Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 28 January 2026
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (December 2025 and January 2026)** *Purpose: To **present** the Employee of the Month awards for December 2025 and January 2026*	Presentation	Chair *(20 mins)*
10.20	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.35	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB26/001 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 26 November 2025*	Report	
	6.	**TB26/002 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				
10.45	7.	**TB26/003 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators	Report	S O'Brien / S Dowson L Neary M Szpakowska G Lawrence *(30 mins)*

		*Purpose: To **note** the Integrated Performance Report*		
Committee Assurance Reports				
11.15	8.	**TB26/004 Committee Assurance Reports** 8.1. Executive Committee 8.2. Quality Committee 8.3. Strategic People Committee 8.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper G Brown L Knight C Spencer *(40 mins)*
Other Board Reports				
11.55	9.	**TB26/005 Clinical Negligence Scheme for Trusts 2024/25 Self Declaration / Maternity Incentive Scheme Year 7** *(Members from the Local Maternity and Neonatal System (LMNS) in attendance)* *Purpose: To **approve** the Clinical Negligence Scheme for Trusts Self Declaration / Maternity Incentive Scheme Year 7*	Report	S O'Brien *(30 mins)* *(supported by Sue Orchard and Kevin Thomas)*
12.25	10.	**TB26/006 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register*	Report	N Bunce *(10 mins)*
12.35	11.	**TB26/007 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
12.45	12.	**TB26/008 Aggregated Incidents, Complaints and Claims Report (Q3)** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for Q3*	Report	S O'Brien *(15 mins)*
13.00	13.	**TB26/009 Learning from Deaths Quarterly Report (Q2 2025/26)** *Purpose: To **note** the Learning from Deaths Quarterly Report for Q2*	Report	S Dowson *(10 mins)*
13.10	14.	**TB26/010 National Quality Board Nurse Establishment Reviews** *Purpose: To **approve** the National Quality Board Nurse Establishment Reviews*	Report	S O'Brien *(15 mins)*

13.25	15.	**TB26/011 Home Birth Services – Risk, Benchmarking and Improvement Programme for Northwest Region** *Purpose: To **note** the Home Birth Services – Risk, Benchmarking and Improvement Programme for Northwest Region*	Report	S O'Brien *(10 mins)*
Concluding Business				
13.35	16.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.40	17.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 25 February 2026 at 09:30		**13.45 close**
15 minutes break				

Chair: Steve Rumbelow

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	28 January 2026
Agenda Item	**TB26/000**			
Report Title	Patient Story: Louby Lou Children's Ward, Ormskirk Hospital			
Executive Lead	Sarah O'Brien, Chief Nursing officer			
Presenting Officer	Michelle Kitson, Matron Patient Experience Nicola Slilem, Children's Ward Manager			
Action Required		**To Approve**	X	**To Note**

Purpose

To inform the Board regarding the visits of Louby Lou to the Children's ward at Ormskirk Hospital and the positive impact this has had on patients, families and staff.

Executive Summary

Louby Lou is a trained "Clown Doctor" with over two decades of experience, who has a deep passion for bringing joy to children who need it most.

During her hospital visits, she uses therapeutic clowning techniques to create moments of happiness and distraction for sick children and their families. Whether through magic or gentle humour, she brightens their day and offers relief during tough times.

An application was put forward to MedEquip4Kids who fundraise in support of children in hospital to support visits to Ormskirk Hospital Children's ward in December 2022. In January 2025 we were notified that funding had been secured to support some visits.

Following collaborative discussions with the children's ward, infection prevention and control and the patient experience team, Louby Lou completed her first visit in February 2025. Her visits have gone from strength to strength and those that attend the ward frequently will often ask if Louby Lou is visiting and feedback is always positive.

"I have welled up more times than I can count and my cheeks are really hurting from smiling non-stop for 2 hours! As discussed, she visited the two bays and was really engaging to those patients who were open to a visit and with those who were initially hesitant or declined, managed in a magical way to gently encourage and entertain them. We have teenagers in both bays who became friends with the patient across from them and shared things about themselves with each other, facilitated by Louby Lou. Parents and Carers were extremely encouraging, supportive and grateful of the time she spent breaking up their day." **Play specialist.**

"She reminded me of my Head of Year, she's mad too. She was brilliant, it gave me a break from thinking." **Patient 14 yrs**

"Absolutely super. X loved her, they were made up! Brilliant, really lifted everyone's spirits." **Carer**

A further successful application has been made to MedEquip4Kids who will start fundraising to enable the continuation of Louby Lou's visits with the intention of also introducing visits to the children's ward at Whiston Hospital.

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
	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 26 November 2025
(Approved at Trust Board on Wednesday 28 January 2026)

Name	Initials	Title
Steve Rumbelow	SR	Chair
Gill Brown	GB	Non-Executive Director and Deputy Chair
Rob Cooper	RC	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Nicola Bunce	NB	Director of Corporate Services
Steve Connor	SC	Non-Executive Director
Claudette Elliott	CE	Non-Executive Director
Simon Dowson	SD	Chief Medical Officer
Neil Fletcher	NF	Associate Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Lisa Knight	LK	Non-Executive Director (via MS Teams)
Gareth Lawrence	GL	Chief Finance Officer
Lesley Neary	LN	Chief Operating Officer
Sarah O'Brien	SO	Chief Nursing Officer
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer

In Attendance

Name	Initials	Title
Elsie Hayford	EH	Shadow Non-Executive Director
Victoria Kilshaw	VK	Unit Manager, Lilac Centre (Agenda Item 2 via MS Teams)
Yvonne Mahambrey	YM	Quality Matron, Patient Experience (Agenda Item 2 via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Marie Wright	MW	Halton Council Representative (Stakeholder Representative) (via MS Teams)

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for November 2025 was Laura Preston, Non-Specific Rapid Diagnosis Service (NSSRD) Specialist Nurse, St Helens Hospital and the Board watched the film of SO reading the citation and presenting the award to Laura. 1.2. SR advised the Board that there would be a change to the format of the Employee of the Month (EOTM) process with effect from January 2026. The EOTM winner would be invited to attend the Board meeting in person to be presented with their certificate and a member of the Communications and Media Team would take a picture of the winner with the Chair, the CEO and the relevant Executive, which will be used for the intranet and Team Brief Live **RESOLVED:** The Board **noted** Employee of the Month for November 2025 and congratulated the winner.
2.	**Patient Story**
	(YM and VK joined the meeting) 2.1. SR welcomed YM and VK to the meeting. 2.2. YM introduced the Patient Story video in which a patient shared his experience of cancer treatment at the Lilac Centre at St Helens Hospital and how the products used had improved his experience and the personalisation of his care and treatment. 2.3. The story reflected on the patient's reactions to being told he would need chemotherapy, and how the choice of an invasive line had given him back a feeling of being in control in this difficult situation. 2.4. The patient had subsequently met with the Procurement Matron and realised the work that took place to ensure that the best, safest and most suitable equipment options were available for patients. 2.5. The patient had spoken highly of the Lilac Centre and had praised the staff for their skill and care. 2.6. YM reflected on the importance of value based procurement to effective and personalised patient care.

	2.7. VK commented that the patient's feedback had highlighted the importance of empowering patients who were undergoing this difficult treatment. 2.8. SR thanked YM and VK for sharing the patient's story. **RESOLVED:** The Board **noted** the Patient Story *(YM and VK left the meeting)*
3.	**Chair's Welcome and Note of Apologies**
	3.1. SR welcomed all to the meeting and in particular welcomed SD who had joined the Trust as Chief Medical Officer. Additionally, SR welcomed EH to her first Board meeting, as part of the NHS Non-Executive Director Insight Programme, who would be shadowing the Board. 3.2. SR acknowledged the following awards and recognition for Trust staff and services: 3.2.1. David Ashton, Management Accountant, was presented with the 'Rhianne Farrell Kindness Award', an annual recognition created in memory of a much-loved colleague who passed away in 2021. Finance colleagues nominated a team member who they thought showed the same level of kindness, warmth and compassion as Rhianne did. 3.2.2. St Helens Hospital was awarded the prestigious Britain in Bloom Award for 'Best Hospital Gardens' in the region. Whiston Hospital also received a 'Gold Award' for its grounds, with both sites being recognised for their commitment to creating and maintaining attractive environments that benefited patients, visitors and staff. 3.2.3. The Diabetes Teams at Ormskirk and St Helens Hospitals were winners at the Quality in Care (QiC) Awards. • The Paediatric Diabetes Team at Ormskirk Hospital won the Diabetes Education Programme - Healthcare Professionals category. • St Helens Hospital's Young Adults Diabetes Team won in the Patient Care Pathway, Secondary, Primary, Specialist or Community Care category 3.2.4. The Catering Teams at both Southport and Ormskirk Hospitals restaurants retained their 5 star food hygiene rating. 3.2.5. MWL's Employment Services Automation Team won the 'Capsticks Award for Innovation at the Healthcare People Management Association (HPMA) Awards. The team were recognised for leading the way in using Robotic Process Automation (RPA) across HR, Lead Employer, Payroll, and Pensions services. 3.2.6. MWL's Procurement Team won the 'Clinical Procurement in Partnership' category at the Health Care Supply Association (HCSA) Awards. The judges praised the team for their creative approach in transforming how procurement was understood, valued and embedded across the Trust.

	Apologies for absence were **noted** as detailed above
4.	**Declaration of Interests**
	4.1. There were no new declarations of interests made in relation to the meeting agenda items.
5.	**TB25/085 Minutes of the previous meeting**
	5.1. The meeting reviewed the minutes of the meeting held on 29 October 2025 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 29 October 2025
6.	**TB25/086 Matters Arising and Action Logs**
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following actions were closed: 6.2.1. Action Log number 23 (TB25/076 Integrated Performance Report/ 6.2 Operational Indicators) – copy of the detailed presentation from the Finance and Performance Committee was circulated to Board members. **Action closed** 6.3. There were no other outstanding actions. **RESOLVED:** The Board **approved** the action log
Performance Reports	
7.	**TB25/087 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for October 2025 was presented.
7.1.	**Quality Indicators**
	7.1.1. SO and SD presented the Quality Indicators and SO highlighted the following: • Three patient falls with a level of harm of moderate and above had been reported. There was an increased focus on falls prevention, however no new learning had emerged from the investigations into these falls, but it had been found that changes that had been introduced previously had not yet been embedded. SO had met with the Falls Team to explore different improvement methodologies, and learning from prior incidents

	had been reviewed to inform changes in practice to reduce the occurrence and severity of falls. • A Tissue Viability Strategy Group had been established to focus on embedding improvement of assessment and management of pressure ulcers across all clinical areas. • The inpatient Family and Friends Test (FFT) recommendation rate was 93.9% (target 94%). The national inpatient survey had highlighted waiting times and communication as the main patient concerns and there was an action plan in place to address this. 7.1.2. SD reported that: • There was a national problem with the Hospital Standardised Mortality Ratio (HSMR) data. Therefore, the metric had not been updated this month and the latest available data was up to May 2025 (86.8 and year to date (YTD) 90), which was below the average of 100. • The Standard Hospital Mortality Indicator (SHMI) was 0.99 for the period June 2024 to May 2025. • No never events, still births or neonatal deaths had been reported in October 2025. 7.1.3. GB reflected on previous discussions about falls at Quality Committee meetings and agreed with SO's focus on embedding learning in order to close the loop, particularly in relation to falls resulting in harm. 7.1.4. SD commented that sustained learning was a key objective of the Patient Safety Incident Response Framework (PSIRF) and suggested a review of how the learning from incidents investigations was being embedded across the Trust. **Action:** A review of learning from incidents investigations to be undertaken to ensure that learning was being embedded. **BY:** March 2026
7.2.	**Operational Indicators**
	7.2.1. LN presented the operational indicators and highlighted the following: <u>Urgent and Emergency Activity</u> 7.2.2. The Trust 4-hour mapped performance for October was 78% (2025/26 YTD 78.7% against the 78% interim national target). This compared to 74% nationally and 72% for Cheshire and Merseyside (C&M). 7.2.3. LN reported that 19.1% of patients in October waited for over 12 hours in the Emergency Department (ED).(19.6% in C&M). 7.2.4. In October 82.2% of ambulances were handed over within the 45-minute target which was a deterioration from 90.6% in September. However, this remained a significant improvement compared to October 2024, which was 62% within 45-minutes. 7.2.5. Bed occupancy in October was 105.2% which equated to an additional 87.3 patients being cared for by the Trust. This had a significant impact on

patient flow and corridor care, and the opening of escalation beds had been required. On the busiest day, the Trust was accommodating an additional 129 patients.

7.2.6. The percentage of patients who did not meet the criteria to reside (NCTR) had improved from 23.4% in September to 22.2% in October. However, this pressure was not evenly spread across sites and there were particular challenges at Southport Hospital where 27% of patients had not met the criteria to reside. Work to reside bed occupancy internally and to liaise with system partners was on-going to optimise patient flow in line with the Winter Plan.

Elective Activity

7.2.7. The 18-week Referral to Treatment (RTT) performance was 63.8% in October.

7.2.8. At the end of October, there were seven patients waiting over 65 weeks, including two individuals awaiting shoulder surgery that required a product which had been recalled, which was recognised as a national issue. This was a reduction from 232 patients in July.

7.2.9. There were three main areas of elective activity focus, namely:

- Elective activity plan – recovery actions to deliver the agreed elective activity plan.
- 52-week waiting time target (less than 1% of patients waiting over 52 weeks by 31 March 2026) – at the end of October MWL was at 2% of the waiting list and remained on track to achieve the 1% target by the end of March.
- Reducing the total waiting list – from 76,000 patients to circa 70,000 by the end of March 2026. A number of validation actions were being undertaken to ensure this target was achieved.

Cancer Services

7.2.10. Performance against the 28-day cancer standard had improved to 65.8% (target 77%) in September but remained challenged. Actions were focussed on three tumour sites (skin, lower gastrointestinal (GI) and breast) and the Trust continued to work with the C&M Cancer Alliance.

7.2.11. Introduction of skin analytics using artificial intelligence (AI) had helped improve 28-day performance for suspected skin cancer.

7.2.12. LN reminded Board members that, due to the delays in validating cancer performance, four proxy metrics had been established to monitor progress internally and to ensure that actions were delivering the intended impact. The following improvements were noted:

- There was a reduction of 13.5 days for the photo clinics supported by AI.
- Time to first appointment had reduced by 16.8 days.
- For skin and colorectal pathways, the average triage time had reduced from 7.7 days to 0.4 days.

7.2.13. AMS noted that, although progress to date was positive, there was still a long way to go particularly at the Southport and Ormskirk Hospital sites and asked how performance would be sustained once the target was achieved.

	LN agreed that maintaining target performance consistently was the focus, with new early warning triggers and moving key pathway milestones earlier in the 28-day window. 7.2.14. NB queried the reported bed occupancy of 105.2%, which was different from the 97.9% in the Integrated Performance Report (IPR). LN confirmed that the bed occupancy of 105.2% was for the General and Acute (G&A) beds, including corridor care, escalation areas and any ring fenced surgical beds.
7.3.	**Workforce Indicators**
	7.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for appraisals was 89% (target 85%). • The compliance rate for mandatory training was 89.7% (target 85%). • Sickness absence had increased to 7.3% in October from 6.9% in September (target 5%). There had been increased sickness absence rates across all clinical staff groups, including qualified nurses and Allied Health Professionals (AHPs). The top three reasons for sickness absence remained anxiety, stress and depression, musculoskeletal health (MSK) and gastrointestinal issues. The immediate actions being taken to address this had been discussed at the Strategic People Committee (SPC), and a further deep dive had been requested. Actions included a winter wellbeing programme, targeted support for the top 20% high sickness absence areas, additional manager training in attendance conversations. Sickness absence also featured at every Divisional Performance Review meeting. • In-month staff turnover had decreased from 0.9% in September to 0.7% in October (target 1.1%). The rolling 12-month staff turnover remained below target at 10.6% (target 13%). 7.3.2. MS provided an update on the flu campaign and reported that over 42% (target 50%) of staff had been vaccinated. This was an improvement compared to the same period in 2024/25. 7.3.3. SR asked if the flu vaccination rate had been higher before the Covid-19 pandemic. MS responded that in some years the former St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) had achieved 90 to 95% uptake. MWL performance was comparable to other acute trusts, with only the Countess of Chester Hospital NHS Foundation Trust (NHSFT) performing better in C&M at 47%. SR asked if this was due to vaccination fatigue and MS reported that the reasons for reduced vaccination take up were being researched nationally to understand the change in public attitudes.
7.4.	**Financial Indicators**
	7.4.1. GL presented the financial performance indicators and reminded the Board that the Trust had set a deficit plan of £10.7m for 2025/26, however, this would have been a £41m deficit plan excluding £31m of deficit support

	funding. The plan was underpinned by £35m of system led and strategic cost reduction opportunities as well as a recurrent internal Cost Improvement Programme (CIP) of £48.2m. GL reported that this plan would break the Trust's breakeven statutory duty. 7.4.2. At month 7, the Trust was reporting an adjusted position of a £38.2m deficit excluding deficit support funding and was £4.6m ahead of plan. Deficit support remained withheld by NHS England (NHSE) for Q3. 7.4.3. GL highlighted the following: • Agency spend was 45% lower than the corresponding period in 2024/25 and bank spend was 13% lower. • The Trust had successfully delivered £28.5m of the CIP YTD against a full year plan of £48.2m (£1.9m ahead of plan) and was on target to deliver the full plan. • The Trust's cash balance was £1.7m and the Trust had received cash support of £22m during September and October, however the request for further cash support in November had been rejected. The cash support requests submitted were in line with the cash plan for the financial year. • The Trust was still forecasting an adverse variance to plan of £6.8m. 7.4.4. GB asked if any other trusts had their requests for cash support rejected. GL responded that all trusts who had requested cash support in September and October had received the support, however, no requests were accepted in November and this mainly impacted the district general hospitals (DGH). GB asked how this would impact MWL. GL responded that currently the cash position was being managed, as the Lead Employer (LE) cash flow remained positive, however, it was a risk and was being closely monitored. GL reflected on the complexity of MWL due to being a LE as well as the having Public Finance Initiative (FPI) payments which could not be delayed. GB asked if it was mainly the North West (NW) that was affected because of the overall financial position, and GL confirmed C&M was the only ICB with deficit support funding being withheld in the NW. 7.4.5. NB asked whether the deficit support funding would be reinstated before the end of the financial year. GL responded that NHSE's reasons for withholding the deficit support funding had not been shared, so it was unclear what C&M organisations needed to do to reinstate the funding. C&M ICB was £1m better than plan at M7 and was the best performing ICB in the NW (excluding deficit support funding). GL speculated that the deficit support funding may be reinstated once the PricewaterhouseCoopers International Limited (PwC) work and all relevant undertakings had been completed. **RESOLVED:**

	The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
8.	**TB25/088 Committee Assurance Reports**
8.1.	**Executive Committee**
	8.1.1. RC presented the Executive Committee Assurance report for the meetings held in October 2025. Bank or agency staff requests that breached the NHSE cost thresholds were reviewed at each meeting, and the Chief Executive's authorisation recorded. Reports from the weekly vacancy control panel were presented at every meeting. 8.1.2. The Committee had received the regular monthly assurance reports for: • Nurse Safer Staffing • Freedom of Information (FOI) compliance • Mandatory training and appraisal compliance • Finance and financial improvement • Procedural Documents Report which provided an update on overdue polices and the harmonisation of polices across MWL. 8.1.3. RC highlighted the following items from the report: • The Committee had received a Patient Level Costings report which provided an overview of the work undertaken by Mersey Care NHSFT (Population Health Management) to analyse individuals in St Helens who had the greatest health needs and incurred the highest healthcare costs over multiple years. The Committee had discussed how using this data to inform targeted interventions could improve outcomes for these communities. RC reported that this work had now been picked up by the C&M Provider Collaborative and was being repeated for every Place. • The Committee had reviewed a draft Service Improvement Strategy which outlined the organisation's approach to service and quality improvement, which formed part of the 2025/26 Trust objectives. **Action** The final draft Service Improvement Strategy to be developed for presentation to Board. **BY:** February 2026 • The Committee had received the NetCall Patient Reminder Messages report. The Trust had two different versions of the same system across the former trusts and the report outlined how these would be aligned and used to regularly communicate with patients to provide information about waiting times. • The Committee received the proposal for the C&M Standard Rate Card for the North West and approved the principle of adopting the standard rate card if agreed by all providers across the ICB. • The Committee received the Getting the Basics Right – 10 Point action plan which included the national guidance on improving the working lives of the resident doctors. MWL and the LE would develop local implementation plans.

	• The Committee received a review of Staff Communications and Engagement which had concluded that all the existing methods of communication and engagement were effective in reaching a diverse range of staff and achieved their objectives, however it was recognised that there was a need to ensure consistent messages were reaching all staff throughout the Trust. • The Committee received the Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) 2024/25, which were reported to Board in October. • The Committee received the Emergency Preparedness, Resilience and Response (EPRR) Core Standards review and the initial report following the EPRR Business Continuity Incident (telephony system outage at Southport Hospital). This had provided an opportunity to test the business continuity plans. • The Committee had received the Outpatient Transformation Programme update which included the revised scope of the programme following the recent refresh. The scope, objectives, measures of success and timelines were discussed, and the need to focus on maximising current capacity as well as aligning with national processes had been discussed. Progress reports would be presented to the Committee every two weeks. 8.1.4. GB asked if there would be a pilot to test the efficacy of targeted interventions, as proposed in the Patient Level Costing report. RC responded that because both St Helens and Sefton had been awarded neighbourhood health pioneer status, this provided an ideal opportunity to progress and test this work. Although RC also noted that many other areas were progressing the same principles without waiting to be Neighbourhood Pioneers. AMS noted that the report had identified a range of factors beyond health that influenced health spend including environmental, unemployment, and housing factors and it was anticipated that the neighbourhood Health Pioneer Programme would need to take a holistic approach to address these matters. RC noted that the St Helen's Partnership Board was intending to focus on a small number of initiatives which would have the greatest impact the health outcomes of the local population. The remainder of the report was **noted.**
8.2.	**Audit Committee**
	8.2.1. SC presented the Audit Committee Assurance report for the meeting held on 12 November 2025 and advised that, following a competitive procurement exercise, Grant Thornton (GT) had been re-appointed at the Trust's External Auditors for the 2025/26, 2026/27 and 2027/28 audits. 8.2.2. SC highlighted the following: • GT had completed the Trust's 2024/25 external audit; however, this audit was being reviewed by the National Audit Office (NAO) and final sign off

	was needed before the Trust's Annual Report and Accounts for 2024/25 could be finalised. • GT had provided an update on the external audit responsibilities for 2025/26. • MIAA had issued one audit review during the period September to November 2025 and moderate assurance had been received for Quality Spot Checks (Infection, Prevention and Control (IPC) observations). Additionally, eight other internal audit reviews were in progress. • The Committee had received the MWL Audit Log, which listed all the recommendations from previous internal and external audits and provided assurance that the agreed management actions had been implemented in the planned timescales. • The Committee received the Anti-Fraud Progress Report which summarised the anti-fraud and investigations activity during September and October 2025. • The Committee received the Conflict of Interest review and action plan report and SC reminded Board members that, in terms of the Counter Fraud Standards, the Trust continually scored 'amber' on Conflict of Interest declaration compliance. The report had provided assurance against the actions that were being taken to improve the rating from 'amber' to 'green'. • The Committee had received the Losses and Special Payments, the Tenders and Quotation Waivers and Aged Debt Reports. A focus remained on reducing the amount of debt which had been outstanding for over 90 days. The remainder of the report was **noted.**
8.3.	**Charitable Funds Committee**
	8.3.1. GB, (acting Chair), presented the Charitable Funds Committee (CFC) Assurance Report for the meeting held on 06 November 2025 and advised that the following had been approved: • a band 5 Butterfly Co-ordinator role • the creation of a staff wellbeing fund • the Charitable Funds Annual Report and Accounts for 2024/25. 8.3.2. The Committee had been notified of a significant legacy of a property and the process involved in transferring ownership. The beneficiary of the legacy was the Spinal Injuries Unit. NB asked whether the Charity or Trust intended to retain the property. GB responded that this matter was still under review. GL reported that a cash flow analysis was being conducted to determine whether retaining the property for a recurring income stream or selling would provide the greatest benefit for the Charity. NB suggested a condition survey should also be undertaken to support this analysis. The remainder of the report was **noted.**

8.4.	**Quality Committee**
	8.4.1. CE, presented the Quality Committee Assurance Report for the meeting held on 18 November 2025, noting the key quality performance indicators had already been reported. 8.4.2. CE highlighted the following: • The Committee received the IPC Report for Q2 and, whilst compliance for IPC Level 1 training was 94.3%, there needed to be a continued focus on Level 2 IPC training where compliance remained below target (82.7%). • Influenza cases remained low and this was attributable to the Flu Campaign. However, there had been an increase in the number of Covid-19 cases, primarily at the Southport and Ormskirk Hospitals and IPC processes were being reviewed to help limit transmission. 8.4.3. There were no other issues to escalate to the Board. The remainder of the report was **noted**.
8.5.	**Strategic People Committee**
	8.5.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 19 November 2025 and noted that some key issues had already been discussed in earlier reports to the Board and would not be repeated. 8.5.2. LK highlighted the following: • The Committee had received an update on the national NHS five year planning approach for Workforce Operational Planning. The key assumptions for the next three years had been discussed. • The Committee had received the PwC Grip and Control action plan for Q2 and the planned improvement in recruitment times and reduction in the use of bank and agency staff had been noted. • The Committee had received the 10 Point Plan to Improve the Working Lives of Resident Doctors and it was noted that the Trust, as a host organisation and as a Lead Employer, employed circa 14,000 resident doctors in training. • The Committee had reviewed the Education Experience Survey Action Plan update which had been developed in response to the concerns raised by NHSE and the General Medical Council (GMC) for doctors in training in the speciality groups at Southport Hospital. Regular updates would continue to be presented at the Strategic People Committee, until all the actions had been delivered. • The Committee received the Equality, Diversity, and Inclusion (EDI) High Impact Actions update for assurance. The remainder of the report was **noted**.

