of staff when they changed job, so this was a big step forward. 12.2.3. CS reflected that NHS jobs was not always accessible to people outside of the NHSE and asked if there was a targeted approach to attract applicants from different backgrounds. AMS responded that the Trust had always worked on the premise that the right individual needed to be appointed for the right job, and this had been discussed at a recent Executive Committee and the feedback from many staff was that they wished to be recruited on merit. AMS acknowledged the importance of making recruitment opportunities available to everyone and agreed that this may require targeted approaches. RF reflected on the Trust's difficulty in attracting BME candidates for NED roles and agreed that the best applicant should be appointed for the role, however, the solution to this was to prepare BME candidates to be the best candidate and noted the initiatives by NHSE to do this. RF noted that the MWL Board was representative of the population served by the Trust but was not now reflective of the Trust workforce. AMS suggested that this be discussed further at the Anti-Racism Roundtable discussion in the Strategy Board session. 12.2.4. IC noted that he had some experience in this field following his own sudden disability and would be happy to share his experiences. **RESOLVED:** The Board **noted** the Workforce Reports and **approved** the action plans
13.	**TB24/078 Infection Prevention and Control Annual Report 2023/24**
	13.1. LB presented the Infection Prevention and Control Annual Report 2023/24 which provided assurance that the Trust was taking the necessary action to monitor, manage and prevent hospital acquired infections. LB highlighted the following:

	13.1.1. The report had been reviewed by the Quality Committee and quarterly IPC reports were included on the Committee workplan. 13.1.2. The Trust had exceeded the C.Diff threshold in 2023/24 and this reflected the national picture for the majority of acute trusts. 13.1.3. The Trust was an outlier for rates of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and LB noted that of the six cases reported four had been avoidable and there had been an enormous amount of learning and activity around this. Year to date for 2024/25 the Trust had reported three MRSA bacteraemia and only one case had related to canula care which was an improvement. 13.1.4. Diarrhoea management remained a challenge, and this included the isolation of patients and cleaning of areas post diarrhoea and vomiting, however, an improvement plan which focused on the key areas of environmental and equipment cleanliness and improved awareness amongst clinical staff had been developed. 13.1.5. A big piece of work around hydration had taken place to reduce the incidences of Urinary Tract Infections (UTI). 13.1.6. There had been a focus on Aseptic Non Touch Technique (ANTT) training and this had been reviewed across all the Trust hospital sites and a new way of working would be introduced from 2025/26. MRSA reductions and compliance with ANTT were Quality Account priorities for 2024/25. 13.1.7. The surveillance of orthopaedic surgical site infections had highlighted an increase in 2023/24, but this had been addressed and the levels had now reduced. 13.1.8. The updating and harmonisation of IPC policies had been a challenge following the transaction, but progress was now being made and this was being closely monitored. 13.1.9. Ventilation at the different hospital sites continued to be monitored and LB noted that there were significant differences in the standard of the estates between the legacy organisations, which would continue to create challenges for IPC management. 13.1.10. Antimicrobial Pharmacy support was a challenge in 2023/24 but there was a plan in place to resolve this. 13.2. LB reported that there were a number of metrics from an IPC perspective that the Trust was not measured on, and this included Covid-19, Respiratory Syncytial Virus (RSV), Carbapenemase-producing Enterobacteriaceae (CPE) and measles, and LB acknowledged the work of the IPC team in dealing with these outbreaks and the work of the Estates and Facilities services especially cleaning for their responsiveness. The role of HWWB team in providing support for staff was also recognised. **RESOLVED:** The Board **approved** the Infection Prevention and Control Annual Report 2023/24
14.	**TB24/079 Nurse Staffing Establishment Review**

	14.1. LB presented the Nurse Staffing Establishment Review which provided assurance that processes were in place to regularly review the nurse staffing establishment as recommended by the National Safety Board, and if necessary to adjust the establishment to maintain safe levels of staffing to meet the needs of patients. LB advised that in 2025/26 two deep dive reviews would be undertaken, with the timing amended so that staffing was reviewed in preparation for winter planning. 14.2. LB highlighted the following: 14.2.1. There were some staff areas that were not included in the review, for example maternity as their establishment reviews were conducted separately. 14.2.2. New national guidance introduced around district and community nursing which would need to be included for the next review. 14.2.3. The inconsistencies in skill mix and headroom had been harmonised across MWL and the allocation of supernumerary management time for ward managers had been standardised 14.2.4. The rates of pay for the temporary workforce had also been aligned. 14.2.5. Where there was a need to review staff levels following the establishment review business cases were being developed for consideration by the Executive Committee. 14.2.6. The outcomes of the review was that the staffing establishment was sufficient to deliver safe levels of staffing. **RESOLVED:** The Board **noted** the Nurse Staffing Establishment Review
Concluding Business	
15.	**Effectiveness of Meeting**
	15.1. RF reflected on the importance of the discussions that had taken place as part of the Executive Committee Assurance report.
16.	**Any Other Business**
	16.1. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 13.25. The next Board meeting would be held on **Wednesday 27 November 2024 at 10:00**

Meeting Attendance 2024/25												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)	✓	✓	✓	A		✓	✓					
Ann Marr	✓	✓	✓	✓		✓	✓					
Anne-Marie Stretch	A	✓	✓	✓		✓	✓					
Geoffrey Appleton	✓	✓	✓									
Lynne Barnes	✓	✓	✓	✓		A	✓					
Gill Brown	✓	✓	✓	✓		✓	✓					
Nicola Bunce	✓	✓	✓	✓		✓	✓					
Ian Clayton	✓	✓	A	✓		✓	✓					
Steve Connor	✓	✓	✓	✓		✓	✓					
Rob Cooper	✓	✓	✓	✓		✓	✓					
Malcolm Gandy	✓	✓	✓	✓		✓	✓					
Paul Growney	✓	✓	✓	✓								
Lisa Knight	✓	✓	✓	✓		✓	✓					
Gareth Lawrence	✓	✓	✓	✓		✓	✓					
Lesley Neary	✓	A	A	✓		✓	✓					
Sue Redfern	A	A	A	A		A	A					
Hazel Scott	✓	✓	✓	A		✓	✓					
Carole Spencer		✓	✓	✓		✓	✓					
Malise Szpakowska			✓	✓		✓	A					
Rani Thind	✓	✓	✓	✓		✓	✓					
Peter Williams	✓	✓	✓	✓		✓	✓					
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball	A	A	✓	✓		A	✓					
Richard Weeks	✓	✓	✓	✓		✓	✓					
✓ = In attendance A = Apologies												

Trust Board (Public)
Matters Arising Action Log
Action Log updated 22 November 2024

Mersey and West Lancashire Teaching Hospitals NHS Trust

Status	
Yellow	On Agenda for this Meeting
Red	Overdue
Green	Not yet due
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
10	25/09/2024	**TB24/065 Learning from Deaths Annual Report 2023/24**	AMS to undertake an audit of the Root Cause Analysis (RCA) reports to identify the common themes associated with falls. Update 22/11/2024 AMS to provide a verbal update	AMS	Nov-24	Report to be presented at Executive Committee	
12	25/09/2024	**TB24/067 Statutory Pay Gap Report 2023/24**	MS to undertake a review of ESR to determine if different types of disabilities can be analysed.	MS	Jan-25		
12	25/09/2024	**TB24/067 Statutory Pay Gap Report 2023/24**	Strategic People Committee asked to consider how the trust value 'we are inclusive' means for staff	MS	Jan-25	Report to be presented at Strategic People Committee	

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 November 2024
Agenda Item	**TB24/082**			
Report Title	**Integrated Performance Report**			
Executive Lead	Gareth Lawrence, Director of Finance, and Information			
Presenting Officer	Gareth Lawrence, Director of Finance, and Information			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) across four key areas:

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

Executive Summary

Performance for MWL is summarised across 30 key metrics. Quality has 10 metrics, Operations 13 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

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

Quality and/or Equality Impact

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

Recommendations

The Trust Board is asked to note performance for assurance.

Strategic Objectives

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

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

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-24	84.5	100	92.7	Best 30%
FFT - Inpatients % Recommended	Oct-24	93.8%	90.0%	94.7%	Worst 50%
Nurse Fill Rates	Sep-24	97.0%	90.0%	96.0%	
C.difficile	Oct-24	13	113	60	
E.coli	Oct-24	12	171	97	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.22	0.00	0.15	
Falls ≥ moderate harm per 1000 bed days	Sep-24	0.22	0.00	0.20	
Stillbirths (intrapartum)	Oct-24	0	0	0	
Neonatal Deaths	Oct-24	1	0	6	
Never Events	Oct-24	0	0	1	
Complaints Responded In 60 Days	Oct-24	56.3%	80.0%	63.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Sep-24	71.0%	77.0%	72.5%	Worst 30%
Cancer 62 Days	Sep-24	78.2%	85.0%	79.3%	Best 20%
% Ambulance Handovers within 30 minutes	Oct-24	41.5%	95.0%	49.9%	
A&E Standard (Mapped)	Oct-24	78.1%	78.0%	77.8%	Best 30%
Average NEL LoS (excl Well Babies)	Oct-24	4.2	4.0	4.2	Best 30%
% of Patients With No Criteria to Reside	Oct-24	17.9%	10.0%	20.7%	
Discharges Before Noon	Oct-24	19.6%	20.0%	18.2%	
G&A Bed Occupancy	Oct-24	97.7%	92.0%	97.4%	Worst 30%
Patients Whose Operation Was Cancelled	Oct-24	1.1%	0.8%	1.0%	
RTT % less than 18 weeks	Oct-24	58.6%	92.0%	58.6%	Worst 50%
RTT 65+	Oct-24	125	0	125	Worst 50%
% of E-discharge Summaries Sent Within 24 Hours	Oct-24	85.1%	90.0%	83.2%	
OP Letters to GP Within 7 Days	Sep-24	67.8%	90.0%	71.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Oct-24	87.4%	85.0%	87.4%	
Mandatory Training	Oct-24	88.4%	85.0%	88.4%	
Sickness: All Staff Sickness Rate	Oct-24	6.2%	5.0%	5.8%	
Staffing: Turnover rate	Oct-24	0.7%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Oct-24		22,700	14,419	
Cash Balances - Days to Cover Operating Expenses	Oct-24	12.6	10		
Reported Surplus/Deficit (000's)	Oct-24		-13,162	-10,224	

Board Summary - Quality

Quality

Friends and Family Test – achieved the overall target despite lower recommendation rates within Inpatient and A&E areas. The 2023 National Inpatient survey action plan agreed and in progress, with monthly audits standardised across MWL to measure ongoing performance against the action plan. An action plan is being developed as a result of the 2024 National Urgent and Emergency care survey results.

Clostridium difficile infection – The Trust remains below the NHSE threshold for 2024/25 and UKHSA Cheshire and Merseyside data indicates that in Q1 and Q2 MWL was a low outlier in terms of C. difficile rates. The CDI Improvement Plan remains on track.

E coli -The E coli Improvement Plan continues, and a urinary catheter point prevalence audit will be completed in Q3 to allow comparison to urinary catheter care last FY.

Pressure Ulcers - Focused and generic actions have been developed in conjunction with wards and departments to address the themes. The TVN Team continue to provide teaching, awareness sessions and support to all areas.

Patient Falls – The Falls Team have put together a specific action plan to reduce the risk of falls in higher incidence areas. There are regular audits of falls compliance and ongoing falls education. Falls reduction initiatives are being trialled, e.g. additional call bells in the A&E ambulance assessment areas, post-fall flowcharts in theatres and trial of decaffeinated drinks at Newton hospital.

Never Events – No Never Events were reported in October (YTD 1).

HSMR - Latest data available up to and including Mar-24. The final 23-24 HSMR remains low at 92.7, with both sites below 100 (legacy STHK site 90.7 and legacy S&O 97.5). The YTD S&O HSMR has increased from 22-23. The factors driving the rise in HSMR have been reviewed and this appears to be driven by a fall in palliative care coding and a drop in patients recorded as having septicaemia. Action has been taken to ensure that patients are coded as accurately as possible to ensure an accurate HSMR. HSMR is monitored via Clinical Effectiveness Council and diagnoses alerting due to a higher than expected number of deaths are reviewed by the Mortality Surveillance Group. SHMI remains within expected levels at 1.05 for the 12 month period ending May 2024.

Neonatal deaths - A baby of extreme prematurity of 22 weeks was delivered and transferred appropriately to the tertiary referral unit but sadly died eight days following birth.

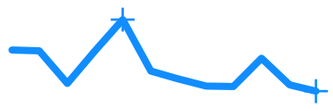
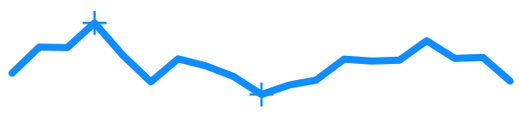
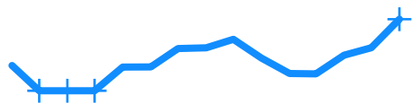
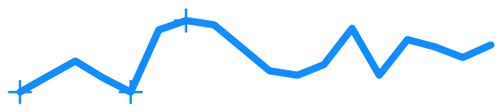
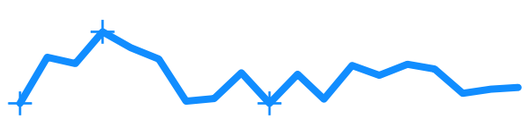
Complaints - % of stage 1 complaints resolved in 60 working days – incremental improvement in month and overall improvement in complaints management with the number of overdue complaints reducing by 29% from September to October. Work continues to reduce overdue complaints whilst maintaining timely responses to new and open complaints. This is further supported through the leadership and oversight of PALS processes.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Mar-24	84.5	100	92.7	Best 30%	
FFT - Inpatients % Recommended	Oct-24	93.8%	90.0%	94.7%	Best 50%	
Nurse Fill Rates	Sep-24	97.0%	90.0%	96.0%		
C.difficile	Oct-24	13	113	60		
E.coli	Oct-24	12	171	97		
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.22	0.00	0.15		
Falls ≥ moderate harm per 1000 bed days	Sep-24	0.22	0.00	0.20		
Stillbirths (intrapartum)	Oct-24	0	0	0		
Neonatal Deaths	Oct-24	1	0	6		
Never Events	Oct-24	0	0	1		
Complaints Responded In 60 Days	Oct-24	56.3%	80.0%	63.8%		

Board Summary - Operations

Operations

A&E - 4-Hour performance decreased in October, achieving 72.6% (all types). Trust performance remained ahead of Cheshire and Mersey (72.3%), but behind national (73%). The Trusts mapped 4-Hour performance achieved 78.1%.

Patient Flow - Bed occupancy across MWL averaged 106.7% in October equating to 111 patients - an increase from 105.4% in September. There was a peak of 132 patients (38 at S&O, 94 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 2% higher than last October, driven by a 12% increase in 1+ LOS, with an 8% decrease in 0-day LOS activity. Average length of stay for emergency admissions remains high, at 9.0 at S&O and 7.4 at StHK, with an overall average of 8.2 days, the impact of non-CTR patients being 17.9% at Organisation level, 1.2% lower than September (20% StHK and 14% S&O).

18 Weeks - The Trust had 2,318 52-week waiters at the end of October (459 S&O and 1,859 StHK), 125 6-week waiters and 0 78-week waiters.
The 52-week position is a decrease of 192 from September. 18 Week performance in September for MWL was 58.6%. This was ahead of national performance (latest month September) of 58.5% and C&M regional performance of 56.2%.

Cancer - Cancer performance for MWL in September decreased to 71% for the 28-day standard (target 77%). Latest published data shows national performance of 74.8% and C&M regional performance of 71.4%. Performance for 62-day also decreased, achieving 78.2% (target 85%). C&M performance was 73% and National 67.3%. 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 2024/25.

Diagnostics -Diagnostic performance continued to exceed the target, achieving 96.7% for MWL. Performance is ahead of national, at 77.3% (latest month September) and C&M regional performance of 91.2%.

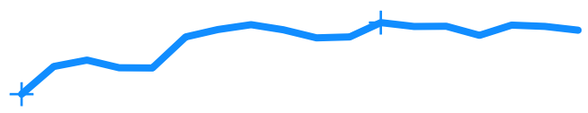
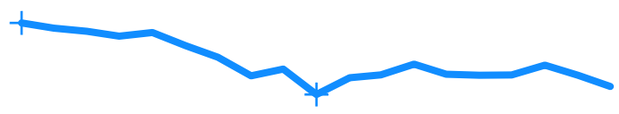
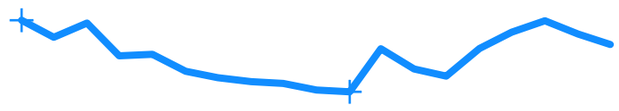
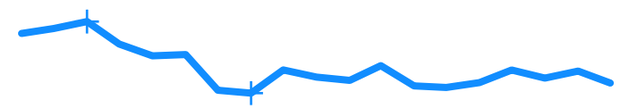
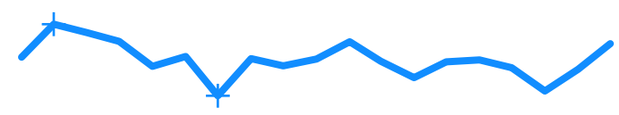
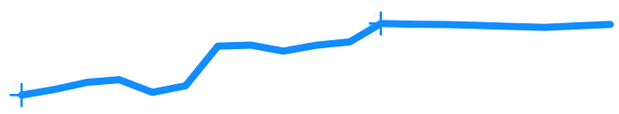
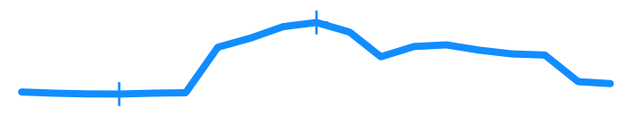
Letters - The Trust had a significant improvement in performance in letters sent to GP's within 7 days. The interim solution will continue to be rolled out. Urgent letters are being produced within 48 hours of appointment.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Sep-24	71.0%	77.0%	72.5%	Worst 30%	
Cancer 62 Days	Sep-24	78.2%	85.0%	79.3%	Best 20%	
% Ambulance Handovers within 30 minutes	Oct-24	41.5%	95.0%	49.9%		
A&E Standard (Mapped)	Oct-24	78.1%	78.0%	77.8%	Best 30%	
Average NEL LoS (excl Well Babies)	Oct-24	4.2	4.0	4.2	Best 30%	
% of Patients With No Criteria to Reside	Oct-24	17.9%	10.0%	20.7%		
Discharges Before Noon	Oct-24	19.6%	20.0%	18.2%		
G&A Bed Occupancy	Oct-24	97.7%	92.0%	97.4%	Worst 30%	
Patients Whose Operation Was Cancelled	Oct-24	1.1%	0.8%	1.0%		
RTT % less than 18 weeks	Oct-24	58.6%	92.0%	58.6%	Best 50%	
RTT 65+	Oct-24	125	0	125	Worst 40%	
% of E-discharge Summaries Sent Within 24 Hours	Oct-24	85.1%	90.0%	83.2%		
OP Letters to GP Within 7 Days	Sep-24	67.8%	90.0%	71.2%		

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its target for mandatory training although it has seen a marginal decrease (0.4%). In October mandatory training compliance was 88.4% against a target of 85%, compared to 88.8% in September.

Appraisals - The Trust annual appraisal window closed on 30th September with the target being exceeded within the window. Appraisal compliance has increased by 0.5% in October to 87.4% against a target of 85%.

Sickness - In-month sickness has increased from 5.7% in September to 6.2% in October against a 5% target. The biggest increase was seen across Registered Nursing & Midwifery staff & HCA's.
The top reason for absence continues to be Anxiety, Stress and Depression and is consistent with the top reason for absence across the NHS.
The Trust continues to focus on supporting all employees who are absent due to Anxiety/Stress/Depression and ensuring that all supportive actions have been undertaken including regular support sessions for managers who are supporting staff.
The HR team are in the process updating the Sickness and Absence policy and are working in collaboration with colleagues to further develop our wellbeing support including the tools and resources available to managers. This includes focusing on the embedding of meaningful wellbeing conversations and reasonable adjustments.

Further support and interventions includes;

- Dedicated HR support for absence and wellbeing
- Targeted focus on early interventions
- Wellbeing support available to all staff through The Wellbeing Hub
- Deep dive into areas with consistent high levels of sickness with feedback to provided to People Performance Council.

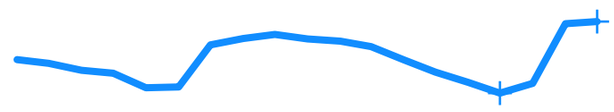
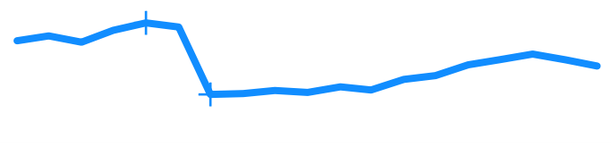
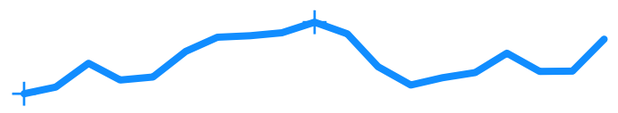
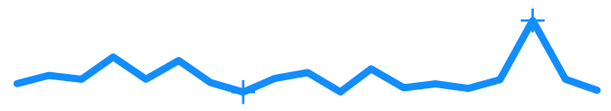
This will focus on the triangulation of data and the identification of drivers for sickness to inform meaningful and targeted interventions.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Oct-24	87.4%	85.0%	87.4%		
Mandatory Training	Oct-24	88.4%	85.0%	88.4%		
Sickness: All Staff Sickness Rate	Oct-24	6.2%	5.0%	5.8%		
Staffing: Turnover rate	Oct-24	0.7%	1.1%	1.0%		

Board Summary - Finance

Finance

The updated approved MWL financial plan for 24/25 is a deficit of £10.9m, which assumed:

- Payment of £12m funds in line with transaction business case
- Delivery of £36.2m recurrent CIP
- Delivery of £11.8m non-recurrent CIP
- Delivery of the 24/25 activity plan, in order to achieve planned levels of income including ERF/API variable funding
- Contract agreements in line with planned values
- Non recurrent deficit support of £15.8m

Surplus/Deficit – At Month 7, the Trust is reporting a year-to-date deficit of £10.2m which is £2.9m better than plan. This favourable variance relates to £4m of transaction support received in September. The plan assumed all funding would be received in March 2025.

CIP - The Trust's CIP target for financial year 2024/25 is £48.0m, of which £36.2m is to be delivered recurrently and £11.8m non-recurrently. As at Month 7, the Trust has successfully transacted CIP of £35.1m, of which £30.9m is recurrent, with a further £1.3m of recurrent CIP at finalisation stage.