8.6.	**Finance and Performance Committee**
	8.6.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 20 November 2025. The Committee had reviewed the Finance and Performance CPR and monthly finance report, but the key points had already been discussed in earlier reports on the Board agenda so would not be repeated. 8.6.2. Other points to highlight from the report were: • The National Cost Collection Index (NCCI) had been published and the Trust scored 97 for point of delivery (PODs) against the national average of 100. The range was between 85 and 106 and Trust services above 100 were being reviewed to identify any future opportunities. • The Committee had received the Finance Report for M7 and had discussed changes to the Trust's cash balance and aged debt profile as a result of the financial pressures within the NHS. • The Committee had received the Women and Children's Division CIP update which highlighted that the Division had delivered against the CIP target for 2025/26 and planning was underway for 2026/27. • The Committee had received the HR Commercial Services Financial Performance Report which included the LE and payroll. • The Committee had received the Diagnostic Targets review, and CS reported that, for several years, the Trust had been ranked among the top five trusts nationally for performance against these targets. However, performance against the targets had declined and the management team had presented a recovery plan to the Committee earlier in the year. The Team had attended the November meeting to share the impact of the actions in improving performance and feedback regarding lessons learned from the decline. It was noted that a more anticipatory approach had since been adopted to prevent similar issues from arising in future. 8.6.3. The Committee had received Council Assurance Reports from the CIP Council, Capital Planning Council, Estates & Facilities Management Council, and IM&T Council, with no issues escalated. The remainder of the report was **noted** 8.6.4. SR noted that he had taken the opportunity to observe the Committee meetings this month, which he had found very informative, and thanked the respective Chairs. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**TB25/089 2025/26 Trust Objectives Mid-Year Review**

	9.1. RC introduced the 2025/26 Trust Objectives Mid-Year Review. NB presented the report which provided an update on the progress in delivering the 2025/26 Trust Objectives. 9.2. NB highlighted the following: 9.2.1. Seven objectives had been assessed as fully achieved (green) 9.2.2. 19 objectives were assessed as being on track to be delivered by the end of the financial year (amber) 9.2.3. One objective was assessed as being behind plan and at risk of not being fully delivered by the end of the year (red) 9.3. NB reported that objective 4.3 (Implement a new speech recognition system to improve the turnaround times for clinic letters) had been superseded by the Ambient Voice Technology (AVT) programme referenced under Objective 4.1. 9.4. The "red" objective (8.1 - deliver the agreed financial plan including outturn, cash balances and capital resourcing limits) was at risk of not delivering by the end of the financial year because the system level savings targets were not being achieved, but the Trust continued to work with the ICB, NHSE and PwC to achieve the 2025/26 financial plan. 9.5. SR asked whether the financial plan included the stretch targets and NB confirmed that this was the case. **RESOLVED:** The Board **noted** the 2025/26 Trust Objectives Mid-Year Review
10.	**TB25/090 Maternity and Neonatal Services Reports**
10.1.	**Maternity and Neonatal Services Q2 Update**
	10.1.1. SO presented the Maternity and Neonatal Services Assurance Report for Q2 of 2025/26. It was noted that the reports had also been presented at the Quality Committee and the Director of Midwifery had gone through them in detail. 10.1.2. This was a standard report that was required by the Local Maternity and Neonatal System (LMNS) as part of the Clinical Negligence Scheme for Trusts (CNST) and the Maternity Incentive Scheme (MIS). 10.1.3. SO confirmed that members would have read the reports and that many had also been at Quality Committee the previous week, and highlighted the following: • There had been four reportable perinatal deaths (one stillbirth in July 2025 at Whiston Maternity Unit and three stillbirths in September at Whiston Maternity Unit). All cases had undergone a multidisciplinary

	team (MDT) review, and the Perinatal Mortality Review Tool (PMRT) process had commenced for any relevant cases. • Two new cases had been referred to the Maternity and Newborn Safety Investigation (MNSI) in Q2. The first case related to a baby born at Ormskirk Maternity Unit which had met criteria for active therapeutic cooling and the second case related to a mother who presented in spontaneous labour at 40+3 weeks' gestation and progressed to a normal vaginal delivery, complicated by a shoulder dystocia. 10.1.4. The report provided assurance to the Board that the correct systems and processes where in place in the Maternity and Neonatal Services and that all reporting was in line with national guidance and that all reviews were being completed. 10.1.5. The LMNS had reviewed the Saving Babies Lives (SBL) Care Bundle information and remained satisfied with the Trust's implementation of the national metric. 10.1.6. The Trust was compliant with the British Association of Perinatal Medicine (BAPM) standards for the following: • Neonatal medical workforce – the Trust was compliant on both Whiston Neonatal unit and Ormskirk Neonatal unit. • Neonatal nursing – the Trust was compliant on Ormskirk site, however, due to the current operational pressure on the Whiston site, there was a 3.45 whole time equivalent (WTE) gap for registered nurses (RNs) and an action plan including mitigations was included in Appendix 9 of the report. 10.1.7. There had been no suspension of maternity services on either site in Q2. However there had been 25 neonatal suspensions of services in Q2 across MWL. The remainder of the report was **noted**
10.2.	**Maternity Incentive Scheme (MIS) Year 7 Update**
	10.2.1. SO presented the Maternity Incentive Scheme (MIS) Year 7 update which provided an update on the Maternity Services position in achieving compliance with the ten Safety Actions (SA) required from NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 7 in order to optimise the safety of women and babies. 10.2.2. Two of the safety actions (SA 3 Transitional Care and SA 4 Neonatal nursing workforce) required further work before they could be declared as achieved and the action plans had been included in the report as Appendices 1 and 2.

	10.2.3. SA 1 (use of the Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard) was currently non-compliant as to date there had been 12 cases that had required a PMRT review which had been started within two months of the death. Although all 12 cases had been started within the required time period, a documentation error had occurred which meant in one case only nine of the ten submission questions had been completed, which meant this case was classified as non- compliant against the standard. SO noted that this had been an administrative oversight and had not impacted on the care delivered or the completion of the review. If the Trust was not compliant with SA1 by the submission deadline there was a financial risk to the CNST discount. SO expressed frustration as there had been a similar error in a previous year but noted there had been a lot of reflection and learning by the team, which had also been reviewed in detail at the Quality Committee. 10.2.4. GB stated that she had reflected on SA 1 and the potential non-compliance resulting from the oversight, noting that the error was associated with the question regarding gestational age. There was documentation in the patient's notes confirming that this information was available and the issue had been an oversight. GB hoped a pragmatic response would be adopted by the LMNS and CNST. SO agreed and confirmed that she would continue to advocate for this approach. 10.2.5. GB reflected on compliance with SA 5 (demonstrating an effective system of midwifery workforce planning to the required standard) and noted that it was positive that women in established labour had received one-to-one care, and that the delivery suite shift co-ordinator had been supernumerary at the start of each shift. 10.2.6. SD reflected on the SA1 error involving a single data point within the substantial volume of data collected and emphasised that this had not held any material clinical significance. RC had observed that the omission of data points was a recurring issue and asked whether it would be possible to work with the centre to make these mandatory fields, thereby preventing submission of the document until all such fields were completed, as this issue may have also occurred in other organisations. SO agreed but noted that, at the time, the national reporting system did not permit this functionality and that mandated fields had been previously requested by the Trust. AMS stated that, following the previous incident, the Board had been assured that a fail-safe had been implemented; however, this measure had proved ineffective and noted that the associated learning had been discussed at the Quality Committee. The remainder of the report was **noted** **RESOLVED:** The Board **noted** the Maternity and Neonatal Service Reports

11.	**TB25/091 Annual Digital Strategy Update**
	11.1. MG presented the Annual Digital Strategy Update which provided a progress report on the delivery of the strategy which had been approved by the Board in March 2024. MG reported that, although the Trust had achieved considerable progress in all areas, further work would be required as a result of national developments. This included the need to align the strategy with both the NHS 10-Year Plan and the ICB midterm plans. 11.2. MG highlighted the following progress that had been made: 11.2.1. A significant amount of work had been undertaken on the Trust's IT infrastructure and this had contributed to improved digital maturity and interoperability. Additionally, improvements were made to the reliability of legacy systems, many of which had been replaced. The data centres had been consolidated, and numerous server upgrades completed. 11.2.2. Improved digital security measures, including the migration to a single firewall. 11.2.3. Completion of the email migration to merseywestlancs.nhs.uk. 11.2.4. All cyber security monitoring tools had been consolidated for the management of infrastructure and services. 11.2.5. Lifecycle management and replacement of end use devices to ensure all staff had the correct IT kit and tools. 11.3. One of the significant developments in 2025 had been the agreement to run a joint Electronic Patient Record (EPR) system re-procurement with Warrington and Halton Teaching Hospitals NHSFT (WHH), for a single, shared-instance EPR that delivered clinical standardisation, operational efficiency, and improved integrated care pathways. 11.4. The Trust continued to focus on a programme of EPR readiness and clinical optimisation, which included the Trust-wide deployment of CareFlow Narrative (the clinical noting solution) to improve accessibility, accuracy of clinical documentation and the exchange of documentation across all hospital sites. CareFlow Vitals allowed the sharing of real time information for nurses and doctors who used the system. 11.5. As part of the Levelling Up Programme, which was aimed at harmonising processes across the two legacy organisations, various initiatives had been undertaken. This included the implementation of the Patient Engagement Portal (PEP) using the NetCall solution for patient reminders. MG reported that the patient portal was fully operational at Southport and Ormskirk Hospitals, however, additional clinical preparation work was required before the solution was fully deployed at Whiston, St Helens and Newton Hospitals. 11.6. The upgrade of the legacy letter production system, Transform, which was used at Whiston, St Helens and Whiston Hospitals, had removed significant information security vulnerabilities.

	11.7. The Trust had implemented several artificial intelligence (AI) solutions to support both clinical and operational activities. Following the deployment of additional AI solutions and robotic process automation (RPA), an AI and RPA Steering Group was established to oversee all aspects of AI governance, safety, security, and ethical considerations. 11.8. MG highlighted the following AI developments: • Brainomix – Diagnostic Tool for stroke patients • Skin Analytics – Diagnostic AI tool • Tideway (Theatre Scheduling) – this was an in-house built solution that used Copilot. The system had been pioneered by the consultant for general surgery with assistance from the Digital team. A pilot was planned to go live in January 2026. 11.9. There had been an increase in the use of D.A.V.E, the chatbot used for IT Service Management, and this has resulted in time saving efficiencies. 11.10. The Trust was also leading on several projects for C&M, including implementation and hosting of the Laboratory Information Management System (LIMS) for five trusts to use a single solution. 11.11. The Digital Strategy would be updated in 2026 to align with the various C&M and NHS initiatives including the introduction of the Federated Data Platform (FDP) and the increased use of the patient portal. 11.12. MG advised that one of the other areas of focus for 2026 would be the Ambient Voice Technology (AVT) pilot. 11.13. CS reflected on the opportunities for vertical integration and asked if there would be new interfaces between, primary, community and hospital services. MG responded that work had already commenced in this area with the creation of a multidisciplinary team to advise on the requirements. 11.14. AMS asked whether Badgernet would be operational by the original target date of March 2026. MG responded that there were challenges to the time scales because of the integration work being undertaken to create a single MWL maternity service. However the Digital team remained committed to working with the service to ensure that Badgernet was implemented as quickly as possible. 11.15. SO reported that the Clinical teams also remained committed to ensuring the single instance of Badgernet could be implemented by March 2026, and it was important that she and MG continued to support the digital and clinical teams to overcome any difficulties.

11.16. RC suggested the Executive Committee undertake a detailed review of the challenges and remedial actions needed to achieve the March 2026 deadline.

Action

Executive Committee to undertake an assessment of issues around the implementation of Badgernet to determine the actions required to ensure implementation by March 2026. **BY**: January 2026

11.17. NF asked for an update on the status of the testing of the Electronic Prescribing and Medicines Administration (EPMA) system at Southport and Ormskirk Hospitals and the implications if the system did not go live, as planned. MG responded that the EPMA system at Southport and Ormskirk Hospitals was working as planned and was not anticipating any delays. NF commented that this would have a positive impact on the generation of the handover of care letters.

11.18. GB thanked MG for the comprehensive report and recognised the work undertaken by the Digital teams and asked if there was sufficient capacity to complete all the planned projects. MG responded that capacity would always be a challenge, however actions were being taken, including the expansion of RPA and AI tools, to utilise the available resources as efficiently as possible. If any projects had to be delayed due to the lack of capacity or skills, this would be escalated to the Executive Committee.

11.19. GB noted that there remained difficulties in accessing the internet at Ormskirk Hospital and MG responded that this was a known issue and work was on-going to improve the service.

11.20. RC reflected on the need to establish a robust digital infrastructure across the Trust, including the provision of reliable WiFi connectivity. The rollout of a single EPR system remained an essential prerequisite for service integration, and the success of various other digital initiatives was reliant upon its effective implementation. RC felt it was important for the Trust to remain focused on these foundational components, as a key enabler for MWL. MG agreed that these fundamental requirements would remain at the core of the Digital Strategy.

11.21. SR agreed that it was essential to ensure that a strong foundation was established before determining future priorities.

11.22. SR commented that in times of limited resources it was important to focus on a core set of organisational priorities, whilst also continuing to pursue innovation.

11.23. SD reflected on his recent experience of his previous Trust implementing a new EPR system and that the need for governance, planning and resources should not be underestimated.

	11.24. MS commented that a significant amount of work had been undertaken with RPA processing, mainly in the HR Commercial Services and the Lead Employer Services, which had been very successful, and the learning and expertise gained was now being targeted at supporting the wider organisation to achieve the same benefits. **RESOLVED:** The Board **noted** the Annual Digital Strategy Update
12.	**TB25/092 Trust Board Meeting Arrangements 2026/27**
	12.1. NB presented the proposed Trust Board Meeting Arrangements 2026/27 which included the proposed dates for meetings and the draft annual workplan. It was proposed that the Board meetings continue to be held on the last Wednesday of every month with Strategy Board meetings being scheduled for April, June, October and February. 12.2. NB reported that the provisional 2026/27 Workplan had been updated to include the NHSE New Experience of Care Framework annual update and self-assessment and the NHSE Oversight Framework – Provider Capability Self-Assessment. The provisional workplan would be finalised as part of the annual meeting effectiveness review. **RESOLVED:** The Board **approved** the Trust Board Meeting Arrangements 2026/27
13.	**TB25/093 Research and Development Annual Report and Capability Statement**
13.1.	2024/25 Research and Development Annual Report
	13.1.1. SD presented the 2024/25 Research, Development and Innovation (RD&I) Annual Report which provided an overview of the activity in the Trust during 2024/25. 13.1.2. SD highlighted the following: • MWL staff recruited 2,046 participants to research studies and this had placed the Trust in eighth position on the new expanded North West Regional Research Delivery Network (NW RRDN) dashboard. • The Trust was a top recruiter across a number of studies. • There was an expanded MWL research footprint across Whiston Hospital, Ormskirk Hospital and Marshalls Cross GP surgery. • Patients participating in any of the research studies were asked to provide feedback and this had been immensely positive with an understanding and appreciation of the benefits to the wider healthcare community. • The Cancer Team had recruited 129 patients with cancer to take part in cancer research. • Performance with regards to meeting the predicted recruitment to time and target for non-commercial studies was over 80%, and 50% for our

commercial studies and it would be important to improve this as the Trust moved more into the commercial studies sector.

- In 2024 MWL had been successful with a bid to become one of the ten spoke organisations of the newly formed National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centre (CRDC).

13.1.3. NF thanked SD for an excellent report and asked what else MWL could do to recruit more patients to clinical research considering the size of the population that it served. SD responded that he and SO had held initial discussions about the approach going forward and there was a need to refine the Trust's research strategy and to explore further opportunities.

13.1.4. SO reported that, although the Trust was highly proficient in research delivery, particularly in relation to NIHR clinical trials, there was a proposed change that could impact the way research activities were evaluated. There was an ongoing national review in progress regarding the methodology for measuring activity within clinical research networks. In previous years, research frequently comprised in-depth qualitative methods and extensive surveys, both of which contributed considerably to the Trust's recruitment figures. However, clinical research networks were now considering the introduction of a weighted system for activity measurement. For example, while surveys would continue to be included in overall counts, their value would be less than that of recruiting a patient into a clinical trial for a new cancer therapy. The RD&I team was aware of these potential changes and were monitoring developments accordingly.

13.1.5. SO also highlighted the importance of growing a culture of research amongst all staff members and noted that staff should not only utilise and evaluate existing research but also actively engage in conducting their own research, particularly within non-medical professions. Currently the majority of the Trust's research nurses were primarily involved in facilitating the research projects of others rather than developing and leading their own, such as pursuing doctoral studies within their respective fields. These were two separate strands to the research agenda and there was a real opportunity to expand research across all professional groups.

13.1.6. GB commented, that despite her previous experience in research management, she continued to be impressed by the extensive level of interest generated within the Trust. There was a marked enthusiasm amongst clinicians for participation in research activities, despite the significant challenges inherent in such endeavours. Undertaking research included a range of obstacles and while certain aspects may have become more manageable in recent years, the process remained demanding. It was important to recognise that clinicians were engaged in these research initiatives in addition to their regular clinical duties. Additionally, GB acknowledged the involvement of other teams in these programmes, and commented that the research activity represented a collaborative, Trust-wide commitment.

	13.1.7. CS also thanked SD for an excellent report. CS reflected on the title of the report, Research, Development and Innovation, and commented that it was important to recognise that innovation and research required different skill sets and had different objectives. CS suggested that it might be valuable to consider how to better acknowledge and celebrate this in future reports. 13.1.8. SR reflected on SD's comments about the development of an MWL Research Strategy as an opportunity to bring together the Trust's ambitions and objectives across each of these different areas. **Action:** SD to develop a new MWL Research Strategy **BY:** June 2026 **RESOLVED:** The Board **noted** the 2024/25 Research and Development Annual Report
13.2.	MWL Research and Capability Statement
	13.2.1. SD presented the MWL Research and Capability Statement and noted that this must be published on the Trust's website. 13.2.2. The statement provided researchers with an operational overview of resources available to support Research and Development in the organisation as well as an overview of research collaborations and partnerships with other organisations, including areas of special interest. **RESOLVED:** The Board **approved** the MWL Research and Capability Statement
14.	**TB25/094 NHS Oversight Framework – Provider Capability Statement Self-Assessment**
	14.1. RC introduced the NHS Oversight Framework – Provider Capability Statement Self-Assessment. NB presented the report and advised that the capability self-assessment had been submitted to NHSE by the agreed deadline. 14.2. NB reported that NHSE had requested supporting information from the Trust and, whilst this has been submitted, no feedback had yet been received. **RESOLVED:** The Board **noted** the NHS Oversight Framework – Provider Capability Statement Self-Assessment
Concluding Business	
15.	**Effectiveness of Meeting**

	15.1. Board members agreed that meeting had been effective.
16.	**Any Other Business**
	16.1. GL reported that, during the latest round of industrial action, NHSE had expected that trusts maintained 95% of their planned activity levels. GL confirmed that MWL had successfully met this requirement. SR acknowledged the strong performance and expressed appreciation to all those involved in maintaining services during this period. 16.2. LN reminded Board members of the forthcoming winter information campaign, which had been developed with the Communications team. LN highlighted that the campaign would involve a significant level of activity both within the Trust and externally, including the sharing of important messages alongside engaging and light-hearted initiatives. 16.3. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12:00. The next Board meeting would be held on **Wednesday 28 January 2026 at 09:30**

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

DRAFT Trust Board (Public)

Matters Arising Action Log (updated 23 January 2026)

Mersey and West Lancashire Teaching Hospitals NHS Trust

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

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
21	24/09/2025	**TB25/072 Statutory Pay Gap Annual Declaration 2024/25**	MS and the CMO to review the current medical leadership structure to better understand if roles were more attractive to male gendered staff. **Update** (23/01/2026) The CMO is about to commence a new leadership recruitment process, and as part of this work we have considered whether aspects of the current medical leadership structure or role design may be perceived as more attractive to male colleagues. This has included reviewing role expectations, the recruitment approach and any potential barriers or unintended impacts to ensure that our leadership opportunities are equitable, inclusive, and accessible to all. A further update once the process has concluded and if any recommendations have been identified will be shared with the Strategic People Committee (SPC).	MS / SD	Jan-26		**Delegated to Strategic People Committee**

24	29/10/2025	**TB25/078 Corporate Risk Register**	MG to review risks 5 and 23 to determine if could be combined into a single Corporate Risk Register (CRR) risk. Update (23/01/2026) Following review, it is not considered appropriate at this stage to merge Corporate Risks 5 (MWL Risk ID 263) and 23 (MWL Risk ID 1125). While there is some thematic overlap, the risks arise from distinct underlying causes, relate to different service areas, and are subject to separate control measures and impact profiles. Risk 1125 is due for further review at the end of March. Subject to the outcome of this review and the effectiveness of existing and planned mitigations, there is an expectation that the residual risk score may reduce. Both risks will be kept under review, and should the risks converge further in cause, control, or impact, the option to merge them can be reconsidered at a future point. **Action closed**	MG	Jan-26		**Closed**
25	29/10/2025	**TB25/080 Aggregated Incidents, Complaints and Claims Report (Q2)**	SO to provide an update on the high rate of community acquired pressure ulcers at a future Quality Committee.	SO	Jan-26		**Delegated to Quality Committee**
26	26/11/2025	**TB25/087 Integrated Performance Report** 7.1 Quality Indicators	A review of learning from incidents investigations to be undertaken to ensure that learning was being embedded.	SO	Mar-26		
27	26/11/2025	**TB25/088 Committee Assurance Reports** 8.1 Executive Committee	The final draft Service Improvement Strategy to be developed for presentation to Board	KC	Feb-26		**Delegated to Strategy Board**
28	26/11/2025	**TB25/091 Annual Digital Strategy Update**	Executive Committee to undertake an assessment of issues around the implementation of Badgernet to determine the actions required to ensure implementation by March 2026. Update (23/01/2026) A report is due to be presented at Executive Committee on 29 January. **Action closed**	RC	Jan-26		**Completed**
29	26/11/2025	**TB25/093 Research and Development Annual Report and Capability Statement**	SD to develop a new MWL Research Strategy.	SD	Jun-26		

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
23	29/10/2025	**TB25/076 Integrated Performance Report** 6.2 Operational Indicators	GB asked about productivity and how this would be measured. LN reported that a detailed report had been presented at F&P Committee and undertook to circulate the presentation to Board members	LN	Nov-25	**21/11/2025** - Copy of presentation circulated to Board Members	**Action closed**

Title of Meeting	**Trust Board**		**Date**	28 January 2026
Agenda Item	**TB26/003**			
Report Title	Integrated Performance Report			
Executive Lead	Gareth Lawrence, Chief Finance Officer			
Presenting Officer	Gareth Lawrence, Chief Finance Officer			
Action Required		**To Approve**	X	**To Note**

Purpose
The Integrated Performance Report provides an overview of performance for MWL across four key areas: 1. Quality 2. Operations 3. Workforce 4. Finance
Executive Summary
Performance for MWL is summarised across 29 key metrics. Quality has 11 metrics, Operations 11 metrics, Workforce 4 metrics and Finance 3 metrics.
Financial Implications
The forecast for 2024/25 financial outturn will have implications for the finances of the Trust.
Quality and/or Equality Impact
The 11 metrics for Quality provide an overview for summary across MWL.
Recommendations
The Trust Board is asked to note 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	Jul-25	90.7	100	89.5	Best 30%
FFT - Inpatients % Recommended	Dec-25	94.9%	90.0%	94.2%	Worst 40%
Nurse Fill Rates	Dec-25	95.7%	90.0%	96.4%	
C.difficile	Dec-25	8		83	
E.coli	Dec-25	13		122	
Hospital Acq Pressure Ulcers per 1000 bed days	Sep-25	0.00	0.00	0.09	
Falls ≥ moderate harm per 1000 bed days	Dec-25	0.11	0.00	0.11	
Stillbirths (intrapartum)	Dec-25	0	0	1	
Neonatal Deaths	Dec-25	3	0	5	
Never Events	Dec-25	0	0	2	
Complaints Responded In 60 Days	Dec-25	63.5%	80.0%	55.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Nov-25	75.9%	77.0%	67.8%	Worst 10%
Cancer 62 Days	Nov-25	78.0%	85.0%	78.2%	Best 20%
Ambulance Arrival to Vehicle Handover: % <45 mins	Dec-25	69.6%	100.0%	84.8%	
A&E Standard (Mapped)	Dec-25	75.4%	78.0%	78.2%	Best 30%
Average NEL LoS (excl Well Babies)	Dec-25	4.4	4.0	4.0	Best 30%
% of Patients With No Criteria to Reside	Dec-25	20.9%	10.0%	21.0%	
Discharges Before Noon	Dec-25	19.1%	20.0%	19.0%	
G&A Bed Occupancy	Dec-25	96.5%	92.0%	97.8%	Worst 10%
Patients Whose Operation Was Cancelled	Dec-25	0.9%	0.8%	1.0%	
RTT % less than 18 weeks	Dec-25	62.8%	92.0%	62.8%	Best 40%
18 weeks: % 52+ RTT waits	Dec-25	2.0%	1.0%	2.0%	Worst 50%

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Dec-25	90.1%	85.0%	90.1%	
Mandatory Training	Dec-25	88.7%	85.0%	88.7%	
Sickness: All Staff Sickness Rate	Dec-25	7.8%	5.0%	6.7%	
Staffing: Turnover rate	Dec-25	0.7%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Dec-25		49,064	26,402	
Cash Balances - Days to Cover Operating Expenses	Dec-25	0.9	10		
Reported Surplus/Deficit (000's)	Dec-25		-29,379	-36,882	

Board Summary - Quality

Quality

HSMR
A paper went to CEC in January with a proposal on how the Trust handles the impact of uncoded data on HSMR reporting. An agreement was made and the latest HSMR for the period Apr-25 to Jul-25 is 89.5. The latest SHMI for the period Sep-24 to Aug-25 is 0.99.

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

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

Pressure Ulcers
Validation of Pressure Ulcers for October has been delayed due to a number of postponed meeting across the December holiday period. October and November HAPUs will be validated for the next reporting period.

Falls
Following review there were 4 falls assessed as moderate harm and above. 2 were assessed as severe, 1 moderate harm and 1 fall resulted in death. PSIRs are underway for these, and they will form part of the aggregated review subsequently informing the improvement plan for 26/27 which is under development. The number of fall with moderate harm remains the same as for October 2025 but there has been a reduction from September 2025

Neonatal Deaths
3 cases of neonatal deaths before 28 days were reported in December all relating to cases of extreme prematurity and below the threshold for viability.

Never Events
There were no reported Never Events for the month of December

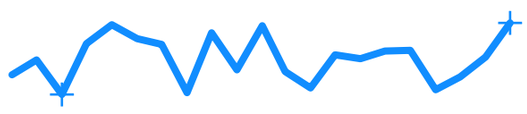
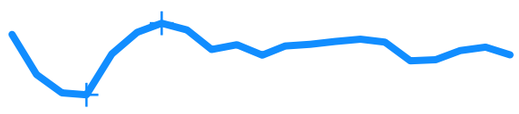
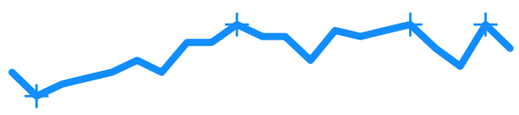
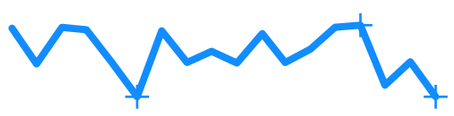
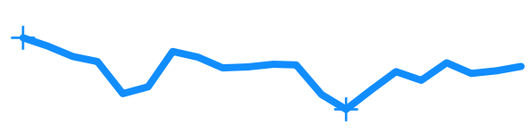
Complaints
December has shown a significant decrease in the number of stage 1 complaints received. In December there were 35 received and in November there were 49. This is a significant decrease on the previous month. 52 complaints were closed in December and within the agreed Trust 60 working day target December compliance is recorded at 63.5%. Of the 52 closed in total, 33 were closed in time and 19 were closed out of time.