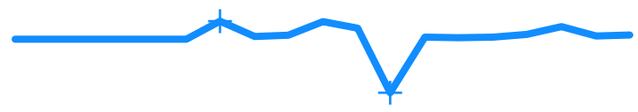
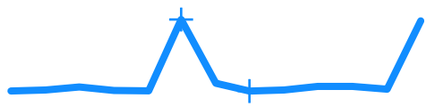
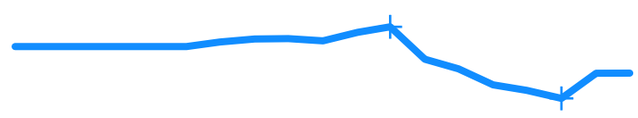
Cash - At the end of M7, the Trust's cash balance was £36.7m. This includes approx. £33.1m of additional lead employer receipts (compared to M6), in order to pay the Resident Doctor's backdated pay award in November. The Trust anticipates a closing cash balance of c.£2.7m as per plan, at the end of the financial year.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Oct-24		22,700	14,419		
Cash Balances - Days to Cover Operating Expenses	Oct-24	12.6	10			
Reported Surplus/Deficit (000's)	Oct-24		-13,1...	-10,2...		

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy Southport & Ormskirk

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-24	82.0	100	97.5	
FFT - Inpatients % Recommended	Oct-24	94.5%	90.0%	94.3%	
Nurse Fill Rates	Sep-24	98.5%	90.0%	94.6%	
C.difficile	Oct-24	4		23	
E.coli	Oct-24	5		37	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.16	0.00	0.13	
Falls ≥ moderate harm per 1000 bed days	Sep-24	0.25	0.00	0.21	
Stillbirths (intrapartum)	Oct-24	0	0	0	
Neonatal Deaths	Oct-24	1	0	2	
Never Events	Oct-24	0	0	0	
Complaints Responded In 60 Days	Oct-24	73.3%	80.0%	67.3%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Sep-24	62.6%	77.0%	67.8%	
Cancer 62 Days	Sep-24	61.7%	85.0%	65.2%	
% Ambulance Handovers within 30 minutes	Oct-24	60.7%	95.0%	62.8%	
A&E Standard (Mapped)	Oct-24				
Average NEL LoS (excl Well Babies)	Oct-24	4.9	4.0	5.3	
% of Patients With No Criteria to Reside	Oct-24	14.4%	10.0%	16.1%	
Discharges Before Noon	Oct-24	20.3%	20.0%	19.2%	
G&A Bed Occupancy	Oct-24	95.6%	92.0%	96.9%	
Patients Whose Operation Was Cancelled	Oct-24	1.0%	0.8%	1.0%	
RTT % less than 18 weeks	Oct-24	64.8%	92.0%	64.8%	
RTT 65+	Oct-24	29	0	29	
% of E-discharge Summaries Sent Within 24 Hours	Oct-24	89.3%	90.0%	80.6%	
OP Letters to GP Within 7 Days	Sep-24	68.8%	90.0%	73.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Oct-24	89.5%	85.0%	89.5%	
Mandatory Training	Oct-24	89.7%	85.0%	89.7%	
Sickness: All Staff Sickness Rate	Oct-24	6.5%	5.0%	6.0%	
Staffing: Turnover rate	Oct-24	0.6%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Oct-24				
Reported Surplus/Deficit (000's)	Oct-24				

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy St Helens & Knowsley

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Mar-24	85.4	100	90.7	
FFT - Inpatients % Recommended	Oct-24	93.6%	94.0%	94.8%	
Nurse Fill Rates	Sep-24	95.5%	90.0%	97.4%	
C.difficile	Oct-24	9		37	
E.coli	Oct-24	7		60	
Hospital Acq Pressure Ulcers per 1000 bed days	Jun-24	0.25	0.00	0.17	
Falls ≥ moderate harm per 1000 bed days	Sep-24	0.21	0.00	0.20	
Stillbirths (intrapartum)	Oct-24	0	0	0	
Neonatal Deaths	Oct-24	0	0	4	
Never Events	Oct-24	0	0	1	
Complaints Responded In 60 Days	Oct-24	48.5%	80.0%	61.9%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Sep-24	76.4%	77.0%	75.6%	
Cancer 62 Days	Sep-24	84.1%	85.0%	85.1%	
% Ambulance Handovers within 30 minutes	Oct-24	29.8%	95.0%	42.8%	
A&E Standard (Mapped)	Oct-24				
Average NEL LoS (excl Well Babies)	Oct-24	3.9	4.0	3.8	
% of Patients With No Criteria to Reside	Oct-24	19.9%	10.0%	23.3%	
Discharges Before Noon	Oct-24	18.9%	20.0%	17.3%	
G&A Bed Occupancy	Oct-24	98.9%	92.0%	97.7%	
Patients Whose Operation Was Cancelled	Oct-24	1.2%	0.8%	0.9%	
RTT % less than 18 weeks	Oct-24	56.3%	92.0%	56.3%	
RTT 65+	Oct-24	96	0	96	
% of E-discharge Summaries Sent Within 24 Hours	Oct-24	84.0%	90.0%	83.9%	
OP Letters to GP Within 7 Days	Sep-24	67.2%	90.0%	70.0%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Oct-24	86.3%	85.0%	86.3%	
Mandatory Training	Oct-24	87.8%	85.0%	87.8%	
Sickness: All Staff Sickness Rate	Oct-24	6.0%	5.0%	5.6%	
Staffing: Turnover rate	Oct-24	0.7%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Oct-24				
Cash Balances - Days to Cover Operating Expenses	Oct-24				
Reported Surplus/Deficit (000's)	Oct-24				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 November 2024
Agenda Item	**TB24/083 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the five Executive Committee meetings held in October 2024		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were five Executive Committee meetings held during October 2024. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. At each meeting the weekly vacancy control panel decisions were also reported.		
03 October 2024		
Urgent and Emergency Care (UEC) Recovery Programme	• The UEC Recovery Programme leads for the MWL footprint joined the Executive Committee to review progress in delivering the three programme workstreams; admission avoidance, acute length of stay and discharge. • The frustrations at the marginal impact to date of any of these workstreams on patient flow in the trusts were raised, with concern expressed in relation to the coming winter. • There was agreement that improvement trajectories would be developed in relation to admission avoidance and improved discharge, so that performance could be monitored.	Assurance
Premium Payments Scrutiny Council Assurance Report - Surgery	• The Acting Director of Human Resources (HR) presented the report, which provided assurance on the actions being taken by the Division of Surgery to reduce reliance on premium payments.	Assurance
Theatre Utilisation Improvement	• The Managing Director introduced the report which provided an update on the improvement programme that had started in August. • It was reported that both capped and uncapped utilisation had improved but more work was required to achieve the target levels. • Recruitment of theatres staff for the new theatres at Whiston had taken longer than planned, but the posts had now been filled.	Assurance

	• It was reported MWL had been selected for the national High Impact Team (HIT) programme, so would now be working with NHSE to refine the improvement programme particularly for the cold sites at Ormkirk and St Helens hospitals.	
Financial Imporvement Group (FIG) Report	• The Committee received feedback from the initial weekly FIG meetings with Divisions, tasked with bringing the run rate back in line with plan. • The focus for the first meetings had been engement and identifying opportunities.	Assurance
Cheshire and Merseyside (C&M) Financial Recovery letter	• Committee reviewed the latest correspondence from C&M Integrated Care Board (ICB0 detailing the additional actions being taken in response to the deteriorating financial position of the system. • This included proposed additional scrutiny of Trust financial decisions to reduce variable pay costs, for Trusts who were assessed as being at high risk of not delivering the 2024/25 financial plan. This did not include MWL. • Committee discussed the Executive and Board responsibilities for quality of care and patient safety alongside financial probity, whilst acknowledging the importance of being able to demonstrate effective financial grip and control.	Assurance
Price Waterhouse Coopers (PwC) Financial Review Report	• Committee reviewed the PwC report recommendations and the planned responses. • Each recommendation was assigned a director lead who would be responsible for ensuring the action was delivered. • Monthly progress reports would be presented to provide assurance the recommendations were being implemented and having the desired impact.	Assurance
Resident Doctor Pay Award – Implications for the Lead Employer	• The Acting Director of HR briefed the Committee on the emerging risk for the Trust of having to pay the resident doctor pay award and agreed backpay in November, which would require cash of circa £100m. • The funds would be allocated to host trusts but would need to paid to MWL in time for the payroll run. • Discussions with NHSE and the host trusts had commenced to ensure they were aware of the need to pass the funds to MWL to service the payroll for the Lead Employer Doctors.	Assurance

October Trust Board Agenda	• The Director of Corporate Services presented the draft Trust Board agenda for review based on the annual workplan. • The Committee selected the Employee of the Month for October from the nominations received during September.	Assurance
10 October 2024		
Review of Trust objectives aligned to the Quality Committee	• The Acting Director of Nursing, Midwifery and Governance presented the report which detailed progress in delivering the quality and safety objectives in quarter 1, which would be presented at the October Quality Committee.	Assurance
Virtual Wards Delivery Model	• The Director of Strategy presented the options for the future delivery of the virtual ward service within the revised C&M funding envelope per bed. • The preferred option was a tiered model, which retained a total of 60 virtual beds, that could be delivered with the reduced funding. • The Committee supported the preferred option but required some additional assurance in relation to TUPE and workforce redeployment.	Approval
Provider Workforce Return - August	• The Acting Director of HR introduced the report. • MWL is delivering the agreed workforce plan, that was re-baselined in July as instructed by the ICB, although there is some variation across the different staff groups. • The report included bank and agency hours as part of the total workforce and Committee reviewed the Health Care Assistant (HCA) usage, noting the majority of requests were for supplementary care. • Development of a live workforce dashboard continued and by mid-October a bank and agency forecasting tool was due to go live to support managers.	Assurance
Six month nurse staffing establishment review	• The Acting Director of Nursing, Midwifery and Governance presented the results of the mid year nurse staffing establishment review, which was due to be presented to the Trust Board. • Committee discussed the review process and the need to develop a business case to support establishment changes. • Assurance was provided that overall the nurse establishment remained appropriate.	Assurance
2024/25 Seasonal Vaccintation Programme	• The Acting Director of HR presented the plans to deliver the 2024/25 Covid-19 and flu vaccination programme.	Assurance

	• The Trust objective was to aim for 75% uptake, although there was no longer a national target.	
Financial Improvement Group (FIG) Report	• The Director of Finance and Information reported on the latest engagement with the Divisional teams and the importance of identifying opportunities. • Discussions had been positive with more suggestions being collated. • It was also reported that the first of the new weekly workforce data submissions had been made to the ICB.	Assurance
Improving Working Lives for Resident Doctors	• The Acting Director of HR provided an update on the Trust actions in response to the national commitments made to resident doctors. • Roster planning was generally good, but late Health Education England (HEE) notifications meant that it was still not always possible to issue rosters eight weeks in advance. • The Trust was working with HEE to try to improve this. • There was assurance that for the issues within the Trust's control, all the necessary actions had been completed.	Assurance
Board Assurance Framework (BAF) – Quarterly Review	• The Director of Corporate Services presented the proposed changes to the BAF following review by each lead Director. • Committee agreed the proposal to recommend to the Board that the BAF 3 risk (delivery of operational performance) score be increased to 20.	Assurance
17 October 2024		
Locally Employed Doctors Terms and Conditions	• The Acting Director of HR presented the report which set out proposals for harmonising the terms and conditions of service for locally employed doctors across MWL. • In 2016 a new resident (then junior) doctors' contract had been introduced nationally which could be adopted for locally employed doctors. At the time this had been adopted by legacy Southport and Ormskirk Hospital NHS Trust (S&O) and other C&M Trusts but not by legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK.) • Committee agreed the recommendation to offer the standard 2016 terms to all newly advertised positions and give current doctors a choice, as for	Approval

	some it could be more beneficial to retain the 2002 contract terms. • Financial modelling indicated there would be a cost in year 1 to make the change, which would then result in a modest saving from year 2 as a result of projected staff tunrover.	
Medical Undergraduate Education	• The Acting Director of HR introduced the report which set out proposals to standardise the medical undergraduate education provision across MWL. • A review had been undertaken of the legacy medical undergraduate education models and an improvement plan developed to ensure the provision at Southport Hospital achieved the same standard as the education offered at Whiston Hospital. • Funding was available from the student tariff to achieve this levelling up of provision.	Approval
National Corporate Benchmarking Results	• The Director of Finance and Information presented the results of the 2023/24 corporate benchmarking. • This was the first year with MWL information. • The costs reflected a position before many of the new corporate structures had been implemented, but generally compared well to the national average. • The results would be reported to the Finance and Performance Committee.	Assurance
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the assurance report from the October RMC meeting. • Work continued to align risks across the new divisions and prepare for the implementation of the new MWL wide risk and incident reporting system in early 2025. • The Executive Committee had undertaken a review of risks escalated to the Corporate Risk Register (CRR) to remove duplication and align risks related to patient flow. This had resulted in a reduction in CRR risks that would be reported to the Board. • The RMC had received an assurance report from the Claims Governance Group, which was now reviewing all new MWL claims. • It had been noted that the first MWL NHS Resolution Claims Scorecard demonstrated a reduction in the number of claims, but an overall increase in the value of the claims.	Assurance

Integrated Performance Report (IPR) - September	• The Director of Finance and Information presented the IPR. • Committee reviewed the performance and supporting commentary and agreed amendments before the report was released for Committee packs.	Assurance
24 October 2024		
Nurse Safer Staffing Report - September	• The Acting Director of Nursing, Midwifery and Governance presented the report which detailed the staffing levels in September, which provided assurance that nurse staffing levels had been safe with triangulation in relation to patient harms and drug errors where staffing had been below 90%. • Committee discussed the actions being taken to reduce the reliance on bank and agency HCA staff to provide one to one supplementary care. • Reviews and check and challenge had confirmed the Supplementary Care Policy was being applied correctly. • In order to reduce the bank and agency costs, alternative models were being explored based on best practice adopted at other trusts. • Bay tagging, bay nursing and open visiting with family support were all options for reducing the reliance on one to one care to keep patients safe.	Assurance
Flexible Endoscopy Decontamination – Managed Equipment Service Contract	• The Director of Corporate Services introduced the report which sought approval to enter into a 10 year managed equipment contract for the decontamination equipment at the new flexible endoscopy decontamination unit at St Helens Hospital. • The financial evaluation demonstrated this option delivered value for money compared to an in house service. • The contract was approved.	Approval
Workforce Race Equality Standard and Workforce Equality Standard Reports	• The Acting Director of HR presented the 2024 statutory reports, which were due to be presented at the Trust Board in October. • Committee discussed the reports and proposed action plans and agreed that some additional information should be included in the board reports about the changes from previous years.	Assurance
Draft Health Inequalities Strategy	• The Director of Integration presented the draft strategy for review and discussion ahead of presentation at the October Strategy Board. • Committee agreed some additional information to be included in the discussion draft.	Assurance

Finance Imporvement Group (FIG) Report	• The Director of Finance and Information introduced the report. • £8.8m run rate reduction opportunities had been identified with the Divisions. • The temporary workforce dashboard is being reviewed each week to ensure actions are effective and an analysis of job plans across MWL had been completed.	Assurance
Inpatient Survey Action Plan Review	• The Deputy CEO had reviewed the inpatient survey action plan with the patient experience team and had been assured by the level of understanding of the issues and approach to identifying actions that would address them. • The team had spoken to over 200 patients to explore what they identified as “kindness and compassion”, and held conversations with many different groups of staff. • The inpatient survey for 2024 took place in November, so the actions put in place following the 2023 results where unlikely to have had time to embed or impact on the results.	Assurance
31 October 2024		
MWL On-Call Arrangements	• The Chief Operating Officer presented the proposals for a single MWL operational on-call structure. • There would be three levels of cover; site, operational and Executive which would also reflect the levels of Emergency Preparedness, Resilience and Response (EPRR) response out of hours. • Due to increasing difficulty sustaining the separate legacy S&O on call rota (as staff had changed roles) the new arrangements would be implemented from 01 December 2024. • Formal consultation had taken place with divisional staff who would populate the different levels of on-call. • Committee also reviewed the required competencies and training requirements for Executives to be competent to undertake strategic commander duties if there were a major incident.	Assurance
Finance Imporvement Group	• The Director of Finance and Information fedback from the weekly meetings and confirmed £9m of run rate reductions had now been identified.	Assurance
Procedural Document Update	• The Acting Director of Nursing, Midwifery and Governance introduced the report.	Assurance

	• There were now 856 procedural documents, with 215 overdue for review or in need of harmonisation and a further 44 due to expire in the following three months. • It was noted that a number of HR Policies were awaiting sign off by the Local Negotiating Committee. • Each director was monitoring the progress of policies that were in their portfolios.	
Appraisal and Mandatory Training Compliance - September	• Appraisal compliance was 84.3% and it was anticipated that this would improve as not all the appraisals undertaken in September were registered on Electronic Staff Records (ESR). • Mandatory training compliance was 88.8% and compulsory training compliance 87.8%. • Committee reviewed the detailed breakdown where teams fell below the 85% target.	Assurance
Trust Board Agenda - November	• The Committee reviewed the draft Trust Board agenda, based on the annual workplan. • The Committee selected the Employee of the Month for November from the nominations received in October.	Assurance
Draft Whiston Emergency Department CQC Report	• The Acting Director of Nursing briefed the Committee on the draft report received from the Care Quality Commission (CQC) which was subject to factual accuracy review (by 08 November). • Committee discussed the findings and the proposed action plan.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during October 2024 were:</u> • Virtual ward delivery model within the revised financial envelope • Harmonisation of locally employed doctors terms and conditions of service across MWL • Model of medical undergraduate education for Southport Hospital • Flexible endoscopy decontamination equipment managed equipment service contract		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	12 November 2024
Agenda Item	**TB24/083 (8.2)**		
Committee being reported	Charitable Funds Committee		
Date of Meeting	12 November 2024		
Committee Chair	Hazel Scott, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Head of Charity Report	• Updates were provided on the considerable work completed on the Charitable funds' transformation project workplan. • New charity systems, fund structure (blending the charities from the different trusts), governance, brand development and planned Christmas activity were outlined.	Assurance
Annual Report and Accounts	• The legacy S&O Charity (April to June 2023) and draft MWL NHS Charity 2023/24 annual report and accounts were approved. • The accounts on the Charity Commission website by 31 January 2025, subject to an independent examination.	Approval
Finance Report	• An update of MWL NHS Charity's financial performance and financial position (fund balances) as at September 2024. • MWL NHS Charity balance at month 6 was £1,737,807.	Assurance
Review of Charity Risk Register	• No change to the risk register has been made since the previous meeting in June 2024. • The risk register will be updated to focus on high level risks.	Assurance
Charity Fundraising and Income Policy	• The Fundraising and Income Policy is the Charity policy, for any member of MWL staff who wishes to raise or receive charitable funds. • The policy was developed in line with Charity Commission, Fundraising Regulator, and Institute of Fundraising Guidance. Discussion was had over the balance of fundraising for	Assurance

	MWL, each site and specialty causes and how best to draw on staff, patient and carer particular connections across these.	
Charity Expenditure Policy	• The Expenditure Policy contains the Charity's Mission Statement, delegated financial limits and detailed guidance on expenditure that qualifies as 'direct patient benefit' in line with Charity Commission guidance. • Discussion was had over the future opportunity to liaise with specialty teams to encourage best use of spend.	Assurance
Summary of Applications approved since last meeting	• A list of approved MWL NHS Charity grants from July to October 2024. • 24 applications with a total value of £237,000 were granted.	Assurance
Alerts:		
Not applicable		
Decisions and Recommendation(s):		
The legacy S&O Charity (April to June 2023) and draft MWL NHS Charity 2023/24 annual report and accounts were approved (subject to completion of the independent examination).		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 November 2024
Agenda Item	**TB24/083 (8.3)**		
Committee being reported	Quality Committee		
Date of Meeting	19 November 2024		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes of the previous meeting	The minutes of the meeting held on 22 October 2024 were approved as a correct and accurate record of the proceedings.	Approved
Matters arising/Action Log	Matters Arising and Action Log reviewed / agreed, as appropriate. • Action 66 – pilot to commence -action completed. • NEWS compliance to be added from January. • Action 85 - remains on action plan awaiting reconciliation of pharmacy systems. • Action 86 - report in pack	Assurance
Quality Committee Corporate Performance Report (CPR)	• No Never events in month • Pressure Ulcers - ongoing monitoring noting pressures in resource to the team and focus on timely validations over the month ahead. • Patient Falls (with moderate harm or above) - normal variation in month. Hot spots targeted for improvement. • Nutrition-Alignment and standardisation across the Trust of Dietetic referrals ongoing with Business Intelligence Team. • Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia on Spinal Injuries Unit (SIU) - learning review and actions in place. • Meticillin sensitive Staphylococcus Aureus (MSSA) bacteraemia – actions from peripheral devices with ongoing review. • Complaints – improvement in overdue complaints and average number of days to close down by 23%. Emergency Department and waiting times remains a focus with the operational and Executive Team members to	Assurance

	review pathways including learning from complaints. • Perinatal Quality Surveillance Model (PQSM) - Clinical Negligence Scheme for Trusts (CNST) new metrics added to CPR. • Increase in stillbirth rates in month - no care issues identified. • One neonatal death. • Mortality data for the year 2023/24 - annual figure for Trust 92.7. • Hospital Standardised Mortality Ratio (HSMR) for S&O sites has increased – attributed to improvements in accuracy of coding. This has been validated by audits. • Summary Hospital-level Mortality Indicator - Deaths associated with hospitalisation (SHMI) - remains low at 1.05 and continues to be monitored. • Downward trend for crude mortality reflective for S&O sites - in month variation can appear pronounced due to fluctuation in numbers of deaths-assurance given regarding review of trends and deteriorating patient. • Friends and Family Test (FFT) - 'poor' responses for Ormskirk antenatal this month increased to 25%. No concerns noted. Improved response rates for Maternity FFT noted. • One (moderate or above) reportable incident for maternity reported – assurance provided that the incident did not meet the criteria for a Maternity and Newborn Investigation (MNSI). Trust internal review has been undertaken. • Noted 2024 National Urgent and Emergency Care patient survey results received - highlight report to future Quality Committee meeting. • Falls and Pressure Ulcer actions - assurance provided against the decaffeinated drinks pilot on one ward area acknowledging the benefits on wider health issues including quality of sleep and preferences of majority of patients. Roll out Trust-wide confirmed. • Maternity Indicator targets to be added to Perinatal Quality Surveillance Model (PQSM) metrics. • Stroke – assurance provided against resource to support data reporting. Teams will be	

	retrospectively reporting the data. Action plan in place to support the new national metrics. • Action - narrative to be amended to CPR. • Action - request for more narrative to support Venous Thromboembolism (VTE) compliance.	
Patient Safety Report (including Council Chair's Report)	• Patient Safety Report for September and October 2024: • 16 Patient Safety Incident Investigations (PSII) inclusive of four maternity and newborn safety investigations criteria (MNSI), have been commissioned since October 2023 and nine remain open with investigations ongoing. • Falls – there were two falls with severe harm, one located in Whiston site Accident and Emergency Department (AED), and both are undergoing falls reviews. • Pressure Ulcers (PU) – there were 135 Trust acquired pressure ulcers in month and validation for all Hospital Acquired Pressure Ulcers (HAPU) up to Q2 is expected by the end of November. The overarching action plan for prevention of PU notes common factors of patient assessment; risk score calculation, recording and appropriate use of equipment. • PU/Falls – further assurance requested for improvement actions and any other initiatives to be included in future reporting, i.e. the specific work for both falls and HAPU reviews being undertaken within AEDs. • Decaffeinated drinks option acknowledged as a positive pilot planned rolled out across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). • Safety training and culture - a mapping exercise planned during November to assure consistent offer for MWL staff across sites. • Committee noted Patient Safety Incident Investigation (PSII) narrative actions were helpful to see initial actions being completed. However, Quality Committee requested additional assurance regarding immediate actions for some of the Patient Safety Incident Response Framework (PSIRF) incidents.	Assurance

Infection Prevention and Control (IPC) Quarterly Report 2024/25 Q2	• Thresholds for MWL for 2024/25 now received. • Most Q2 outbreaks were associated with Covid-19 and Norovirus. • Up to the end of Q2 (2024/25) there have been two MRSA bacteraemia's. The first case was deemed avoidable, and the cannula related improvement plan continues. The second case was associated with an episiotomy wound and deemed unavoidable. • Aseptic non-touch technique (ANTT) project near completion. Training needs analysis (TNA) completed, and policy approved. Improvement noted in Level 1 training Q2 with S&O just below target. Ongoing promotion of compliance of Level 2 across all workforce and compliance recording into Electronic Staff Records (ESR) ongoing. • IPC Team are undertaking monthly Peripheral intravenous catheter (PIVC) spot check audits. Improvement in compliance from Q1 noted for S&O sites (Q2 90%) with Whiston seeing a reduction in compliance (Q2 80.88%). Improvement on cannula care remains a focus. • MRSA screening – MWL 95% target achieved - compliance at STHK sites almost at 99%. Emergency screening at S&O requires further improvement achieving just above 90%. • Q2 MSSA cases have increased - deep dive planned. • MSSA 45 cases (to date). IPC Team completing deep dive to understand themes. • C-Difficile – Positive position low outlier for Q1 and Q2 due to improvement plan. Trust represented at NHSE Provider Collaborative with C-Difficile an objective and sharing of good practice. • Antimicrobial Stewardship (AMS) pharmacist appointed to S&O. • EColi equal to NHSE threshold in Q1/Q2 and MWL Q2 data is below Cheshire and Merseyside (C&M) rate. However, we are exceeding our MWL 15% internal stretch target. Most actions in the E-Coli Improvement Plan have been completed. A point prevalence audit planned for Q2 will be undertaken in Q3.	

	• Klebsiella pneumoniae - equal to year to date (YTD) threshold with 24 cases YTD. Below C&M rate for 12 months. • Pseudomonas - eight cases, currently above C&M rate. • Covid-19 cases within Q1/2 - noted proportions double for S&O sites associated to estate which impacts on outbreaks. In total 39 outbreaks. • IPC audit programme continues noting strengthening of ongoing improvements and reporting. • IPC E-learning – level 1 compliant and focus to improve level 2. • IPC policies – harmonised 8/40 and work continues. • Assurance given against priority policies effecting clinical care with ambition to complete all policy reviews by end of Q4. • Estate challenges at S&O site Covid-19 cases - assurance provided against serious outcomes and reviewed by medical examiner with no cases to Patient Safety Panel. • Assurance provided on Tendable audits now supporting specific ward/department focus for vascular access. • Flow and bed occupancy acknowledged as impacting on IPC, however, assurances regarding additional capacity being reviewed for the future at Ormskirk Hospital in the new year as a priority. Noted the estate will remain the challenge despite additional capacity. • Clostridioides difficile (C.Diff) position commended and AMS Pharmacist at S&O sites and recruitment of medical microbiology consultant with have a positive impact. • MSSA deep dive – Quality Committee requested an action plan. • Level 2 ANTT practical assessment - assurance given that assessments are taking place.	

	• Noted ANTT is compulsory training and priority within the mapping into ESR. • Noted resources into the team are being reviewed supported through a business case.	
Freedom to Speak Up (FTSU) Reports	• Q1 & Q2 report. • 45 referrals made - 21% higher compared to previous year. • Themes noted and addressed. • Nine anonymous concerns – assurance provided on work regarding Trust Culture and organisational development and journey. • Nursing and Midwifery staff group are highest users of the process. • New data capture process provides information regarding detriment. One staff member reported detriment in Q1. No detriments noted in Q2. • Staff who raise concerns outside of FTSU process data is also captured. • The Trust has 44 FTSU Champions, October FTSU month - planned awareness sessions noted. • National reports noted-Benchmarking ongoing. • Assurance sort on robustness and strengthening of processes when supporting staff through investigations. • Ethnicity and protected characteristics data for future reporting via InPhase.	Assurance
Clinical Negligence Scheme for Trusts (CNST) Update	• Maternity Incentive Scheme (MIS) year 6 update. • The paper detailed MWL compliance across both sites. • The MIS scheme formally ends on the 30 November and final compliance data cannot be provided until after this data for many of the safety actions: • **Safety Action1**: Use of Perinatal Mortality Review Tool (PMRT) to the required standard. To date, in the reporting period, 19 deaths with 100% compliance to all the required standards including presentation of quarterly reports. Q1 24/25 report to be presented within the next maternity quarterly update paper.	Assurance

	• **Safety Action 2:** Maternity Services Data Set (MSDS) – Confirmation received from NHS Digital that the maternity service has achieved 11/11 required targets including 98.2% of women had a valid ethnic category recorded for the July 2024 submission. Full compliance achieved. • **Safety Action 3:** Transitional Care (TC) services. Services at Ormskirk have a TC service with an identified staff member allocated per shift. This model was discussed with the Operational Delivery Network (ODN) / Local Maternity and Neonatal System (LMNS) recently and confirmed that this model meets the criteria for TC. Whiston site progressing with TC action plan. Nursing staff recruited and undergoing induction and orientation. Support staff continues recruitment process and anticipated implementation January 2025. Date to present to LMNS confirmed - on track for compliance. Quality Initiative projects registered, and a presentation is scheduled with the LMNS for 21 November. On track for compliance. • **Safety Action 4:** Obstetric, anaesthetic and neonatal staffing – Audits in progress, Standard Operating Procedures (SOP) in place, collation of anaesthetic rosters and neonatal medical and nurse staffing audits aligned to British Association of Perinatal Medicine (BAPM) being completed. On track for full compliance and previous update papers have identified staffing compliance to BAPM. • **Safety Action 5:** Maternity staffing: January to June 2024 staffing paper presented at July 2024 Quality Committee that includes all the required elements. All evidence has been uploaded to the LMNS portal and verbal confirmation received of LMNS validation since writing the MIS update paper. • **Safety Action 6**: Saving Babies Lives (SBL) Care Bundle V3 – ability to demonstrate quarterly quality improvement meetings with the Integrated Care Board (ICB) ongoing following	

	which validation of evidence is received determining compliance. For the Q2 submission, Ormskirk are fully compliant for all elements of SBL and Whiston are overall 93%, with two elements not meeting full compliance. Q3 evidence has been submitted but not validated as yet from LMNS. Element 2 relates to fetal surveillance of growth restriction. Electron BP monitors are now in use for community midwives and continued audits which are achieving 85%. Action plans in place to further improve audit findings. Element 5 relates to reducing pre term birth. Actions in place to improve documentation of discussions by the neonatal team regarding care options for women and babies. MIS published an updated version in November 2024. Previous version included that a signed declaration from the Executive Medical Director declaring that SBL is fully or in place as agreed with the ICB. The changes now stipulate the requirement is the provision of evidence and that the Board have oversight of progress with SBL either supporting that it is fully achieved or will be in place with progress as agreed with the ICB. The aim is to be fully compliant for Saving Babies' Lives (SBL) however the compliance relates to agreement by the LMNS that adequate improvement is occurring. Currently no concerns and LMNS confirmed they are happy with progress raised and increased compliance awaited following next evidence review. • **Safety Action 7**: Listening to women, parents and families: Evidence of Maternity and Neonatal Voices Partnership (MNVP) engagement, action/ work plans developed utilising data from the maternity safety survey plans and evidence of a fully funded MNVP service. All evidence submitted to the LMNS for review and validation. On track for full compliance. Verbal validation received as fully compliant since report received to Quality Committee. • **Safety Action 8:** Training: • Fetal Surveillance - Fully compliant.	

	• Practical Obstetric Multi-Professional Training (PROMPT) - report details October data. All staff except maternity support workers (MSW) at Whiston and Consultant Obstetricians at Ormskirk are below the 90% compliance. Data provided verbally including training sessions already undertaken in November identify those junior obstetricians on both sites. Consultant anaesthetists at Whiston and other anaesthetic doctors at Ormskirk are just below the 90% threshold. • Neonatal Life Support (NLS) - October data: Midwives on both sites just below target. Verbal update for training to date in November, Ormskirk midwives are below the 90% compliance rate at 83%. For all staff who are non-compliant, sessions booked. Confident against reaching full compliance by 30 November. • **Safety Action 9:** Assurance to Board - PQSM reported to Quality Committee and fully embedded and now included in monthly IPR and additionally presented at Trust Safety Champion meetings. The Trust is on target for full compliance including representation at LMNS/ ICB meetings, safety champion and MNVP walkabouts, presentation of Claims score card and attendance of the Board safety champion meeting with the Perinatal quadrumvirate leadership team. No issues in progress towards full compliance. • **Safety Action 10:** 100% reporting of qualifying cases to MNSI and Early notification scheme - Currently compliant with only one case required reporting in the MIS reporting period and fully compliant with all criteria. Evidence will be uploaded into the portal by 02 December for LMNS review and ICB Board approval alongside providing evidence to MIAA who have been engaged to review submitted evidence and MIS preparation and processes.	

	• LMNS annual visit undertaken on 18 November 2024 at the Whiston site. Brief walkabout at Ormskirk site planned. Verbal feedback of their assurance regarding MIS sign off process. • The LMNS stated they were overwhelmed with the positivity of the teams friendliness, engagement, the clean environment and clear vision on PSIRF and good safety culture, passion for improvement, positive environment and good communication between Board and ward. Individual staff identified as outstanding and engaged and knowledgeable including commitment from the Non-Executive Director (NED). • Acknowledged award presented to Bereavement midwife from LMNS. • December 2024 update report will be provided to Executive Committee. Final report to January Quality Committee and Board in January 2025. Proposed ICB attendance at January Quality Committee meeting.	
Patient Experience Report (inc. Council Chairs Report)	• Bi-monthly update reporting for September and October 2024. • Nine actions completed within the National Inpatient Survey action plan. • MWL Respect and Dignity Policy in place. • Introduction of new Nursing Care indicators to audit pain management and the creation of a seven-minute briefing for pain management. • Harmonisation of Trust discharge booklet. • Tendable audits for October reported at 90.86%. New audit tool due to merging of legacy audits. Audit tool standardised across MWL reflecting the areas for improvement from the national inpatient survey. Tendable project team working with senior ED colleagues to create a new audit based on the principles of the C&M red line audit tool monitoring communication and corridor care. • Patient Experience and Inclusion Strategy consultation complete. • FFT provider platform expected go live on 01 December 2024.	Assurance

	• Average response rate for S&O sites remain unchanged. Positive satisfaction rates were all met with the exception antenatal and postnatal ward. • FFT Whiston site slight reduction of 7% on response rates. All areas met against positive rates with exception of AED and antenatal but only 2% below target. • Communication Themes: Most frequent themes remain communication with patients and relatives. Noted increase in the breakdown in communication regarding appointments and waiting times for beds. • Key highlights from Patient Experience Council assurance reports noted. • Noted request for October patient story to be heard at future Board meeting. • Assurance on approval process in place for maternity chairs STHK site. • Assurance provided on improved Tendable audit numbers going forward. • Noted effectiveness of actions aligned to the inpatient survey. • Agreement sharing of the patient experience newsletter to Committee members.	
Mandatory Training Compliance Report	• Q2 report received noting Core Mandatory and Compulsory Skills training compliance. • Focus of divisions will be on non-complaint subjects going forward. • Coaching provided to support staff groups in accessing systems to complete training. • New Training Needs Analysis (TNA) approval process and master TNA under development for sharing with divisional leads. • Compulsory skills review with proposal to Executive Committee. • Focus also remains on National project through NHSE – assured on good position to respond effectively going forward. • MIAA Audit of Mandatory Training – Positive response. • Compliance reporting to executives noted. • Action: SME reporting of total training provision to be included in the next report.	Assurance

	Whilst acknowledging progress, the Committee noted slow progress in some subjects.	
Alerts:		
None		
Decisions and Recommendation(s):		
The Board is recommended to note the report, alerts and the assurances sought by the Committee.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 November 2024
Agenda Item	**TB24/083 (8.4)**		
Committee being reported	Strategic People Committee		
Date of Meeting	18 November 2024		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	The minutes of the meeting held on the 23 October 2024 were approved.	Decision
Action Log and Matters Arising	The Committee reviewed the outstanding and approved the completed actions.	Assurance
Workforce Dashboard	The CPR dashboard was presented, and the following points were noted: • Mandatory training exceeded target at 88.4% (target 85%) • Appraisal – the Trust appraisal window closed on the 30 September with an overall compliance rate of 87.4%. • Sickness – in October sickness was 5.75% against the 5% target. • Turnover – was 0.7% and remains positively below target for the 12-month rolling average. • Vacancies – 6.8% (target 8%). Vacancy rates for Health Care Assistants (HCA) are 13.2% in month with legacy S&O challenged at 15.5% compared to legacy STHK at 11.9%. There is a strong pipeline of candidates across all staff groups. • Time to Hire - 52 days in October with the Trust target reduced to 30 days in line with NHS best practice.	Assurance
ED&I Statutory Pay Report, WRES and WDES Action Plans	• The Equality, Diversity, and Inclusion (ED&I) Statutory Pay Report, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Action Plans were presented highlighting the following key area for focus where the Trust is committed to:	Assurance

	• Women in Medicine • Men working for MWL • A disability inclusive Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) • Anti-Racist MWL • The key metrics for the Statutory Pay Gap as reported to board in October were discussed. • The practical actions noted were: • Improve disclosure rates so that we can better understand the makeup of our workforce. • Review the reasonable adjustments process to improve the current experiences. • Review the MWL offer for work experience and volunteering. • Review career pathway information and support. Consider positive action programmes i.e. women leadership, women in medicine, men in healthcare. • Identify commonly recommended adjustments with the aim of improving the ease of access for adjustment purposes e.g. IT/ assistive software. • Improve organisation wide knowledge of neurodiversity and research best practice in creating neurodiverse workplaces to make recommendations to the Trust. • Review and re-launch our staff networks and provide support to them to be active in the organisation. • Improve organisational knowledge and understanding of anti-racism at Trust, Division, Team and personal levels including development of awareness and cultural competence. • Engage our local community regarding careers in healthcare at MWL including conscious and deliberate engagement with underrepresented groups.	
Employment Services/ Payroll Annual Assurance Update	• The Committee received the report which highlighted the following key areas: • Employment Services consists of 120 dedicated Payroll, Pension and HR Admin	Assurance

	professionals. Providing services to a client base of 14 NHS organisations and managing c.100,000 payslips per month (for monthly & weekly payroll).
	
	• Achievements in the last 12 months include:
	  • Payroll Assurance Scheme (PAS) accredited.
	  • MIAA - High Assurance achieved:
	  • MWL Excellence in Support Services 2024 Award:
	  • HSJ Partnership Awards - Finalists:
	
	• The current challenges were noted as:
	  • On-going complex changes to NHS Terms and Conditions which Employee Service Records (ESR) is not always compatible with.
	  • Short time frames of pay award notifications and implementation.
	  • Implementation of new/automated processes.
	  • ESR (national) system performance can be unreliable.
	
	• Business development activity was discussed including the onboarding of new contracts:
	
	• Monthly Payroll Activity - a 10.41% increase in monthly payslips in2023/24, with a further 16.97% increase anticipated in 2024/25.
	
	• Weekly Payroll Activity - a 22.48% increase in weekly payslip totals in 2023/24 with a further 4.26% anticipated in 2024/25.
	
	• It was noted that a Cheshire and Merseyside system wide payroll model was being explored by Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) as part of efficiency at scale with low, medium and high pricing options based on digital maturity of the organisation
	
	• Robotic Process Automation (RPA) - circa 8,000 hours saved from the bots developed, enabling staff to focus on more value-added activities to	

	better support our clients and increase efficiency. It was noted that MWL is a national leader in this field and is exploring how bots can be used to support other corporate functions. • Improvements had been implemented for MWL as an internal client to support the improving working lives agenda.	

Sexual Safety Assurance Framework	• The Committee received the Sexual Safety Assurance Framework report highlighting the areas of focus for the Trust including to eradicate sexual harassment and abuse in the workplace.
	• Promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
	• Provide support for those who experience unwanted, inappropriate and/or harmful sexual behaviours
	• Clearly communicate the expected standards of behaviour at work. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
	• Ensure appropriate, specific, and clear policies are in place, supported by training.
	• To capture and share data on prevalence and staff experience transparently.
	
	• Next steps include :
	  • November to December 2024: Education of senior managers on legal duties, embed NHS resources and to review policies and processes in line with national standards.
	  • January to February 2025: Draft Sexual Misconduct Policy consultation, launch reporting mechanisms, and to develop on-going training and awareness for managers
	  • April 2025**:** To launch the new policy.
		Assurance

Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the People Performance Council and the HR Commercial Services Steering Group.	Assurance
Terms of Reference	The Committee approved the Terms of Reference for the People Performance Council.	Decision

Alerts:
None
Decisions and Recommendation(s):
Decision: Approval of the terms of reference for the People Performance Council.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 November 2024
Agenda Item	**TB24/083 (8.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	21 November 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	No		

Agenda items

Title	Description	Purpose
Director of Finance Update	• Noted change in leadership at ICB and NHSE • No formal guidance received following update to the budget from Treasury.	Assurance
Financial Improvement and Price Waterhouse Coopers (PwC) Financial Review	• Committee reviewed action log associated with PwC review commissioned by the ICB. • To date, of the 32 actions identified, 12 have been completed and 20 remain in progress. • All actions have been allocated to a lead Director to support and have a clear oversight of delivery.	Assurance
Integrated Performance Report Month 7 2024/25	• Bed occupancy across MWL averaged 106.7% in October equating to 111 patients – an increase from 105.4% in September. • Average length of stay for emergency admissions is high at 8.2 days, (9.0 days at S&O and 7.4 days) at STHK, the impact of non-criteria to reside (NCTR) patients remains high but has decreased slightly in October, being 17.9% at Organisation level (20% STHK and 14% S&O). • 4-Hour performance decreased in October achieving 72.6% (all types), national performance 73% and providers across Cheshire and Merseyside (C&M) averaging 72.3%. • 18 Week performance in October for MWL was 58.6%, S&O 64.8% and STHK 56.3%. National Performance (latest month September) was 58.5% and C&M regional performance was 56.2% • The Trust had 2,318 52-week waiters at the end of September (459 S&O and 1,859 STHK) and zero 78-week waiters.	Assurance

	• Diagnostic performance in October for MWL exceeded the target at 96.7% (S&O 95.7% and STHK 97.2%). • Cancer performance for MWL in September decreased to 71% for the 28-day standard and 78.2% for the 62-day standard.	
Business Case Benefits Realisation Reports	• Total number of benefits identified and mapped is 266 across 38 business cases. 255 are on track with 11 requiring mitigating actions or not yet reporting delivery. • Significant work supporting Frontline Digitisation (FD) workstreams. • Example of non-FD benefits review shared and discussed.	Assurance
Month 7 2024/25 Cost Improvement Programme (CIP) Update Womens and Childrens Division CIP update	• Total targets for 24/25 is £48m in year and £36.2m recurrently. • There is currently a delivered/low risk value of £36.9m in year (77% of the £48m target) and £32.2m recurrently (89% of the £36.2m target). • Schemes identified to date are £58m with £55.7m recurrent. Based on historic performance a further £5m to £10m of schemes is required to be identified to continue with the progress made to date. • Division CIP update provided including overview of governance process to provide assurance.	Assurance
Diagnostics Targets Review	• Overview provided of the latest position on diagnostic performance for MWL including update of key actions being taken across the system to improve C&M performance. • MWL consistently performs well within the provider group across the C&M Integrated Care Board (ICB), noting the significant volume of activity within Trust services. • Number of modalities under focus and the Trust has been asked to provide mutual aid.	Assurance
2025/26 Planning and Budget Setting Process	• Update given to committee on the process being undertaken to complete the 2025/26 budget setting cycle. • Draft timetable shared incorporating internal processes, to be updated as necessary when external guidance is received from ICB/NHSE.	Assurance

	• Discussion had around ensuring the new Divisions are engaged and supported through the planning process.	
Assurance Reports from Subgroups:	• Procurement Council • CIP Council • Capital Planning Council • Estates & Facilities Management Council • IM&T Council update	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 November 2024
Agenda Item	**TB24/084**			
Report Title	Trust Objectives 2024/25 – Mid Year Review of Progress			
Executive Lead	Ann Marr, Chief Executive			
Presenting Officer	Ann Marr, Chief Executive			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide assurance to the Board on the progress being made to deliver the 2024/25 Trust Objectives.

Executive Summary

1. The Executive Leads have reviewed progress at the end of quarter 2 in delivering the 2024/25 Trust Objectives, and rated them on the following scale –

Fully achieved by 31/10/24	
On track to be delivered by 31/3/25	
At risk of not being fully delivered by 31/3/25	

2. The Trust objectives (appendix 1) are aligned to the Trust vision to deliver Five Star Patient Care: 5 representing the Five Star Patient Care criteria of care, safety, pathways, communication, and systems. A further four categories covering; organisational culture and support for the workforce; operational performance; financial performance, efficiency, and productivity; and strategic planning are also included.