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	Jul-25	90.7	100	89.5	Best 30%	
FFT - Inpatients % Recommended	Dec-25	94.9%	90.0%	94.2%	Worst 40%	
Nurse Fill Rates	Dec-25	95.7%	90.0%	96.4%		
C.difficile	Dec-25	8		83		
E.coli	Dec-25	13		122		
Hospital Acq Pressure Ulcers per 1000 bed days	Sep-25	0.00	0.00	0.09		
Falls ≥ moderate harm per 1000 bed days	Dec-25	0.11	0.00	0.11		
Stillbirths (intrapartum)	Dec-25	0	0	1		
Neonatal Deaths	Dec-25	3	0	5		
Never Events	Dec-25	0	0	2		
Complaints Responded In 60 Days	Dec-25	63.5%	80.0%	55.4%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E

4-Hour performance decreased in December, achieving 69.78% (all types). Trust performance is below National (73.8%) and C&M (71.5%). The Trusts mapped 4-Hour performance achieved 75.4%.

Patient Flow

Bed occupancy across MWL averaged 105.1% in December equating to 103.6 patients - an ongoing trend of high occupancy. There was a peak of 162 patients (67 at S&O, 95 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 4% lower than last December, driven by a 6% reduction in 0 day LOS activity, 1+ day LOS activity was also 3% lower than last year. Southport had a 4.9% increase in 0 LOS from December 24 to December 25, driven by the use of the new ED SDEC. Average length of stay for emergency admissions remains high, at 9.5 at S&O and 8.1 at StHK, with an overall average of 8.6 days, the impact of non CTR patients being 20.9% at Organisation level, 0.6% higher than November and 0.2% higher than December 2024 (17.9% S&O and 22.3% StHK).

Elective Activity

The Trust had 1,495 52-week waiters at the end of December, (361 S&O and 1,134 StHK), 2 65-week waiters and zero 78-week waiters.
The 52-week position is a decrease of 38 from November and the 65-week waiters have increased by 1 from November to December. 18-Week performance in December for MWL was 62.8%, S&O 62.6% and StHK 62.9%. This was ahead of national performance (latest month November) of 60.9% and C&M regional performance of 59.1%.

Cancer

Cancer performance for MWL in November improved, at 75.9% for the 28 day standard (target 77%), with Southport achieving 68.4% and St Helens performance being 81.0%. Latest published data (November) shows national performance of 76.5% and C&M regional performance of 74.8%. Performance for 62-day also improved, achieving 78.0% (target 85%), with Southport achieving 72.4% and St Helens 80.2%. C&M performance was 74.2% and National 70.2%. Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2025/26.

Diagnostics

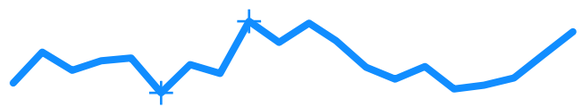
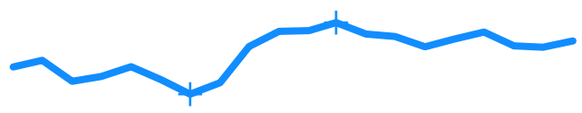
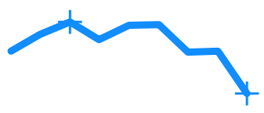
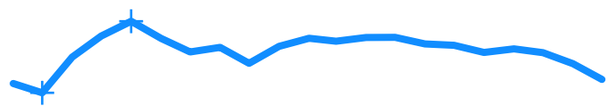
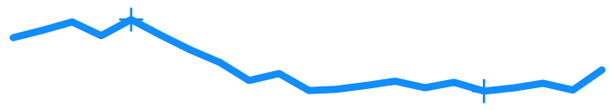
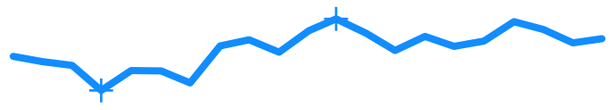
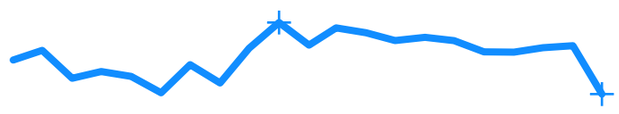
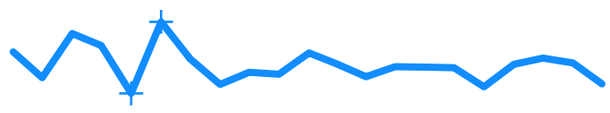
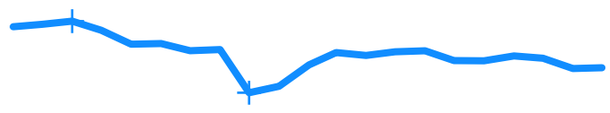
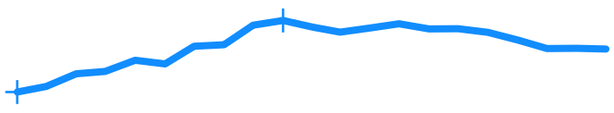
Diagnostic performance in December was 93.6% for MWL, failing to achieve the 95% target, with S&O achieving 90.3% and StHK 96.3%. MWL performance is ahead of national performance (latest month November) of 78.3% and C&M regional performance of 90.8%.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Nov-25	75.9%	77.0%	67.8%	Worst 10%	
Cancer 62 Days	Nov-25	78.0%	85.0%	78.2%	Best 20%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Dec-25	69.6%	100.0%	84.8%		
A&E Standard (Mapped)	Dec-25	75.4%	78.0%	78.2%	Best 30%	
Average NEL LoS (excl Well Babies)	Dec-25	4.4	4.0	4.0	Best 30%	
% of Patients With No Criteria to Reside	Dec-25	20.9%	10.0%	21.0%		
Discharges Before Noon	Dec-25	19.1%	20.0%	19.0%		
G&A Bed Occupancy	Dec-25	96.5%	92.0%	97.8%	Worst 10%	
Patients Whose Operation Was Cancelled	Dec-25	0.9%	0.8%	1.0%		
RTT % less than 18 weeks	Dec-25	62.8%	92.0%	62.8%	Best 40%	
18 weeks: % 52+ RTT waits	Dec-25	2.0%	1.0%	2.0%	Worst 50%	

Board Summary - Workforce

Workforce

Mandatory Training
The Trust continues to exceed its mandatory training target, maintaining performance at 88.7% in December 25 against a target of 85%. Targeted support remains in place to enable front-line clinical staff to access training, ensuring continued compliance and improvement.

Appraisals
Appraisal compliance is positively exceeding the 85% target at 90.1% in December 25.

Sickness Absence
Sickness absence has increased again in December 25 to 7.8%, from 7.3% in November 25, remaining above the Trust target of 5%. This is a key priority area for the HR and for MWL.

Top 3 reasons for sickness absence:

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

A comprehensive sickness absence improvement plan is in place, with progress monitored through the People Performance Council and Strategic People Committee. Targeted initiatives under the Looking After Our People pillar of the Trust People Plan are being implemented, and the Absence Support Team continues to provide focused support to teams with the highest levels of absence. Despite the high levels of support, it is recognised that absence continues to be a key area of concern.

A deep dive into absence data has taken place, and a Taskforce Group started early in January 26 to further consider the data and where we may need to focus efforts in areas of high need. There has been some triangulation of sickness data with employee relations cases for wider consideration of the impact and a small team have met weekly to ensure we have a solid data set to inform decisions. In late January 26, the Task Force group membership is being extended to Nursing, Operational and Communication teams to consider what immediate, medium and long term actions can be taken forward to drive down absence in a sustained way, informed by the data. Strong leadership and an organisational approach to holistic wellbeing is required to ensure we Look After Our People in a way that helps them to stay in work. This group will be led by the AD of HR for LOD and HWWB

Turnover
In-month turnover for December 25 is 0.8% against a target of 1.1%.

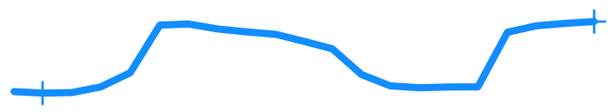
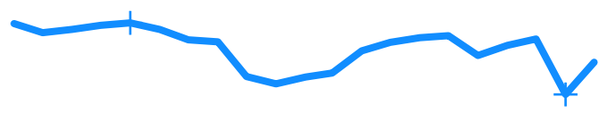
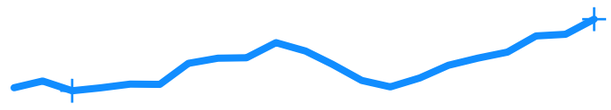
Time to Hire
Time to hire has been a particular challenge for us since the summer months, and a recovery plan has been in place in recruitment and HWWB to drive it down. The average time to hire in December 25 was at 58.4 days against a target of 40; however for context, since the recovery plan, time to hire has decreased from 100.2 in July 25 and trajectory plans were for us to have cleared within 60 days by December - this demonstrates that the recovery plan is working. Additionally, for those offered in month was an average of 46.31 days which is slightly above target but significantly improved. Occupational Health clearance is down to 6.09 days from 53.5 days in August when the recovery plan launched, which has contributed to the overall position around Time to Hire.

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	Dec-25	90.1%	85.0%	90.1%		
Mandatory Training	Dec-25	88.7%	85.0%	88.7%		
Sickness: All Staff Sickness Rate	Dec-25	7.8%	5.0%	6.7%		
Staffing: Turnover rate	Dec-25	0.7%	1.1%	0.8%		

Board Summary - Finance

Finance

The approved MWL financial plan for 2025/26 submitted in May 2025 gives a deficit of £10.7m, assuming:
-Non-recurrent deficit support of £30.2m.
-Delivery of £48.2m recurrent CIP
-Realisation or reallocation of strategic opportunities of £8m
-Realisation or reallocation of system led cost reductions of £27m

The current plan breaks the Trust's statutory break even duty.

Surplus/Deficit – At the end of Month 9, the Trust is reporting an adjusted position of £36.9m deficit. Excluding deficit support funding, the adjusted position is £44.4m deficit, £7.6m better than plan. This includes the impact of the revised pay award and industrial action costs which are offset against cost reductions delivered ahead of plan and additional industrial action funding of £3.9m.

CIP - The Trust's CIP target for financial year 2025/26 is £48.2m, all if which is to be delivered recurrently. As at Month 9, the Trust has successfully transacted CIP of £37.3m year to date, £2.0m above plan. 100% of the £48.2m recurrent target is covered by fully developed schemes.

Cash - At the end of M9, the Trust's cash balance was £2.3m. As part of the original plan submitted to NHSE, the Trust assumed the receipt of £30m deficit support funding by the end of the financial year. As at M9, only Q1 2025/26 has been received, the Trust continues to monitor cash closely and implement mitigations to the removal of deficit support funding. To date, the Trust has received PDC support of £10.9m (September) and £11m (October).

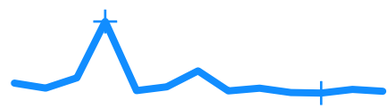
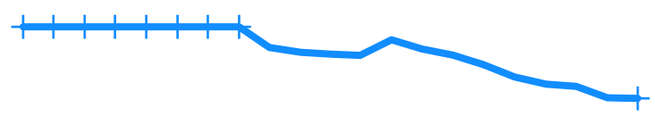
Capital - The original capital plan for the year is £64.6m (including PFI lifecycle and lease remeasurements). Capital expenditure for the year to date [including PFI lifecycle maintenance and lease remeasurements] totals £26.4m, which is £22.3m below the original plan. However, if we exclude ePR and CDC schemes from this profile, the revised variance is c. £6.2m below plan. Since submitting its plan, the Trust has been awarded an additional c. £5.6m in PDC funding. The Trust anticipates that its revised programme of c. £48.3m will be delivered in full by the end of the 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	Dec-25		49,064	26,402		
Cash Balances - Days to Cover Operating Expenses	Dec-25	0.9	10			
Reported Surplus/Deficit (000's)	Dec-25		-29,3...	-36,8...		

How to Interpret - Summary Table

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

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

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

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

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

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

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

Metric Category Description - Quality

Quality Metrics

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

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

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

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

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

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

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

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

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

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

Metric Category Description - Operations

Operational Metrics

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

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

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

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

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

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

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

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

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

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

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

Metric Category Description - Workforce

Workforce Metrics

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

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

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

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

Metric Category Description - Finance

Finance Metrics

Capital Spend £M
Capital Spend £M

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

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

Board Summary

Jce_aw QRF I

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	Jul-25	95.3	100	85.6	
FFT - Inpatients % Recommended	Dec-25	94.4%	94.0%	93.7%	
Nurse Fill Rates	Dec-25	95.0%	90.0%	96.3%	
C.difficile	Dec-25	4		54	
E.coli	Dec-25	10		79	
Hospital Acq Pressure Ulcers per 1000 bed days	Sep-25	0.00	0.00	0.07	
Falls ≥ moderate harm per 1000 bed days	Dec-25	0.17	0.00	0.13	
Stillbirths (intrapartum)	Dec-25	0	0	0	
Neonatal Deaths	Dec-25	3	0	5	
Never Events	Dec-25	0	0	0	
Complaints Responded In 60 Days	Dec-25	52.9%	80.0%	53.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Nov-25	81.0%	77.0%	76.4%	
Cancer 62 Days	Nov-25	80.2%	85.0%	84.5%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Dec-25	58.8%	100.0%	79.7%	
A&E Standard (Mapped)	Dec-25				
Average NEL LoS (excl Well Babies)	Dec-25	4.0	4.0	4.0	
% of Patients With No Criteria to Reside	Dec-25	18.8%	10.0%	19.6%	
Discharges Before Noon	Dec-25	19.1%	20.0%	19.8%	
G&A Bed Occupancy	Dec-25	96.8%	92.0%	98.2%	
Patients Whose Operation Was Cancelled	Dec-25	0.8%	0.8%	1.0%	
RTT % less than 18 weeks	Dec-25	62.9%	92.0%	62.9%	
18 weeks: % 52+ RTT waits	Dec-25	2.2%	1.0%	2.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Dec-25	90.6%	85.0%	90.6%	
Mandatory Training	Dec-25	89.2%	85.0%	89.2%	
Sickness: All Staff Sickness Rate	Dec-25	7.6%	5.0%	6.8%	
Staffing: Turnover rate	Dec-25	0.6%	1.1%	0.8%	

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

Board Summary

Jce_aw Q$M

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	Jul-25	78.1	100	99.2	
FFT - Inpatients % Recommended	Dec-25	96.0%	90.0%	95.2%	
Nurse Fill Rates	Dec-25	96.8%	90.0%	96.6%	
C.difficile	Dec-25	4		29	
E.coli	Dec-25	3		43	
Hospital Acq Pressure Ulcers per 1000 bed days	Sep-25	0.00	0.00	0.14	
Falls ≥ moderate harm per 1000 bed days	Dec-25	0.00	0.00	0.07	
Stillbirths (intrapartum)	Dec-25	0	0	1	
Neonatal Deaths	Dec-25	0	0	0	
Never Events	Dec-25	0	0	2	
Complaints Responded In 60 Days	Dec-25	83.3%	80.0%	57.7%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Nov-25	68.4%	77.0%	54.8%	
Cancer 62 Days	Nov-25	72.4%	85.0%	63.6%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Dec-25	88.3%	100.0%	93.7%	
A&E Standard (Mapped)	Dec-25				
Average NEL LoS (excl Well Babies)	Dec-25	5.1	4.0	4.0	
% of Patients With No Criteria to Reside	Dec-25	24.5%	10.0%	23.4%	
Discharges Before Noon	Dec-25	19.2%	20.0%	18.2%	
G&A Bed Occupancy	Dec-25	95.9%	92.0%	97.1%	
Patients Whose Operation Was Cancelled	Dec-25	1.2%	0.8%	1.1%	
RTT % less than 18 weeks	Dec-25	62.6%	92.0%	62.6%	
18 weeks: % 52+ RTT waits	Dec-25	1.7%	1.0%	1.7%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Dec-25	88.8%	85.0%	88.8%	
Mandatory Training	Dec-25	87.5%	85.0%	87.5%	
Sickness: All Staff Sickness Rate	Dec-25	8.1%	5.0%	6.7%	
Staffing: Turnover rate	Dec-25	0.8%	1.1%	0.7%	

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	28 January 2026
Agenda Item	**TB26/004 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the seven Executive Committee meetings held in November and December 2025		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were seven Executive Committee meetings held during November and December 2025. No meeting was held on 25 December, due to the bank holiday. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The weekly vacancy control panel decisions were also reported, at each committee meeting.		
06 November 2025		
Nurse safe staffing report – September 2025	• The Chief Nursing Officer presented the safe staffing report for September. Total Registered Nurse (RN) fill rates had been 95.10% and total Health Care Assistant (HCA) fill rates had been 114.21%. • RN fill rate on days had fallen below 95% at 93.99%. • There were some wards which the average fill rate for RNs or HCAs had been below 90%. Wherever possible staff were moved between wards to ensure all wards remained safe, but in specialist areas this was more difficult. • Of 1,293 RN temporary staffing requests, 1,041 had been filled with bank or agency shifts. • Continued high levels of sickness absence on some wards remained a concern and directly impacted fill rates. • 157 patient safety incidents had been reported in September, of which 151 caused no harm and six low harm. No incidents were reported from the wards with fill rates below 90%.	Assurance
Breast Reconstruction Service Locum	• The Chief Operating Officer introduced the business case to recruit a further Breast and Micro Reconstructive Consultant Surgeon.	Approval

Consultant Business Case	• This was proposed as succession planning to build the resilience and sustainability of the team and assist with capacity to reduce the waiting lists for DIEP and breast reconstruction surgery. • The Executive sought assurance that this additional capacity would be aligned to opportunities to maximise productivity. • The business case was approved based on temporary double running costs.	
Freedom of Information (FOI) compliance report – October 2025	• The Director of Informatics presented the report which detailed the compliance rate against the 20-day response time for FOIs within each director's portfolio. • Overall, Trust compliance remained below the 90% target for responding within 20 days and Committee discussed the impact of the actions taken to date to improve compliance, acknowledging the increasing complexity and number of questions asked in each individual FOI, that required coordination across multiple services to provide the requested information.	Assurance
Bed Moves (Quarter 2 2025/26)	• The Chief Operating Officer presented the report which demonstrated most bed moves were taking place as part of patient pathways e.g. endoscopy • It was agreed that the report be reconfigured to focus on exceptions from the clinically necessary bed moves.	Assurance
10 Point Plan to Improve the working lives of Resident Doctors.	• The Chief People Officer presented the Trust action plan that had been developed in response to the NHS England (NHSE) 10 Point Plan to improve the working lives of Resident Doctors, and the previously reported self-assessment against each of the ambitions. • It was noted that for three of the initiatives – the carryover of annual leave, advance rotas and locker provision, further national guidance was awaited, however it was expected that investment would be required for the Trust to be able to implement these elements of the plan. • Progress on delivery of the Trust action plan would be reported to the People Performance Council, with assurance to the Strategic People Committee. • Committee also supported the proposal to create a single MWL Resident Doctor forum to support engagement and involvement in delivering the Trust action plan.	Approval

	• Committee approved the plan and the governance arrangements.	
Finance and Performance Review (FPRM) Meeting	• The Chief Finance Officer briefed the directors on the FPRM which had taken place with NHSE and PricewaterhouseCoopers International Limited (PwC). • The meeting focused on delivery of financial and operational plans the second half of 2025/26.	Assurance
13 November 2025		
Resident Doctors Industrial Action	• The Chief Operating Officer briefed the Committee in relation to the impact of the latest period of industrial action, and the plans in place to continue delivering at least 95% of normal elective activity.	Assurance
Trust Objectives – mid-year review	• The Director of Corporate Services presented the review which collated the Trust objectives updates from each director. • Committee reviewed the responses to ensure consistency • The mid-year review would be presented to the November Trust Board.	Assurance
Maternity Safety Support Programme (MSSP) Report	• Amy Stubbs from the NHSE national MSSP team joined the Executive Committee to present the MSSP report following the reviews undertaken of the MWL maternity services. • The review had been commissioned by NHSE Northwest following the assessment of risk by the Northwest Clinical Senate and the Cheshire and Merseyside (C&M) Local Maternity and Neonatal Network (LMNS) and the MWL Board decision to review the pathways for high-risk births. • Committee had discussed the differences between safety and risk. • The Chief Executive explained the report was to be presented to the Trust Board at the November Board meeting.	Assurance
Estates and Facilities Budget	• The Director of Corporate Services presented the report which set out proposals to include the standard “headroom” allowances in the Estates and Facilities staffing budget for the S&O sites. • Historically this had not been built into budgets, but funded from central reserves, which was inefficient and increased reliance on bank staff. • A similar rebasing exercise was also being undertaken in relation to energy and utilities costs for the S&O sites.	Approval

	• This was not new investment, but rather an adjustment of the budgets to increase accountability and control. • The proposal was approved.	
2025/26 Workforce Plan	• The Chief People Officer introduced the report which detailed progress against the 2025/26 workforce plan, including bank and agency staff, as reported in the September Provider Workforce Return (PWR). Overall, the Trust remained ahead of plan and on course to deliver the year end position. • The Committee reviewed the changes for each staff group and requested further assurance of quality impact assessments and mitigation of risks to patient care.	Assurance
Financial Position – Month 7	• The Chief Finance Officer summarised the Month 7 financial position and the actions agreed with PwC and NHSE to deliver the planned outturn position by the end of the financial year.	Assurance
Outpatient Transformation Programme update	• The Chief Operating Officer introduced the report, which detailed progress made in developing the interim performance metrics, process mapping of variation across specialities and the legacy Trust sites and the work that had commenced on data cleansing of the waiting list for each speciality. • The Patient Access policy had been harmonised and included performance metrics for clinic booking horizons and late cancellations. Divisional performance reports against these metrics were being issued and used to support the weekly patient tracking list (PTL) meetings. • Roles and responsibilities for each stage of the process were being clarified and standardised. • Next steps included a review of DNAs, PIFU, advice and guidance and patient follow up practices. • The Committee was assured that the programme was now focused on the key issues and making progress.	Assurance
General Medical Council (GMC) National Training Survey and Action Plan	• The Chief People Officer presented the Trust results from the 2025 GMC survey of doctors in training hosted by MWL. The survey is used to monitor the quality of Postgraduate Medical Education and Training. • Although the overall survey results had been broadly similar since 2022, eight indicators had improved and ten had stayed the same or	Assurance

	deteriorated. The Trust scores were within the national benchmark range for 17 of the 18 indicators. • Following the publication of the survey results, NHSE had written with specific concerns about the feedback from doctors in training at Southport Hospital in General Surgery, Obstetrics and Gynaecology, General Medicine and Urology, asking the Trust to investigate and develop an improvement plan. • Assurance on delivery of the improvement action plan would be provided via the Strategic People Committee.	
Joint Advisory Group (JAG) Endoscopy Accreditation	• The Chief Operating Officer briefed the Committee on the JAG review of the endoscopy unit at St Helens Hospital and the actions required to retain accreditation of the service. • The required actions included immediate changes to the layout to ensure separation of male and female pathways, and then a commitment to complete capital works in 2026/27 to formalise this separation of facilities.	Assurance
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the report from the RMC meeting on 11 November • 1,030 risks were reported on the Trust risk register, with 67 new risks reported during October and 47 risks closed. • 24 risks had been escalated to the Corporate Risk Register (CRR) • The legacy S&O tolerated risk register had been closed and these risks absorbed back into the live risk register. • The RMC received the assurance report from the Claims Governance Group, which had considered 16 new NHS Resolution instructed claims received during July and August 2025.	Assurance
20 November 2025		
Post Take Ward Round (PTWR)	• The Chief Operating Officer introduced the proposal from the Medical and Urgent Care Division to formalise the current locum arrangements to provide 7-day consultant led cover for the PTWR at Whiston Hospital. • The paper demonstrated the benefits of the model in moving patients to speciality areas or discharging home faster, which improved patient flow. Formalising the model increased consistency and delivered a financial saving.	Approval

	• A similar model was being developed for the Southport site. • The proposal was approved.	
Digital Strategy annual review	• The Director of Informatics presented the draft annual update on delivery of the Trust Digital Strategy. • Committee discussed the report and agreed several additions to the final report for the Trust Board.	Assurance
Draft MWL Organisational Strategy 2026-2031	• The Director of Strategy presented the latest iteration of the strategy for review and comment. • Committee considered how the strategy should be presented to different target audiences. • It was agreed the final draft should be considered at the next Strategy Board session in February 2026, and if approved would be launched in April 2026.	Assurance
C&M Pathology and Radiology Order Comms Business Case	• The Director of Informatics introduced the proposal to procure a single order comms system for the five acute providers in C&M to replace current end of life systems. This would complement the shared Laboratory Information System (LIMS) that was also being procured collectively and hosted by MWL. • NHSE funding was available to support this procurement and if all the trusts agreed the proposal a bid would be submitted. • The Executive Committee approved the proposal for MWL	Approval
C&M Rate Card Impact	• The Chief People Officer presented an evaluation of the impact of implementing the C&M standard rate card for the Trust. • In the four weeks following implementation of the Integrated Care Board (ICB) directive, fill rates had remained stable, however it was noted that not all were new bookings. • It was therefore proposed to continue monitoring the impact.	Assurance
Appraisal and Mandatory Training Compliance – October 2025	• The Chief People Officer presented the Trust compliance report for October. • Mandatory training compliance was 89.7% • Compulsory skills training compliance was 88.8% • Appraisal compliance for Agenda for Change staff was 89% • Medical and Dental mandatory training compliance had increased to 80.8% (from 77.3% in September)	Assurance

27 November 2025		
National Cancer Patient Experience Survey Results and Improvement Plan	• The Chief Nursing Officer introduced the report which summarised the results of the first MWL national cancer patient experience survey, and the improvement plan that had been developed in response. • The MWL 2024 survey response rate was 47% (423 patients) of the target patient group. This compared to a national response rate of 50%. • The survey included 59 questions and for MWL six responses were above the expected range, and the remainder had scored within the expected range. • The lowest scoring question had been 'patient has had a review of cancer care by GP practice' (but still within the expected range) • The cancer services team had identified three areas for improvement from the results – information about cancer support services, enhancing shared decision making and clarifying patients' understanding of the side effects of cancer treatment. • Committee noted that the results were not consistent across all tumour pathways and Trust sites, and that more work was required to standardise cancer care. There was assurance that each tumour site was also developing a pathway improvement plan.	Assurance
Medical Model for patients lodged in the Emergency Department	• The Chief Operating Officer introduced a report which explored options for improving the safety and care of patients lodged in the Emergency Department and the interface with the Acute Medical Unit. • Committee discussed the proposals and the additional work required, including engagement with the medical teams before a business case could be finalised.	Assurance
Southport and Ormskirk Hospital site bed reconfiguration proposals	• The Chief Operating Officer presented proposals for the reconfiguration of beds at Southport Hospital to respond to changes in demand and for bed moves to the Ormskirk site to facilitate the ward refurbishment programme. • Plans to work with the Sefton Local Authority to maintain step down capacity with ICB funding were also presented. • Committee discussed the requirements for medical and emergency response team and site	Assurance

	management cover on the Ormskirk site due to the proposed changes and agreed further work was required on this aspect.	
Outpatient Transformation Programme update	• The Chief Operating Officer introduced the report. • The data cleansing and process standardisation phases of the programme were progressing well, and it was planned that the data cleanse of clinics for all specialities would be completed by 31 December to enable a full understanding of true capacity. • Booking and cancellation processes were being reviewed, alongside mapping of the staff with authorisation to change clinics. • The un-booked appointments report was now produced weekly and circulated to each speciality.	Assurance
FOI Working Group	• The Director of Informatics presented a proposal to establish an FOI working group, with representatives from each Division and Corporate department to improve FOI response times and optimise the Trust publication scheme. • The proposal was supported and Directors were asked to confirm nominations for the group.	Approval
NetCall Update	• The Committee considered the report from the Digital Team and noted the unintended impact on DNA rates and clinic utilisation of enabling patients to cancel appointments at short notice. • It was agreed that the development and refinement of the use of NetCall should be progressed as a workstream of the Outpatient Transformation Programme. • It was agreed to standardise the recording of patient cancellations on CareFlow to allow the patient access policy to be consistently applied.	Assurance
Inter-speciality referral time stamps	• The Committee received the report from the Digital Team which provided assurance that the EPR now recorded the time of speciality referral from the Emergency Department (ED), which had been a concern of the ED team and a recommendation from the last Care Quality Commission (CQC) inspection of ED. • There were still some issues to be resolved with the Business Intelligence Team to ensure this information could be reported correctly for performance management.	Assurance
Training Provision – Whiston Hospital Emergency Medicine	• The Chief Medical Officer reported that following the GMC National Training Survey (NTS) results a further letter had been received from NHSE	Assurance

	about Emergency Medicine at Whiston Hospital, with the Trust being asked to present a response and action plan by February 2026. • Committee discussed the actions already taken since the NTS, including additional support for Post Take Ward Rounds • The draft action plan would be presented to the Committee in January for review prior to submission.	
Review of Decontamination and Sterile Services Equipment and Facilities at the Southport and Ormskirk Hospital sites.	• The Director of Corporate Services introduced the review, which had been commissioned by the Committee following a similar risk assessment of decontamination equipment and facilities at Whiston Hospital. • The review considered both cold decontamination facilities and sterile services. • Much of the equipment and facilities had been found to be end of life, or non-compliant with current guidance and the report included an investment profile for the following three years to replace or upgrade the equipment. • Committee noted that this profile would be presented by the Division of Surgery for prioritisation within the 2026/27 equipment capital programme.	Assurance
Communications and Media Report – Quarter 2	• The Deputy CEO presented the report which detailed the Communications and Media activity that had taken place between July and September and the planned activities for quarter 3.	Assurance
04 December 2025		
Workforce Grip and Control Actions progress report	• The Chief People Officer provided an update on the workforce grip and control actions recommended by PwC. • It was noted that most of the actions were already included in the existing Trust Cost Improvement Programme (CIP) plans and would not result in additional financial savings. • The greatest potential savings were from additional reductions in bank and agency staff usage. • All staffing establishments and temporary workforce use had been reviewed and for non-clinical areas this had been risk rated for the impact on patient care. • It was agreed that the impact of vacancies, sickness and other planned absence should be	Assurance

	reported separately to identify any further opportunities.	
Mersey Care CQC Mental Health Action Plan	• The Chief Nursing Officer presented the actions for MWL that had arisen from a CQC inspection of Mersey Care which had included the section 136 suite at Southport Hospital. This facility was in fact a designated Place of Safety rather than a section 136 suite and the CQC had been informed of this inaccuracy in the report. There were two actions for the Trust relating to – lack of therapeutic activities and diet and fluid monitoring, to which the Trust had now provided a response for inclusion in the action plan.	Assurance
Maternity Patient Survey Action Plan progress report	• The Chief Nursing Officer presented the report which detailed that 14 of the 35 agreed actions had been completed, a further 17 remained on track for delivery but four were behind plan. These actions all related to the implementation of the Maternity Information System. • It was noted that 2025 national maternity patient survey would be live from 10 December, and any actions not completed would be unlikely to impact the 2025 results. • It was agreed that the Women and Children's Division and Informatics Team should produce a joint report on the challenges to implementing the Maternity Information Scheme and identify the support needed to achieve the target implementation date.	Assurance
Clinical Leadership Structure	• The Chief Medical Officer presented proposals for an integrated medical leadership structure for MWL. • Committee reviewed the proposals and identified further information needed to provide assurance on consistency and affordability.	Assurance
January Trust Board Agenda	• The Director of Corporate Services presented the draft Trust Board agenda for January for review. • It was agreed to defer the Clinical Strategy review, until later in the year, when the overall Trust Strategy would be finalised and published. • Committee noted the proposals to present the Employee of the Month (EOTM) award in-person at the Board meetings from January. • The Committee reviewed the EOTM nominations and selected the EOTM for December.	Assurance

Nurse Safer Staffing Report – October 2025	• The Chief Nursing Officer presented the safer staffing report for October. Total Registered Nurse (RN) fill rates had been 96.22% and total Health Care Assistant (HCA) fill rates had been 112.16%. • The RN fill rate on days had increased to 95.78 in October. • There were some wards which the average fill rate for RNs or HCAs had been below 90%. Wherever possible staff were moved between wards to ensure all wards remained safe, but in specialist areas this was more difficult. • Of 1,280 RN temporary staffing requests, 1,022 had been filled with bank or agency shifts. • 191 patient safety incidents had been reported in October, of which 184 caused no harm and six low harm. There had been one incident where fill rates below 90% on the shift may have been a contributory factor, and this was under investigation.	Assurance
Procedural Documents Report	• The Chief Nursing Officer introduced the report. • There were 866 current procedural documents of which 137 were overdue, with a further 55 due to expire in the next three months. • This was an improving position, and the Committee commended the on-going work to harmonise MWL policies and procedural documents and ensure they were reviewed on a regular basis.	Assurance
Finance Improvement Group (FIG) Assurance Report	• The Chief Finance Officer presented the assurance report from FIG, which had focused on the Surgery Division and improvement plans for theatre staffing and utilisation.	Assurance
11 December 2025		
Neighbourhood Health Pioneer Pilot (NHPP) Update	• The Director of Integration provided updates from the St Helens and Sefton NHPPs. • Workshops had been held to agree the areas of priority for joint working. • Sefton had selected frailty, and St Helens had selected Families First programmes. • Committee discussed how momentum for the local NHPPs and the national policy would be maintained with the planned staffing changes at ICBs. The pilots were due to move to implementation in spring 2026.	Assurance

Outpatient Transformation Programme Update	• The Chief Operating Officer introduced the report. • The workstreams to cleanse clinic data and harmonise processes were progressing as planned. • The three improvement metrics – requests for urgent cancer clinics (72 hours), requests for routine clinics with less than four weeks' notice and clinic cancellations with less than six weeks' notice had all continued to improve. • The trajectory to reduce 52+ waits to less than 1% of the waiting list by March 2026, had been reviewed and updated.	Assurance
North Mersey Integrated Stroke Network Service Level Agreement (SLA)	• The Chief Operating Officer introduced the paper which updated the Committee on progress in negotiating the new North Mersey Integrated Stroke Network SLA. • There was agreement that the Hyper Acute Stroke Unit (HASU) at Aintree would provide the step down and rehabilitation service consultant input at Broadgreen and Southport Hospitals. • Further negotiations were required to map the financial flows and agree who would manage the Transient ischaemic attack (TIA) service.	Assurance
Leading Operational Excellence Development Programme	• The Chief Operating Officer introduced the report which proposed establishing an MWL development programme for operational managers, based on core competencies. • A national competency framework for operational managers had been expected, as there were no recognised professional development routes for operational managers, but this had not yet been published. • Committee agreed that the proposal would ensure consistent standards across the Trust and promote career progression. • It was also recognised that many of the modules were generic and could also benefit other new managers. • It was agreed to progress the programme with an initial cohort and then evaluate the impact. • The programme would be funded from the existing learning and development budget and did not require new investment.	Approval
Finance and Planning	• The Chief Finance Officer presented the month 7 position and mitigating actions to deliver the 2025/26 outturn.	Assurance

	• The Chief Finance Officer also provided an update on the latest position in the 2026/27 planning discussions and assumptions ahead of first plan submission to NHSE.	
Supplementary Care Business Case – six months benefits realisation review	• The Chief Nursing Officer presented the review of the impact of increasing the HCA establishment on supplementary care staffing requests, the pilot wards. • The results showed that although the requests for additional temporary staffing to provide supplementary care for patients had reduced, this downward trend had not yet achieved the levels expected or needed to deliver a return on investment. • Actions had been identified to strengthen the monitoring and performance management for the second six months of the pilot.	Assurance
Enhanced Therapeutic Observations and Care (ETOC) Evaluation	• The Chief Nursing Officer presented the paper which evaluated the impact of the Trust's participation in the NHSE ETOC Collaborative from May 2025 to improve patient safety and enhance recovery. • Two medical wards at Southport Hospital and two at Whiston Hospital had adopted ETOC. • A range of data and monitoring information was submitted to NHSE for all the ETOC sites, which would enable national evaluation of the efficacy of the ETOC approach, which would allow for good practice to be shared with other trusts.	Assurance
Quality Impact Assessment (QIA) Policy Review	• The Chief Nursing Officer presented the draft revised QIA policy for review and comment. • It was agreed that the new policy, once ratified, would have a 12 month review date so that the impact of the new process could be evaluated.	Assurance
18 December 2025		
Nurse Establishment Review	• The Chief Nursing Officer presented the outcome of the Nurse Establishment Review and recommendations that was due to be reported to the Trust Board in January. • The report also included an update on the band 2-3 banding review where the initial assessment process was close to being concluded, and plans for implementation and monitoring developed. • Further discussions on the financial impact and benefits realisation were required before implementation could commence.	Assurance

	• The process had identified the HCA skill mix required for each ward with an overall ratio of 75%:25% band 3:2. • The establishment review had identified areas where additional capacity (beds) or patient acuity had resulted in staffing pressures. These would be subject to individual business cases	
Consultant Job Planning	• The Chief People Officer presented the report which provided assurance that MWL would achieve the national 90% first sign off target by 31 December • However, it was recognised that progress was not consistent across all specialities and the paper outlined the actions being taken to improve both the quality and consistency of job planning.	Assurance
Medical Leadership Structure	• The Chief Medical Officer presented updated proposals for the Medical Leadership Structure. • There remained some outstanding issues in relation to the financial envelope, and approaches taken by the legacy trusts to medical leadership appointments, however committee recognised that progressing the single structure was a key enabler for clinical service integration. • Committee supported the plans to commence Clinical Director recruitment, whilst the remaining funding and HR issues were resolved.	Approval
Maternity and Neonatal Service Access Review	• The Director of Corporate Services presented the review that had been undertaken of door access arrangements, following concerns raised by staff. • Additional CCTV points, intercoms, swipe exit points and fire evacuation processes would be required at the Whiston site to standardise access measures across the MWL services. • Committee agreed that the recommendations should be accepted and the works undertaken at Whiston Hospital as soon as possible. • The estimated capital cost was £55k, from the existing approved 2025/26 capital programme	Approval
Risk Management Council (RMC) Assurance Report	• The Director of Corporate Services presented the assurance report for the RMC meeting on 9 December. • 1,030 risks were reported to the MWL risk register. • 225 (21.9%) risks had shown as overdue at the end of November, but following action taken by the Quality and Risk team to review all overdue risks with the divisions this had reduced to 23 overdue risks by 16 December.	Assurance

	• 41 new risks had been added to the risk register and 46 risks had been closed. • 21 risks were escalated to the CRR. • Of the 20 policies and procedural documents aligned to the RMC, two were overdue – one finance and one IT policy and assurance was sought that these were undergoing the review process.	
Freedom of Information (FOI) Compliance Report	• The Director of Informatics reported that October compliance with the 20 day response standard had been confirmed as 65.52% and the provisional compliance figure for November was similar. • The FOI working group would hold its initial meeting in January	Assurance
Stroke Sentinel National Audit Process (SSNAP) audit results.	• Members of the Trust stroke team attended the Committee to present the SSNAP Q2 results for both the Whiston Hyper Acute Stroke Unit and the Southport stroke service • These were the first published SSNAP results under the new audit criteria. • The Trust results had been positive for both units and the Whiston HASU had achieved the highest score of all units in England. • The Committee congratulated the stroke team.	Assurance
Finance Improvement Group (FIG) Assurance Report	• The Chief Finance Officer and Chief People officer presented the assurance report, covering both finance and workforce improvement actions. • A review was being undertaken of the cancer workforce, in relation to the temporary external funding of Clinical Nurse Specialist positions.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during November and December 2025 were:</u> • None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	28 January 2026
Agenda Item	**TB26/004 (8.2)**		
Committee being reported	Quality Committee		
Date of Meeting	20 January 2026		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Maternity Incentive Scheme (MIS) Clinical Negligence Scheme for Trusts (CNST) Year 7 Presentation	• The report provided the final MWL position for MIS Year 7 reporting period of 01 December 2024 until 30 November 2025. Committee recommendation is approval of non-compliance declaration by Trust Board on 28 January. • Committee informed of non-compliance for Element 1c due to missing data point therefore 92.3% compliance against 95% requirement. Assurance no patient safety issues. • Trust actions in place to mitigate future compliance issues. • NHS Resolution portal concerns being raised. • Safety action 2-10 compliant. • Safety Action 3 - compliance declared noting Whiston site following action plan for transitional care service fully aligned to the British Association of Perinatal Medicine (BAPM) framework. • Safety Action 4 - Neonatal nursing workforce deficit Whiston site, declared compliance as workforce plans and actions continue. • Safety Action 8 - MWL complaint across three CNST elements of training. • Financial impact / reputational impact of non-compliance noted.	Assurance
Maternity Homebirth Services	• Report noted issuance of a national Prevention of Future Deaths report following an incident at Manchester University NHS Foundation Trust (NHSFT) and the deaths of a mother and her baby.	Assurance

	• The Northwest Regional Maternity Team initiated regional benchmarking and standard setting programme to improve safety and quality of home birth services. • Assurance MWL completed a regional scoping exercise. Areas of good practice and opportunities noted. • A Regional Rapid Task and Finish Group was established to set regional standards by April 2026 and to develop a Northwest Home Birth Charter. MWL formal gap analysis to follow.	
Quality Committee Corporate Performance Report (CPR).	• The Committee reviewed the Corporate Performance Report for December. • No never events for December. • Focused work on timely validation of Pressure Ulcers discussed to support timely reporting. • Overall Falls numbers are down however four falls reported as moderate harm or above. • Nutrition - data accuracy improvement project ongoing, noting real-time reporting from Careflow/vitals for Malnutrition Universal Screening Tool (MUST) screening. All three indicators below expected parameters with reference to Whiston site. Keeping Nourished % of patient's high risk referred to a dietician - data requires validation. • Mortality – Hospital Standardised Mortality Ratio (HSMR) remains positive at <90% with proposal to review a lower data tolerance to enable timely data reporting, increasing assurance. • Three neonatal deaths reviewed - no safety concerns reported. • Upward trajectory for percentage ventouse births and forceps deliveries at Ormskirk site - further assurances requested. • Noted data issue aligned to recording and reporting of 12 hour trolley waits - assurances provided on overall performance.	Assurance
Patient Safety Report (Inc. Chair's Assurance Report)	• Assurance no emerging areas of concern from October 2025 incident data and non-reported under Patient Safety Incident Investigations (PSII) framework. • Good level of assurance on the use of local safety standards for invasive procedures (LocSSIPs) with action plans ongoing.	Assurance

	• Three new Patient Safety Incident Response (PSIRs) and four Learning Reviews through Trust Patient Safety Panel and two Maternity and Newborn Safety Investigations (MNSI) PSIIs approved for sharing. • Reduced falls in October (217) with two severe and zero fatal falls. • In October two Patient Safety Incidents were graded as fatal. Early actions noted and further reviews to be undertaken. • Slight increase in pressure ulcer incidents reported for MWL in October including non-MWL acquired. Assurance provided on non-MWL and MWL acquired reporting. Further reporting request to understand and assure on contributory factors behind resource/equipment lapses.	
Patient Engagement Portal (PEP) Report	• PEP core functionality deployed across Southport and Ormskirk sites with plan to fully implement across MWL. • Key deliverables noted. • Waiting list validation module implemented across MWL – over 48,000 patients validated safely discharging >3,500 patients. • Waiting well module – to date nearly 30,000 notifications to patients - looking to roll out across Whiston, St Helens and Newton sites. • Ongoing benefits noted and continued rollout programme. • Exploring Artificial Intelligence (AI) elements to further reduce administration burden. • Patient experience - structured survey completed for the pilot area. Patient experience outcomes to be shared via Patient Experience report in February. • Ambient voice technology (AVT) project - update provided.	Assurance
Controlled Drug Responsible Officer Annual Report	• Increase in reported Controlled Drug (CD) incidents in 2024/25 largely due to improved reporting methodology. Key incident themes noted. • Specific alerts regarding individuals of concern noted. • Due to national Home Office issue, Controlled Drug Licence issue resolved and assurance now in place.	Assurance

	• Policies and Standard Operating procedures (SOPs) for CD management harmonised and updated. • Controlled Drugs Accountable Officer (CDAO) providing ongoing training. • Recommendations for future improvements noted including introducing electronic CD registers and order systems, updating induction materials for lead employers and CDAO increased visibility and communication. • Assurance provided that Trust complies with statutory requirements for CD management with robust internal governance structures.	
Clinical Effectiveness Report (including Council Chair's report)	• Urgent and Emergency Care pressures noted • Mortality data and retrospective HMSR data coding under review including proposed new local tolerances. For further discussion at Executive Committee. • Trust Transgender policy - Committee noted national guidance awaited and agreed further local review regarding clinical concerns raised. • Non-Medical Prescribing, risks mitigated currently with review of resources planned. • Positive recruitment to Histopathology vacancies. • Positive Research data updates noted.	Assurance
Care Quality Commission (CQC) Quarterly Report	• No CQC Inspection activity in Q3. • 13 enquiries received and responded to within timescales with no follow up actions. • Long standing incident from May 2024 concluded with no further action. • Ward accreditation programme embedded well with seven 5 Star wards across MWL.	Assurance
6 Monthly Safer Staffing Report	• Report for January 2026 Trust Board. • Core staffing has flagged areas where further work is required but not currently impacting on total number of staff required. • Recommendation to change ratios of Healthcare Assistant Band 2 and 3 which follows national concerns. • Overall Nursing Establishment review provides assurances.	Assurance
Any other Business	• Received MIAA Spot check review - Infection Prevention and Control Observations 2025/26	Assurance

	• Received MWL presentation - Mid & North Mersey Stroke Services Performance Update December 2025.	

Alerts:

- Maternity Incentive Scheme Year 7, Safety Action 1 has not met the 95% compliance requirement for Element 1c.
- Financial / reputational impact of non-compliance.

Decisions and Recommendation(s):

The Trust Board is asked to note the report.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	28 January 2026
Agenda Item	**TB26/004 (8.3)**		
Committee being reported	Strategic People Committee		
Date of Meeting	21 January 2026		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Workforce Dashboard	Mandatory Training - the Trust continues to exceed its mandatory training target, achieving 88.7% compliance in December, above the 85% threshold. Those staff groups and teams where Mandatory Training is below the 85% threshold have developed a recovery plan which is being monitored at the Divisional Performance Review monthly meetings. Medical Workforce are starting to make improvements. Appraisals - Appraisal compliance in December is at 90.6% against the 85% target. Sickness - all staff sickness has increased in December to 7.8% from 7.3% in November. A sickness absence improvement plan was shared at the HR Divisional Performance Review with progress being monitored via the People Performance Committee. This includes identifying those hot spot areas and providing targeted supporting including Health, Work and Well Being (HWWB), Organisational Development (OD), bespoke training, Infection Prevention and Control and Manual Handling. Vacancy Rate - the Trust's overall vacancy rate remains favourable at 6.6%, below the 8% target. Most staff groups are within thresholds, though Health Care Assistants (HCAs) remain high at 15.8%. Nursing colleagues have concluded the nursing establishment review with the findings due to be presented at Trust Board. Time to Hire (T2H) - Time to Hire continues to improve while above the 40-day target has reduced to 58.4 days. People Performance Council continues to monitor the improve plan. Turnover - turnover remains stable and below target: • In-month turnover: 0.7% (target: 1.1%) • 12-month rolling turnover: 10.7% (target: 13.2%)	Assurance

	Health Work and Wellbeing (HWWB) - Pre-Placement Questionnaires - the total number received to cleared KPI average days: 3 days. The did not attend (DNA) rate for appointments has deteriorated in month (12.5%) however year to date (YTD) is within tolerated thresholds (10%).	
Staff Story – Preceptorship Kitemark	The staff story was provided by the Preceptorship Lead about the trusts preceptorship programme and the progress made since its inception in 2021. The Trust has been recognised for the following awards and accreditation: • Achieved the interim Quality Mark in 2023 and 2024 as part of the National Preceptorship for Nursing Quality Mark. • Shortlisted for the Preceptorship programme of the year in 2023 and 2025 • MWL won Preceptor of the Year in 2024 • Team awarded Cavell Star in recognition of staff support The team have also been selected to be part of a national pilot for 2025 new Muliti-Professional standards, part of the NHS Commitment Strategy for new registrants and to be a Case Study Trust for Preceptorships by NHS England (NHSE).	Assurance
Sexual Safety Charter Update	An update was provided to the SPC following a letter to Chief Executives and Chief People Officer's from NHSE on the 05 December 2025 on further actions to prevent sexual misconduct in the NHS. New Requirements include: • Improving chaperoning practice in the NHS – key principles and guidance • Sexual Safety Charter – self-assurance checklist for primary care providers • Two people professions to take part in national training on sexual misconduct investigations • Train the trainer roll out on sexual misconduct investigations • The provision of specialist training in sexual misconduct allegations for investigators in the national sexual misconduct policy framework • Ask members of staff to complete the national e-learning module on sexual safety awareness • A reminder of the Trusts legal duty to make barring referrals to DBS where concerns are raised. • The need for Trust to have any cases of concerns about sexual misconduct considered by review groups, supported by appropriate safeguarding advice, to ensure sexual misconduct	Assurance

	reports are correctly and robustly considered and investigated where appropriate. A further requirement is the completion of a self-assessment of the assurance framework which needs to be submitted to NHSE on the 02 February 2026. The self-assessment on the sexual safety actions and the impact of the Sexual Safety Charter was presented for assurance to the Executive Committee on the 15 January 2025 and to the SPC. The audit is to help NHSE understand how the NHS is progressing in making itself a sexually safe place for patients and staff, by asking about the extent of board assurance, review of policy and processes and gathering feedback about impact of the sexual safety charter and national policy framework. The SPC received assurance that the Trust and Lead Employer action plans monitored via the People Performance Council and HR Commercial Services Council remain on trajectory for Q4 2025/26. A further update will be provided to the Strategic People Committee April 2026.	
Employee Relations Oversight Group (EROG) Report (including EROG Assurance)	A presentation was delivered providing a triangulated analysis of key workforce indicators, including sickness absence rates, employee relations cases, organisational development interventions, and both formal and informal Freedom to Speak Up cases. Themes relating to management style and capability, values and behaviours, incivility, and organisational culture were also explored. An employee relations update was then provided for the following Trust departments: • Neonates • Surgery Management Team • Patient Booking Services (PBS) and Medical Secretaries As a result, a high-level plan is being developed aligned to the Trust Values and Behaviours Framework which includes outputs from the STAR conference in May 2025 to develop a behaviours framework to support the MWL Values with desired behaviours.	Assurance
Assurance Reports from Subgroup(s)	The assurance reports for People Performance Council, Valuing our People Council, and HR Commercial Services Council were noted. The following Trust policies were approved by the People Performance Council: • Capability Policy • Fit and Proper Persons Policy It was noted that the Terms of Reference for two new groups to support the development and delivery of the HR Transformation and Digital strategy had been approved by the HR Commercial Services Council.	Assurance

	• HR Transformation and Digital Steering Group • HR Transformation and Digital Delivery Group	
Alerts:		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board Meeting**	**Date**	28 January 2026
Agenda Item	**TB26/004 (8.4)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	22 January 2026		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Chief Finance Officer (CFO) Update	• Update of changes in leadership at Integrated Care Board (ICB) since last meeting.	Assurance
Committee Performance Report Month 9 2025/26	• Emergency Department (ED) performance declined to 69.8% in December, below the national at 73.1%, but ahead of Cheshire and Merseyside (C&M) at 71.5%. • Long waits in ED were a challenge – 20.6% waited over 12 hours in December. This was an increase from the previous month. • Handover 45 – a decline in performance to 69.6% of patients arriving by ambulance being handed over within 45 minutes. • No Criteria to Reside (NC2R) patients was at 20.9% • 18 Week performance in December was 62.8%. • The Trust had 1,495 52-week waiters at the end of December; 2 65-week waiters and zero 78-week waiters. • Diagnostic 6-week performance for December was 93.6% which remained ahead of both national performance at 78.3% and C&M performance at 90.8%. The target remains at 95%. • Cancer performance in November improved again to 75.9% for the 28-day standard (target 77%). and for the 62-day standard at 78% (target 85%). • Bed occupancy averaged 96.5% • Discussion regarding the impact of pressures over Winter set out the context for the position.	Assurance