3. There are 30 individual objectives, each with measures of success.

4. The assessment of achievement at the midyear point is –

Fully achieved by 31/10/24	4
On track to be delivered by 31/3/25	23
At risk of not being fully delivered by 31/3/25	3

5. Remedial actions are being put in place for the three objectives where delivery by the end of the financial year is at risk, and these actions plans will be performance managed by the Executive Committee.

Financial Implications

Included in 2024/25 budgets

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the mid-year assessment of delivering the Trust objectives for 2024/25 and the actions being taken where performance is behind plan.

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

Appendix 1

Mersey and West Lancashire Teaching Hospitals NHS Trust

2024/25 Trust Objectives – Mid-Year Review

	Objective fully delivered by 31/10/24		Objective on track to be delivered by 31/3/25		Objective behind plan and at risk of not being fully delivered by 31/3/25

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**					
1.1	Continue to improve the overall experience for women using the Trust's Maternity Services	DoN	• Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys and feedback from women receiving maternity care and delivery of the agreed action plan. • Create a MWL Maternity Strategy to support delivery of the national three-year maternity plan.	Quality Committee	• Improvement not demonstrated in the latest national, which was the first for MWL. However, these results do not correlate local surveys and patient feedback via complaints, FFT, Maternity and Neonatal Voices Partnership (MNVP) forum etc. The next national survey results will be published in 2025/26. • Actions plans have been developed in collaboration with the MNVP, including actions to address the provision and availability of information resources and education sessions, supporting birth partners to stay as long as wanted in the inpatient areas and improving communication with families. • The MWL Maternity Strategy is in development and a period of consultation with staff, service users and stakeholders is taking place in Q3.
1.2	Ensure patients in hospital remain hydrated to improve recovery times and reduce the risk of deterioration, kidney injury, delirium, and falls.	DoN	• Monthly audits on every ward to ensure all patients identified as requiring assistance with hydration have red jugs in place.	Quality Committee	Red Jug Audits have demonstrated improvements. | | Q1 | Q2 | | Red Jugs | 82% | 92%% | Fluid balance audits have also demonstrated improvement. | | Q1 | Q2 | | Fluid Balance | 82% | 87.4% |

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			• Monthly audits on every ward to ensure fluid balance charts are up-to-date and completed accurately. • High compliance with Advancing Quality (AQ) audit results		MWL is first in C&M for performance against the advancing Quality (AQ) targets for acute kidney injury (AKI). AKI pathways continue to be standardised and improved.
1.3	Launch and deliver the Trust wide *Nursing Pride* quality programme to support and deliver consistently high-quality compassionate care.	DoN	• Re-launch back to basics best practice programme by September 2024 • Measure improvement in nursing quality indicators in the IPR (Quality Committee CPR) • Evaluate the impact of the programme via the new MWL ward accreditation scheme. • Achieve substantial assurance in the internal audit quality ward spot checks.	Quality Committee	**Back to Basics** was launched at the nursing conference in June. Weekly quality walkabouts focus on safety documentation (fluid balance, MUST, falls, pressure ulcers, DNACPR, supplementary care, pain, staffing – (action cards for bank and agency RNs and HCAs). Results sent out following the audits to divisions. **Nursing care indicators (NCI)** completed monthly by inpatient areas across all MWL sites and performance monitored by the quality matrons, ward managers, matrons and divisional leads via the Tendable dashboard. Results posters are sent to all clinical areas for display. The quality bus programme is being further developed across all sites. **5 Star Accreditation Programme** commenced in June 2024. 36 areas have had their first assessments and 4 have been reassessed. This includes IPC focusing on ANTT, visual infusion phlebitis (VIP) scores, education and training, safe cannula care and documentation. Supported with environmental walkabouts, quarterly audits of practice and environment, spot checks, and bite size practical training. **MIAA** spot checks are being undertaken in December 2024.
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**					
2.1	Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.	COO	• All patients requiring triage are either triaged within 15 mins or have a baseline set of observations within 15 minutes based on monthly audits.	Quality Committee	Performance remains below 90% target for 15 minute triage – Q1 = 56.4% and Q2 = 49.8% To improve compliance the ED leadership teams are: • Ring fencing an HCA in triage and providing cover for breaks. • Increasing monitoring of the triage screen

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Mid-year progress review and RAG rating</th></tr>
<tr><td></td><td></td><td></td><td>• First clinical assessment median time of <2 hours over each 24-hour period

• Compliance with the Trusts Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits.

• Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring.</td><td></td><td>• Escalating patients not triaged in 15 minutes.
• Developing a front door escalation tool to highlight any capacity issues.

First clinical assessment in less than 2 hours achieved in Q1 and Q2

News compliance 94% in Q1 and 92.8% in Q2 in line with Trust policy

Sepsis – NEWS score within 1 hour of arrival is 100%.

Sepsis – administration of antibiotics within 1 hour of diagnosis is below target, with improvement plan implemented from August</td></tr>
<tr><td>2.2</td><td>Reduce the incidence of methicillin-resistant Staphylococcus aureus (MRSA) healthcare associated bacteraemia infections to meet the zero-tolerance threshold and a 15% reduction of avoidable hospital onset MSSA bacteraemia’s.</td><td>DoN/ Med D</td><td>• Achieve minimum aseptic non-touch technique compliance of 85% for Level 1 (theory) and Level 2 (practical).

• Achievement of 95% compliance

• 90% compliance with visual infusion phlebitis monitoring</td><td>Quality Committee</td><td><table><tr><th></th><th>StHK Sites</th><th>S&O Sites</th><th>MWL</th></tr><tr><td>Achieve minimum aseptic non-touch technique compliance of 85% for Level 1</td><td>94%</td><td>84%</td><td>87%</td></tr><tr><td>Achieve minimum aseptic non-touch technique compliance of 85% for Level 2</td><td>71%</td><td>n/a</td><td>71%</td></tr><tr><td>Achievement of 95% compliance with MRSA screening</td><td>99%</td><td>94%</td><td>96%</td></tr><tr><td>90% compliance with visual infusion phlebitis monitoring</td><td>81%</td><td>90%</td><td>86%</td></tr></table>• ANTT training requirements have now been harmonised across MWL and will be implemented from Q4.
• The learning from the four PIVC-related MRSA bacteraemia cases in 2023/24 informed the development of the Peripheral Intravenous Cannula (PIVC) Improvement Plan. A regular PIVC spot check audit of clinical areas is included in the IPC Team audit plan for 2024/25.</td></tr>
<tr><td>2.3</td><td>Reduce avoidable harm by preventing falls</td><td>DoN</td><td>• Reduction in the incidence of falls per 1000 bed days compared to 2023/24.

• Benchmark in the top 25% of acute Trusts.</td><td>Quality Committee</td><td>Actions taken by the falls:
• Daily walkarounds to identify areas for improvement e.g. documentation compliance and enhanced education when issues are noted,
• Daily snapshot audits of falls risk assessment compliance performed on 10 patients across two wards of concern.</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Mid-year progress review and RAG rating</th></tr>
<tr><td></td><td></td><td></td><td>• 95% of patients to have a documented falls risk assessment within 6 hours of admission and repeat assessments at every change of the patient's condition (evidenced via monthly audits)

• Develop and implement training for HCAs to improve patient enrichment and engagement activities</td><td></td><td>• Enhanced attendance by the falls team to wards where harms have occurred or increased rates of falls noted to provide additional support and education to staff,
• Bespoke training delivered in areas where harms have been reported, using patient story-focused training which incorporate the lessons learned from recent investigations of falls.
Decaffeinated drinks option trialled at Newton Hospital for 2 months, showed a 30% reduction in falls from previous quarter.

<table><tr><th colspan="4">Falls rate</th></tr><tr><td></td><td>StHK Sites</td><td>S&O Sites</td><td>MWL</td></tr><tr><td>2023/24</td><td>7.1</td><td>4.2</td><td>6.0</td></tr><tr><td>2024/25 (YTD)</td><td>6.7</td><td>5.1</td><td>6.1</td></tr></table>
• No national falls benchmarking data published to date.
• In Q2 falls risk assessment been fully completed on admission within 6 hrs for 95% of adult in patient areas.
• Comprehensive training for all new health care assistants/support workers via the Healthcare Academy programme.
• The Dementia and Delirium team deliver Tier 1 and 2 Dementia training.</td></tr>
<tr><td colspan="6">3. 5 STAR PATIENT CARE – Pathways
As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient</td></tr>
<tr><td>3.1</td><td>Continue to improve the effectiveness of the discharge process for patients and carers.</td><td>COO</td><td>• Improved Inpatient Survey satisfaction rates for receiving discharge information.

• Achievement of 20% target for patients discharged before noon during the week.

• Review of discharge data to confirm reason for delay is not</td><td>Quality Committee</td><td>First MWL national inpatient survey results (2023) showed reduced scores for several discharge question scores, although there were improvements against previous years for the S&O sites.

20% discharge before noon not achieved (Q1 = 18.3% and Q2 = 17.7%).

Improvement actions include:</td></tr>
</table>

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			due to waits for take home medication		• Harmonisation of the patient booklet given on admission to explain the process and empower involvement in their discharge planning. • Roll out of the 'What Matters to me' initiative for all discharge discussions. • Identification of golden patient for the transfer lounge the day prior to discharge with night/site manager. • UEC recovery programme, ECIST supporting ward and board processes to support timelier discharge. Delays due to waits for TTO medication have increased. Q1 = 2.13% and Q2 = 9.1%. Improvement actions include: • ECIST UEC recovery programme, includes support for timelier TTO's. • Discharge Lounge to accept patients waiting for TTO's. • Data review to understand if the delay is for doctors writing the TTO request or delays in dispensing from pharmacy. Improvement expected Q4 2024/25.
3.2	Reduce Cancer waiting times.	COO/ Med D	• Achieve the NHS Faster Diagnosis Standard (FDS) for Cancer to ensure that 77% of patients referred with a suspicion of cancer have a this diagnosed or ruled out within 21 days of referral by March 2025. • Ensure that local pathways support the delivery of the FDS through the FDS Prioritisation Group.	Finance and Performance Committee	August 28 day FDS performance 74.4% with improving trajectory to achieve 77% by 31/3/25. FDS governance and performance tracker in place 62 day cancer treatment standard was 80.2% in August for MWL, with differences across legacy sites and tumour site specific action plans in place.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			• Achieve the 62-day Cancer Treatment Standard of to a 85% by March 2025.		
3.3	Implement unified clinical pathways across MWL, aligned to best practice guidance for SDEC, Fractured neck of femur and Day Case Surgery	Med D	• Patients follow the same pathway for common conditions irrespective of where they present across MWL	Quality Committee	• Clinical leadership structure approved by Executive Team to provide unified leadership for clinical specialities. Following Consultation process, recruitment to posts will ensure alignment and implementation of unified clinical pathways. • Strategy sessions for Orthopaedics has taken place to begin process of unification of the clinical pathway for fractured neck of femur. • GIRFT Further Faster 20 onboarding sessions have taken place to share best practice with clinical and operational teams for theatre efficiency. • SDEC session planned across Trust to share best practice
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1	1 Implement a new speech recognition system to improve the turnaround times for clinic letters.	DoI/MD	• Implement the new system and train staff in its use. • Achieve a 48-hour (working week) turnaround for urgent letters and 7 days for routine letters.	Finance and Performance Committee	A replacement Digital Dictation solution, (Dictate IT) has been implemented. Improvement trajectory for letter turnaround times on track to deliver by 31 March 2025, but not yet achieving 90%.
4.2	Continue to align the internal and external communications systems across MWL to ensure they are effective.	Deputy CEO	• Encourage and support staff to be part of the new MWL culture programme and to share stories, ideas, successes, and suggestions for improvement. • Develop innovative and creative digital communications channels to ensure staff and	Executive Committee	• All staff invited to become part of the MWL Facebook group (currently 2,068 followers) – updated daily. • Digital communications have focused on films and reels for the first half of 2024/25 to promote the Trust. • Developing the MWL Linkedin page with HR to attract new staff with stories and staff info. • Facebook reach has increased by 600% and there has been a 300% increase in visits.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			patients can access clear information conveniently and with ease. • Enhance the use of digital and social channels and continue to grow engagement with staff, stakeholders, patients and people across all our communities		• #MWL people campaign following specific members of staff have been viewed 19,000 times.
4.3	To complete the implementation of technology to support and improve patient engagement, and experience with the trust	DoI	• To complete the implementation of phase 1 of the patient engagement portal (PEP), enabling patients to view their outpatient letters on the NHS app.	Finance and Performance Committee	Outpatient letters, appointment information and NHS app integration went live in September 2024 with Gynaecology outpatients at the Southport and Ormskirk Hospital sites. Completion of the rollout for these sites planned for Q4. Implementation at Whiston and St Helens hospital is dependent on completion of the clinic reconfiguration project, and this may not be completed before 31/3/25, which would push back the implementation of PEP across the whole of MWL to 2025/26. The clinic reconfiguration project timetable is being reviewed to see if this can be recovered.
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**					
5.1	To progress the convergence and unification of clinical digital systems to ensure collaborative working across MWL.	DoI	• To complete the procurement of a new EPR, so that the FBC is approved, and the contract signed. • To review clinical digital systems across the trust and understand the clinical prioritisation for system convergence and develop a programme that complements the EPR implementation programme.	Finance and Performance Committee	• The EPR procurement will be re-launched following a re-basing exercise. This will impact the overall programme timetable. • Digital systems are being reviewed as part of EPR readiness. • St Helens Care Record was migrated to the Cheshire & Mersey Connected Care Record (C&MCCR) in July 2024. SSOs were created to implement C&MCCR at Southport Hospital and Ormskirk District General Hospital in July 2024. Knowsley, Sefton, and Halton Places have their GP SSOs and accounts created. Roll out plan and dates to be confirmed by C&M project team, communications to be

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			• To support the ongoing development of the St Helens Care Record, including the onboarding of additional places – Knowsley, Southport, Sefton, Halton, and the migration to the C&M cloud		finalised and distributed, following Senior Engagement. This is expected to be completed prior to March 2025.
5.2	Improve access to patient information via the implementation of Narrative Digital Clinical Documentation	DoI	• Clinicians can access the patient information they need. • Patient information entered electronically only entered once.	Finance and Performance Committee	• Completed for legacy STHK sites and due for completion at legacy S&O sites by March 2025.
5.3	Achieve the same level of technology across all Trust sites which is safe, secure, and available, this will allow staff to work from any sits and access the systems they need to carry out their roles, from any device	DoI	• To have a fully reviewed and updated information asset register with highlighted consolidation opportunities. • Complete the email migration work to ensure all staff have a single-branded email address for MWL. • To consolidate the server and storage infrastructure across the data centres allowing for the removal of one or two of the data centres. • Setup infrastructure to facilitate shared working with a single set of network drives across the whole organisation.	Finance and Performance Committee	• Asset register has been fully reviewed and updated. Further consolidation opportunities currently being assessed with an expectation to complete before end of March 2025. • Email migration completed for legacy S&O sites and due for completion at legacy STHK sites by 31 December 2024. • New server and storage infrastructure has been installed and systems being migrated. Due for completion by 31 December 2024. • Network drives and print services now available cross site for all staff regardless of site they go to or device they use. • Network services such as VPN and Internet traffic have moved over to use the same network link/technologies. Final part of the project underway to move over the Health and Social Care network traffic which is expected to be completed by February 2025.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			• Move the networking over to a single outbound network link which will reduce the need for further investment in firewalls and other associated networking equipment. • Agree opportunities to expand Single Sign On, resulting in easier/ quicker log ins.		• All new applications being procured are being added to single sign on ensuring staff do not need to remember multiple usernames/passwords.
6. DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.					
Looking after our people					
6.1	Continue to support the standardisation of our staff support services and polices ensuring that all staff have access to the same levels of support wherever they work	DoHR	• Continue to harmonise workforce policies across MWL • Review the wellbeing support offer so it continues to be accessible, proactive and meets the needs of staff and managers.	Strategic People Committee	Significant progress has been made on policies, with 45% of overdue policies updated, ratified, and implemented. Work is continuing to ensure the remaining policies are reviewed and implemented by Q1 2025/26 following consultation with Trade Union colleagues. Wellbeing support policies developed and in place including Menopause and Stress Awareness. Wellbeing timetable in place. Development of Wellbeing Network to support wellbeing champions across the Trust and provide support and guidance to colleagues following the Southport major incident. Seasonal vaccinations programme in place. A range of Health and Wellbeing support services, guidance, and tools available to managers and staff to support staff to be well in work. Work ongoing to integrate the wellbeing services across MWL
Belonging to the NHS					
6.2	Create a culture of compassionate leadership and one that celebrates inclusivity and embraces	DoHR	• Agree the priority actions from the 2023 staff survey to improve staff experience,	Strategic People Committee	• Detailed action plans development under each of the themes and progress was reported to Strategic People Council in October 2024.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
	flexibility through the embedding of the new values and behaviours of the organisation.		confidence in speaking up and engagement for delivery during 2024/25. • Launch the new Trust values and promote and explain them to all staff. • Increase access to immediate line manager training programmes such as Making the Transition • Improve access to flexibly working opportunities for all staff groups across MWL. • Deliver the Equality Diversity and Inclusion operational action plan. • Implementation of the 10 principles relating to the Sexual Safety Charter by June 2024.		• New Values and Behaviours launched in April 2024, and they have been embedded them into all training and development offers and incorporate into polices and processes as they are being revised. • Trust Welcome (Induction) includes dedicated session of Values and Behaviours • Internal leadership development programmes have been expanded to provide access to line managers or aspiring leaders from all sites have been available all year to all. • The HR Ops team and L&OD are developing a training offer for everyone in a managerial role, including bitesize learning to help build confidence and capability. Session 1 - Family Friendly Support, commenced in October 2024. • Sexual Safety Charter – The principles of the sexual safety charter have been implemented and following the release of national policy and training resources work is ongoing to embed. • Amended the Respect & Dignity at Work Policy to make explicit reference to sexual harassment as a form of workplace harassment, • Launched the sexual safety pledge and to date 213 members of staff have signed the pledge. • Developed training and supporting materials/ resources, • developed intranet hub to include section on the Sexual Safety Charter; Harassment, Sexual harassment and Sexual Misconduct guidance; signposting to sexual harassment, misconduct and domestic abuse training offered through the NHS.
6.3	Achieve 85% appraisal and mandatory training compliance target, so that	DoHR	• Improve the access to learning opportunities through a range	Strategic People Committee	85% compliance in both mandatory training and appraisals achieved at the end of Q2.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
	staff across the Trust are equipped with clear objectives and the knowledge to help them undertake their role successfully and fulfil their ambitions for career development and progression within our organisation.		of offers including the new career development platform. • Embed the new appraisal process across the whole of MWL during the 2024 appraisal window. • Continue to develop career pathways for a wider range of roles across the Trust. • Undertake a review of mandatory training requirements and delivery models. • Provide reports and analysis to support managers target activities to improve compliance levels in particular departments, staff groups or subjects		Career Development Portal - launched in April 2024 where staff can access free interactive tools & resources. Personal Development funding - Establishment of a single simple accessible process for NHSE CPD across MWL funding introduced in July 2024. Further development of Nursing Associate role as part of nursing workforce strategy supported by business case for more cohorts of trainees. Clinical Development opportunities - implementation of a cyclical Registered Nurse Degree Apprenticeship Top Up Programme from March 2024 Advanced Clinical Practitioners Masters Programmes available to staff. Preceptorship Champions - supporting 250-300 people a year, providing approximately 250 hours of clinical support per month. HCA Academy & Preceptorship - revised in line with National Standards and achieved national accreditation. The programme has been extended to over 14 professional groups. Healthcare Academy has inducted and trained 353 new health care support workers (bank and substantive). Single Appraisal Process - implemented across MWL for the 2024 appraisal window. All mandatory and compulsory training subjects have been through an initial 'check & challenge' (except IPC). New TNAs to be implemented in 2025/26.
New ways of working					