Finance Report Month 9	• The approved MWL financial plan for 2025/26 is a deficit of £10.7m. This is a £41m deficit excluding the deficit support funding. • The plan includes £35m of system led strategic opportunities/cost reductions to be realised or reallocated by C&M during 2025/26. • The Trust is reporting a M9 deficit of £36.9m (excluding deficit support funding) which demonstrated an improved run rate and £7.6m better than plan. • Income assumes all variable activity and the Southport Community Diagnostic Centre (CDC) being funded by commissioners. Contracts are not yet finalised, and negotiations continue. • The Trust's combined 2025/26 Cost Improvement Programme (CIP) target is £48.2m. In M9, the target has been exceeded with £37.3m delivered to date, £2m above plan. • At M9 agency costs equate to £10.4m (2.1% of total pay costs). • The Trust had a closing cash balance of £2.3m in line with cash recovery plan. • Aged debt (debt greater than 90 days) is £15.2m in December. • The capital plan for the year totals £64.6m which includes Public Finance Initiative (PFI) Lifecycle and IFRS16 Lease Remeasurement. Year to date (YTD) spend is below plan however there are plans in place to ensure no slippage by year end.	Assurance
M9 Forecast	• Current plan less deficit support stands at £40.9m deficit • Current run rate would give a £61.6m deficit, therefore improvement required of £20.7m. • Current forecast is a (£4.9m) variance to plan excluding deficit support funding - this includes non-recurrent mitigations and industrial action impact. • Delivery of the forecast depends on significant internal workstreams realising the savings such as bank and agency reductions, plus maintaining the reduction on overtime across the Trust. • Conversations with Commissioners ongoing regarding non-payment for activity undertaken.	Assurance

	• Continue to improve the position as we work to ensure the organisation meets the financial plan. •	
Cash Update	• Key risks to cash remain deficit funding being withdrawn and delivery of Income and Expense (I&E) forecast • Two Provider Revenue Support cash applications have so far been approved at £10.9m and £11m • A further application for Provider capital support has been approved at £15.7m in January. • Low risk cash mitigations are being implemented such as ensuring supplier payments are not early and ensuring debt is paid to ensure we can meet financial obligations. • MWL have been exploring options with the regional NHSE England (NHSE) team. • The current cash position is in line with plans submitted to NHS England and the start of the financial year. • Trust Lead Employer arrangements are not factored in to the current cash regime. This is being picked up with NHSE.	Assurance
Month 9 2025/26 CIP Programme Update Estates and Facilities (E&F)	• Total Trust efficiency target for 2025/26 is £48.2m recurrently, which equates to 5% for all departments. • At M9, 215 schemes have been delivered with a further 118 schemes at finalisation stage. Current delivered/low risk schemes have a value of £58.2m in year and £45.8m recurrently, 95% of the target. • E&F update outlined the overdelivered CIP position for 2025/26, with a focus on recurrent CIP delivery. Planning for 2026/27 is underway.	Assurance
Review of outturn risks	• Committee discussed current risks included within forecast and reflected further discussion would be needed at Board to meet the current £4.9m gap to the financial plan.	Assurance
National Cost Collection and productivity	• National Cost Collection Index (NCCI) for 2024/25 is 97.	Assurance

	• National team have produced productivity packs utilising the National Cost Collection (NCC) data to identify opportunities for improvements in productivity. • MWL opportunities identified across urgent care and elective care.	
Informatics Update	• Committee received updates on key performance metrics across Digital services including increased resolution of IT incidents, reduced instances of high severity cyber security services. • Discussion regarding challenges around health record scanning and actions in place to resolve.	Assurance
Planning 2026-27 – 2030-31	• Paper shared setting out the Trust draft plan submitted on 16 December including an overview of the national planning guidance. • Plan derived from the underlying position and cost drivers reviewed during 2025/26. • Supporting information regarding productivity and population health used to develop plans for delivery. • Paper included finance, workforce and performance metrics and highlighted the process for triangulation. • Final three numerical and five year narrative plans due to be submitted on 12 February. • No formal contract offer received in advance of the draft plan submission. • Committee discussed outstanding items and importance of further discussion at Board.	Assurance
Estates Returns Information Collection (ERIC) Estates and Facilities Benchmarking Data 2024/25	• Annual output of the ERIC return setting out key findings and ongoing actions undertaken across the department to use the output of the benchmarking exercise to improve service and value for money.	
Cancer Targets Review	• An overview of the current performance and trends with a comparison to other system providers. • There continues to be increased referrals across areas. Update given on performance by area.	Assurance

Assurance Reports from Subgroups:	• CIP Council Update • Capital Planning Council • Estates & Facilities Management Council Update • IM&T Council update	Assurance

Alerts

The Board is asked to note the report and be informed that the Finance and Performance Committee is fully sighted on the actions required to deliver the plan and the risks therein. There are a number of longstanding and significant decisions outstanding at ICB level. The Committee is concerned that despite the best efforts of the Executive, these may not be resolved by year end, adding risk to the plan.

Decisions and Recommendation(s):

The Board is asked to note the report

Title of Meeting	**Trust Board**		**Date**	28 January 2026
Agenda Item	**TB26/005**			
Report Title	Clinical Negligence Scheme for Trusts 2024/25 Self Declaration / Maternity Incentive Scheme Year 7			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Sue Orchard, Divisional Director of Midwifery Kevin Thomas, Divisional Medical Director for Women and Children's			
Action Required	X	**To Approve**		**To Note**

Purpose

This report is to provide the final MWL position update for the Maternity and Neonatal Services in relation to the 10 safety actions (SA) required for NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 7 (CNST MIS) in order to optimise the safety of women and babies in our care.

Executive Summary

The report provides the final MWL position for the MIS Year 7 reporting period of 01 December 2024 until 30 November 2025.

The Board are informed that for Safety Action (SA) 1, the service has not met the 95% compliance requirement for Element 1c). The standard is that 95% of deaths of babies born and died at MWL must have a Perinatal Mortality Review Too (PMRT) review started within two months of the death. 12 out of 13 cases were compliant and therefore the compliance was 92.3%. The technical guidance stipulates that the PMRT must be complete to declare starting a review and that as an absolute minimum all of the 'factual' questions in the PMRT tool must be fully completed. One question of gestational age was not completed within the timeframe and therefore the advice from NHSR is to declare non-compliance. This question was missed in February 2025 as advised via the quarterly maternity and neonatal updates to Quality Committee and the Local Maternity and Neonatal System (LMNS) following recognition. For the service to reach 95% before the end of the MIS period, 20 cases within the reporting period were required which positively we did not achieve.

Safety Actions 2-10 have met the required criteria for declaration of compliance with the following points to note for SA3 and SA4:

- SA3: The implementation of a transitional care service fully aligned to the British Association of Perinatal Medicine (BAPM) framework on the Whiston site has been further delayed due to challenges in recruitment, retention, sickness and unavailability of neonatal staff. The transitional care (TC) action plan was revised with clear timescales of the end March 2026. The action plan was presented to Quality committee, Trust Board, the LMNS and Operational Delivery Network (ODN) in November which enables declaration of compliance to establish compliance for this safety action.

- SA 4: Neonatal nursing workforce. The neonatal unit on the Whiston site identified a deficit of 3.45 Whole Time Equivalent (WTE) registered nurses based on activity levels following completion of the Q2 workforce calculator tool in October 2025. An action plan was developed and presented to Quality Committee, Trust Board, the ODN and LMNS in November 2025 and continues to be monitored via the risk register whilst work force plans and actions continue which enables declaration of compliance for this safety action.

The LMNS were provided with evidence in relation to safety actions 3, 4, 5, 6, 7, 8 and 9 via quarterly

engagement assurance meetings and the provision of evidence onto the Futures platform for review. Safety actions 1, 2 and 10 were not reviewed by the LMNS as this was not within their remit as triangulation of compliance will be undertaken by NHSR in conjunction with other sources such as Mothers and Babies: Reducing Risk through Audits (MBRRACE) and Maternity and Newborn Safety Investigation (MNSI).

The Trust is required if assured, to submit a completed Board declaration form to NHSR by 12 noon on 03 March 2026. The Trust CEO must ensure that the Accountable Officer (AO) for the Integrated Care System (ICB) is appraised of the MIS safety actions evidence and the declaration form and that they are both required to sign the declaration form to confirm they are both fully assured and in agreement with the compliance submission. Due to the non-compliance to SA 1 the associated Board declaration action plan template is required to be completed.

Financial Implications

Failure of the Maternity Service to achieve the required compliance with all the safety actions within CNST MIS, will result in the service not recovering the 10% element of the CNST contribution from the scheme.

Quality and/or Equality Impact

There would be a safety and reputational impact if full compliance was not achieved.

Recommendations

The Board is asked to approve the Clinical Negligence Scheme for Trusts Self Declaration

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
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Maternity Incentive Scheme Year 7 Update

1. Introduction

NHS Resolution produced guidance for the Maternity Incentive Scheme Year 7 in April 2025.

To be eligible to recover a 10% element of the Maternity Services contribution, we are required to submit a completed Board declaration form to NHS Resolution by 12 noon on 03 March 2026 and comply with the following conditions.

- Trusts must achieve all ten maternity safety actions.
- The declaration form to be submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of midwifery/Head of midwifery and Clinical Director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO only.

The declaration form must be signed by the CEO to confirm that:

- The Trust Board is satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance.

- There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of Maternity Services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) / MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

- Any reports covering an earlier time – period may prompt a review of a previous MIS submission.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHSR.

A range of external verification points for MIS submissions are undertaken which include cross checking with:

- MBRRACE- UK for SA 1 standards a, b and c
- NHS England relating to the Maternity Services Data Set (MSDS) for SA2, all criteria.
- MNSI will cross check the National Neonatal Research database (NNRD) and NHSR will cross check their database for qualifying incidents MNSI and early notification (EN) incidents reportable for SA10 including the completion of the NHSR claims

There are ten safety actions with related technical guidance for the evidence, which the Maternity Service must achieve compliance with:

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths that occurred from 01 December 2024 to 30 November 2025 to the required standard?

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety action 3: Can you demonstrate that you have transitional care services (TC) in place and undertaking quality improvements to minimise separation of parents and their babies?

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Obstetric medical workforce, Anaesthetic medical workforce, neonatal medical workforce, and neonatal nursing workforce.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Safety action 8: Can you evidence the three elements of local training plans and 'in-house', one day multi professional training? Fetal monitoring training, multiprofessional maternity emergencies training and neonatal resuscitation training.

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 01 December 2024 to 30 November 2025?

This paper outlines the current progress with the safety actions for the Board to note.

2. Safety Action Compliance

Each Safety Action will be discussed individually with details of evidence of compliance.

2.1 : Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

The reportable criteria include late miscarriages/ late fetal losses (22+0 to 23+6 weeks gestation), stillbirths (from 24+0 weeks gestation) and neonatal deaths from 22 weeks (or 500g if gestation unknown) up to 28 days after birth. The required standards are:

a) Notification of all eligible perinatal deaths to MBRRACE-UK within 7 working days.
b) For at least 95% of all the deaths of babies eligible for PMRT review, trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.

c) 95% of deaths of babies who were born and died at the Trust from 01/12/24 onwards are required to have a PMRT multidisciplinary review started within 2 months of the death and a minimum of 75% of these reviews should be completed and published within 6 months.
For a minimum of 50% of deaths reviewed, an external member should be present at the MDT review panel meeting which should be documented within the PMRT.
d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1st December 2024.

The reporting period for Safety action 1 is 01 December 2024 to 30 November 2025.

a) Notification of all eligible perinatal deaths to MBRRACE-UK within 7 working days.

There have been 17 eligible deaths that have been required to be notified to MBRRACE. 12 deaths on the Whiston site and 5 on the Ormskirk site. All 17 deaths have been notified within 0-4 days of the death demonstrating 100% compliance.

Compliant

b) For at least 95% of all the deaths of babies eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.

Of the 17 deaths, 13 cases were eligible for a PMRT review. 3 cases were excluded due to being terminations of pregnancy and parents' views are not applicable in these cases and 1 case was a baby born who was born alive at 21+6 weeks gestation but sadly subsequently died and does not meet the criteria for PMRT review.

100% compliance was achieved as all the eligible 13 deaths met criteria 1b. Parents were informed and had their perspectives of care sought with an opportunity to ask any questions. (95% required)

Compliant

c) i: 95% of deaths of babies who were born and died at the Trust from 01 December 2024 onwards are required to have a PMRT multidisciplinary review started within 2 months of the death.

Of the13 cases that required a PMRT review, all 13 cases had a review started within 2 months of the death. The technical guidance however states that in order to fully comply with the definition of starting a review, the death is required to be notified to MBRRACE, the PMRT tool must be used to complete the first review session (which may be one of several sessions) and as an absolute minimum all of the 'factual' questions in the PMRT tool must be fully completed for the review to be regarded as started.
12 of the 13 cases met this criterion. One case was started using the tool within the required time frame on the 20 February 2025 however on FQ question (Gestational age) was not entered and therefore from an MIS position this case is classed as non-compliant as the compliance for this criterion is 92.3% and not the required 95%. The error was not detected and corrected until the 21 March 2025 which is outside of the required two-month timeframe.

The LMNS were updated as soon as the omission was identified and progress updates at the engagement meetings including feedback received from NHSR.

NHSR have been contacted for advice. They have advised that the MIS external verification process for PMRT referrals is conducted by MBRRACE, and they are the final arbiter of any decisions made. NHSR and MBRRACE are not looking to penalise a Trust for isolated incidents in reporting, however these would be considered alongside any other breaches within the MIS reporting period that may be identified, and the complete picture will be reviewed by the team at the end of the MIS period. MBRRACE will take into consideration if the Trust has acknowledged any potential issue/s and has put in place steps to rectify them.
The NHSR team have advised that they have previously notified MBRACCE to explore ways to try and make a failsafe within the system and will inform them of our contact.

In order for MWL to achieve the required 95% due to one non-compliant case the Trust would require 20 deaths within the reporting period. As this has not been the case due to 13 eligible cases, the advice provided from NHSR is to declare non-compliance with SA1 with a clear narrative in our update report and Board papers report of the data and issues. The MIS Board notification form will require the associated action plan section completing prior to submission.

The LMNS/ICB were updated as soon as the omission was identified with progress updates provided at the engagement meetings including the feedback received from NHSR.

Within the reporting period there were 13 eligible cases with 12/13 being compliant which makes an overall rate of 92.3% which does not meet the 95% requirement, and this element is therefore non-compliant.

Non-Compliant

ii: A minimum of 75% of these PMRT reviews should be completed and published within 6 months.

Of the 13 cases, six of these cases were eligible for completion and publication within six months of the death before the end of the MIS reporting period of the 30 November 2025.
All six have met the required standard as the reports have been completed and published within the required timeframe.

The other seven cases are all on track for completion within the required timeframes.

Compliant

iii: For a minimum of 50% of deaths reviewed, an external member should be present at the MDT review panel meeting which should be documented within the PMRT.
The six cases within the MIS reporting period have undergone a PMRT review and all have had an external panel member present at the review meetings demonstrating 100% compliance.

Compliant

d) Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 01 December 2024.

A quarterly maternity and neonatal update paper is presented to Quality Committee which details all deaths, including themes and lessons learnt. All required quarterly reports have been completed and presented as required in February, May, September and November 2025. The Quality Committee receives a monthly IPR alongside data from the Perinatal Quality Surveillance Model (PQSM) as a standing agenda item additionally detailing perinatal mortality.

Compliant

Due to the documentation error in element 1ci) the overall outcome for safety action 1 is non-compliant.

2.2 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

To achieve this standard the service submissions to the Maternity Services Data Set (MSDS) are assessed for quality and completeness.

- The July 2025 data must contain valid birthweight information for at least 80% of babies born in the month.

- The July 2025 data is required to contain valid ethnic category (Mother) for at least 90% of women booked in month. Not stated, missing and not known are not included as valid records for this assessment and are expected to be used only in exceptional circumstances.

The MSDS score card from NHSE was published on 23 October 2025 and confirmed that MWL had achieved 100% compliance for the required month of July 2025 to both of the required standards and therefore the MWL maternity service has fully met the required compliance for MIS Year 7.

Compliant

2.3 Safety action 3: **Can you demonstrate that you have transitional care services in place and undertaking quality improvements to minimise separation of parents and their babies?**

The required standards for SA3 are:

a) There are pathways of care into Transitional care (TC) in place which include babies between 34+0 and 35+6 in alignment with the BAPM TC framework for practice or be able to evidence progress towards a TC pathway from 34 +0 weeks which has been presented to the Trust and the ODN on behalf of the LMNS Boards.

The Ormskirk site has a TC service with TC pathways in place in alignment with the BAPM TC framework which meets the required admission criteria.

The Whiston site currently provides elements of the BAPM TC framework with current associated pathways in place. An action plan was developed to enable full implementation of the TC pathway which was approved and signed off by the Trust with clear timescales following approval for additional funding for staff. Evidence of progress towards full implementation has been monitored via quarterly maternity and neonatal update papers.

The additional funding received included additional nurse and maternity support worker staffing. Recruitment has proved challenging and numerous recruitment drives has been undertaken. Several staff declined posts immediately prior to their commencement date alongside staff leaving quickly after starting that required further advertisement.
Employed staff are in various stages of recruitment, orientation and training and alongside current neonatal nursing vacancies and sickness and absence this has resulted in deferments of implementation dates. A revised commencement date of end March 2026 has been proposed. Progress updates have regularly been shared with the Quality Committee via the quarterly maternity and neonatal papers with the latest paper and updated action plan being presented on 18 November 2025 and to Trust Board, Trust Safety Champions meetings, Executive monthly Divisional performance reviews and quarterly LMNS meetings in November 2025.

The Trust is compliant with the TC local admission criteria based on BAPM, which requires demonstration of at least one element of HRG XA04 activity which includes low birth weight babies, babies who are on a stable reducing programme of opiate withdrawal, tube feeding, intravenous antibiotics and phototherapy.

Compliant

b) Element b, states that drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, trusts must undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on the initiatives must be shared with the safety champions and LMNS.
Trusts must register the Quality Improvement (QI) project by 02 September 2025 and by the end of the reporting period of 30 November 2025 must have presented an update to the LMNS and Safety Champions regarding development and progress or if the project is a continuing project from MIS Year 6, demonstrate progress at 6 months and the end of the MIS reporting period also to the LMNS and Safety Champions.

Both maternity sites identified quality improvement initiatives and registered the projects with the Trust quality/ service improvement team as part of MIS year 6.

The Whiston site registered their project on the 06 August 2024 which related to the implementation of Newborn Early Warning Track and Trigger framework (NEWTT 2) that is used in the postnatal care environment to support monitoring of baby. Elements including promotion of skin to skin and the completion of neonatal observations were identified to ensure timely interventions were undertaken.
The Ormskirk site registered their project on 29 August 2024 which relates to thermoregulation of the newborn.

Both quality improvement initiatives have continued from MIS Year 6 and significant progress and improvement has been demonstrated six months into Year 7 and at the end of the MIS reporting period. Progress updates have been shared with the LMNS and Trust Safety Champions at the six monthly review date in September 2025 with the end of the MIS reporting period update provided at the November Trust Safety Champions meeting alongside a presentation update to the LMNS with an ODN representative on 25 November.

The maternity and Neonatal services have met the required standard for safety action 3.

Compliant

2.4 Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a) Obstetric Workforce:

1. Requirement to demonstrate compliance for employing short term locum obstetric and gynaecology doctors (2 weeks or less) on the 2 or 3 tier rotas.

   One of the following criteria is required to be met:
   a) Currently work in the unit on the tier 2 or 3 rota or:
   b) Have worked on the unit within the last 5 years on the tier 2 or 3 rota as a postgraduate doctor in training and remain in the training programme with satisfactory annual review of competency progression (ARCP) or:
   c) Hold a certificate of eligibility (CEL) to undertake short term locums.

   An audit relating to short term doctors was undertaken between February and August 2025 in conjunction with medical human resources. The audit period covers the time frame detailed in the SA 4 technical guidance and as required in the Board notification form.

   For this reporting period there were 24 short term locum doctors who undertook shifts on the tier 2 and 3 rotas, and all locums fulfilled criteria c) of holding a certificate of eligibility and therefore 100% compliance was achieved.

   Compliant

2. Trusts should implement the Royal Collect of Obstetrics and Gynaecology (RCOG) guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Board, Trust board Safety Champions and the LMNS Board.

   A six-month audit is required for the period after February 2025 to 30 November 2025 for the engagement of long-term locums in accordance with RCOG guidance. The audit period covered 01 February to 31 August 2025 and during this period there were no long-term locums employed.

   The audits were included in the quarterly maternity and neonatal update paper presented at Quality Committee in October and November and subsequently to Trust Board in November 2025. The audits were also presented at the Trust Safety Champions meeting on 07 November 2025 providing evidence of assurance and compliance to MIS requirements.

   Compliant

3. Trusts should be working towards implementation of the RCOG guidance on compensatory rest where consultants and Senior speciality, Associate Specialist and Specialty and Specialist Doctors (SAS) doctors are working as non-resident on call out of hours and do not have sufficient rest to undertake their normal working duties the following day.

   This element will not be measured in MIS year 7 but the guidance identifies the importance for services to develop action plans to address this guidance.

   - At MWL, standard operating procedures have been and remain in place since November 2023 with in date guidance for both the Whiston and Ormskirk sites ensuring that compensatory rest is undertaken, and actions required to be undertaken as required.

   Compliant

4. Trusts need to ensure they are compliant of consultant with consultant attendance in person for clinical situations as listed in RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' in their service. Trusts are required to audit any three-month period from February to 30th November 2025.

   Audits of each month's activity has been maintained throughout the year. There are two separate audits which relate to monitoring clinical situations where a consultant obstetricians' presence is mandatory alongside audits of clinical situations where a consultant presence, or a suitability trained medic is required to attend.

   On the Whiston site, the monthly audits are presented and monitored at Maternity Forum and the Obstetrics and Gynaecology Clinical Governance and Quality meeting. On the Ormskirk site the audits are collated quarterly due to the smaller number of clinical incidents and presented via the Governance meetings. A combined MWL aggregated audit has been presented to Trust Safety Champions meeting on 07 November which included as appendices the individual audits Evidence of compliance was included in the maternity and Neonatal update report presented at Quality Committee and additionally submitted to the LMNS via the reporting portal for review at the quarterly MIS meetings.

   The six-month aggregated report was additionally split into Q1 and Q2 2025/26 period, April – September 2025. In total, there were 48 clinical situations across both maternity sites where a consultant must attend. 25 in Q1 and 23 in Q2. The consultant was in attendance in total for 42 (94%) cases. In Q1 22/25 (88%) of the clinical situations there were three cases where a consultant was not in attendance which were: a woman who had a total blood loss of severe Post-Partum Haemorrhage (PPH) 2020mls. The Consultant was notified when the blood loss reached 1650mls but there was no further ongoing bleeding and therefore did not attend. The final blood loss was confirmed as being over 2000mls, the second incident to a woman who had a Caesarean section (Cs) with a body mass index (BMI) of 50 and a woman who sustained a fourth-degree tear. In Q2, 100% of the 23 cases were attended by a consultant.

   All three non-compliant cases have been reviewed and discussions undertaken with relevant staff in relation to escalation and documentation. The fourth-degree incident additionally underwent a PSIR review.

   There were 302 cases within the six-month reporting period for situations in which the Consultant must attend unless the most senior doctor present has documented evidence as being signed off as competent. 145 situations in Q1 and 157 in Q2. There was 100% compliance to this criterion across both quarters.
   The audits demonstrate compliance to this criterion.

   Compliant

b) Anaesthetic Workforce:

There is a requirement that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day who should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients with evidence provided by a representative month of an anaesthetic rota.

There is availability of a duty anaesthetist immediately for the obstetric units 24 hours per day at both the Whiston and Ormskirk sites that always have clear lines of communication to the supervising Anaesthetic Consultant which is evidenced by the production of anaesthetic rotas. The rotas were uploaded as evidence to the Futures platform for LMNS review to provide assurance of full compliance.

Compliant

c) Neonatal Medical Workforce:

This safety action requires the neonatal unit to meet the BAPM national standards of medical staffing or if the standards are not met, there is an action plan with progress against any previously developed action plans and monitored via the risk register. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

For the both the Whiston and Ormskirk sites the neonatal medical staffing is compliant to BAPM standards for Tier 1, 2 and 3 as agreed by the ODN during their annual visit on 01 May 2025 and remains currently compliant to date.

Medical staffing compliance has been provided to Quality Committee and Trust Board in November 2025.

Compliant

d) Neonatal Nursing Workforce:

This safety action requires the neonatal unit to meet the BAPM neonatal nursing standards or if the standards are not met, there is an action plan with progress against any previously developed action plans and monitored via the risk register. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

The neonatal unit on the Ormskirk site meets the BAPM Neonatal Nursing Standards in MIS Year 7 utilising the Neonatal workforce calculator within the MIS reporting period which has been shared with the ODN. Compliance has been achieved and the findings provided to the LMNS for review in consultation with the ODN representative.

The neonatal unit on the Whiston site completed the Q2 workforce calculator tool which was submitted to the ODN in October 2025. The tool identified that there is now a deficit of 3.45WTE registered nurses based on activity levels. The tool includes a separate tab for transitional care staffing. Although transitional care to the full BAPM standards has not been commenced as detailed in SA3, allocated staffing for TC is required to be entered into the appropriate columns and the increased activity identifies a deficit.
An action plan has therefore been developed which was presented to Quality Committee, Trust Board and the ODN in November 2025 within the Maternity and Neonatal Update and identifies the requirement to review the nursing establishment, undertake a business case and review neonatal cot configuration across MWL. The staffing deficit has been added to the risk register and will continue to be monitored with updates included in the quarterly update papers.

Compliant

MWL has evidence of assurance for all elements of safety action 4 to enable declaration of full compliance.

2.5 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

A Birthrate Plus maternity workforce assessment has been undertaken for both sites in 2022 and within the last three years that provided an evidence-based process to calculate midwifery staffing establishment in accordance with MIS SA5 standard a) requirements.
Discussions and meetings have commenced with Birthrate + (BR+) to undertake a full maternity workforce assessment which is intended to commence in Q4 2025/26.

100% compliance has continually been achieved to both the provision of 1-1 care in labour and the supernummary shift coordinator. At MWL, 100% compliance to a delivery suite shift coordinator has been achieved for the entire shift and not just at the start of a shift which was introduced in MIS year 6 as the service strives to continue the oversight of all birth activity within the service to maintain safety.

Maternity and Neonatal quarterly update reports, monthly clinical dashboards and evidence of workforce safe staffing data are presented to Quality Committee providing evidence that the midwifery staffing budget reflects the minimum staffing establishment as outlined in BR+ alongside providing evidence of the delivery suite shift co-ordinator being supernumerary at the start of every shift and that women in established labour receive 1:1 care.

Alongside the maternity and neonatal quarterly update papers, biannual staffing reports are produced. The January – June 2025, Biannual staffing reports were presented to Quality Committee in September 2025 and presented to Board in November 2025. The staffing reports demonstrate evidence of the breakdown of BR+ and that the staffing budget reflects the establishment as recommended by BR+ based on the current model of care, the midwife to birth ratio, maternity red flags and the percentage of specialist midwives / management employed. The service is currently reviewing midwives in fixed term externally funded posts to ensure continuation of these services in the future and those recommended by Ockenden which is likely to require a business case in the future.