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
6.4	Maximising workforce systems and technology to aid efficiency of the workforce to deliver safe care.	DoHR	• Harmonisation of workforce systems e.g., Occupational Health • Maximise the use of technology and digital solutions across the HR directorate to deliver the best possible people services.	Strategic People Committee	Implementation of a new Occupation Health System is due to go live on 13/1/2025 with a period of transition ending 31/3/2025 with a fully functional system. Workforce data dashboards utilising Power BI in development to provide reliable and up to date information on all key workforce metrics. Work ongoing to integrate E-Roster systems and processes across MWL and ensure consistency across the workforce. Ongoing utilisation of ESR as the single data source for workforce and establishment information in partnership with finance colleagues
Growing for the future					
6.5	Ensure the Trust has effective workforce plans in place to support new models of care. Create a sustainable workforce supply which meets the needs of our patients.	DoHR	• In partnership with the Medical Director and Director of Nursing, Midwifery & Governance continue to create a strong pipeline of new clinical roles including Trainee Nurse Associates and Advanced Clinical Practitioners • Continue to create diverse and innovative offerings to aid recruitment and retention in staff groups with a traditionally high turnover. • Maximise the use of the apprenticeship levy to support more staff to undertake further training in Advanced Clinical Practice and Leadership Development	Executive Committee	TNA requirements across MWL are currently being reviewed by Corporate Nursing. 14 Trainee ACPs commenced training in Autumn 2024 with 5 scheduled to commence training in Spring 2025. The next funding round is expected to be communicated to Trusts by January 2025. In partnership with the SAS working group, SAS career pathway to be developed including the development of Specialist Grade roles. Working across Cheshire and Mersey to identify areas where entry level apprentice roles could be utilised. Apprenticeship first approach to requesting funding from NHSE for Trainee ACPs. 8 of the 14 commenced in August 2024 and funded via the apprenticeship levy with the remainder due to commence in early 2025. Workforce Development Team developing workforce plans to deliver the clinical strategy.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			• Develop workforce plans to support the Trust with the delivery of its Clinical Strategy		
6.6.	Create the right conditions for continuous improvement so staff feel empowered to suggest or seek new ways to improve care and outcomes for patients	MD/MedD	• Develop an MWL approach to continuous improvement. • Promote and create awareness of the MWL continuous improvement culture and methodology. • Develop a MWL Research, Development and Innovation Strategy and increase the Trust involvement in both clinical research and research targeted at identifying and reducing health inequalities. • Increase the number of patients recruited to commercial contract research studies in line with NIHR objectives.	Executive Committee	• Development of continuous improvement strategy progressing in partnership with AQUA. • Initial continuous improvement learning and development programme for all senior leaders including divisional triumvirates underway. • Post senior leadership development programme, further cascade planned. • MWL Research and Innovation Strategy in development, with notable increases in no of patients recruited to research studies in Q1&Q2.
7. OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**					
7.1	Deliver the 2024/25 elective recovery targets	COO	• Eliminate waits of over 65 weeks for elective care by September 2024 (except where the patient chooses to wait longer) • Deliver the C&M ICS system specific activity targets assigned to the Trust.	Finance and Performance Committee	There were 144 x 65 week waiters at the end of September 2024, with 17 due to patient choice. Majority due to specialist plastic surgery capacity. Target not achieved. Recovery trajectory in place to eliminate all 65 week waits by 22 December 2024, with weekly executive monitoring. In September MWL delivered 114% of the 2019/20 baseline against the ICB target of 109%.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			• Maximise the capacity and efficiency of the Trusts resources to reduce long waiting times. • Provide mutual aid in specific specialities to support the delivery of system recovery targets. • Improve theatre productivity and efficiency to maximise capacity		Theatre Productivity - performance has improved from 74.6% to 78.2% against the target of 85%. An external review has been undertaken in theatres and a theatres improvement group has been established to continue to drive further improvement. MWL have provided mutual aid for diagnostic tests, so support system recovery targets.
7.2	Deliver the diagnostic recovery targets	COO	• Eliminate waits of over 26 weeks by June 2024 and 13 weeks by March 2025 for diagnostic tests (except where the patient chooses to wait longer) • Deliver 95% diagnostic tests in < 6 weeks. • Deliver the system specific Community Diagnostic Centre (CDC) activity targets	Finance and Performance Committee	Diagnostic Long Waiters – on 30 June 24, there were 3 x 26-week waiters (Echocardiography). On 31 October 24 no patients were waiting over 26 weeks. In October there were 23 x13-week waiters the trust remains on track to achieve this target by March 2025. In September 6 weeks diagnostic performance = 96.8% Both the CDCs (St Helens and Ormskirk) are delivering above target activity levels.
7.3	Deliver the NHS urgent and emergency care performance targets	COO	• Improve A&E waiting times so that no less than 77% of patient are seen within 4 hours by March 2025 • Reduce the average length of stay in the Emergency Departments	Finance and Performance Committee	• Mapped performance in September = 79.4%. Target achieved. • Average length of stay in the ED has increased (April – September) for Whiston to 584 minutes but decreased at Southport to 486 minutes. Target partially achieved. • Average ambulance handover time at Whiston in September was 69 minutes and at Southport was 38 minutes. Trust wide % handovers in 30 minutes = 48.8% (September). Target not achieved.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
			• Consistently achieve ambulance handover times of less than 30 minutes • Increase the number of direct access pathways for assessment/speciality review. • Urgent Community Response – respond to 70% calls within 2 hours. • Increase the number of patients accessing SDEC services.		• Urgent community response – 2 hours target achieved for 80% of calls. Target achieved. • SDEC activity has remained stable and is limited if the SDEC beds needed for escalation. Trust working with ECIST to support 3 workstreams – Criteria to admit, call before convey, and in hospital processes.
8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**					
8.1	Deliver the agreed financial plan including outturn, cash balances and capital resourcing limits.	DoF	• Achieve the approved financial plan for 2024/25 • Delivery of the agreed Cost Improvement Programme and transaction business case benefits • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income. • Deliver the approved capital programme, to progress the strategic estates delivery plans, equipment replacement and IT investments.	Finance and Performance Committee	The Trust is currently forecasting to: • Deliver the adjusted/agreed financial outturn. • Deliver the CIP target for 24/25. • Deliver the approved capital programme adjusted for the change in EPR purchase. • Deliver the minimum cash balance.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
8.2	Deliver the agreed capital schemes to deliver the capacity needed to meet service demand and a safe, high-quality environment for patients and staff.	DoCS	• Deliver the planned capital developments for 2024/25 including the CDC/TiF schemes. • Deliver year two of the backlog maintenance reduction programme at Southport and Ormskirk Hospitals • Deliver the agreed capital programme to optimise capacity/space utilisation and improve patient experience.	Finance and Performance Committee	On track to deliver the agreed capital schemes. Some challenges in respect of the impact of the new Building Safety Act, the discovery of asbestos in some of the buildings at Ormskirk Hospital and operational pressures limiting access to patient areas.
8.3	Work with partner organisations across the ICS to develop and deliver opportunities for collaboration at scale and increased efficiency	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system. • Drive forward other opportunities for collaboration with system partners.	Executive Committee	The Trust has continued to support the collaboration at scale and efficiency programmes and has progressed developments within: • Payroll – Plan in place to on Board 5 further C&M Trusts within the next 6 months. • Pathology collaboration with WHH Opportunities for system wide HWWB and procurement being explored in Q3 & Q4
9. STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**					
9.1	Ensure the Trust continues to influence and fully participate in the Integrated Care System to achieve a clinically and financially sustainable acute provider services.	CEO	• Develop areas for collaboration that bring benefits for patients and partner organisations. • Continue the development of effective Provider Collaboratives that enhance collaboration and integration of services that support the objectives of the ICS.	Trust Board	ICB operating model review underway which may change the Provider Collaborative model. MWL continues at the forefront of shared services and collaboration.

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
9.2	Complete the post transaction effectiveness reviews with NHS England and the ICBs	DoCS	• All transaction risk rating recommendations completed. • 12 month post transaction review with NHSE is positive	Trust Board	Completed. 12-month post transaction review took place in October.
9.3	Continue to deliver the post transaction transition and transformation programme to fully integrate services and systems across MWL.	MD	• Fewer fragile services • Delivery of the planned integration and transaction benefits	Trust Board	Of the original 18 fragile services identified pre-transaction, 6 have been stabilised with a further 6 having transformation plans underway. 3 require a system level solution working with partner organisations and the final 3 will be addressed are being addressed as part of the divisional business as usual plans. Transaction benefits - Patients • Improved access to services • Improved cancer waiting times and RTT for S&O pop • Better/safer environment • New equipment and re-opening services to referrals • Shaping care together to resolve service configuration. • Single EPR/Integrated IT systems • East Pathology Hub being taken forward • Levelling up standards Staff • Access to training/development • staff support and the resources. • More career opportunities • Improved/safer environment. • Better equipment and IT connectivity • Improved recruitment e.g. Southport ED
9.4.	Deliver the key milestones of the Shaping Care Together Programme for 2024/25 in collaboration with Place and ICB partners.	MD	• Achieve the 2024/25 milestones for the Shaping Care Together Programme – including approval of the Pre-Consultation Business Case	Trust Board	Case for Change approved at the Cheshire and Merseyside (C&M), and Lancashire and South Cumbria (L&SC) Integrated Care Boards (ICB) in July 2024 and subsequently published. A ten-week period of pre-consultation engagement undertaken, to October 2024. Public roadshow events, public

No	Objective	Lead Director	Measurement	Governance Route	Mid-year progress review and RAG rating
					townhall meetings and staff engagement events have taken place across Southport, Formby, and West Lancashire. C&M and L&SC ICB boards approved in principle the creation of a joint committee, with terms of reference to be approved at November 2024 Board meetings. Programme options currently being developed in line with NHSE guidance, for inclusion in the Pre-Consultation Business Case (PCBC) due for completion February 2025.
9.5	Work with each of the Place Based Partnerships where the Trust provides services to improve the health of the local population and reduce health inequalities	DoInt	• Position the Trust as a key partner in each Place Based Partnership • Maximise the potential of the Trust as an anchor institution in our communities to improve health, education, and employment. • Work with Places to turn data into action through targeted programmes with a focus on health inequalities	Executive Committee	• MWL is an active partner in all places; taking the leading role in St Helens, Supporting the SEND Strategic Improvement Board and leading a cancer improvement group in Halton. Presenting Trust progress in other Health and Wellbeing Boards. • MWL is the Lead Partner developing a Health and Social Care Academy. A Business Case has been approved by the St Helens Town Deal Board for the establishment of a £1.3m venue. • MWL has developed a Health Inequalities Dashboard which is being developed to be used across Cheshire and Merseyside. Several initiatives using data dashboards to inform changes in practice for mental health, diabetes, frailty have been developed. • Working with Places to reduce delays in discharge pathways.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 November 2024
Agenda Item	**TB24/085**			
Report Title	Digital Strategy Update			
Executive Lead	Malcolm Gandy, Director of Informatics			
Presenting Officer	Malcolm Gandy, Director of Informatics			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide an update of progress to the Board on the delivery of the Digital Strategy that was published in March 2024.

Executive Summary

The Trust's Digital Strategy was launched in March 2024; since this period the previous Director of Informatics has left, and the Trust appointed a new Director of Informatics. The aims of the strategy are as follows:

- The needs of our population and addressing health inequalities.
  - Enabling 5-star integrated, safe and sustainable care.
  - Workforce, funding and capacity challenges.
  - The needs of our acute and community clinical and administrative users.
  - Supporting our ICS partners in improving integration and interoperability and in converging on as few clinical systems as is practicable.
  - National strategies for digital and clinical systems maturity, using digital technologies to empower patients and supporting Net Zero.

The key objectives of the strategy relating to digital systems were to procure and implement a single Electronic Patient Record (EPR) across the Trust; to look at optimising the Trust digital infrastructure, with an ambition to level up and rationalise this across the Trust; and to increase levels of digital maturity across the Trust.

The Trust launched its procurement for a single EPR in March 2024, but has recently taken the decision to abandon the current procurement, following a legal challenge from the incumbent EPR supplier. The Trust is now looking to launch a re-procurement and is currently reviewing the procurement process with ICS partners, NHS England to understand what the process will look like going forward. It is anticipated that the next procurement will be launched in early January 2025.

Other works ongoing include significant infrastructure activities, and positive progressive made on the implementation of an ICS Laboratory Information System (LIMS) which is being led by Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). The forecast go live date for this March 2027.

Financial Implications

Not applicable

Quality and/or Equality Impact

The delay in the EPR procurement process will have an impact on the Trust's transaction programme; options are being explored to understand what actions can be taken in the interim to

alleviate this position.	
Recommendations	
The Board is asked to note the Informatics Strategy Update.	
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

Introduction

The Digital strategy was approved by the Trust board in March 2024; this paper provides an update on the progress on delivery of the strategic objectives. The updates on the objectives are contained within the table below. Significant progress has been made on a number of the items, including email migration from legacy email addresses to a new single Trust email address, the commencement of the LIMS (Laboratory Information Management System) programme and the roll out of digital dictation programme.

Areas of focus for 2025

Core areas of focus for the 2025 are as follows:

a) EPR procurement recommencement
b) EPR readiness workload – current and future state mappings, initiate data migration, data archive strategy
c) Interim levelling up programme review – in particular Pharmacy and maternity system deployment, and Outpatient clinic rebuild at STHK.
d) Complete email migration
e) Converge the back-end infrastructure so that all 5 sites are on the same network, domain and infrastructure
f) Review digital strategy to incorporate data services and business intelligence, and a review of Community Services digital requirements; liaise with divisional colleagues to ensure divisional digital requirements are incorporated

These strategic development initiatives are focused on enhancing digital capabilities and improving patient care through a series of key projects. These projects include the procurement and deployment of a new single Electronic Patient Record (EPR) system, the digitisation of patient records and clinical pathways, and the optimisation of existing clinical solutions. Some key headline projects include:

1. **Single EPR Procurement and Deployment**: The Trust is working on procuring a new EPR system to replace the current two EPRs. This new system will include functionality for critical care and is expected to start procurement in early 2025. The deployment will replace all current functionalities and level up across sites.

2. **Digitisation of Patient Records and Clinical Pathways**: An accelerated program is underway to fully digitise end-to-end clinical workflows, improving patient safety and care delivery efficiency3. Despite some delays, efforts continue towards digitising workflows at legacy sites and aligning digital handover and referrals.

3. **Optimising Existing Clinical Solutions**: The Trust is reviewing all duplicate clinical digital systems to develop a strategy for convergence to a single Trust-wide solution. This includes the implementation of specialist functions to replace paper processes in critical care units and enhancing interoperability with other clinical systems.

4. **Technology Workstreams**: Key technology initiatives include data centre and server upgrades, the implementation of a single firewall and digital telephony solution, and the

migration to a single domain network. These efforts aim to provide a solid foundation for all digital systems and services.

5. **Corporate RPA Initiatives**: The Trust is continuing to deploy Robotic Process Automation (RPA) technologies in corporate services to automate repetitive tasks, with a business case being developed to roll out the technology across the Trust.
6. **Regional Integration**: The Trust is aligning with regional initiatives to increase interoperability for diagnostic services and other regional systems. This includes the implementation of a regional Laboratory Information Management System (LIMS) and the migration to the Cheshire & Mersey Care Record solution

Recommendation

The Trust Board is asked to note the progress against the deliverables as described in the table below, and to note the focus areas as outlined above for 2025.

This following table aims to provide an updated overview of the current detailed plans of implementation within our digital strategy. While the contents are comprehensive, they focus more on the operational aspects rather than a strategic approach. A further strategy report, including a strategic timeline, will be presented at the agreed annual strategy update.

The following deliverables that are covered by the Digital Strategy, they are presented by category, in date order.

Strategic Development	Description	Update – November 2024	Forecast date
Single EPR			
Single EPR Procurement	Procurement of a new EPR to replace our two current EPRs, following public sector procurement regulations.	Following the completion of the EPR procurement in July 2024, following a legal challenge the Trust decided to abandon the current procurement. Work is now underway to design and launch the EPR re-procurement; this will include functionality for critical care (amongst other areas)	Procurement to start early 2025. Est. implementation date Sept 2027
Single EPR Deployment	Implementation of our new single EPR, to replace all our current functionality and level up across sites.		
Critical Care Solution	Implementation of specialist functions to replace paper processes in our critical care units as part of our single EPR implementation.		
Optimising our Existing Clinical Solutions			
Digital Dictation	Replace our currently unsupported digital dictation solution at the Whiston and St Helens sites until speech recognition is implemented.	This has been fully deployed across the STHK site and is now in BAU state	Completed June 2024
Patient Portal	Roll out and development of our patient portal to provide patient access to their letters, appointment management functions, condition specific information, completion of questionnaires and direct communication with care professionals. Aligned with our current EPRs and our new single EPR.	Analysis of this, and potential deployment within the functional capability of the existing EPR and capacity and benefit of doing pre single EPR deployment. Live with some services at S&O.	Full deployment estimated to be completed at S&O by March 2025. Deployment at STHK dependent on OP clinic rebuild

Strategic Development	Description	Update – November 2024	Forecast date
Order Communications and laboratory processes optimisation	Fully deploy order communications across the organisation and review and modernise laboratory process on our Whiston, St Helens and Newton sites.	The use of electronic ordering / resulting has been reviewed and issues identified which are impacting the process going fully paperless. The paper will be reviewed with lab and operational colleagues and an action plan agreed. Work is ongoing to enable the lab results to be available within the S&O instance of Careflow and allow the removal of the 'Review' product. This will mean orders and results can be actioned through the S&O instance of Careflow.	Estimated completion by June 2025
Pre-operative assessments	Providing functionality to digitise pre-operative assessments, implementing initially on our Southport and Ormskirk sites and extending to all sites in line with the roll out of the Theatres solution.	This will be delivered as part of the BlueSpier upgrade at Southport and Ormskirk – this is planned for the spring of 2025	Estimated delivery by July 2025
Community Care Record Optimisation and Consolidation	Develop plans to move to a single community care records system. Optimise our existing solutions to remove paper from community care processes.	The community care records are halfway through moving to a single solution. Plans are in place to complete the roll out during 25/26.	To be completed by March 2026
Systems Convergence	Review all duplicate clinical digital systems and develop a strategy for convergence for each to a single Trust wide solution. Align the plan with the single EPR implementation and clinical service transformation plans.	As part of the EPR implementation, a roadmap will be developed to understand duplicate and stand-alone system convergence, ensuring alignment to a single EPR and removal of duplicate systems (e.g. document management systems, Somerset cancer tracking etc)	Review to be completed by December 2025
Digitisation of Patient Records and Clinical Pathways	An accelerated programme of work to fully digitise end-to-end clinical workflows to improve patient safety and care delivery efficiency in advance of a single EPR.	Work continues towards digitising workflows at legacy STHK & rolling Connect out at pace at S&O sites to align digital handover, photography within the patient record and referrals	This is not a specific deliverable, there is work ongoing to digitise as

Strategic Development	Description	Update – November 2024	Forecast date
			much as possible in the Trust
Maternity	Replace the current CareFlow Maternity system with the Badgernet solution to support the provision of electronic notes held by the pregnant person ('red book' notes) and accessed via a mobile phone app.	Analysis of this, and potential deployment within the functional capability of the existing EPR and capacity and benefit of doing pre single EPR deployment	Options being reviewed with Maternity services Dec 2024, for the Trust to determine how to progress with deployment of Badgernet.
Clinic Letters & Reconfiguration	Outpatient clinics rebuild and process redesign to enable the production of clinic letters in the current Careflow EPRs and the decommissioning of the current solution. Modernise and streamline outpatient booking processes across the Trust in advance of a single EPR.	Analysis of this, and potential solution within the functional capability of the existing EPR and capacity and benefit of doing pre single EPR deployment	Option appraisal Dec 2024, for the Trust to determine how to progress
Extend Pharmacy to Southport and Ormskirk Sites	The replacement of the current Pharmacy system on the Southport and Ormskirk sites, adopting the system used on the Whiston and St Helens sites.	This was initially paused due to the EPR procurement; a feasibility study will be conducted over the next period to understand the option to extend EPR and pharmacy system across the Trust whilst the next EPR procurement is developed and undertaken	Option appraisal Dec 2024. This will determine whether the Trust deploys this or awaits the new EPR
Extend EPMA to Southport and Ormskirk Sites	Extending the system used on the Whiston and St Helens sites to the Southport and Ormskirk sites.		
Clinical Narrative Expansion	Enhancing our current EPRs, data input and access processes to reduce duplication of effort. Enhancing interoperability with other clinical systems to ensure data is captured once and used many times.	Clinical Narrative continues to roll out across the legacy STHK sites – all legacy Noting forms are Live in Narrative, and newly digitised forms Go Live monthly at STHK, reducing paper and documentation burden, while improving workflows (e.g. the eDIS form). S&O Narrative Go Live is delayed, due to the Doc Editor issues, however work continues in the background to	This is not a specific deliverable, there is work ongoing to digitise as much as possible in the Trust

Strategic Development	Description	Update – November 2024	Forecast date
		ensure all currently Live Noting forms will be built in Narrative in time for Go Live. When S&O is Live with Narrative, we plan to roll out documentation that is Live in Narrative at STHK, but still on paper at S&O, to improve the digital maturity of those sites and to bring processes and standards into alignment – the largest example of this is the nursing admission and social history/ADL documentation	
CareFlow Handover of Care Letters & To Take Out (TTO) Prescribing Information	Migration away from the ICE and EMIS Secondary care solutions used for the production of in-patient handover of care letters to the production of these from our current CareFlow EPRs.	Analysis of this, and potential solution within the functional capability of the existing EPR and capacity and benefit of doing pre single EPR deployment	Analysis to take place by March 2025. This will determine whether the Trust deploys this or awaits the new EPR
Corporate RPA initiatives	Continue to deploy Robotic Process Automation (RPA) technologies in corporate services to automate repetitive tasks.	There have been many processes that have been automated within HR.	The intention is to develop a business case, by the end of 24/25, to roll out the technology to automate other processes across the Trust
Theatre Management Solution	Implementing a Trust wide Theatre Management Solution to replace the obsolete system on the Whiston and St Helens sites and replace the remaining paper processes on the Southport and Ormskirk sites.	Analysis of this, and potential solution within the functional capability of the existing EPR and capacity and benefit of doing pre single EPR deployment	Option appraisal spring 2025
Care Records Document	Develop a strategy for the convergence of our two Electronic Document Management Solutions (EDMS) to deliver a single point of	This will be considered as part of the post EPR deployment optimisation strategy	To be determined (likely to be post EPR optimisation work

Strategic Development	Description	Update – November 2024	Forecast date
management system review	access for digitised copies of paper care records. Set out a roadmap for a single solution in alignment with the single EPR programme.		programme) – options appraisal estimated to take place by Sept 2025
Community order communications, results reporting and prescribing	Implement laboratory order communications and results reporting and electronic prescribing and medicines administration for our community teams, aligned with our single EPR deployment.	This will be considered as part of the post EPR deployment, optimisation strategy	To be determined (likely to be post EPR optimisation work programme) – est. March 2026
Speech Recognition	Speech enabled direct entry of information into the patient record in real time to reduce data input effort and streamline the production of clinic outcome letters.	An options appraisal and full business case needs to be developed for the implementation of speech recognition	To be determined (likely to be post EPR optimisation work programme) – est. 2028
ICS Workstreams			
Cheshire & Mersey Shared Care Record	Migrate the current St Helens Care Record to the Cheshire & Mersey Care Record solution in line with the ICS digital strategy.	Completed	Complete in July 2024
Clinical Network Support Regional LIMS	Support the development and deployment of a regional Laboratory Information Management System (LIMS).	Implementation of regional LIMS is ongoing, MWL are leading on this; go live planned for early 2027	Go live planned for March 2027
Regional Integration	Aligning with regional initiatives to increase interoperability for diagnostic services and other regional systems. Work is currently in the planning stage.	Regional PACS, Endoscopy both live at MWL, LIMS as above Regional integration engine will be built as part of the LIMS programme and further use explored	This is not a specific deliverable, work ongoing, e.g. regional integration engine post LIMS go live
Regional Clinical Network Support	Aligning with regional initiatives to increase interoperability for clinical networks and general practice communications.	This is a catch all to cover the Trust's involvement in various ICB-wide initiatives. For example, in addition to LIMS mentioned above, we are involved with a single ICE across C&M, a	Not a specific deliverable, work ongoing to align with regional initiatives

Strategic Development	Description	Update – November 2024	Forecast date
		single endoscopy solution and the Federated Data Platform.	
Technology Workstreams			
Trusted Network Domain Status	Increase the level of sharing between our two current networks to a 'Trusted relationship' status so that whilst separate, they appear to be as one.	The Trust relationship between the two domains has been completed	Completed in April 2024
Integrated Technology Team	Move to a single team, focussed on building the specialist technical skills required to achieve our strategic aims.	The team mergers have been completed across Informatics	Completed in April 2024
Remote access capability	Provide a new single solution to enable consistent and reliable remote access to our systems and services supporting our homeworkers.	Single remote access solution now utilised across all sites for home/remote workers.	Completed in May 2024
Single Monitoring Tools	Single monitoring solutions and tools for the management of all our infrastructure and services.	All monitoring tools have now been consolidated providing a single pane of glass for detecting and troubleshooting issues across all sites. Complete	Completed May 2024
Bring Your Own Device	To reduce the need for multiple devices and to improve the user experience of our staff.	All Microsoft 365 applications such as email and teams are available from personal devices. Some clinical applications, such as Careflow Connect, are available for use from personal devices.	Complete, as policy in place, BYOD will be further implemented if appropriate
Rolling device replacement	Maintain our laptop, desktop and hand held device refresh programme (if affordable) so that no device is over 5 years old.	Rolling programme still underway with the focus being on replacing devices that won't run Windows 11 which is the latest operating system from Microsoft which we need to move to by October 2025.	Ongoing, programme in place every year
Single Sign on	Integrate more applications into our Single Sign-on solution to reduce the need for multiple system logins.	Any news systems are implemented with Single Sign On and strategy includes new systems requiring to integrate with existing identity sources.	All systems identified in situ have been completed.