The staffing papers reflect all the required evidence demonstrating compliance for MIS Year 7.
The non clinical midwifery workforce establishment was calculated based on 9% of the required clinical workforce. Whiston is currently in alignment and Ormskirk is above the required establishment figure. Both maternity sites are above the BR+ recommended staffing, one site due to the ability to overrecruit by 6WTE midwives to cover maternity leave and the other site received additional funding for the introduction of elective CS in main theatre alongside an increased headroom uplift. Both sites have maintained their ability to achieve 100% supernummary delivery suite shift coordinator status and 100% provision of 1-1 care in labour.
Quarterly updates and Biannual staffing papers are submitted to the LMNS for review at the MWL quarterly review.

Compliant

2.6 Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three (SBLCB v3.0)?

The standard requires the provision of assurance to the Trust Board and ICB of being on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.

The six elements for SBL are:

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
- Element 3: Raising Awareness of Reduced Fetal Movements
- Element 4: Effective Fetal Monitoring in Labour
- Element 5: Reducing Preterm Birth
- Element 6: Management of pre-existing diabetes

To fully achieve this safety action for year 7 the Maternity and Neonatal Services must be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB and the Trust which should include:

- Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
- Progress against locally agreed improvement aims.
- Evidence of sustained improvement where high levels of reliability have already been achieved.
- Regular review of local themes and trends with regard to potential harms in each of the six elements.
- Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.

The Division has worked closely with the LMNS and have, to date, held nine quality improvement discussions with scrutiny of progress monitored using the national SBLCBV3 Implementation Tool through the NHS Future Portal. In the year 7 reporting period of 02 April to30 November 2025, there have been two LMNS review meetings and have therefore met the minimum requirements of at least two in the MIS reporting period.

- The Q1 LMNS quarterly improvement discussion meeting was held in June and reviewed data for both Ormskirk and Whiston sites separately as has been the case since the introduction of the review meetings in November 2023. During this time period the two maternity sites were assessed separately with both sites achieving 99% overall compliance.

- The Q2 meeting in September 2025 was the first meeting that MWL merged data was submitted and assessed. As a result, it is no longer possible to directly compare progress data. Furthermore, the NHS England toolkit was updated, introducing new stretch compliance requirements that differ from those used in Q1 2025/26 that require a higher compliance rate.

	Assessment 7 Whiston site	Assessment 7 Ormskirk site	MWL: Assessment 1
Review Quarter in which meeting held	Q1	Q1	Q2
Assurance review	10/06/25	10/06/25	30/09/25
Element 1	100%	100%	100%
Element 2	100%	100%	70%
Element 3	100%	100%	100%
Element 4	100%	100%	100%
Element 5	96%	96%	96%
Element 6	100%	100%	83%
Total	99%	99%	88%

Q2 review update findings:

Element 1: Reducing Smoking in Pregnancy
Both sites have maintained 100% compliance, supported by increased referrals to the in-house smoking cessation team. Ongoing audits continue, and harmonisation of policies ensures sustained improvement.

Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
Compliance has decreased. Services are transitioning from GROW 1.5 (paper-based) to GROW 2.0 (electronic) for monitoring fetal growth. An action plan is in place for full implementation.
The service is also reviewing capacity to introduce a reduced scan interval (from 3–4 weeks to 3 weeks) for women at risk of a small for gestational age or growth restricted baby, in line with the Regional Guideline. If the current 3–4-week interval is retained, a Trust-specific guideline will need to be drafted and receive LMNS approval.

Element 3: Raising Awareness of Reduced Fetal Movements
Both sites remain 100% compliant, with ongoing audits and continued policy harmonisation.

Element 4: Effective Fetal Monitoring in Labour
Sustained 100% compliance at both sites in Q2, following on from achieving full compliance in the previous quarter.

Element 5: Reducing Preterm Birth
Review of evidence of compliance highlighted issues for this element which related to the recommendations for administering magnesium sulphate to women at risk of preterm birth, between 22- and 29-weeks' gestation, for neuroprotection of the babies and subsequent rates of intraventricular haemorrhage in babies born between 22- and 31-weeks gestation.

No evidence was uploaded from the Ormskirk site relating to the rates of intraventricular haemorrhage in neonates from the Neonatal Unit (NNU's) National Neonatal Audit Programme (NNAP) data that affected the overall compliance rates. This data will be available for the next evidence submission in December, and the compliance rate will increase.
The issue identified on the Whiston site related to documentation and confirming to the LMNS that there were no cases that occurred in Q4 and therefore no audit was required but was assessed as non-compliant as the narrative was not presented.

Element 6: Management of Pre-existing Diabetes

Five of six recommendations are fully compliant.

The one recommendation not fully met is a new recommendation addressing the risk of fetal death from diabetic ketoacidosis (DKA). It requires that all pregnant women presenting with DKA in secondary care receive ongoing multidisciplinary consultant input and care in accordance with a jointly agreed Trust policy. The services are currently aligning the previously separate DKA policies with the Trust-wide diabetes policy.

The next evidence submissions were uploaded to the NHS Futures platform with a further improvement discussion with the LMNS utilising the SBL implementation tool undertaken on 16 December. The validated data identified an overall improvement compliance of 97% but is not part of the submissible evidence for MIS die to being outside the relevant time period.

The three-year delivery plan for maternity and neonatal services sets out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours and sufficient progress has been made towards full implementation in line with the locally agreed improvement trajectory.

The LMNS have confirmed that they remain satisfied with the ongoing progress at MWL with the implementation of the Saving Babies' Lives Care Bundle. Monitored action plans focus predominantly on audits and documentation, noting the changes introduced that increased the compliance target

Compliant

2.7 Safety action 7: **Listen to women, parents and families using maternity and neonatal services and coproduce services with users.**

Standard 1 identifies that the Maternity Service is required to work with the LMNS/ICB to ensure a funded user led Maternity and Neonatal Voices Partnership (MNVP) in line with the Delivery Plan and MNVP guidance including supporting:

- Infrastructure.
- Strategic influence and decision making
- Engagement and listening to families.

Infrastructure.
The service currently has two MNVP leads with funding via the ICB. The leads have job descriptions, person specifications, service agreements which includes confirmation of availability of funding for, out of pocket expenses, childcare if required, IT, training and communication etc. The MNVP leads provide an independent view to the maternity service but work alongside the service leads.

Additional monies have been received to support delivery of the MNVP action plan and strengthen attendance at maternity governance meetings. Recruitment processes have been in progress in 2025 and an additional MNVP lead has now been appointed and will be joining the team shortly. The new MNVP person has direct service user experience of our neonatal services.

Strategic influence and decision making
The minimum evidential requirements identify that the terms of reference (TOR) for Trust safety and governance meetings must showing the MNVP lead as a member. The service can evidence that the

following meetings terms of reference are compliant, Trust Safety Champion meetings, Maternity quality and governance and Intrapartum forum.

Currently the MWL MNVP's do not have capacity, the experience, and/or training to support consistent and meaningful participation in PMRT panels and key governance meetings. As such, the service is currently unable to guarantee MNVP representation as a quorate member at these meetings, which is a recognised requirement within the broader Maternity Incentive Scheme (MIS) framework. In line with NHSE guidance, where an MNVP service does not meet all elements, the Trust is still able to declare compliance with Safety Action 7 following escalation to Trust Board. This issue was presented and discussed within the maternity and neonatal quarterly update presented to Quality Committee on 16 September for escalation to Board. The issue of MNVP attendance at PMRT meetings has been raised by regionally and nationally by MWL and other organisations including discussions with the LMNS and NHSR. NHSR have advised this issue is under consideration. The concern identified has related to the MNVP exposure to graphic medical illustration details and content within pathology findings which can be upsetting. MBRRACE have released online training for Trusts and MNVP to access.

Discussions have been undertaken and continue with our current MNVP leads in order to reprioritise governance meetings and engagement work based on their views and will include additional hours following commencement of our newly appointed MNVP lead. Attendance at the PMRT meetings is still undecided to date as a decision from all our MNVP leads is not known. The service will support any of the MNVP leads to access MBRRACE training and develop restorative and reflective discussions to ensure support due to the sensitive nature of cases discussed.

Engagement and listening to families

Engagement and listening to families require evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

Actions that have been undertaken to date to support engagement and listening to families include:

- Continuation of action plan following the 15 steps challenges undertaken in 2024.
- Service user visibility in areas across both sites to meet and engage with service users within maternity and neonatal services. This has included the use of volunteers and 'Dads matters'
- The service has developed an action plan in response to the maternity patient survey co-produced with the MNVP. An annual MNVP workplan was developed and approved by the MNVP lead. The workplan identifies priorities to listen to women's voices including their families including those that have experienced neonatal and bereavement care and those from BAME backgrounds and areas of deprivation. The workplan includes actions to support, expand on feedback received to address and improve patient care and experiences identified from the survey scores and narrative. The action plans have been submitted to the Trust safety champions and to the LMNS and updated following the MWL MNVP leads return.
- Due to maternity leave of our MWL MNVP leads, support has kindly been provided from another Cheshire and Merseyside (C&M) MNVP lead and an engagement officer. This has included an additional review of the MNVP work/ action plan, attendance at inpatient and outpatient areas and community settings to obtain feedback and presenting findings to the maternity team and at Trust Safety Champion meetings.

Compliant

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

In order to meet the required standard for this safety action there is a requirement that annually, a minimum of 90% attendance in each relevant staff groups working within the maternity services attend training within the reporting period of 1st December 2024- 30th November 2025.

1. Fetal monitoring training
2. Multi-professional maternity emergencies training
3. Neonatal resuscitation training

Ormskirk Site:

CNST Y7 Training Period 1st December 2024- 31st November 2025		
Fetal Surveillance	Consultant Obstetrician	100.0%
	Other Obstetric Doctors	100.0%
	Midwives	97.7%
PROMPT	Consultant Obstetrician	92.3%
	Other Obstetric Doctors	100.0%
	Midwives	96.9%
	MSW	100.0%
	Consultant Anaesthetist	100.0%
	Other Anaesthetic Doctors	100.0%
NLS	Midwives	94.6%
	Neonatal Consultants	100.0%
	Other Neonatal Doctors	100.0%
	Neonatal Nurses	96.9%
	ANNP	100.0%

Whiston Site:

CNST Y7 Training Period 1st December 2024- 31st November 2025		
Fetal Surveillance	Consultant Obstetrician	95.0%
	Other Obstetric Doctors	95.2%
	Midwives	97.9%
PROMPT	Consultant Obstetrician	100.0%
	Other Obstetric Doctors	96.6%
	Midwives	98.9%
	MSW	97.6%
	Consultant Anaesthetist	100.0%
	Other Anaesthetic Doctors	92.9%
NLS	Midwives	98.9%
	Neonatal Consultants	90.9%
	Other Neonatal Doctors	96.6%
	Neonatal Nurses	92.1%
	ANNP	100%

The required standard for safety action 8 has been met with all required staff groups at both the Ormskirk and Whiston sites for attendance for each training element >90% between the required time period of 01 December 2024 to 30 November 2025.

Whilst not formally monitored as part of MIS, throughout the scheme year other staff groups who are part of the multidisciplinary team providing maternity care at MWL including theatre staff, anaesthetists who do not contribute to the obstetric rotas, paramedics and student midwives have

attended the training days for their own personal development. This is considered to be good practice and demonstrates recognition that multi-professional training contributes to safer maternity care.

It is important for units to continue to implement all six core modules of the core competency framework, which is undertaken but this is not measured in safety Action 8.

Compliant

2.8 Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

a) A national recommendation from the Ockenden Report was the introduction of the Perinatal Quality Surveillance Model (PQSM). The required standard is that all requirements of the PQSM must be fully embedded with evidence of the Trust working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025.
b) There is an expectation that discussions regarding safety intelligence takes place at Trust Board (or an appropriate subcommittee with delegated responsibility) which include ongoing monitoring of services and trends with evidence of reporting and escalation to the LMNS/ ODN/ ICB/ Local and regional learning systems.
c) All Trusts must have Maternity and Neonatal Board Safety Champion who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.

The Perinatal Quality Surveillance Model (PQSM) template developed by NHS England is utilised and a combined PQSM for MWL was developed and provided monthly. And includes site specific data and MWL totals. The data is additionally included in the monthly Integrated Performance Reports (IPR). Monthly IPR and patient safety incidents are reported to Quality Committee and Board as standing agenda items alongside being included within the local and regional maternity clinical dashboard and the maternity and neonatal quarterly update papers. The PQSM is additionally included monthly in the Quality Committee and Trust Safety Champion meeting agendas.

All serious incidents are reportable and escalated to MNSI. All completed reports are submitted to the LMNS/ODN and presented at the single serious incident C&M patient safety meetings. Ongoing work in relation to the revised PQOM.

The MWL PQSM template includes data for the MIS year 7 reporting period. The template provides a summary of the number of incidents per month graded as moderate or above, MNSI reportable incidents, term admissions to NICU from Delivery Suite (DS), Intrapartum stillbirths, neonatal deaths before 28 days at MWL, 1-1 care in labour, supernumerary DS shift leader availability and babies identified with HIE grade 2 or 3.

Quarterly Maternity and Neonatal update reports are submitted to Quality Committee and presented by the Divisional Director of Midwifery or member of the perinatal leadership team providing evidence of how information is shared at Trust level to ensure that early action and support for areas of concern are highlighted.

The Maternity Claims Scorecard is discussed at the Trust Safety Champions Meeting, presented to Patient Safety Council and included and triangulated alongside incident and complaint data within the maternity and neonatal quarterly update and is used to agree targeted interventions aimed at improving patient safety.

The Trust has an appointed Non-Executive Director who attends the Maternity and Neonatal Safety Champions meetings, undertakes safety champion walkabouts within the maternity and neonatal services across MWL, attends Quality Committee and Trust Board and works with the Board and maternity safety champions alongside the Perinatal leadership team.

Details of trends, safety issues, staff concerns and any safety escalations are discussed, logged, actioned and presented at the Safety Champions Meeting. Feedback to staff is completed through a wide variety of communication channels including face to face discussions, newsletters, safety briefing and 'Feedback Friday' communication.

The Board Safety Champion additionally has an open invitation to the weekly Triumvirate meeting. A log of attendance and actions is maintained, and compliance has been achieved of attendance of a minimum of three in MIS reporting period which has vastly been exceeded.

There is representation from the maternity and neonatal services who attend shared meetings with the LMNS/ICB where Trust and system level intelligence are presented and discussed. Examples of this include the Maternity Safety Oversight Group (MNSG) , Quarterly engagement meetings reviewing Saving Babies Lives v3, MIS compliance and Clinical Quality Safety Surveillance Group (CQSG), Maternity Performance Oversight Panel (MPOP). There are annual ODN and LMNS assurance visits demonstrating how Trust-level intelligence is escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

The service has a variety of methods of engagement sessions with staff which include:

- Monthly unit meetings to enable feedback and provide the opportunity for staff to raise issues, concerns, suggestions for improvement etc.
- HR drop in sessions
- Learning and development accessibility and sessions within the clinical area for staff
- Promotion of freedom to speak up alongside feedback and development of action plans if required of issues raised
- Monthly Safety champions walkabout
- Triumvirate 'Talk to us Tuesdays and Thursdays'
- Clinical workstreams and feedback to Pathway Project Board meetings following temporary pathway changes to enable formal governance processes for pathway change approval and communication to Executive Committee and staff.

The Maternity and Neonatal Service participated in the Perinatal Culture and Leadership programme. Both sites attended separately but then combined sessions as cultural work progressed. As part of this programme a safety, culture, operational risk, resilience and engagement (SCORE) Culture survey was undertaken and an improvement plan has been developed based on the diagnostic findings. An updated action plan was submitted to Quality Committee and Trust Board in November 2025.

The Board Safety Champion has a weekly invite to the Perinatal Quadrumvirate leadership team to better understand local cultures, safety and any concerns. The minimum of three attendances in the MIS year 7 reporting period has been exceeded.

Compliant

2.10: Safety action 10: **Have you reported 100% of qualifying cases to the Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 01 December 2024 to 30 November 2025**

The standards for this safety action include the requirement to report all qualifying cases to MNSI and to report all qualifying Early Notification (EN) cases to NHSR EN scheme for the reporting period 01 December 2024 until 30 November 2025.

From the 01 December 2024 until 30 November 2025, there were six cases that were eligible for reporting to MNSI which were all reported.

Case 1: Reported to MNSI and NHSR EN scheme. Declined by NHSR as the baby had a perinatal stroke.
Case 2: Reported to MNSI. The baby was referred as required cooling. The MRI was normal however an MNSI investigation continued at the parents' request. This case was initially reported to NHSR EN scheme but declined as not a reportable criterion
Case 3: Reported to MNSI due to the case being a neonatal death but did not require reporting to NHSR.
Case 4: Reported to MNSI due to requirement for cooling. Reported to NHSR EN scheme due to MRI scan findings.
Case 5: Reported to MNSI and NHSR EN scheme due to requirement for cooling.
Case 6: Reported to MNSI due to requirement for cooling following a shoulder dystocia. MRI scan normal and therefore not reportable to NHSR.

All six cases reported appropriately to MNSI. Four cases were originally reported to the NHSR EN scheme. Two cases were accepted and two declined. These were declined as one baby had a perinatal stroke and the MRI was confirmed as normal in the second case following referral.

The two remaining cases were both appropriately reported to the NHSR EN scheme with confirmation that the required fields were completed on the NHSR Claims reporting wizard.

When a case is identified as potentially reportable to MNSI the Maternity Service is required to ensure that the family receive information on the role of MNSI and NHSR EN scheme and that duty of candour is completed. There is evidence of compliance for all cases of these actions being undertaken.

Following an incident, verbal, and written duty of candour regarding both the local and MNSI investigations are provided. The service uses the tools provided by MNSI to provide information explaining the investigation process and the roles of MNSI and NHSR. Copies of the letter, which also confirms the verbal conversation are attached to the InPhase report for the incident as evidence.

Monitoring and information of cases that require reporting to MNSI is via the monthly incident, complaints and claims reports that are presented at the Obstetric Clinical Governance and Quality meeting and within the quarterly maternity and neonatal update report that is presented at Quality Committee.

The Maternity Service escalates any cases accepted by MNSI to the Legal Services Department, who ensure that they are reported to NHS Resolutions Early Notification Scheme via the NHS resolutions claims reporting wizard advising whether families have been advised of NHSR involvement. This action has been completed for all reportable cases.

Once investigations are completed, the Maternity Service shares the final reports with Legal Services, who ensure they are uploaded to the EN service. The Maternity Service writes to complete duty of candour to the family and to offer a further copy of the report and a meeting to discuss the findings with a Consultant and Senior Midwife if they so wish.

Compliant

3. Conclusion

The Maternity Incentive Scheme Year 7 evidence has been reviewed by the Maternity Services and at MIS meetings chaired by the Executive lead throughout the reporting period timeframe. Quarterly maternity and neonatal update papers are presented to Quality Committee and Trust Board providing information, progress and assurance against the 10 safety actions.

Evidence in relation to safety actions 3-9 have been submitted to the LMNS/ ICB/ODN via evidence uploaded to the futures platform and further review and discussion at the quarterly improvement discussions.

The evidence in relation to all 10 safety actions demonstrating the current compliance status to MIS year 7 is identified below:

Safety Action	Safety Action Title	Compliance
1	Use of the National Perinatal Mortality Review Tool to review perinatal deaths that occurred from 1st December 2024 to 30th November 2025 to the required standard?	Non-compliant
2	Submission of data to the Maternity Services Data Set (MSDS) to the required standard?	Compliant
3	Demonstration of transitional care services in place and undertaking quality improvements to minimise separation of parents and their babies	Compliant
4	Demonstrate an effective system of clinical workforce planning for Obstetric, Anaesthetic and neonatal medical workforce and the neonatal nursing workforce.	Compliant
5	Demonstrate an effective system of midwifery workforce planning to the required standard.	Compliant
6	Demonstrate that the service is on track to achieve compliance with all elements of the SBLCB V3	Compliant
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Compliant
8	Evidence of compliance to the 3 elements of local training plans and ‘in-house’, one day multi professional training and neonatal resuscitation training.	Compliant
9	Demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues	Compliant

10	Reporting of 100% of qualifying cases to MNSI and to NHSR Early Notification Scheme from 1 December 2024 to 30 November 2025	Compliant

9/10 safety actions have evidence to support declaration of compliance. Safety action 1, Element 1c stipulates that 95% of deaths of babies who were born and died at the Trust from 01/12/24 onwards are required to have a PMRT multidisciplinary review started within two months of the death.

12 of the 13 cases met this criterion however one case was started within the required time frame on the 20 February 2025. This case however had one omitted FQ question. Gestational age was not entered at the start of the review and the error not realised within the timeframe and therefore from an MIS position this case is classed as non-compliant as the % compliance is 92.3% and not the required 95%.

4. Recommendations

Trust Board is asked to accept and approve the contents of the report

5. Next Steps

- Completion of supporting action plan within the Trust declaration form due to non-compliance with Safety Action 1
- The Trust declaration form to be signed by the Trust CEO and by the AO of the ICB and submitted to NHSR by 12 noon on 03rMarch 2026 once Board approval of status is confirmed.

Mersey and West Lancashire Teaching Hospitals NHS Trust

CNST Maternity Incentive Scheme MWL Year 7 Compliance:

Trust Board 28th January 2026

Introduction

- NHS resolution is operating year 7 of the CNST Maternity Incentive Scheme to continue to support the delivery of safer maternity care.
- The ten safety actions for year 7 were published in April 2025.
- Trusts that can demonstrate achievement to **ALL** ten safety actions will recover the element of their contribution relating to the maternity incentive fund and may also receive a share of any unallocated funds.
- Trusts that do not meet **ALL** ten, may be eligible for a smaller discretionary payment to help progress against non achieved actions
- Individual legacy services have successfully achieved all MIS safety actions in the years 1-5 years alongside compliance to Year 6 as an MWL submission.
- Any CNST Maternity Incentive Scheme (MIS) refund should be used exclusively for improving maternity safety.
- Evidence for SA 3,4,5,6,7,8,and 9 was provided to LMNS/ ICB Board for review throughout 2025.

Safety Action 1: Use of the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard from 1st December 2024 - 30th November 2025

17 eligible cases within the reporting period

12 deaths on the Whiston site and 5 on the Ormskirk site.

1a. 100% of eligible cases notified to MBRRACE within 7 working days.(100% required)

1b. 100% all eligible deaths met criteria 1b. Parents were informed and had their perspectives of care sought with an opportunity to ask any questions.(95% required)

1c. 92.3% cases had an MDT PMRT review started within 2 months of death. (95% required) 12/13 cases

100% of MDT reviews achieved the required completion and publication within 6-month timescales within MIS reporting framework (75% required)

100% cases had attendance by an external panel member at MDT review and documented in PMRT tool (50% required)

1d. Quarterly reports submitted in February, May, September and November 2025.

1 case was commenced within the 2-month period however 1 Frequent Question (FQ)(gestational age) was not entered at the time of commencement of the review using the PMRT tool and not corrected until after the 2-month deadline. All FQ questions required to be completed based on technical guidance

Non – Compliant due to 1 data entry point not being entered at the start of the review. This omission did not pose any clinical risk.

Safety Action 2: Submission of data to the maternity Services data Set (MSDS) to the required standard

To achieve this standard the service submissions to the Maternity Services Data Set (MSDS) are assessed for quality and completeness.

1. The July 25 data must contain valid birthweight information for at least 80% of babies born in that month.

2. The July 25 data is required to contain valid ethnic category (Mother) for at least 90% of women booked in that month. ‘Not stated, missing and not known’ are not included as valid records for this assessment and are expected to be used only in exceptional circumstances.

The MSDS score card from NHSE was published on 23rd October 2025 and confirmed that MWL had achieved 100% compliance for the required month of July 2025 to both the required standards and therefore MWL has fully met the required compliance for MIS Year 7.

Compliant

Safety Action 3: Demonstrate that TC services are in place and undertaking quality improvement to minimise separation of parents and their babies

3a

- Ormskirk site has a TC service with TC pathways in place which includes babies between 34+0 and 35+6 in alignment with the BAPM TC framework for practice.
- Whiston site provides elements of BAPM TC framework with associated pathways in place. Action plan in place agreed by Trust and submitted to the ODN and LMNS. Business case approved to increase staffing to enable full implementation with defined timescales. Staff recruitment has been challenging and required several recruitment drives. Due to continued vacancies, sickness and absence a revised action plan with a proposed implementation date of end March 2026 was presented to QC, Trust Board, Trust safety champions, ODN and LMNS in Nov 25.
- The Trust is compliant with the TC local admission criteria based on BAPM demonstrating at least 1 element of HRG XA04 activity which includes low birth weight babies, babies on a stable reducing programme of opiate withdrawal, tube feeding, intravenous antibiotics and phototherapy.

3b

- Both sites identified quality improvement initiatives and registered them in August 24 within MIS Year 6 and were both continuing projects into MIS year 7.
- Both sites provided updates in Sept 25 (Month 6 of MIS) to the safety champions and the LMNS and at the end of the MIS reporting period on 25/11/25 also to the safety champions and the LMNS with an ODN representative present.

Compliant

Safety Action 4: Effective system of clinical workforce planning

4a. Obstetric Medical workforce

1. 6-month audit undertaken (February to August 25) with medical human resources regarding employing short term locum obstetric doctors on tier 2/3 rota. 26 employed doctors.

- 24 short term locum doctors employed on tier 2 or 3 rota
- **All 24 held a certificate of eligibility**

2. No long-term locums employed at MWL within the 6-month audit period. (February- August 25)

3. Formal SOPs in place based on the RCOG guidance on compensatory rest.

4. Continuous monthly monitoring at Governance meetings and Delivery suite forum of Consultant attendance in person for clinical situations is mandatory **(Minimum 80% attendance required)** as per RCOG workforce document and clinical situations where consultant presence or a suitability trained medic is required to attend.

Thematic quarterly and six-monthly audits collated. Total MWL findings:

Consultant mandatory presence = **Q1 = 88% (22/25 cases) and Q2 = 100% (23/23 cases)**

Consultant presence/ suitability trained medic attendance = **Q1 =100% (145/145) and Q2= 100% (157/157 cases)**

All non-compliant cases reviewed for learning and agreed actions for improvement where applicable.

Audits submitted to Quality committee Board, Trust safety champions and the LMNS November 25

Compliant

Safety Action 4: Effective clinical workforce planning; Continued

4b. Anaesthetic Medical workforce

Anaesthetic medical workforce compliant with ACSA standard 1.7.2.1 with compliance demonstrated via duty rotas ensuring immediate availability of a duty anaesthetist 24/7 with clear lines of communication to a supervising Anaesthetic Consultant.

Rotas provided to the LMNS demonstrating full compliance across MWL.

Compliant

Safety Action 4: Effective clinical workforce planning; Continued

4c. Neonatal Medical workforce

- Whiston and Ormskirk sites compliant to BAPM standards for Tier 1, 2 and 3 as agreed by the ODN during their annual visits in 2025 and have been maintained.

4d. Neonatal nursing workforce.

- Neonatal nursing staffing on Ormskirk site meets BAPM standards using the neonatal nursing calculator provided to the ODN.
- There is a 3.45wte nursing deficit identified in the October nursing calculator submitted to the ODN on the Whiston site
- An action plan has been developed and presented to Quality committee, Trust Board, ODN and Trust safety champions in November 25.
- Requirement to further review the nursing establishment and potential business case alongside review of cot configuration across MWL.
- Continual risk register review of staffing and quarterly updates to Quality Committee.

Compliant

Safety Action 5: Effective midwifery workforce planning

- Birthrate plus utilised as a systematic process to calculate midwifery staffing establishment with completed reports in 2022.
- Discussions and plans to commence a Birthrate + full review in Q4 2025/26.
- Maternity staffing reports submitted a minimum of six monthly to QC and Board which includes a breakdown of funded vs actual establishment compared to BR+, mitigation and escalation as required for managing shortfalls in staffing, midwife to Birth ratio and the percentage of specialist midwives which is 9%, in line with BR+ recommendation lowest parameter.
- Current funded establishment reflects current BR+ findings within current models of care for both direct and non direct staff.
- Requirement for DS shift coordinator to have supernummary status (Rostered and planned supernummary status at the start of every shift). Monthly audits undertaken and presented at Obs and Gynae Governance and Quality meeting and Delivery suite forum.100% compliance to all audits for the reporting period of 02/04/24 -30/11/24 for the whole shift. Findings detailed in the quarterly maternity and neonatal updates and staffing papers to Quality Committee.
- 100% compliance to 1-1 care in labour. Reported monthly on the clinical dashboard and presented within the monthly IPR quarterly Maternity and neonatal papers and staffing papers.

Compliant

Safety Action 6: Demonstration of being on track to compliance to all elements of Saving Babies Lives Care bundle Version 3

- National implementation toolkit utilised to track compliance.
- Evidence submitted via the NHS Futures Platform
- Requirement to undertake at least 2 and up to 3 quarterly improvement discussion meetings held with LMNS between 02/04/25 - 30/11/25.
- 2 sessions undertaken within the MIS reporting period in June and September 25.
    - June 2025. Data for Ormskirk and Whiston continued to be reviewed as site specific.
    - Sept 25: Data presented and reviewed as MWL. New stretch targets introduced requiring a higher compliance rate.

Safety Action 6: Demonstration of being on track to compliance to all elements of Saving Babies Lives Care bundle Version 3; Continued

	Assessment 7 Whiston site	Assessment 7 Ormskirk site	MWL: Assessment 1
Review Quarter in which meeting held	Q1	Q1	Q2
Assurance review	10/06/25	10/06/25	30/09/25
Element 1	100%	100%	100%
Element 2	100%	100%	70%
Element 3	100%	100%	100%
Element 4	100%	100%	100%
Element 5	96%	96%	96%
Element 6	100%	100%	83%
Total	99%	99%	88%

- Action plans and continued monitoring to achieve full compliance ongoing alongside continued quarterly quality improvement discussions. Q3 meeting undertaken on 12th December 25.
- LMNS confirmed that they are happy with continued progress.

Compliant

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users

SA7: Element 1: Infrastructure, Strategic influence and decision making and engagement and listening to families.

- 2 MNVP leads in place, fully funded including, service agreements, payments for out-of-pocket expenses, IT, training and childcare payments if required etc. Confirmed via the MNVP leads.
- Terms of reference for Trust safety champions, Maternity and neonatal quality governance and intrapartum forum meetings that include MNVP as core members.
- Escalation to the Board in Sept 25 re nonattendance at additional key governance meetings including PMRT panels by MNVP . Escalation and updates provided regionally and nationally to ICB/ LMNS and NHSR.
- 1 MNVP lead undergoing recruitment process for a fixed term post with direct service user experience of neonatal. Discussions ongoing to reprioritise MNVP functions once new member commences in post.
- Engagement and listening to families enabling parent with neonatal service feedback.
    - Evidence from local community groups prioritising hearing from families experiencing the worst outcomes, as per the LMNS Equity & Equality plan.
    - Includes additional feedback from ‘Dads Matters’ and volunteers.
    - 15 steps and attendance at in inpatient and outpatient areas across sites.
    - Families who have experienced bereavement
- Co production of information including environmental improvements
- Monitoring of themes of feedback and evidence of actions

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users: Continued:

Element 2:

- Action plan developed based on findings of the annual CQC Maternity survey which includes actions from the free text data
- Workplan developed and coproduced in conjunction with MNVP leads.
  - Includes actions following the findings of the Maternity survey including free text narrative.
  - Local feedback and survey responses
  - Supports, utilised to expand further on feedback received in order to address and improve patient care and experiences.
  - Prioritises listening to women's and their families' voices including those that have experienced neonatal care, bereavement care and those from BAME backgrounds and areas of deprivation.
  - Monthly meeting with MNVP leads and provider
  - Ongoing review and additions to workplan as required.
- Workplans presented to Trust safety champion meetings and the LMNS. Work plan coproduction supported by C+M MNVP lead and engagement officer and re reviewed and updated following return from maternity leave of MWL MNVP leads

Compliant

Safety Action 8:
Evidence for 3 elements of local training plans and in house one day MDT training.

Training compliance requires at least 90% for each relevant staff group within the reporting period 1st December 2024 – 30th November 2025 for:

a) Fetal Monitoring training

Ormskirk Site	
Consultant Obstetricians	100%
Other Obstetric doctors	100%
Midwives	97.7%

Whiston Site	
Consultant Obstetricians	95%
Other Obstetric doctors	95.2%
Midwives	97.9%

Compliant

Safety Action 8:
Evidence for 3 elements of local training plans and in house one day MDT training. Continued:

Training compliance requires at least 90% for each relevant staff group within the reporting period 1st December 2024 – 30th November 2025 for

b) Multi-Professional Maternity Emergency Training (PROMPT)

Ormskirk Site	
Consultant Obstetricians	92.3%
All other Obstetric doctors	100%
Midwives	96.9%
MSW	100%
Consultant Anaesthetists	100%
Other Anaesthetic doctors	100%

Whiston Site	
Consultant Obstetricians	100%
All other Obstetric doctors	96.6%
Midwives	98.9%
MSW	97.6%
Consultant Anaesthetists	100%
Other Anaesthetic doctors	92.9%

Compliant

Safety Action 8:
Evidence of 3 elements of local training plans and in house one day MDT training. Continued:

Training compliance requires at least 90% for each relevant staff group within the reporting period 1st December 2024 – 30th November 2025 for

c) Neonatal resuscitation training

Ormskirk Site	
Midwives	94.6%
Neonatal Consultants	100%
Other Neonatal doctors	100%
Neonatal Nurses	96.9%
ANNP	100%

Whiston Site	
Midwives	98.9%
Neonatal Consultants	90.9%
Other Neonatal doctors	96.6%
Neonatal Nurses	92.1%
ANNP	100%

Compliant

Safety Action 9: Demonstrate clear oversight to provide assurance to the Board on maternity and neonatal safety and quality issues

- Utilisation of a monthly Perinatal Quality surveillance Model tool (PQSM) with data also included in monthly IPR. Both presented monthly to Quality Committee.
- Quarterly maternity update reports provided to QC includes data from PQSM, maternity dashboard, IPR data, serious incidents, training, staffing, service user and staff feedback, perinatal culture feedback, PSIRF and MNSI cases. Trends and monitoring is undertaken. Reports presented by Divisional Director of Midwifery.
- Trust latest claims score card alongside data from incidents and complaints presented to QC in October 24 and included in quarterly updates. Discussed at Trust safety champions and patient safety council.
- Non-Executive Director in place who works with the Board safety champion.
- Maternity and Neonatal, Board and NED safety champion walk-about rota with feedback at Trust Safety champion meetings.
- Reporting schedule and workplan for Trust safety champion meetings which includes local dashboard, incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff feedback from frontline champions; minimum staffing in maternity services and training compliance.

Safety Action 9: Demonstrate clear oversight to provide assurance to the Board on maternity and neonatal safety and quality issues

- Maternity/ neonatal representation at shared LMNS/ ICB meetings. E.g. Maternity Safety Oversight Group, Saving Babies Lives Oversight Meeting, Quality Safety Surveillance Group, Women's Health and Maternity (WHAM), Maternity Performance Oversight Panel (MPOP) and LMNS provider touchpoint meetings etc.
- The service has a variety of methods of engagement sessions with staff which include:
    - Monthly unit meetings to enable feedback and provide the opportunity for staff to raise issues, concerns, suggestions for improvement etc.
    - HR drop in sessions
    - Learning and development accessibility and sessions within the clinical area for staff
    - Freedom to speak up
    - Monthly Safety champions walkabout
    - Triumvirate 'Talk to us Tuesdays and Thursdays'
- Board safety champion has a weekly invite to the Perinatal Quadrumvirate leadership team to better understand local cultures, safety and any concerns. The minimum of 3 in the MIS year 7 reporting period has been exceeded.
- Both sites attended the Perinatal cultural leadership programme separately but then combined sessions as cultural work progresses. Perinatal maternity and neonatal culture improvement plan update presented to QC and Trust Board in November 2025

Compliant

Safety Action 10: 100% of qualifying cases reported to MNSI to NHS Resolution's Early Notification scheme from 1 December 24 to 30 Nov 25

6 reportable cases in the reporting period:

10a. All 6 reportable cases submitted to MNSI

10b. 4 cases reported to NHS EN scheme. 2 subsequently declined.

10c. All families received information on the role of MNSI and the NHSR EN scheme.
One family received information in Tamil in the format accessible to them.
Evidence of provision of undertaking duty of candour for all cases.

Evidence of compliance to both elements are uploaded onto Datix

Details of number of cases, reported cases, family involvement and duty of candour are reported within the quarterly Maternity update reports and MIS update papers presented to Quality Committee and Trust Board

Compliant

Overall Compliance

Safety Action	Title	Compliance
Safety Action 1	Use of the National Perinatal Mortality Review Tool	Non-Compliant
Safety Action 2	Submission of data to the MSDS	Compliant
Safety Action 3	Demonstrate TC services are in place and undertaking quality improvement to minimise separation.	Compliant
Safety Action 4	Effective clinical workforce planning	Compliant
Safety Action 5	Effective midwifery workforce planning	Compliant
Safety Action 6	Demonstration of being on track to compliance to all elements of SBLC bundle Version 3	Compliant
Safety Action 7	Listen to women, parents and families using maternity and neonatal services and coproduce services.	Compliant
Safety Action 8	Training	Compliant
Safety Action 9	Robust processes in place to provide assurance on maternity and neonatal safety and quality issues	Compliant
Safety Action 10	100% of qualifying cases reported to MNSI and NHS Resolution's Early Notification scheme	Compliant

Thank you
Any Questions ?

Title of Meeting	**Trust Board**		**Date**	28 January 2026
Agenda Item	**TB26/006**			
Report Title	Corporate Risk Register			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

1. Risk Management Systems

A new single electronic system for managing risks, incidents, claims and complaints was implemented in March 2025. This new system (InPhase) replaced the two legacy Trust risk management systems. Following the transition phase normal reporting resumed in July 2025 and the Risk Management Framework agreed in 2023 is now being reviewed.

Work continues to support the consistent description, scoring and reporting of risks and the systems and processes in each Division/Service to maintain effective risk management. The Executive Committee agreed to close the legacy Southport & Ormskirk Hospital NHS Trust tolerated risk register in November, and these risks have now been absorbed back into the live risk register.

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

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

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

2. Risk Registers and Corporate Risk Registers

This report is a snapshot of the risk registers on 01 January 2026 and reflects risks reported and reviewed during December 2025.

Risk Register Summary (Appendix 1)

The total number of risks on the MWL risk register was 1,067 compared to 994 in October 2025.

25 risks are escalated to the CRR compared to 23 in October.

Nine new escalated risks are reported on the CRR in January compared to October and five risks have been closed or de-escalated from the CRR.	
Financial Implications	
None as a direct result of this report	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Corporate Risk Register	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

JANUARY 2026 – Corporate Risk Register Report

1. Risk Register Summary for the Reporting Period

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

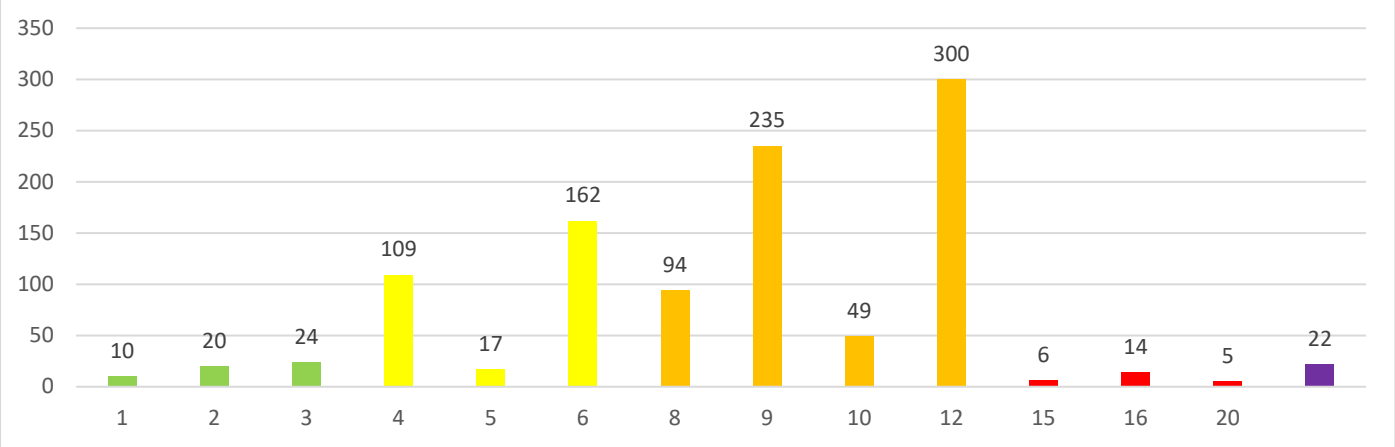
RISK REGISTER MWL SITES	Current Reporting Period (January 2026)	Previous Reporting Period (December 2025)	Previous Reporting Period (November 2025)
Number of new risks reported	42	41	67
Number of risks closed or removed	25	46	47
Number of risks overdue for review	30	225	214
Total Number of InPhase risks	**1067***	**1030***	**1030***

**Includes 22 new risks, awaiting review and scoring*

2. Risk Profiles

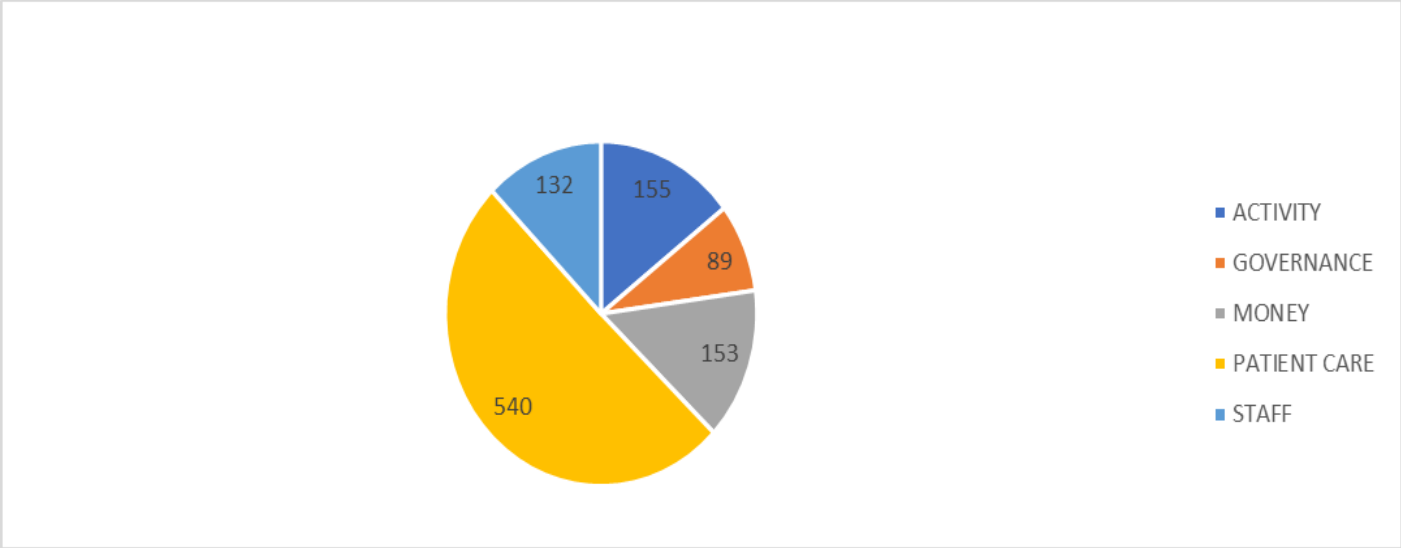
MWL Organisational Risk Profile

(Number of risks by risk score)



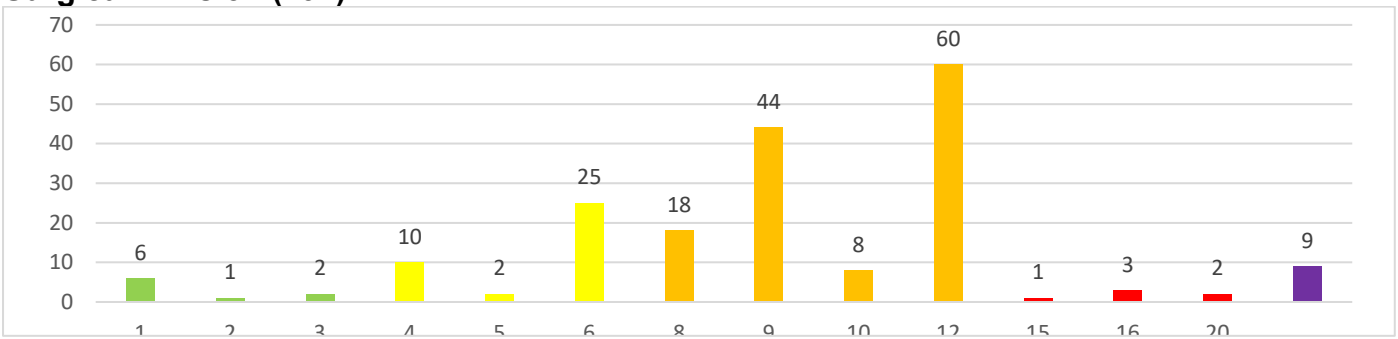
* *22 new risks awaiting review and control*

Risk Category Overview



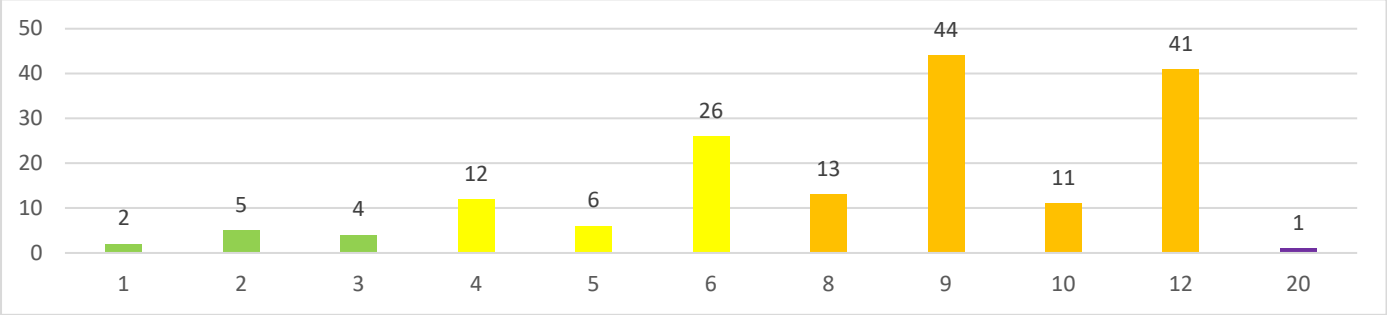
The risk profiles for each of the Trust Care Groups and for the collective Corporate Services are:

Surgical Division (191)



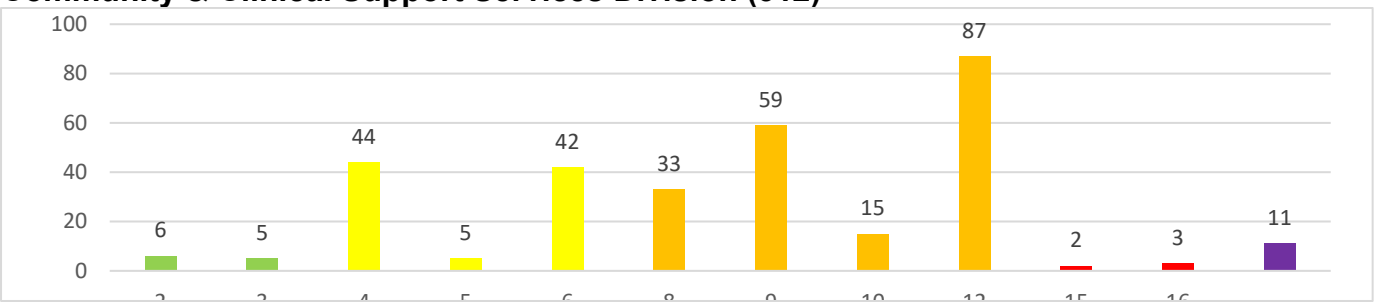
* *9 new risks awaiting review and control*

Medicine & Urgent Care Division (165)



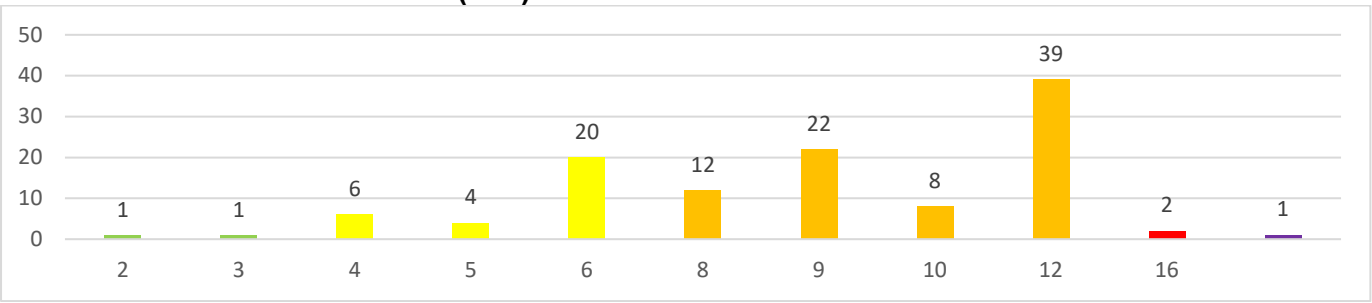
** 1 new risk awaiting review and control*

Community & Clinical Support Services Division (312)



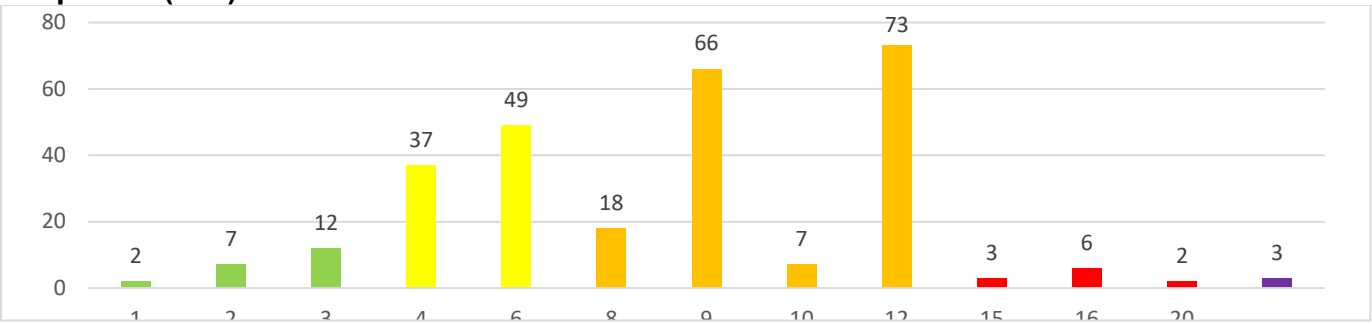
** 11 new risks awaiting review and control*

Women & Children's Division (116)



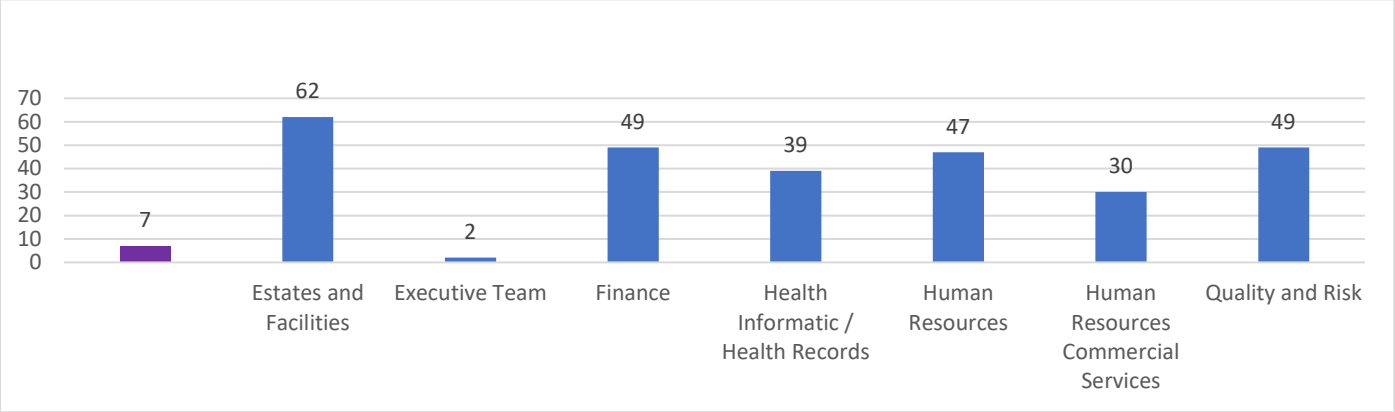
** 1 new risks awaiting review and control*

Corporate (285)