Strategic Development	Description	Update – November 2024	Forecast date
Data Centre and Server Upgrades	Implement new on-premises server and storage infrastructure equipment in the Trust's two main data centres.	The new hardware has now been installed and is configured in the two main data centres. Programme now underway to move systems to the new hardware following testing.	Aim to be completed by Feb 2025
Single Firewall	Migrate to a single firewall and cyber security processes to further protect the Trust from cyber security threats.	Several of the key workloads have been migrated to single firewall (internet traffic, VPN). The last service from the legacy S&O sites, Health and Social Care Network, is currently being planned at which point this will be complete	Scheduled to be completed by Feb 2025
Single Domain Network	Migrate fully to a single domain network – the final step for providing a solid foundation upon which all our digital systems and services are provided.	Business case is being developed to secure the funding to carry out this piece of work	To be scheduled in 25/26, aim to complete by March 2026
Standard device build	Roll out a standard build for all our access devices to streamline technical support requirements which will make it easier to move devices between sites.	There is a dependency on Single Domain Network. Not yet started.	Estimate implementation date March 2027
Single Integration Engine	Move to a single provision of the technology that allows us to exchange data between our clinical systems.	This has not yet started, plan to implement it in 26/27 but will review in line with the regional integration engine	Estimated implementation date March 2027
Single Digital telephony	Implement a single digital telephony solution replacing our current obsolete solutions to improve reliability and provide a modern capability.	Not yet started	Scheduled to take place in 2027/28, with funding identified within the draft capital plan

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	27 November 2024
Agenda Item	**TB24/086 (11.1)**				
Report Title	Research and Development Operational Capability Statement (RDOCS)				
Executive Lead	Dr Peter Williams, Medical Director				
Presenting Officer	Dr Peter Williams, Medical Director				
Action Required	X	**To Approve**		**To Note**	

Purpose

The Research and Development Operational Capability Statement (RDOCS) is a tool to improve effectiveness and collaborations in research activities.

Executive Summary

The statement provides researchers with an operational overview of resources available to support Research & Development in the organisation and an overview of research collaborations and partnerships with other organisations, including areas of special interest.

Financial Implications

None, however, the RDOCS is viewed by commercial companies who are looking to invest in research and will use the RDOCS to seek out potential sites.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the Research and Development Operational Capability Statement.

Strategic Objectives

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

NIHR Guideline B01
RDI Operational Capability Statement

Note: This spreadsheet is protected to help avoid inadvertent changes. However there is no password set so that users can unlock the sheet and edit their own content if required.

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
Statement 001					
Statement 002	01/11/2013	01/11/2014	27/11/2013	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 003	18/11/2014	18/11/2015	18/11/2014	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 004	31/12/2015	31/12/2016	27/01/2016	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 005			12/01/2017	Professor Kevin Hardy	Mrs Jeanette Anders
Statement 006	01/12/2017	01/12/2018	29/11/2017	Trust Board	Mrs Jeanette Anders
Statement 007	01/12/2018	01/12/2019	28/11/2018	Trust Board	Mrs Jeanette Anders
Statement 008	01/12/2019	01/12/2020	27/11/2019	Trust Board	Mrs Jeanette Anders
Statement 009	01/12/2020	01/12/2021	25/11/2020	Trust Board	Mrs Jeanette Anders
Statement 010	01/12/2021	01/12/2022	24/11/2021	Trust Board	Mrs Jeanette Anders
Statement 011	01/12/2022	01/12/2023	30/11/2022	Trust Board	Mrs Jeanette Anders
Statement 012	01/12/2023	01/12/2024	29/11/2023	Trust Board	Mrs Jeanette Anders and Mrs Jill Simpson
Statement 013	01/12/2024	01/12/2025			

Contents

Organisation RDI management arrangements

Information on key contacts.

Name of organisation	Mersey and West Lancashire Teaching Hospitals NHS Trust
Role:	Research Development and Innovation Executive Lead (Medical Director)
Name:	Dr Peter Williams
Contact number:	Contact by email
Contact email	Peter.Williams3@sthk.nhs.uk
Role:	Clinical Director of Research - Whiston site
Name:	Dr Ascanio Tridente
Contact number:	Contact by email
Contact email	Ascanio.Tridente@sthk.nhs.uk
Role:	Clinical Director of Research - Southport/Ormskirk site
Name:	Dr Craig Rimmer
Contact number:	Contact by email
Contact email	craig.rimmer1@merseywestlancs.nhs.uk
RDI office details:	
Name:	Research Development and Innovation Department - Whiston site
Address:	The Research Hub, Whiston Hospital, Ground Floor , Yellow Zone, Warrington Road, Prescot, Merseyside, L35 5DR
Contact number:	0151 430 2334 / 1218
Contact email:	research@sthk.nhs.uk
Name:	Research Development and Innovation Department - Southport/Ormskirk site
Address:	Innovation Centre, Ormskirk District General Hospital, Wigan Road, Ormskirk, Lancashire, L39 2AZ
Contact number:	01695 656506/6419
Contact email:	soh-tr.researchsonhs@merseywestlancs.nhs.uk
Key contact details e.g. Feasibility, confirmation of capacity and capability to conduct research at MWL	
Contact 1:	
Role:	Research Development and Innovation Department Manager (RDI) - Whiston site
Name:	Jeanette Anders
Contact number:	0151 478 7850
Contact email:	jeanette.anders@sthk.nhs.uk
Contact 2:	
Role:	Research Development and Innovation Department Manager (RDI) - Southport/Ormskirk site
Name:	Jillian Simpson
Contact number:	01704 703457
Contact email:	Jillian.Simpson@MerseyWestLancs.nhs.uk
Contact 3:	
Role:	Research Development and Innovation Co-ordinator
Name:	Paula Scott
Contact number:	0151 430 1218
Contact email:	paula.scott@sthk.nhs.uk
Contact 4:	
Role:	Research Development and Innovation Co-ordinator
Name:	Julie Ditchfield
Contact number:	01695 656506
Contact email:	Julie.Ditchfield@MerseyWestLancs.nhs.uk

Contact 4:	
Role:	Research Development and Innovation Research Support Officer
Name:	Jennifer Miller
Contact number:	0151 290 4898
Contact email:	jennifer.miller@sthk.nhs.uk

Information on staffing of the RDI office.

RDI office roles (e.g. Governance, contracts, etc.)	Whole time equivalent	Comments indicate if shared/joint/week days in office etc.
Research Development and Innovation Manager - Whiston	0.6 WTE	Wednesday to Friday
Research Development and Innovation Manager - Southport	0.8 WTE	Monday to Thursday
Research Development and Innovation Co-ordinator - Whiston	1.0 WTE	
Research Development and Innovation Co-ordinator- Ormskirk	1.0 WTE	
Research Development and Innovation Support Officer	1.0 WTE	

Information on reporting structure in organisation (include information on any relevant committees, for example, a clinical research board / research committee / steering committee).

Trust Board		The Medical Director reports to the Trust Board.
The Medical Director reports to the Quality Committee.		The Quality Committee advises the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Managers report to the Clinical Effectiveness Council (CEC)		The CEC Council investigates any issue that sits within its terms of reference. Its aim is to seek and receive from any department or service assurance on the maintenance and improvement of clinical effectiveness. The Council is authorised by the Quality Committee to investigate any issue that may pose a risk to Clinical Effectiveness. The Committee shall advise the Board on all matters pertaining to Quality of services and subsequent risk to patients and the Trust. In establishing the Committee the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered to be of Board level significance it is to be reported to the Board for approval before action.
RDI Managers report to the Research Development & Innovation Group (RDIG)		The RDI Group reports to the Quality Committee to provide assurance about all aspects of RDIG activity within and involving the Trust. The Chair of the RDI Group is the Clinical Director for Research Development and Innovation. The RDI Group is responsible for: Review and approval of the RDI strategy consistent and compliant with contemporary (inter)national guidance Review and approval of the Annual RDI Report (written by the RDI Managers) Review and approval of the Research Capability and Capacity Statement Review and approval of the Research Standard Operating Procedures Oversee operational delivery of the RDI strategy via updates received from the RDI Managers Review of research studies deemed high risk or with identified issues/concerns will be referred to RDIG for consideration (by the RDI Managers). Any risk or safety issues relating to research activity will be reported to the RDI Group for discussion and action plan. The Core membership of the RDI Group oversees the reinvestment (in research) of the commercial and non-commercial funding and the income distribution plan.
The Research Practitioner Group (RPG)		The Research Practitioner Group (RPG) The RPG is responsible for: Review Research Standard Operating Procedures (SOPs) prior to submission to RDIG for approval. Ensure that the Trust is prepared for a Research MHRA (Medicines and Healthcare Products Regulatory Agency) inspection through the review and discussion of regular action plans Support the aim to embed a positive research culture throughout the organisation Ensure that lessons are learned from research audits/issues and that effective improvement is implemented Ensure that on a day to day basis RDI activities are conducted according to RDI Standard Operating Procedures (SOPs) Support the training programme for Research Nurses to ensure that they are fully complaint in accordance with nursing/trust requirements.

Information on research networks supporting/working with the organisation.
Information on how the organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research network (name/location)	Role/relationship of the research network e.g. host organisation
The NIHR Research Delivery Network North West (NIHR RDN NW) provide the Trust with funding for staff	Funding for - Senior Research Nurses, Research Nurses, Research Midwives/ Paediatric Research Nurses, Data Managers, Project Support Officers, Associate Research Practitioner, Research Support Assistants

Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, other NHS organisations, higher education institutes, industry).

Organisation name	Details of collaboration / partnership (e.g. university/organisation joint office, external provider of pathology services to organisation, etc., effective dates)	Contact name	Email address	Contact number
University of Liverpool University of Edge Hill	Professor Rowan Pritchard Jones, Consultant Plastic Surgeon at MWL is an Honorary Clinical Professor at Edge Hill University, and an Honorary Clinical Professor at the University of Liverpool. MWL are involved in a number of research projects with Liverpool and Edge Hill University Professor Rowan Pritchard Jones is also the Medical Director of the Cheshire and Merseyside Integrated Care Board.	Professor Rowan Pritchard Jones		By email only

University of Edge Hill	Professor Greg Irving is an academic GP with an ineterest in primary care research and medical education. Greg is Director of the Health Research Institute and Director of the Edge Hill Primary and Integrated Care (EPIC). Greg's research interests have focused on developing and evaluating complex interventions for use in primary care. He has experience in systematic reviews, randomised trials, observational studies along with qualitative research approaches. Greg is the Deputy Lead for the NIHR North West Coast Complex Intervention Theme and Deputy Speciality GP Lead for NIHR Reserach Delviery Netowrk West Coast.	Professor Greg Irving		
Manchester Metropolitan University	The Trust is involved in a number of research projects with Manchester Metropolitan University, involving collaborations with Critical care (Dr A Tridente, CD and Visiting Professor, Manchester Metropolitan University) and Burns and Plastics (Mr K Shokrollahi, Clinical Lead, Mersey Regional Burns Service)	For details of studies please contact Jeanette Anders, RDI Manager		0151 478 7850
Liverpool School of Tropical Medicine	The Trust has established links with the Liverpool School of Tropical Medicine.	Angela Hyder-Wright Accelerator Research Clinic (ARC) Manager/ Senior Research Nurse Liverpool School of Tropical Medicine		By email only
St Helens Primary care	The Trust has links to Primary Care through the Marshall Cross . These links are vital and offer us the potential to collaborate on joint research projects as well as recruiting from the primary care sector.	Dr Greg Irviing GP and Consultant in Primary Care St.Helens CCG Governing Body Member		
NIHR Research Delivery Network North West (NIHR RDN NW)	MWL are a partner organisation of the Research Delivery Network in the North West Coast (RDN NWC).	Andy Ustianowski, Network Director, North West RRDN (currently RDN Executive Director for an interim period)		
NIHR Applied Research Collaboration (ARC) North West Coast	MWL are a partner of the ARC NWC. The aims of the ARC NWC are to improve outcomes for patients and the public through collaboration working by bringing together academics, health and social care providers, members of the public, universities and local authorities. Its vision is to improve the quality, delivery and efficiency of health and care services; reduce health inequalities and increase the sustainability of the health and care system both locally and nationally.	Professor Mark Gaby, Director NIHR CLAHRC NWC		
Liverpool Health Partners	MWL have links with Liverpool Health Partners (LHP). LHP work together with Academic and NHS partners to develop groundbreaking research by encouraging conversations across the region, and sharing expertise to improve population health outcomes and economic productivity for the better.	Seamus O'Neil, Managing Director, LHP Board	lhpadmin@lhch.nhs.uk	
UK Research and Innovation	MWL have links UKRI. UKRI organisation brings together the seven disciplinary research councils, Research England, which is responsible for supporting research and knowledge exchange at higher education institutions in England, and the UK's innovation agency, Innovate UK.	Professor Dame Ottoline Leyser ,Chief Executive	communications@ukri.org	communications@ukri.org
NIHR Research Support Service -North West	The Research Support Service in the North West is part of the NIHR infrastructure and exists to provide support and advice for people preparing NIHR grant applications.		https://www.nihr.ac.uk/support-and-services/research-support-service	

Liverpool Heart and Chest Hosptial	Professor Gregory Lip is a clinical researcher and Price-Evans Chair of Cardiovascular Medicine, at the University of Liverpool. He is Director of the Liverpool Centre for Cardiovascular Science at the University of Liverpool, Liverpool John Moores University and Liverpool Heart & Chest Hospital. Professor Greg Lip is working on a number of reserach studies at Whiston Hospital.	Professor Greg Lip		
Clatterbridge Centre for Oncology (CCC)	MWL & CCC work collaboratively with CCC. There is an agreement in place whereby patients have access to Systemic Anti-Cancer Therapy (SACT) trials at STHK through the availability of CCC employed staff working to CCC governance arrangements.	Dr Gillian Heap		By email only
Innovation Agency (Academic Health Science Network, North West Coast)	The Trust is a partner of the AHSN, we work together to embed innovation as a core part of the business within MWL .	Chief Executive,Dr Phil Jennings	info@innovationagencynwc.nhs.uk	0151 254 3400

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
Go to top of document

Organisation study capabilities

Information on the types of studies that can be supported by the organisation to the relevant regulatory standards.

	CTIMPs (indicate phases)	Clinical trial of a medical device	Other clinical studies	Human tissue: Tissue samples studies	Study administering questionnaires	Qualitative study	OTHER
As sponsoring organisation			√	√	√	√	
As participating organisation	√ (Phase, II, III, IV,)	√	√	√	√	√	
As participant identification centre	√ (Phase, II, III, IV,)	√	√	√	√	√	

Information on any licences held by the organisation which may be relevant to research.

Licence name Example: Human Tissue Authority licence	Licence details				Licence start date (if applicable)		Licence end date (if applicable)
Human Tissue Act 2004	Licence number 12043						On-going

For organisations with responsibilities for GPs: Information on the practices which are able to conduct research.

Marshalls Cross Surgery, sits within St Helens Hospital and is currently conducting a number of research studies. MWL are provide support with the research finances.

Organisation services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting RDI governance decisions across the organisation.

Service department	Specialist facilities that may be provided (e.g. number/type of scanners)	Contact name within service department	Contact email	Contact number	Details of any internal agreement templates and other comments
Designated Research Clinics located within the Research Hub at Whiston Hospital		Jeanette Anders	jeanette.anders@sthk.nhs.uk		
Pharmacy - Whiston site	Designated Research Pharmacist	Jodie Kirk			
Pharmacy - Whiston site	Back up Research Pharmacist	Sophie Helsby			
Pharmacy - Whiston site	Pharmacy Technician	Gafar Baruwa			
Pharmacy -Southport/Ormskirk site	Designated Research Pharmacist	Carla Silva			
Pathology - Whiston and Southport sites	Minus 20, 30 and 80 freezers	Kevin McLachlan			
Pathology - Whiston and Southport sites		Generic contact	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Biochemistry	Lesley Mather Biochemistry Service Manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Biochemistry	Jane Turnbull Biochemistry Operational manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Haematology/ Transfusion	Jude Raine Haematology/Transfusion Service Manager	pathology.support@sthk.nhs.uk		
Pathology -Whiston and Southport sites	Haematology/ Transfusion	Stacy Burrows Haematology/Transfusion Operational Manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Microbiology	Diane MartinBiaz Microbiology Service Manager	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Generic Pathology	Marc Seddon /Victoria Gaylor Pathology Reception Leads	pathology.support@sthk.nhs.uk		
Pathology - Whiston and Southport sites	Microbiology	Neil Rathbone/Paul McMullen Microbiology Operational Managers			
Pathology - Southport site	Generic	Mr Andrew Taylor			
Radiology - Whiston site	Clinical Radiation Expert	Dr Meenal Abhyankar			Clinical Director for Radiology
Radiology -Whiston	Clinical Radiation Expert	Dr Andrea Howes			
Radiology - Whiston site	Medical Physics Expert	Ryan Jones			Ryan Jones from IRS Ltd is one of the Medical Physics experts for the Trust
Radiology - Whiston site	2x 1.5 GE MRI 1 x 3.0T MRI 5 X GE128 slice CT scanners 1 x GE512 slice CT scan	Sue Conroy			
Radiology - Whiston site	2x Digital Mammography including tomosynthesis	Sue Conroy			
Radiology - Whiston site	1x Digital dental including cephalometry Cone Beam CT 1 x Digital dental including cephalometry	Sue Conroy			
Radiology - Whiston site	2x Fluoroscopy /1 x interventional	Sue Conroy			
Radiology - Whiston site	30X Ultrasound including Cardiac	Sue Conroy			
Radiology - Whiston site	10x Digital radiography including tomosynthesis	Sue Conroy			
Radiology - Southport/Ormskirk site	Radiology Systems Administrator	David Lodwig			
Cardio-Respiratory Department - Whiston site	24 hour ambulatory electrocardiography Extended ambulatory electrocardiography Event Recording Ambulatory blood pressure monitoring Electrocardiograms: 12 lead ECGs Transthoracic echocardiography Transoesophageal echocardiography Stress echocardiography Exercise electrocardiography Spirometry Measurement of maximum expiratory and inspiratory flow volume loop Oximetry assessment Carbon monoxide transfer factor test Simple lung function exercise test Measurement of static lung volume Measurement of respiratory muscle strength Measurement of maximum expiratory and inspiratory flow volume loop Bronchial Reactivity Overnight oximetry (Includes: Measurement of oxygen desaturation index FENO testing Cardio-Pulmonary Exercise testing	Gina Rogers			
Cardio-Respiratory Department - Whiston site	Assessment for fitness to fly (hypoxic challenge) - flight assessment Pacemaker Implantation - single / dual [plus Box Changes]	Gina Rogers			

Information on key management contacts for supporting RDI governance decisions across the organisation.

Department	Specialist services that may be provided	Contact name within service department	Contact email	Contact number	Details of any internal agreement
Archiving	Archiving arrangements are part of the Trust approval process and are detailed in the Clinical Trial Agreement for each study. The Trust also holds a Standard Operating Procedure for archiving.	Jennifer Miller - Whiston site Julie Ditchfield - Southport site			
Contracts (study related)	Completion and Review - See comments	Jeanette Anders and Paula Scott - Whiston Site Jill Simpson and Julie Ditchfield - Southport Site	research@sthk.nhs.uk soh-tr.researchsonhs@merseywestlancs.nhs.uk		The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by Mersey and West Lancashire Teaching Hospitals NHS Trust
Contracts (study related)	Sign off of clinical trial agreements	Dr Peter Williams	Peter.Williams3@sthk.nhs.uk		The model agreement for non-commercial research and the model agreement for pharmaceutical and biopharmaceutical industry sponsored research is used by Mersey and West Lancashire Teaching Hospitals NHS Trust
Finance - Whiston site	Corporate Accountant	Karen Gerrard			The RDI Department has links with finance and are fully supported in all areas relating to research.
Finance - Southport/Ormskirk site	Deputy Finance Business Partner - Corporate Services	Karen Gerrard			The RD&I Department has links with finance and are fully supported in all areas relating to research.
Information Technology	Director of Informatics	Malcom Gandy			RDI Department is fully supported by the Director of ICT. IT training, IT system set up, hardware and software configuration set up, firewall configuration and connection to external servers.
Legal - Whiston site	Head of Complaints & Legal Services	Tom Briggs			Support and advice with the legal aspects of research is provided when necessary.
HR	Research Passports, Letters of Access	Employment Services	Employment.Services@merseywestlancs.nhs.uk		
Training -- Whiston site	Essential In house Standard Operating Procedure Training	Jeanette Anders, Senior Research Nurses	research@sthk.nhs.uk		In house training on essential Standard Operating Procedures is provided for new starters or as updates if required.
Training -- Whiston site	Good Clinical Practice (GCP) training. Principal Investigator Essentials training. The RDI Manager at the Whiston site is a Facilitator for the above NIHR training courses.	Jeanette Anders	research@sthk.nhs.uk		.
Performance Management of studies - Whiston site	Audit and on-going review of studies.	Contact via RDI Department	research@sthk.nhs.uk		During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment & facilities, realistic recruitment target etc. After approval is granted, the RDI Department remain a point of contact, reviewing the progress of each study. A yearly audit is conducted and when a need is identified ad hoc audits will be completed.
Performance Management of studies - Southport/Ormskirk site	Audit and on-going review of studies.	Contact via RDI Department	soh-tr.researchsonhs@merseywestlancs.nhs.uk		During the RDI approval process, feasibility, capacity and capability checks take place including requirement for nurse support, appropriate resources, equipment & facilities, realistic recruitment target etc. After approval is granted, the RDI Department

Organisation RDI interests

Information on the research areas of interest to the organisation (provide detailed or summary information as appropriate).

Area of interest	Details	Contact name		Contact number
Whiston, St Helens and Newton Hospitals				
Acute Medical Unit		Dr Thiru Desa		
Anaesthetics	Anaesthetist for Obs & Gynae	Dr P Yoxall		
Anaesthetics		Dr K Mukhtar		
Anaesthetics		Dr S Miller		
Anaesthetics		Dr Goel		
Anaesthetics		Dr Atherton		
Anaesthetics		Dr Kingston		
Anaesthetics		Dr Narayanaswamy		
Burns and Plastics		Professor Rowan Pritchard-Jones		
Burns and Plastics		Mr P Brackley		
Burns and Plastics		Professor K Shokrollahi		
Burns and Plastics		Mr A Benson		
Burns and Plastics		Mr S Liew		
Burns and Plastics		Ms A Harper		
Burns and Plastics		Mr Hosain		
Burns and Plastics		Mr D Gurusinghe		
Lung Cancer (Radiology)		Dr Meenal Abhyankar		
Cancer		Dr Mike Horner		
Cancer		Dr Puneet Malhotra		
Cancer		Ms Leena Chagla		
Cancer		Dr T Nicholson		
Cancer		Dr E Hindle		
Cancer		Miss T Kiernan		
Cancer		Mr A Khattak		
Cancer		Dr Taylor		
Cancer		Mr R Pritchard-Jones		
Cancer		Mr P Brackley		
Cancer		Mr Samad		
Cancer		Mr J McCabe		
Cancer		Dr N Hamnett		
Cancer		Miss Sonia Bathla		
Cancer		Dr S Evans		
Cancer		Dr Raj Sripadam (CCC)		
Cancer		Dr S Cook		
Cancer		Dr Zafir Malik		
Cancer		Dr Helen Innes (CCC)		
Cardiology		Dr R Katira		
Cardiology		Dr AlChaghouri		
Care of the Elderly		Dr A Gatignol		
Critical Care		Dr A Tridente		
Critical Care/Anaesthetics		Dr Hanumanthu		
Critical Care		Dr A Cochrane		
Critical Care		Dr Martin Udgerg		
Critical Care		Dr Murray		
Dermatology		Dr J Ellison		
Dermatology		Dr E Pang		
Dermatology		Dr M Walsh		
Dermatology		Dr K Eustace		
Dermatology		Dr Ngan		
Dermatology		Dr Layla Hanna-Bashara		
Diabetes		Dr N Furlong		
Diabetes		Dr P Narayanan		
Diabetes		Dr S Westall		
Diabetes		Dr H Sullivan		
Emergency Medicine		Dr R Fuller		
Emergency Medicine		Dr J Matthews		
Emergency Medicine		Dr M Hedley		
Emergency Medicine		Dr C O'Leary		
Emergency Medicine		Dr G Inkster		
ENT		Mr V Sankar		
Gastro		Dr A Bassi		
Gastro		Dr R Chandy		
Gastro		Dr D McClements		
Gastro		Dr S Priestley		
Gastro		Dr V Theis		
Gastro		Dr C Watters		
Gastro		Dr K Clarke		
Haematology		Dr K Moss		
Heptology		Dr N Tayor		
Histopathology		Dr Hasan		
Histopathology		Dr C Ross		
General Medicine		Dr M Nasher		
Microbiology		Dr M Vardhan		
Musculoskeletal		Dr M Mahindrakar		
Musculoskeletal		Dr J Dawson		
Musculoskeletal		Mrs D Lenton		
Nephrology and Acute Medicine		Dr M Khandaker		
Opthalmology		Miss F Shams		
Orthopaedics		Mr Ballester		
Orthopaedics		Ms Wharton		
Orthopaedics		Mr Lipscombe		
Orthopaedics & Trauma		Mr N Howard		
Orthopaedics		Mr Cartwright Terry		
Palliative Care		Dr A Thompson		
Pathology	Whiston and Southport sites	Mr K McLachlan		
Pathology (cellular)		Charlotte Cox		
Paediatrics		Dr R Garr		
Paediatrics		Dr M Aziz		

Paediatrics		Dr L Chilukuri		
Paediatrics		Dr H Bentur		
Paediatrics		Dr Archna Prasad		
Paediatrics		Dr Basavaraju		
Paediatrics		Dr R Wockenforth		
Paediatrics		Dr D Wharton		
Paediatrics		Dr Ijaz Ahmad		
Paediatrics		Dr Matthew Roberts		
Paediatrics		Mr K Saldanha		
Paediatrics		Dr Amel Mohamed		
Parkinson's		Dr R Mason		
Pharmacy		Mr Greg Barton		
Psychiatry (old age)		Dr Nash		
Psychiatry		Dr C Findlay		
Psychiatry		Dr N Mercadillo		
Psychotherapy (child and adolescent)		Dr J Boardman		
Radiology		Dr V Rachapalli		
Radiology		Dr N Ellerby		
Radiology		Dr Abhyankar		
Reproductive and Child Health		Mrs Sandhya Rao		
Reproductive and Child Health		Miss Vicky Cording		
Reproductive and Child Health		Mrs Tabassum Safdar		
Reproductive and Child Health		Mrs Nidhi Srivastava		
Reproductive and Child Health		Mr T Idama		
Reproductive and Child Health		Miss Zoe Boyes		
Reproductive and Child Health		Ms Saru Palaniappan		
Reproductive and Child Health		Ms A Roberts		
Reproductive and Child Health		Ms C Stewart		
Reproductive and Child Health		Ms R Agass		
Respiratory		Dr J Marlow		
Respiratory		Dr J Heaton		
Sexual Health		Dr Rebecca Thompson Glover		
Stroke		Dr H Cooper		
Stroke		Dr Ganjam		
Stroke		Dr F Elnagi		
Stroke		Dr Lalitha Ranga		
Stroke		Dr S Mavinamane		
Stroke		Dr A Hill		
Stroke		Dr A L Kalathil		
Stroke		Dr Anastasia Liaretidou		
Stroke		Dr Ciprian Rusu Stroke		
Stroke		Dr Azmil Abdul-Rahim		
Surgery		Mr Chadwick		
Surgery		Mr Appleton		
Surgery		Mr Bagade		
Surgery		Ms R Kalaiselvan		
Surgery		Mr A Samad		
Surgery		Mr R Rajaganeshan		
Surgery		Mr S Kanwar		
Surgery		Mr Rapasinghe		
Surgery (colorectal)		Mr Kalaiselvan		
Urology		Mr J McCabe		
Urology		Mr Omar		
Urology		Mr Samsudin		
Southport and Ormskirk Hospitals				
Ageing		Sophie Pradhan		
Anaesthesia, Perioperative Medicine and Pain		Dr Abdul Khan		
		Dr Tauseef Ahmed		
		Mr Khushroo Suraliwala		
Cancer		Dr Neeraj Bhalla		
		Rahul Mistry		
Children		Dr Michael Roberts		
		Dr Sharryn Gardner		
		Dr Sudhakar Kandsamy		
		Prof May Ng		
Critical Care		Dr Arvind Nune		
		Dr Chris Goddard		
Dementias and Neurodegeneration		Helen Terrett		
Dermatology		Dr Tapati Sinha		
Diabetes		Prof May Ng		
Gastroenterology		Dr Michael Roberts		
		Dr Nikolaos Apostolou		
Haematology		Dr Arpad Gabor Toth		
Health Services Research		Dr Craig Rimmer		
Hepatology		Dr Alan Owens		
		Dr Michael Roberts		
		Dr Nikolas Apostolou		
Infection		Dr Craig Rimmer		
		Dr Katherine Gray		
		Dr Sharryn Gardner		
		Dr Stefania Pintus		
Mental Health		Dr Sharryn Gardner		
Musculoskeletal Disorders		Dr Arvind Nune		
		Dr Hannah Sykes		
		Mr Shiv Sha		
Neurological Disorders		Dr Shyam Mariguddi		
		Helen Terrett		
Renal Disorders		Rahul Mistry		
Reproductive Health and Childbirth		Linda Bishop		
		Dr Wilfred Kumakech		
		Nikos Chados		
Respiratory Disorders		Dr Chris McManus		
Stroke		Stefanie Henry		

		Amy Slack		
		Dr Patrick McDonald		
Surgery		Vaidyanathan Subramanian		
Trauma and Emergency Care		Dr Craig Rimmer		
		Dr Sharryn Gardner		
		Mr Chetan Sangani		
		Mr Deepak Sree		
		Mr Eugene Toh		
		Mr Khushroo Suraliwala		

Information on local / national specialty group membership within the organisation which has been shared with the CLRN.

National / local	Specialty group	Specialty area (if only specific areas within group)	Contact name	Contact email	Contact number
North West RDI Managers meeting	Research	Research and Development	Jeanette Anders	jeanette.anders@sthk.nhs.uk	0151 478 7850
North West RDI Managers meeting	Research	Research and Development	Jillian Simpson	Jillian.Simpson@MerseyWestLancs.nhs.uk	01704 703457

Organisation RDI planning and investments

Area of investment (e.g. Facilities, training, recruitment, equipment etc.)	Description of planned investment	Value of investment	Indicative dates
Research Infrastructure Bid	At Whiston Hospital we have refurbished the existing Research Hub to provide a larger clinic room which has created a more confortable space which will be more beneficial to patients on complex trials where they are attending for long visitswith mutiple interventions throughout the day. At the Southport and Ormskirk sites we have now converted part of the Fracture Clinic to become a Research Hub which consists of a waiting room, clinic space and kitchen area. This will enable us to provice a better participant experience for those taking part in research across the Trust.	£70K	Both facilities are now open and in use.
Research Delivery infrastructure (e.g. research nurses, health care assistants, administrators)	Ad hoc requests submitted by RDI Manager to the Clinical Research Network, North West Coast for resources to enable delivery of NIHR portfolio studies.	Ad hoc	
Release of clinician time (to prepare NIHR grant applications or to act as Principal Investigators)	Ad hoc requests submitted by researchers for resources to enable delivery of both Commercial and Non-Commercial research.	Ad hoc	

Organisation RDI standard operating procedures register

A suite of SOPs are available upon request.		The SOPs have now been updated across the wider MWL Trust and ratified for use.		

Information on the processes used for managing research passports.

Research Passports are accepted at MWL and letters of access are issued via the RDI Department.

Information on the agreed escalation process to be used when RDI governance issues cannot be resolved through normal processes.

In accordance with RDI management structure: The Research Development and Innovation Group report to the Clinical Effectiveness Council who report to the Quality Committee then to the Trust Board.

Planned and actual studies register

The organisation should maintain or have access to a current list of planned and actual studies which its staff lead or in which they are involved.

Whiston site records every research project on the local ReDA database and recruitment data on NIHR CRN NWC Edge system. These systems are used to register and manage all research projects. The Southport site record study and recruitment data on NIHR CRN NWC Edge system.

Other information

For example, where information can be found about the publications and other outcomes of research which key staff have led or have otherwise contributed.

MWL continue to aim to increase the number of commercially sponsored studies as these are valuable source of support for NHS trusts. This income can be used to encourage key stakeholders to develop capacity for new research within the Trust and increase the volume, and, therefore, future income generation.
Information about publications and other outcomes of research can be requested via the research office at research@sthk.nhs.uk for the Whiston site and soh-tr.researchsonhs@merseywestlancs.nhs.uk for the Southport/Ormskirk site .

Title of Meeting	**Trust Board**		**Date**	27 November 2024
Agenda Item	**TB24/087**			
Report Title	Compliance with the NHS Constitution			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To approve**	X	**To note**

Purpose

To provide assurance to the Board on the Trust's compliance with the patient, public and staff rights contained within the NHS Constitution.

Executive Summary

Summary:
The NHS Constitution establishes a number of rights for patients and staff, with pledges that the NHS is committed to achieving. It outlines the responsibilities of staff and patients to make the NHS work more effectively.

The Trust is legally required to take account of the NHS Constitution in performing its NHS functions, in both the decisions made and actions taken. The Constitution was last updated in August 2023, with a minor amendment made to add a link to current guidance on the NHS website and amend the contact DHSC information in the making a complaint section.

The Constitution contains seven areas relating to patients, which are:
1. Access to health services
2. Quality of care and environment
3. Nationally approved treatments, drugs and programmes
4. Respect, consent and confidentiality
5. Informed choice
6. Involvement in their healthcare and the NHS
7. Complaint and redress

It contains seven rights relating to staff, to ensure they:
1. Have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives
2. Have a fair pay and contract framework
3. Can be involved and represented in the workplace
4. Have healthy and safe working conditions and an environment free from harassment, bullying or violence
5. Are treated fairly, equally and free from discrimination
6. Can in certain circumstances take a complaint about their employer to an employment tribunal
7. Can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.

It is good governance for Boards to gain assurance that the Trust meets, and can continue to meet, the requirements. This paper provides a summary of the Trust's position to provide the Board with assurance of compliance. The previous review was undertaken and reported to the Board in 2022.

Appendix 1 provides the position statement of the Trust's compliance with the rights of patients and the public and Appendix 2 outlines compliance with rights of staff.
Financial Implications
There are no direct financial implications arising out of this assurance report.
Quality and/or Equality Impact
Not applicable for this assurance report.
Recommendations
The Board is asked to consider the assurances provided in the report.

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

Appendix 1: NHS Constitution – Trust position for patients and public rights

Key

Compliant	Additional work required to strengthen compliance

No	Right	Position statement	Exec Lead	Rating	Comment/ Evidence
1.	Access to health services				
1.1.	You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	The Trust provides NHS services free of charge, other than the exceptions sanctioned by Parliament (e.g. overseas visitors)	Chief Operating Officer		Private Patient / Overseas Visitors Policy – currently being reviewed. Legacy S&O Overseas Visitors Cost Recovery Policy Corp 57 due for review in May 2025.

1.2.	You have the right to access NHS services. You will not be refused access on unreasonable grounds.	Patients can access emergency and urgent care through the Emergency Department or via their GP for access to specific assessment units. There are streaming pathways in place with direct entry to services including frailty. Elective care is accessed via a patient's GP. Where necessary, referral criteria are agreed with commissioners to ensure that the most appropriate care is delivered to those who need it. The Trust has a Patient Access Policy in place to ensure that patients receive treatment in accordance with national objectives and targets and the Trust follows all the national guidance and criteria for patient selection. The Trust complies with the Equality Act 2010, ensuring that patients are not refused treatment on unreasonable grounds. It uses the Equality Delivery System for the NHS (EDS2022) as the mechanism for reviewing compliance and this is monitored through the Trust's Equality and Diversity Steering Group, which includes representatives from the local community. Improved patient access and experience was rated as achieved for the 2024 submission of EDS2022. The Trust has an Equality and Human Rights Policy which aims to: • Ensure that the Trust meets its statutory requirements as defined by the Equality Act 2010 • Support the Human Rights of patients, visitors and employees in the Trust as defined by the Human Rights Act 2008 • Ensure that the Trust anticipates the consequences of its actions on our local communities and ensure that, as far as possible, negative consequences are eliminated and opportunities for promoting equality are maximised wherever possible. Patients who have paid privately for some elements of the care are still able to access free NHS services at the Trust. Those who are not ordinarily resident in the UK are able to access free NHS care in certain circumstances including emergency care in line with national guidance. An equality analysis is conducted on proposed service changes, including cost improvement plans to ensure that any disadvantages or negative impacts are identified and eliminated wherever possible.	Chief Operating Officer & Director of Nursing, Midwifery and Governance		Patient Access Policy, Equality and Human Rights Policy and Standard Operating Procedure for carrying out an Equality Analysis are in date and available on intranet. Equality and Diversity Steering Group reports to People Council. Annual update on delivery of equality and diversity is included in the Quality Account.

1.3.	You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	Assessment of patients' individualised needs and plans of care are documented within clinical records, including a number of risk assessments. These are regularly audited for completeness. A system of electronic alerts is in place to identify those who require reasonable adjustments to be made to their journey and adjusted pathways have been developed in a number of areas to provide bespoke processes for those with additional needs/protected characteristics, including accessible information. Suitably qualified staff are in place to support this right, with all staff required to complete robust recruitment checks, induction, mandatory training and annual appraisals.	Chief Operating Officer & Director of Nursing, Midwifery and Governance		Trust wide record keeping audit programme reported to the Clinical Effectiveness Council (CEC) Patient surveys, complaint reports and nursing care indicator audits reviewed by the Patient Experience Council (PEC)
1.4.	Not Applicable – Commissioning responsibility to commission and put in place services to meet community needs.				
1.5.	Not Applicable – Commissioning responsibility in certain circumstances, to go to other countries for treatment				
1.6.	Not Applicable – Commissioning responsibility in certain circumstances, to go to other countries for treatment if covered by Withdrawal Agreement				
1.7.	You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of sex, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	See 1.2 above	Director of Nursing, Midwifery and Governance		See 1.2 above

1.8.	You have the right to access certain services commissioned by NHS bodies within maximum waiting times or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution and relate to 2 week cancer target and 18 week target.	The Trust has historically met the majority of national referral to treatment times, which are monitored by the Board monthly with action plans in place to meet any areas of underperformance. Industrial action and the pandemic impacted negatively on the Trust's ability to consistently meet all of the referral times, however, the Trust's performance compares favourably with other trusts and staff continue to implement the recovery plans to regain a compliant position.	Chief Operating Officer		Integrated Performance Report (IPR)
2.	Quality of care & environment				
2.1.	You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	The Trust is registered with the CQC without conditions and has remained rated as outstanding, since March 2019. Clinical Strategy in place. All staff are subject to the full recruitment checks prior to commencing in post and are required to complete induction/mandatory training and annual appraisals. Safer staffing reports are reviewed by the Quality Committee. Medical and nursing staff are required to complete revalidation. Patient Safety Council (PSC) maintains overview of the safety of services, including incident reporting and follow-up of actions arising from investigations into serious incidents. Lessons learned are shared via daily safety huddles, bulletins, team meetings at ward level to ensure safety culture across the Trust. Medical Care has a lessons learned forum in place. System in place for cascading and acting on patient safety alerts via the Central Alerting System (CAS).	Director of Nursing, Midwifery and Governance		Clinical Strategy progress report IPR including training figures & CQC registration. Annual Medical Revalidation Report. CAS report to PSC. Safer staffing reports to the QC and the Board Latest review by MIAA provided substantial assurance on lessons learned (2021) Quarterly incidents report.

2.2.	You have the right to be cared for in a clean, safe, secure and suitable environment.	Services are provided from two relatively new hospitals that are well-maintained through the PFI contract and three other hospital sites, including a community hospital, with effective contract monitoring in place. Regular infection prevention and control audits are completed and actions developed to improve standards. The Trust completes internal inspections of the care environment and participates in the national patient led assessment of the care environment (PLACE) inspections. The Trust is compliant with Health and Safety legislation. The Trust has a Crime Prevention and Reduction Officer in place to actively promote a safe and secure environment, including awareness raising via e-bulletin. The Trust introduced an on-line hate crime reporting mechanism to support staff, patients, visitors and members of the local community who are victims of hate crime.	Director of Estates and Facilities		PLACE inspection reports IPR Health and Safety reports to Estates & Facilities Management (FM) Council Friends and Family Test (FFT) results and patient surveys reported to the PEC Complaints and PALS reports to the QC and Board IPC audits and quarterly reports to QC and Board.

2.3.	You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	Nutrition and hydration for patients is monitored via the monthly audits of nursing care indicators, which are reported to the Nutrition and Hydration Steering Group and PEC. Aligned to Trust objectives and quality priorities. Patients are risk assessed using the National Institute for Health and Care Excellence (NICE) recommended Malnutrition Universal Screening Tool (MUST) to ensure appropriate nutrition is provided to the patients as per the documented plan of care. A number of wards throughout the hospital have protected mealtimes, which is assessed via the 5 star accreditation programme. Nutrition and Hydration Steering Group and Task and Finish group in place to monitor improvements. Volunteer service support with dining companions.	Director of Nursing, Midwifery and Governance		Healthwatch, patient survey and nursing care indicator reports to PEC. 5 star accreditation peer assessments. Tendable Audits PLACE inspections- Completed November 2024 National Standards for Healthcare Food and Drink gap analysis and action plan ongoing, monitored through Estates and Facilities Governance and Nutrition and Hydration Steering Group.

2.4.	You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	The Trust has a comprehensive clinical audit programme in place, which includes action plans to address any areas identified for improvement as part of the audit process. There is a 5 star accreditation programme in place, which has been revised in 2024 in line with the CQC's 5 key questions. Patient feedback is used to drive continuous improvement, through the internal patient experience surveys, FFT, Healthwatch reports and national patient surveys. Wards display their FFT results and the actions being taken to address issues, via You said We did poster. The Trust sets annual objectives, which include quality targets. The published annual Quality Account provides a succinct summary of the quality of care provided by the Trust. Commissioners hold the Trust to account to deliver a range of quality targets. The Trust continues to implement its policy for learning from deaths, 'Mortality Review – Responding to and Learning from the Deaths Policy, which is currently under review.	Medical Director/ Director of Nursing, Midwifery and Governance		Clinical and Quality Strategy IPR Clinical Audit Programme reports to the CEC FFT report to PEC Annual Quality Account Trust's annual objectives Reports to Clinical Quality and Safety Group (CQSG) Learning from Deaths Reports to Board.
3.	Nationally approved treatments, drugs & programmes				
3.1.	You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.	The Trust has a Medicines Management Policy in place to ensure that patients receive appropriate drugs. All NICE guidance is reviewed to ensure it is relevant and compliance is monitored when guidance does apply, in line with the Policy for the Implementation of NICE Guidelines. Please note that a key part of this right relates to the funding of drugs and treatments, which is a commissioning responsibility.	Medical Director		NICE and medicines management reports to the CEC
3.2.	Not applicable – Commissioner responsibility regarding drug funding				
3.3.	Not applicable – Relates to national immunisation programme				

4.	Respect, consent & confidentiality				
4.1.	You have the right to be treated with dignity and respect, in accordance with your human rights.	The Trust's values include kind, open and inclusive and are supported by behavioural standards that focus on ensuring patients have a positive experience. There are procedures in place for managing any instances where these standards are not maintained. Staff are actively encouraged to challenge poor behaviour and compliance with this is assessed during local quality reviews and the 5 star accreditation programme. Code of Confidentiality Policy in place and applicable to all staff, Chaperone Policy and Provision of Same-Sex Accommodation Policy. Professional standards and codes of conduct in operation for a number of clinical staff, including medical and nursing staff, through their regulatory bodies. The Trust received a positive score (9.2/10) for ensuring privacy for discussing conditions and for patients being treated in the latest in-patient survey (2023), with work underway to improve the score further.	Director of Nursing, Midwifery and Governance		Trust vision, values and behavioural standards Policies available on intranet In-patient Survey and improvement plans reported to the PEC and QC.
4.2.	You have the right to be protected from abuse and neglect, and care and treatment that is degrading.	Safeguarding Policy and Procedures in place. Safeguarding Assurance Group for adults and children meets regularly to review the effectiveness of the policy and the Trust's arrangements for protecting patients from abuse. Safeguarding training is part of the mandatory training requirement for staff, with compliance monitored by the Executive Committee. Staff are aware of the need to report any abuse and to take action to prevent further abuse. Any allegations of abuse raised by patients/carers are thoroughly investigated and actions taken.			Safeguarding Policy Safeguarding reports to QC IPR Incident Reporting and Management Policy

4.3.	You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests	Consent Policy in place and being implemented. Consent audits undertaken as part of the Trust's Clinical Audit Programme. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy supported by checklist to aid communication. MCA/DoLS training is mandatory for all staff. Learning Disability passports in use in the Trust and learning disability training is now mandatory for clinical staff.	Medical Director		Clinical Audit Programme reports to CEC All policies are available on the intranet Mandatory training figures reported in IPR
4.4.	You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.	Consent Policy has been updated to reflect the Montgomery ruling and the need to ensure greater level of detail is provided when gaining consent. Where possible consent is obtained during pre-operative appointment to allow maximum time for information to be provided to patients and considered by them. Consent audits undertaken as part of the Trust's Clinical Audit Programme. Regular consent training available. Number of information leaflets in place for patients to support decision-making	Medical Director		Consent Policy Information leaflets Consent audit
4.5.	You have the right of access to your own health records and to have any factual inaccuracies corrected.	Access to Health Records Policy available on the Trust's website for patients/public. The policy includes flowchart of the process to obtaining health records and how to have amendments to inaccurate entries recorded. This is currently being reviewed and will be replaced by the Individual Rights Policy.	Director of Informatics		Access to Health Records Policy

4.6.	You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.	Code of Confidentiality applicable to all staff which gives staff clear guidance on how to keep information and secure. Information Governance training is mandatory for all staff and we have a proactive Information Governance Team who issue regular updates to all staff groups on the importance of information security. The Trust is compliant with the Data Security and Protection Toolkit and received substantial assurance from MIAA for the latest self-assessment completed in June. The Trust has a robust Information Governance Structure and has a Caldicott Guardian and Senior Information Risk Owner (SIRO) in place.	Director of Informatics		Data Security and Protection Toolkit monitoring via Information Governance (IG) Steering Group IG report to the Board IG Steering Group Minutes
4.7.	You have the right to be informed about how your information is used.	In line with its obligations under the Data Protection Act the Trust displays its “fair processing notice” on the Trust website which informs service users how we use their information. This information is also displayed in all wards and other public facing locations in the form of leaflets entitled, “The NHS & Your Information” and “How We Use and Protect Your Personal Information” these leaflets clarify how service user information is used, stored, shared and kept secure.	Director of Informatics		Patient leaflets & Trust Website
4.8.	You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.	See 4.7 above	Director of Informatics		See 4.7 above
5.	Informed choice				

5.1.	You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	Marshalls Cross Medical Centre do not refuse patients without a valid reason, for example outside the boundary.	Chief Operating Officer		
5.2.	You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.	The practice tries to meet requests to see a specific doctor, working with patients to ensure a suitable appointment is secured. The practice regularly reviews the number of appointments available to ensure capacity is aligned to demand. The practice has recently signed up to the General Practice Improvement Programme with NHS England to improve access.	Chief Operating Officer		Patient Survey action plan
5.3.	You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally	The Trust publishes its Quality Account on an annual basis, complying with the information requirements established by the Department of Health and provides performance information as part of the public Board papers on-line. In addition, information is provided centrally and used by regulators to monitor the Trust's performance, including regularity of inspection by CQC who publish their ratings on the website. The Trust publicises its CQC rating in line with the legal requirement.	Chief Operating Officer		NHS website
5.4.	You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution	The Trust provides information about its services through the website and via GPs. Patients are able to select their provider of choice for services accessed through the NHS e-referral service. Please note partial responsibility for upholding this right rests with commissioners – please refer to the NHS Constitution Handbook for further details.	Chief Operating Officer		Patient & Visitor and GP sections of Trust's website.

6.	Involvement in your healthcare & in the NHS				
6.1.	You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.	A key part of the care planning process and patient documentation includes involvement of patients/carers, including identifying what matters to them. Individual Care and Communication Record for patients at the end of their life includes sections for communication and patient/carer preferences. Results from the latest in-patient survey show a score of 7/10 for patients feeling they were as involved as much as they wanted to be in decisions about care and treatment, which is in line with the national average. Please note an element of upholding this right rests with commissioners, including the options for personal health budgets.	Medical Director/ Director of Nursing, Midwifery and Governance		Clinical and nursing documentation Individual Care and communication record
6.2.	You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	The Trust has being open as one of its three values. There are systems and processes in place to support staff and to ensure compliance with the duty of candour, including Being Open Policy/Being Open and Duty of Candour Policy and mandatory fields when reporting moderate and severe harm incidents on Datix. Being open and the duty of candour are covered in the incident reporting section of mandatory training. In addition, the Trust has a policy for learning from deaths.	Director of Nursing, Midwifery and Governance		Being Open and Duty of Candour Policy Duty of Candour fields on Datix Letters submitted to patients/carers following investigations. Mortality Review – Responding to and Learning from the Deaths Policy

6.3.	You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.	Improvements to services are made as a result of feedback from patients through the friends and family test, patient surveys and through the complaints system. The Trust has a Patient Participation Group who provide their views on a range of issues, including the Patient Experience and Inclusion Strategy. Patients/patient representatives are involved in discussions about building modifications and provide input into making them fit for purpose. Full public consultations are undertaken as required, including Shaping Care Together. Please note an element of upholding this right rests with commissioners when planning which services to commission.	Director of Nursing, Midwifery and Governance		Quality Account includes information on changes made as a result of patient input.

7.	Complaint and redress				
7.1.	You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated	The Managing Concerns and Complaints Policy includes requirement to acknowledge complaints within 3 working days, which is reported to the Quality Committee. 100% of complaints have been acknowledged within this timeframe for each year for the last three years. There is a formal process in place for ensuring that all complaints are managed appropriately, including a full investigation and providing feedback to complainants.	Director of Nursing, Midwifery and Governance		Managing Concerns and Complaints Policy Complaint report to QC Complaints section in Quality Account
7.2.	You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent	Managing Complaints, Concerns and Compliments Policy includes a section on discussing the handling of the complaint with the complainant. The Complaints Team ensure that patients are fully involved in the process as required. Each acknowledgement letter provides information on the timescales for providing the response.			Managing Complaints, Concerns and Compliments Policy
7.3.	You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken	The Complaints Team liaise with the complainant to ensure they are aware of any delays. Each complaint has a written response, which informs the complainant of the outcome of the investigation and what actions are to be taken to resolve any issues identified. Where required, face-to-face meetings are held between complainants and members of the Trust to ensure that the complainant is satisfied with the Trust's response. Complaint surveys are undertaken to ascertain if patients are happy with the process and the results are presented to PEC and the Board. Complaint responses are signed off by the Chief Executive, the Director of Nursing, Midwifery and Governance or the Deputy Chief Executive.			Managing Complaints, Concerns and Compliments Policy

7.4.	You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS	Managing Complaints, Concerns and Compliments Policy includes a section on Parliamentary and Health Service Ombudsman The aggregated data report to the Board provides an update on the number of complaints that have been reviewed by the Ombudsman.			Managing Complaints, Concerns and Compliments Policy Aggregated data report to the Board
7.5.	Not applicable – Relates to the right to seek judicial review, but any person with a direct/personal interest in a decision made or action taken by the Trust would seek independent legal advice				
7.6.	You have the right to compensation where you have been harmed by negligent treatment	Claims and Inquest Policy in operation and overseen by the Legal Department. Trust is covered by NHS Resolution and works closely with them on responding to any claims that are received.	Director of Nursing, Midwifery and Governance		Summary of claims included in aggregated data report submitted to the Board.

Appendix 2: NHS Constitution – Staff rights

No.	Right	Position statement	Exec Lead		Comment/ Evidence
1.	Have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives				
1.1.	Right to fair treatment regarding leave, rights and flexible working and other statutory leave requests relating to work and family, including caring for adults with whom you live.	There are a number of workforce policies in place to ensure fair treatment including those for Special Leave, Reasonable Adjustments, Annual Leave, Flexible Working and other associated Equality Diversity & Inclusion policies. The Trust scored better than average in the themes 'We are Flexible' and 'We are Compassionate and Inclusive' in the 2023 Staff survey report The Trust also has a range of Health, Work and Wellbeing resources available to all staff	Director of HR		Annual Staff survey results Policies available Regular monitoring and oversight of HR KPI's
1.2.	Right to request other 'reasonable' time off for emergencies (paid and unpaid) and other statutory leave (subject to exceptions).	Special Leave Policy in place, allowing for staff to take time off for emergencies and to undertake work in public positions, for example as a school governor or justice of the peace. There is also the Reasonable Adjustment Policy which includes disability leave allowance.			Policies available on the intranet Staff survey results
1.3.	Right to expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients and others (e.g. bullying or harassment)	Range of policies in place to protect staff, including, Respect and Dignity at Work, Resolution & Grievance, Transgender Staff Support Policy and other associated ED&I policies. In addition we have processes in place to support staff experiencing violence and aggression from patients including our joint initiative with Merseyside Police The Trust was positively above average for the Staff Survey Theme 'We are Safe and Healthy' however any experiences of less favourable treatment are not acceptable, and we have a committing to addressing behaviours that are not in keeping with our Trust values.			Policies available on the intranet Staff survey results National Quarterly Pulse Survey (NQPS)
2.	Have a fair pay and contract framework				
2.1.	Right to pay; consistent with the National Minimum Wage or alternative contractual agreement and right to fair treatment regarding pay.	All non-medical roles below very senior manager level are covered by Agenda for Change (A4C) – all these posts are reviewed against the job evaluation handbook. Medical and dental staff pay scales are compliant with appropriate Terms and Conditions. VSM posts are job evaluated as per the role and pay scales set accordingly – these are published in the Remuneration Report in the Trust's Annual Report Local negotiating committees meet to agree workforce policy.	Director of HR		A4C T&C and job evaluation handbook Trust Annual Report NHS England Guidance on pay for very senior managers in NHS trusts and foundation trusts JNCC & TJLNC minutes

3.	Be involved and represented in the workplace				
3.1.	Right to be accompanied by either a Trade Union official or a work colleague at disciplinary or grievance hearings in line with legislation, your employer's policies or your contractual rights	This statutory right is covered in the relevant policies, including Disciplinary Policy and Resolution & Grievance Policy	Director of HR		Policies available on the intranet in line with ACAS guidance and best practice
3.2.	Right to consultation and representation either through a Trade Union or other staff representatives (for example where there is no Trade Union in place) in line with legislation and any collective agreements that may be in force	Please see 3.1 Range of trade union representation throughout the Trust. Established Consultation and Negotiation meetings in place			Policies available on the intranet
4.	Have healthy and safe working conditions and an environment free from harassment, bullying or violence				
4.1.	Right to work within a healthy and safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff, to work your contractual hours, take annual leave and to take regular breaks from work	Number of workforce policies in place that are underpinned by our Trust values and behaviours e.g. The Respect and Dignity at Work Policy, Violence & Aggression Against Staff Policy. In addition, there are a number of other relevant policies in place, including Incident Reporting and Management, Health and Safety and Security Management. Local Security Management Specialist in place in the Trust to provide expert advice and guidance. All frontline staff are required to undergo conflict resolution training every three years. Action plan in place to address any issues highlighted in staff survey, which is monitored by Valuing our People Council and Strategic People Council. Health Work and Wellbeing Service in place which offers a wide range of support for staff.	Director of HR		Valuing our People and Strategic People Council in Place Staff Survey results and action plan in place and reported and monitored through the governance structure up to Trust Board

5.	Be treated fairly, equally and free from discrimination				
5.1.	Right to a working environment (including practices on recruitment and promotion) free from unlawful discrimination on the basis of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status	Equality and Human Rights Policies are in place, supported by a number of other policies, including Recruitment and Selection, to reduce risk of discrimination. The Trust monitors compliance with the Equality Act through the Equality Delivery System 2022. This includes key elements relating to staff and working practices within the Trust. The Trust also monitors workforce compliance through WRES, WDES, Equality Pay Gap Reporting & PSED reporting. We have an number of EDI accreditations in place to support our commitment of providing a inclusive work environment for all	Director of HR		Policies available on the intranet Equality Delivery System (EDS2022) WRES & WDES PSED Staff survey results HR KPI monitoring
6.	Can in certain circumstances take a complaint about their employer to an Employment Tribunal				
6.1.	Right to appeal against wrongful dismissal	This is covered in the relevant polices, staff have the right of appeal for all stages of relevant formal HR processes in line with ACAS guidance. There is a clear appeal process outlined	Director of HR		Policies available on the intranet
6.2.	If internal processes fail to overturn a dismissal, you have the right to pursue a claim in the employment tribunal, if you meet required criteria	All of our policies are in line with ACAS guidance and employment law. Staff have the right to an appeal against their dismissal. The Trust works with ACAS conciliation service try to mitigate cases being pursued at Employment Tribunal			Policies available on the intranet
7.	Can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest				
7.1.	Right to protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace	We promote an open culture, encouraging colleagues to speak up, speak out and raise concerns. We're committed to making sure any concerns raised are heard and acted upon. Freedom to Speak up policy in place which is reflective of national guidance Staff can raise concerns through the following routes; • Freedom to Speak Up Guardians • Line manager • Raising Concerns Hotline • Anonymously through 'speak in confidence' portal In the 2023 Staff survey we performed better than average against the sub-theme of being able to raise concerns.	Director of HR		Policies available on the intranet Resources available on dedicated Freedom to Speak up intranet page
7.2.	Right to protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace	Freedom to Speak up policy provides protection for staff who speak up in line with national guidance and legislation.			Policies available on the intranet

8.	Have employment protection (NHS employees only).				
8.1.	Right to employment protection in terms of continuity of service for redundancy purposes if moving between NHS employers	There are a number of contractual obligations and Trust Policies in place for staff that are legally compliant and in line with the nationally determined terms and conditions of employment and legislation	Director of HR		Policies available on the intranet Agenda for Change Terms and Conditions Handbook
9.	Can join the NHS Pension Scheme				
9.1.	Right to join the NHS Pension Scheme	All new starters who are eligible to join the NHS Pension Scheme are automatically registered.	Director of HR		Included with new starter information when staff join the Trust

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	27 November 2024
Agenda Item	**TB24/088**				
Report Title	Trust Board Meeting Arrangements 2025/26				
Executive Lead	Nicola Bunce, Director of Corporate Services				
Presenting Officer	Nicola Bunce, Director of Corporate Services				
Action Required	X	**To Approve**		**To Note**	

Purpose

To advise Board members of the proposed dates for Trust Board meetings throughout the next Financial Year; the supporting timetable and agreed work plan.

Executive Summary

1) Board meetings have been held on the last Wednesday of each month and it is proposed that this arrangement will continue during 2025/26.
2) The paper confirms the dates for agenda setting, collation and distribution of papers and of actual meetings.
3) The Board work plan to schedule agenda items throughout each year has been reviewed to ensure that it meets all statutory requirements and delivers the duties and responsibilities in the Trust's standing orders.
4) This schedule, once approved, is used to inform the work plans of the Board committees
5) The work plan may be further amended following the annual board effectiveness review that is conducted between January and April each year or considering any new statutory or regulatory requirements.

Financial Implications

None directly from this report.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to approve the proposed dates and associated administrative timetable for Trust Board meetings as well as the proposed schedule of planned agenda items for Trust Board meetings.

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

SCHEDULE OF TRUST BOARD MEETING DATES (2025/26)

1. Meeting Schedule

1.1. Board meetings will be held on the last Wednesday of each month except for August and December.

1.2. The Trust believes in being open and transparent and members of the public can observe the public section of each Board meetings, via video link. Members of the public can also submit questions to the Board, in advance of the public board meetings. Public Trust Board Meetings commence at 09.30 or 10.00a.m.and are scheduled to run for two to three hours each.

1.3. Four meetings a year (April, June, October, and February) include discrete sessions for discussion of strategy, which are held in private following public Trust Board meetings.

1.4. In addition, where necessary, meetings will include discrete closed sessions for discussion of items of a sensitive or confidential nature, which are held in private following public Trust Board meetings.

2. Administrative Arrangements

2.1. Board agendas are developed by the Executive Committee on behalf of the Chairman at least ten days in advance of meetings.

2.2. Electronic versions of the Board papers are distributed electronically to members on the Friday preceding each Board meeting and hard copies can also be posted to Non-executive Directors if they wish.

2.3. Papers for Public Board Meetings are uploaded onto the Trust website on the Tuesday before each meeting.

2.4. The following table captures the schedule for the 2025/26 Financial Year. Meetings that include a strategy session are shaded grey.

Financial Year 2025/26	Agenda Setting	Call for Papers Circulated	Deadline for receipt of Papers	Electronic & hard copies circulated	Electronic copies on internet	Board date
April 2025	Thurs 03 April	Fri 04 April	Tues 22 April	Fri 25 April	Tues 29 April	Wed 30 April
May 2025	Thurs 01 May	Fri 02 May	Tues 20 May	Fri 23 May	Tues 27 May	Wed 28 May
June 2025	Thurs 29 May	Fri 30 May	Tues 17 June	Fri 20 June	Tues 24 June	Wed 25 June
July 2025	Thurs 03 July	Fri 04 July	Tues 22 July	Fri 25 July	Tues 29 July	Wed 30 Julu
August 2025	NO MEETING					
September 2025	Thurs 28 Aug	Fri 29 Aug	Tues 17 Sept	Fri 19 Sept	Tues 23 Sept	Wed 24 Sept
October 2025	Thurs 02 Oct	Fri 03 Oct	Tues 21 Oct	Fri 24 Oct	Tues 28 Oct	Wed 29 Oct
November 2025	Thurs 30 Oct	Fri 31 Oct	Tues 18 Nov	Fri 21 Nov	Tues 25 Nov	Wed 26 Nov
December 2025	NO MEETING					
January 2026	Thurs 12 Dec	Tues 31 Dec	Tues 20 Jan	Fri 23 Jan	Tues 27 Jan	Wed 28 Jan
February 2026	Thurs 29 Jan	Fri 30 Jan	Tues 17 Feb	Fri 20 Feb	Tues 24 Feb	Wed 25 Feb
March 2026	Thurs 26 Feb	Fri 27 Feb	Tues 17 Mar	Fri 20 Mar	Tues 24 Mar	Wed 25 Mar

3. Proposed Trust Board Work Plan (2025/26)

The work plan is provisional pending the annual Board and Committee effectiveness reviews which will be conducted between February and May.

ANNUAL TRUST BOARD CALENDAR 2025/26 (PROPOSED)																		
Month			A	M	J	J	A	S	O	N	D	J	F	M	Report	Presenter		
Scheduled agenda items	General	Employee of the month	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Dep CEO	Chair		
		Patient story		✓		✓		✓		✓		✓		✓	DoN	Various		
		Apologies	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair			
		Declaration of interests	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair			
		Minutes of the previous meeting	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair			
		Action list / matters arising	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair			
		Meeting Effectiveness Review	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair			
		Any other business	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair			
	Committee Reports	Audit (inc approval of Corp Governance Manual and Standing Financial Instructions)	✓	✓				✓	✓				✓		DoF	NED		
		Executive	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	DofCS	CEO		
		Finance and Performance	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	DoF	NED		
		Quality (inc Safer Staffing, Maternity and Infection Control)	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	DoN	NED		
		Strategic People Committee	✓			✓			✓			✓			Dof HR	NED		
		Charitable Funds			✓				✓				✓		DoF	NED		
	Operational performance reports	Integrated performance report	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	DoF			
		Corporate Risk Register	✓			✓			✓			✓			DofCS			
		Board Assurance Framework	✓			✓			✓			✓			DofCS			
		Aggregated Incidents, Complaints and Claims report		✓		✓			✓			✓			DoN			
		Informatics Report and Strategy update								✓					Dof Inf			
		Learning from Deaths Quarterly Report and Annual Report (July)	✓			✓			✓			✓			Medical Director			
		Maternity and Neonatal Services Assurance Report				✓						✓			DoN			
	Annual reports	Approval of the Annual Accounts			✓										DoF			
		Approval of Quality Account		✓											DoN			
		NHS Licence Conditions Board declarations			✓										DofCS			
		Board and Committee Effectiveness Review		✓											DofCS			
		Cyber Assessment Framework (CAF) Toolkit Results and Information Governance Annual Report				✓									Dof Inf			
		Trust objectives approval & mid year review		✓						✓				✓	DofCS	CEO		
		Medical revalidation annual declaration						✓							Medical Director			
		Audit Letter sign-off						✓							Dof			
		Charitable Funds Accounts & Annual Report							✓						Dof			
		Research & Development Annual Report								✓					Medical Director			
		Research & Development Annual Capability Statement								✓					Medical Director			
		Biennial Review of NHS Constitution (next scheduled for 2026)								✓					DofCS			
		Trust Board meeting arrangements								✓					Dof CS			
		EPRR Annual Report				✓									COO			
		EPRR Compliance statement						✓							COO			
		WRES & WDES Reports and Action Plans							✓						DofHR			
		Clinical Strategy annual update							✓						Medical Director			
		Safeguarding Annual Report (Adult & Children)			✓										DoN			
		Operational Plan - Budget and activity approval										✓		✓	DoF/COO			
		National Quality Board - nursing workforce plan/staffing review						✓					✓		DoN	DofHR		
		Infection Control Annual Report						✓							DoN			
		CQC registration												✓	DoN			
		Mixed sex annual declaration												✓	DoN			
		Fit and Proper Persons Chair's Annual Declaration			✓										DofCS	Chair		
		Freedom to speak up - Board Self Assessment											✓		Dep CEO			
		CNST MIS Self Declaration & Approval										✓			DoN			
		Pay Gap Annual Declaration						✓							DofHR			
		Staff survey report and action plan												✓	DofHR			
		Total scheduled items	16	17	16	20	0	19	21	18	0	20	15	17				
Closed Session	Chair and NED meeting (or as required)		✓		✓				✓				✓		Chair			
	Chief Executives report			✓		✓		✓		✓		✓		✓	CEO			
	Transition and Transformation Assurance Report		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	TBC			
	Patient Safety Incident Investigation Report			✓		✓		✓		✓		✓		✓	DoN			
	Suspensions			✓		✓		✓		✓		✓		✓	Dof HR			
	Cyber Security Assurance Report			✓				✓		✓				✓	DofInf			
	Feedback from external meetings and events			✓		✓		✓		✓		✓		✓	All			
	Review of meeting effectivness			✓		✓		✓		✓		✓		✓	Chair			