** 3 new risks awaiting review and control*

The split of the risks across the corporate departments is



**7 unallocated to a service*

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

No	MWL Risk ID	Title	Risk Owner	Opened	Next review date	Grade	Division
1	30	**If** the Trust relies on bank and agency staffing **then** there is a risk to the quality of care, contract delivery and finance performance	Malise Szpakowska	29 Mar 2022	28 Feb 2026	16	Corporate (HR)
2	33	**If** the end-of-life ADS (Automatic Dispensing System) Pharmacy Robot at Southport Hospital malfunctions or fails before replacement, **then** there is a risk to the efficient delivery of the service	Lesley Neary	11 Jan 2023	14 Jan 2026	16	Clinical Support and Community
3	47	**If** the Trust cannot recruit and retain sufficient skilled staff, **then** there is a risk to safe staffing.	Malise Szpakowska	07 May 2013	28 Feb 2026	16	Corporate (HR)
4	80	**If** the critical estates Infrastructure at the Southport and Ormskirk Hospital sites fail, **then** there is a risk to delivery of services and the safety of staff and patients	Nicola Bunce	25 Mar 2025	30 Jan 2026	15	Corporate (Estates and Facilities)
5	263	**If** patients have duplicate hospital numbers, **then** there is a risk of causing patient harm.	Malcolm Gandy	05 Apr 2024	15 Jan 2026	15	Clinical Support and Community
6	319	**If** the Trust cannot secure a sustainable Interventional Radiology service, **then** there is a risk of patient harm	Simon Dowson	11 Apr 2025	15 Jan 2026	16	Clinical Support and Community
7	361	**If** there is a malicious cyber-attack that the Trust cannot block, **then** there is a risk to the delivery of services and patient/staff information.	Malcolm Gandy	12 Oct 2016	28 Feb 2026	16	Corporate (Informatics)
8	400	**If** obsolete audiology equipment is not replaced at Ormskirk Hospital, **then** there is a risk to continued service provision	Lesley Neary	04 Dec 2023	30 Jan 2026	15	Surgery
9	510	**If** obsolete and non-compliant HSDU equipment is not replaced, **then** there is a risk to the safe and sustainable delivery of the endoscopy service and elective programme	Nicola Bunce	21 Jul 2017	08 Jan 2026	16	Surgery

10	521	**If** the Trusts cannot deliver sufficient out of hours anaesthetic support, **then** there is a risk to patients in a 2nd time critical maternity emergency at ODGH	Simon Dowson	25 May 2023	30 Jan 2026	20	Women and Children's
11	587	**If** the Trust cannot recruit and retain consultant ENT staff, **then** it would not be able deliver the commissioned service	Lesley Neary	02 Nov 2023	30 Jan 2026	16	Surgery
12	591	**If** the Trust does not have effective booking and patient tracking systems in ophthalmology, **then** there is a risk of increased waiting times and patient harm	Lesley Neary	28 Apr 2025	30 Jan 2026	20	Surgery
13	630	**If** the Trust cannot move to a single EPR **then** there is a risk of duplication of effort, barriers to integrating clinical services and suboptimal use of available facilities	Malcolm Gandy	30 Apr 2025	31 Mar 2026	15	Corporate (Informatics)
14	648	**If** the Trusts underperforms against the 2025/26 activity plan because of Industrial Action by the BMA, **then** it will not generate the expected income to deliver the agreed financial plan	Gareth Lawrence	24 Jul 2024	31 Jan 2026	16	Corporate (Finance)
15	663	**If** the Trusts underperforms against the 2025/26 variable activity plan, **then** it will not generate the expected income to deliver the agreed financial plan	Gareth Lawrence	17 Oct 2024	31 Jan 2026	16	Corporate (Finance)
16	748	**If** the Paediatric/Neonatal service lacks the capacity to update and harmonise Clinical Guidelines & SOPS, **then** there is a risk to patient safety.	Sarah O'Brien	25 Mar 2022	31 Dec 2025	16	Women and Children's
17	758	**If** the Trust cannot achieve sustainable solutions for the clinical services assessed as fragile **then** patient access and safety will be at risk	Kate Clark	07 Feb 2025	30 Jan 2026	16	Executive
18	791	**If** the Trust cannot agree a service specification with commissioners, **then** there is a risk to the delivery of a quality Dietetic service for children and young people	Sarah O'Brien	06 May 2025	22 Feb 2026	15	Clinical Support and Community

19	914	**If** the Trust experiences increased demand and bed occupancy above planned capacity, **then** there will be reduced patient flow	Lesley Neary	13 Apr 2015	30 Jan 2026	20	Medicine and Urgent Care
20	978	**If** there is insufficient funding from NHS Wales, **then** there is a risk to the level of care MWL can deliver for plastic surgery patients in North Wales	Lesley Neary	15 Sep 2022	31 Jan 2026	16	Surgery
21	1008	**If** Commissioners do not agree contracts for 2025/26 **then** there is a risk to Trust income	Gareth Lawrence	13 May 2025	31 Jan 2026	20	Corporate (Finance)
22	1118	**If** the 2025/26 Financial plan system-wide CIP schemes and risk share opportunities do not materialise, **then** the Trust will not be able to deliver the agreed financial plan.	Gareth Lawrence	05 Jun 2025	31 Jan 2026	20	Corporate (Finance)
23	1125	**If** there are data quality errors and patient number mismatches due to legacy IT systems, **then** there is a risk of patient harm	Malcolm Gandy	04 Sep 2019	31 Mar 2026	15	Corporate (Informatics)
24	1351	**If** the current Radiology Managed Equipment Service contracts end without a replacement in place, **then** the Trust would face increased pressure on capital to maintain a safe equipment replacement programme.	Nicola Bunce	22 Oct 2025	31 Jan 2026	16	Clinical Support and Community
25	1355	**If** the Trust cannot recruit, **then** there is a risk to the safe delivery of the Paediatric Cardiology service	Simon Dowson	23 Oct 2025	31 Dec 2026	16	Women and Children's

Blue Text = new CRR risks escalated since the October report

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

No	MWL Risk ID	Risk Description

1	428	If the Trust does not replace the end of life/un-supported outpatient letter solution, then there would be delays in communicating with patients/GPs etc.
2	445	If there is insufficient capacity in the Endoscopy Booking Team, then there will be delays in booking appointments and waiting times will increase
3	934	If Commissioners do not honour the revenue funding for the Southport Community Diagnostic Centre, then the Trust will have an increased financial pressure
4	1044	If the obsolete Whiston Hospital Decontamination Unit FC4 Washer Disinfectors are not prioritised for replacement, then there is a risk of service disruption which will delay patient care.
5	1117	If the 2025/26 Block contract for UEC activity does not reflect demand, then the Trust will have insufficient income to fund the service

Title of Meeting	**Trust Board**		**Date**	28 January 2026
Agenda Item	**TB26/007**			
Report Title	Board Assurance Framework (January 2026)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

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

Executive Summary

The MWL BAF is reviewed four times a year, the last review was in October 2025, and this review captures the changes that have occurred during Q3 (2025/26).

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

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

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

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

Proposed changes to risk scores.
At the October meeting the Board discussed whether the score of BAF 3 should be reduced due to increased confidence in achieving the key operational performance targets, the decision at that time was to defer this until the Q3 review, to better understand the impact of winter pressures. The Executive are not recommending a change of score at this review, reflecting the extreme pressures with patient flow and levels of escalation currently.

There are no other proposed changes to BAF risk scores.

Financial Implications

None directly because of this report.

Quality and/or Equality Impact

Not applicable

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

Appendix 1

Board Assurance Framework Quarterly Review – Q3 2025/26

BOARD ASSURANCE FRAMEWORK 2025-26									
BAF	Risk Description	Exec Lead	Risk Score						
			Inherent	Jan 25	April 25	July 2025	Oct 2025	Jan 2026	Target
1	Systemic failures in the quality of care	Chief Medical Officer/Chief Nursing Officer	20	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	5
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Chief Finance Officer	20	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	10
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	16	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	12
4	Failure to maintain patient, partner and stakeholder confidence in the Trust	Deputy CEO	16	12 ↔	12 ↔	16 ↑	16 ↔	16 ↔	8
5	Failure to work in partnership with stakeholders	Chief People Officer	16	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	8
6	Failure to attract and retain staff with the skills required to deliver high quality services	Chief People Officer	20	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	10
7	Major and sustained failure of essential assets and infrastructure	Director of Corporate Services	16	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	8
8	Major and sustained failure of essential IT systems	Director of Informatics	20	20 ↑	20 ↔	20 ↔	20 ↔	20 ↔	8

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

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

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Chief Medical Officer/Chief Nursing Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets. • ~~Failure to deliver CQUIN element of contracts, if required~~ • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care. • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness, or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints. • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Midwifery Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • ~~CIP~~ Quality & Equality Impact Assessment Process • IG monitoring and audit • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • Maternity Incentive Scheme. • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family test scores • Quality Ward Rounds • Ward accreditation programme • Patient survey action plans **LEVEL 2** Board Assurance • IPR/CPR/DPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing & Midwifery Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework • Maternity High Risk Pathways Project Board **LEVEL 3** Independent Assurance • National clinical audits • ~~Annual CQUIN Delivery~~ • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital • Maternity Incentive Scheme/Saving Babies Lives	Quality metrics embedded in divisional performance management/governance systems. Complete implementation of post transaction corporate nursing and medical management structures. Completion of Quality Impact Assessment and Board Assurance Checklist for the system led financial savings schemes for 2025/26 Close regulatory breaches identified in the CQC UEC Reports – work continues the action plan (Revised to February 2026)	Routinely achieve 30% of discharges by midday 7 days a week to improve patient flow (2025/26 interim target of 20%) Single set of key clinical and quality policies for MWL (March 2026) Finalise N&M strategy on appointment of Chief Nursing Officer (Revised to March 2026) ~~Response to the NW Clinical Senate Report and JOSG – Ormskirk Maternity Unit (Revised to December 2025)~~ Implementation of the new Standards for care of acutely unwell patients in their first 72 hours in hospital (January 2026)	Aim for response time of 60 days with month-on-month improvement (Revised to March 2026). Achieve 2025/26 agreed quality improvement Trust Objectives (March 2026) ~~Delivery of the GMC trainee survey results action plan (Revised to December 2025)~~ ~~Review of MWL ward accreditation programme (revised to November 2025)~~ Following review of MWL ward accreditation programme introduce cross site quality assurance by subject matter experts from February 2026. ~~Review MWL QIA SOP in line with ICB process (Revised to December 2025)~~ Completion of the Northwest Home Birth benchmarking tool (January 2026)

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

Exec Lead: Chief Finance Officer

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

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

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

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

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

BAF 4 Failure to maintain patient, partner and stakeholder confidence in the Trust

Exec Lead: Deputy CEO

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

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

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Chief People Officer

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

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

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

Exec Lead: Chief People Officer

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation Loss of market share	• Trust brief live • MWL News • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • Workforce & Development Operational Plan • Learning and Organisational Development Operational Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Delivery ~~Operational~~ plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • Trust Values • Medical Workforce Delivery ~~OD~~ plan • Talent Management action plan • Equality, Diversity, and Inclusion Delivery ~~Operational~~ plan	**LEVEL 1** Operational Assurance • Finance and workforce Improvement Group • Monitoring of bank, agency and locum spend • Workforce operational plans and information dashboards • Vacancy control panel **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council, Equality, Diversity and Inclusions Council and HR Commercial Services Council • Finance and Performance Committee • Committee Performance Report • Staff Survey • Monitoring of vacancy rates/labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group • MWL People Plan 2025-2028 • Nurse safer staffing % fill rates **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report • Northwest BAME Assembly Anti-Racism Framework - bronze	Monthly Provider Workforce Returns (PWR) ~~Achieve bronze level Northwest Anti-Racism Framework (revised to November 2025)~~ Delivery of the updated NHSE Sexual Safety Charter Assurance Framework action plan by April 2026, Delivery of MWL action plan for the NHSE 10 Point Plan to Improve the Working Lives of Resident Doctors.	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (On-going)	Continue to provide the necessary support for organisational change to implement the remaining management structure for the MWL integrated operating model (continues in 2025/26) Delivery of the 2024 staff survey action plan and engagement events (March 2026) Continue Healthcare Support Worker quarterly recruitment events for each hospital site for substantive and bank staff (on-going) ~~Complete an updated options appraisal of the service delivery and financial benefits of moving to a single resourcing solution aligned to the current NHS context. (November 2025)~~ Deliver the agreed 2025/26 workforce plans to support the operational and financial targets set out in the National Planning Guidance (March 2026) Deliver the agreed Trust EDI ~~priority developments 2025-2028 (March 2029~~) priorities as outlined in the MWL People Plan 2025-28 and the High Impact Actions Delivery Plan 2025-26 (March 2026) Implementation of single resourcing solution from April 2026

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • Statutory safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data • Green Plan annual monitoring reports **LEVEL 3** Independent Assurance • Authorising Engineer Appointments and audits • Condition surveys • Premises Assurance Model (PAM) benchmarking • Model Hospital • PLACE Audit Results and benchmarking • Building Safety Act • ERIC/PAM benchmarking	Maintain up to date 10-year strategic estates development plans for MWL to support the Trusts service development and integration strategies. Development of an updated Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	~~Develop the final business case to fully implement National Standards of Cleaning across MWL (re based budgets to be agreed for 2025/26)~~ Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 – guidance on application to the NHS being developed by NHSE.	Deliver the agreed capital programme for 2025/26 (March 2026) Deliver the agreed backlog maintenance reduction programme for 2025/26 (March 2026) Deliver the PFI lifecycle programme for 2025/26 agreed with NewHospitals (March 2025/26) ~~Single MWL Green Plan 2025 -2028 (November 2025)~~

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

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

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

Title of Meeting	**Trust Board**		**Date**	28 January 2026
Agenda Item	**TB26/008**			
Report Title	Aggregated Incidents, Complaints and Claims Report (Q3)			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Sarah O'Brien, Chief Nurse			
Action Required		**To Approve**	X	**To Note**

Purpose

The aim of this paper is to provide the Board with a closure report on the management of incidents, complaints, concerns and claims during Quarter 3 2025/26.

Executive Summary

Incidents

- A total of 7,997 incidents were reported across MWL in Q3 2025/26.
- Of these, 5,842 were patient safety incidents.
- 58 patient safety incidents were classified as moderate harm or above (0.62 % of all incidents)
- The most frequently reported patient safety incidents in Q3 were:
  - Pressure Ulcers, including those not acquired under Trust care, were the highest reported Trust wide (952)
  - Accidents including slips, trips, falls, and collisions were the second highest reported incidents in Q3 (831)

Complaints & Patient Advise and Liaison Service (PALS)

- The Trust received 145 first stage complaints in Q3.
- The Trust received 18 stage 2/reopened complaints in Q3.
- The Trust closed 169 complaints in Q3.
- Clinical treatment was the main theme for complaints, in line with previous quarters.
- Emergency Departments remained the main areas to receive complaints.
- The Trust received 1,112 PALS contacts in Q3 (not including Ask Rob or Compliments).

Claims & Inquests

- In Q3 the Trust received 17 new claims: 12 across Whiston and St Helens sites and five across Southport and Ormskirk sites.
- The Trust received 20 new inquests, and 38 inquests concluded
- No Prevention of Future Death (PFDs) were issued during that period

Financial Implications

None as a direct consequence of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Aggregated Incidents, Complaints and Claims Report (Q3).

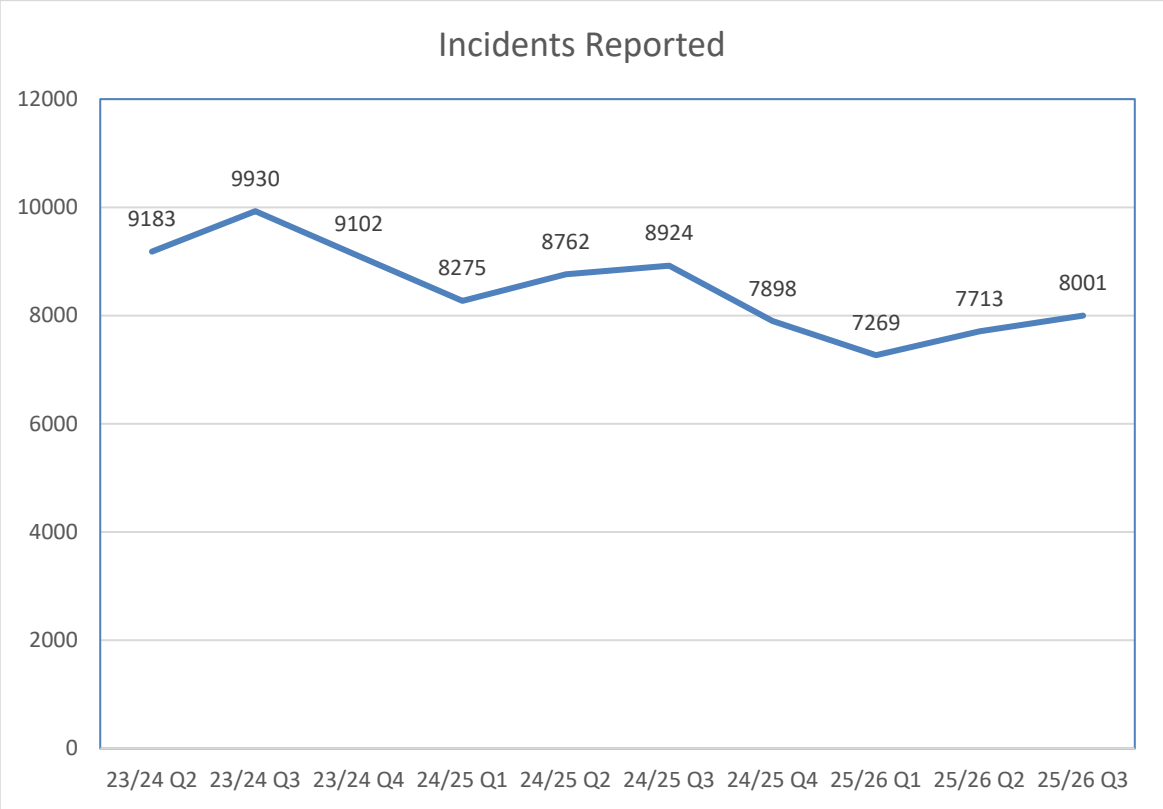
Strategic Objectives

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

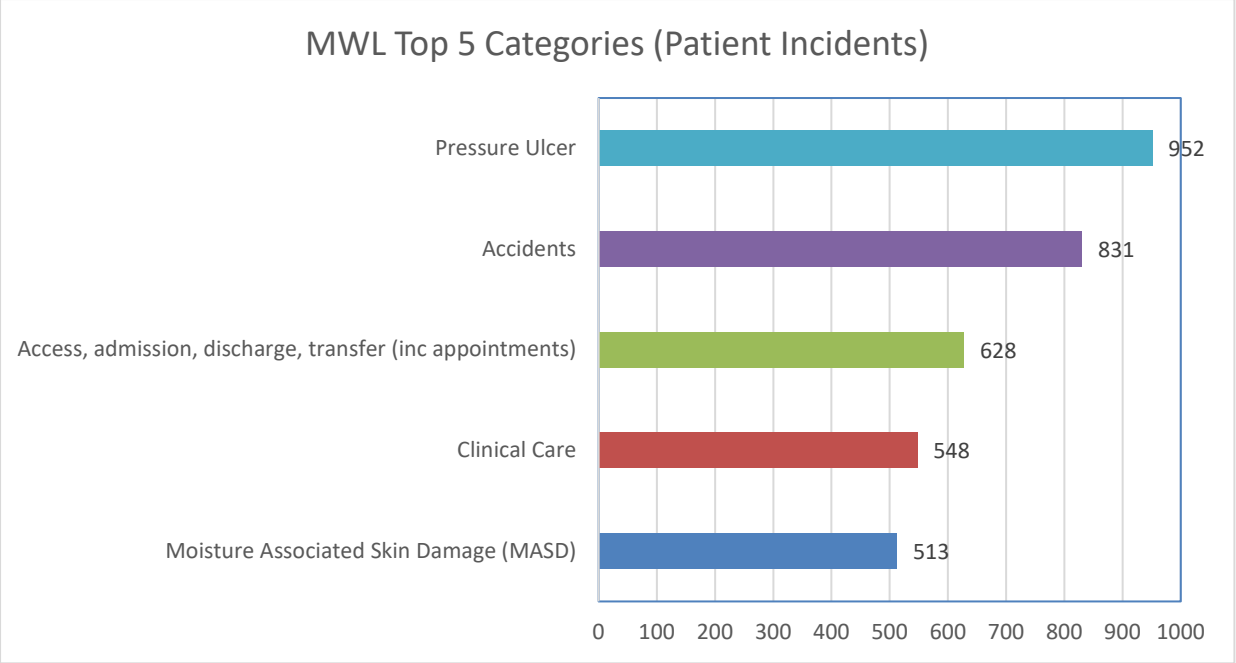
1. Introduction

This paper includes reported incidents, complaints, PALS contacts, claims, and inquests during Quarter 3 2025/26, highlighting any trends, areas of concern and the learning that has taken place. In March 2025 the Trust moved to a new Incident Reporting System, InPhase, which brought all sites onto one reporting platform to record incidents, complaints, PALS, claims and inquests.

2. Incidents



MWL Q3 incidents reported	
5,846	Incidents affecting patients
733	Incidents affecting staff
1,372	Incidents affecting the Trust or other organisation (examples include bed availability; notifications of staffing levels; delayed discharges; equipment issues and queries raised by system partners)
50	Incidents affecting visitors, contractors or members of the public



There was an increase in the number of incidents reported across MWL during Quarter 3 of 2025/26, with a total of **8,001** incidents, up from **7,713** in Quarter 2. The majority of these were patient-related incidents, accounting for **5,846** cases. Incident numbers overall continue to increase post implementation of InPhase.

Among the highest categories for patient-related incidents:

- **Pressure ulcers** – including both those acquired while under MWL care and those acquired externally – were the most frequently reported in Q3, with 952 cases, which is an increase on Q2. An example of non-MWL acquired pressure ulcers would be when the patient comes from their house, care home, or other Trust to an MWL hospital / service with a pressure ulcer, assessed in AED, Ward or MWL community services and noted to have preexisting skin breakdown at the point of assessment
- **Accidents** – including slips, trips, falls, and collisions – were the second highest reported patient events (831) which is a decrease on the previous quarter.

2.1 Incidents by harm category

The table below illustrates incidents by harm for Quarter 3 2025/26.

In Q3 there were seven deaths recorded across all sites which is an increase on the previous quarter. The percentage of severe incidents and deaths against the total of all patient incidents is 0.22% for Q3 2025-26 compared with 0.23% for the year 2024/25. This will continue to be monitored in the coming quarters.

The fatal incidents reported in Q3 relate to positive E.coli MSU not acted upon, deterioration of a patient under section with a complex medical history, delay in Radiological intervention, delay / failure of referral to Gastroenterology, and NIV machine not connected to oxygen. All cases have been presented to Executive Patient Safety Panel for initial learning with ongoing reviews underway. The remaining two are both related to falls incidents, with one being investigated from a medication perspective.

MWL	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3
Moderate	37	35	33	54	67	38	45
Severe	15	9	9	6	14	14	6
Death	0	2	4	2	4	4	7
Total	52	46	46	62	85	56	58

2.2 Patient Safety Incident Investigations (PSII) incidents and Learning

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

Q3 2025/26 – Discussed at Patient Safety Panel	Total
Learning Reviews	3
Expanded Learning Reviews	2
MDT / AAR	0
Number of Patient Safety Incident Investigations (PSII) commissioned (including MNSI)	2

There were two PSIIs commissioned for Q3 2025/26. These were both Maternity and newborn Safety Investigations (MNSI) cases.

2.3 Duty of Candour

The duty of candour process has been commenced or completed for all incidents where harm has been confirmed as moderate or above. The investigation and validation of a number of Q3 reported incidents is still ongoing. In accordance with policy, Duty of Candour will be initiated following confirmation of harm and is monitored at divisional safety meetings to promote completion.

Duty of Candour is required for all incidents where the harm is identified and validated by the responsible manager as moderate or above or for incidents identified for PSIIs. Under the Health and Social Care Act 2008 Regulations 2014: Regulation 20 requires NHS providers to comply with Duty of candour principles as soon as reasonably practicable after becoming aware that a notifiable safety incident by notification of the incident and providing reasonable support. A "notifiable safety incident" means any

unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in the death of the service user, where the death relates directly to the incident, or severe harm, moderate harm or prolonged psychological harm to the service user.

3. Complaints

Closed Complaints	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
Not Upheld	12	22	17	20
Partially Upheld	79	89	86	127
Upheld	16	24	17	22
Total	**107**	**135**	**120**	**169**

Themes of Closed Complaints	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
Clinical Treatment	63	61	54	65
Patient Care (Nursing)	20	19	17	29
Values & Behaviours	6	2	5	8
Communication	14	14	21	26
Access to Drugs & Treatment	-	-	-	9
Admission & Discharge	1	9	4	7
Apps & Waiting Times	-	-	-	16

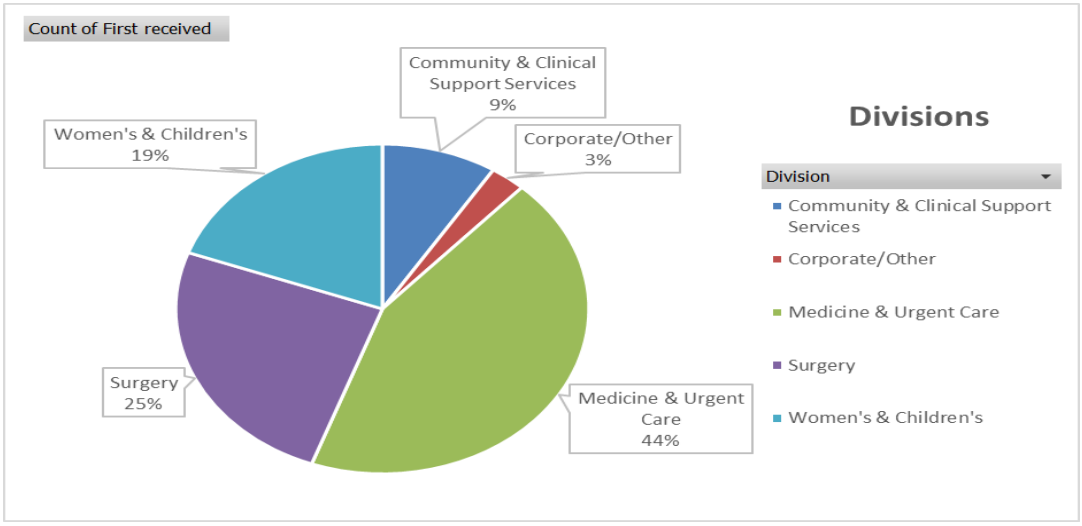
*Figures correct at time of reporting from InPhase

Whilst currently no emerging trend the highlighted sections above indicate new themes not seen in the last 12 months.

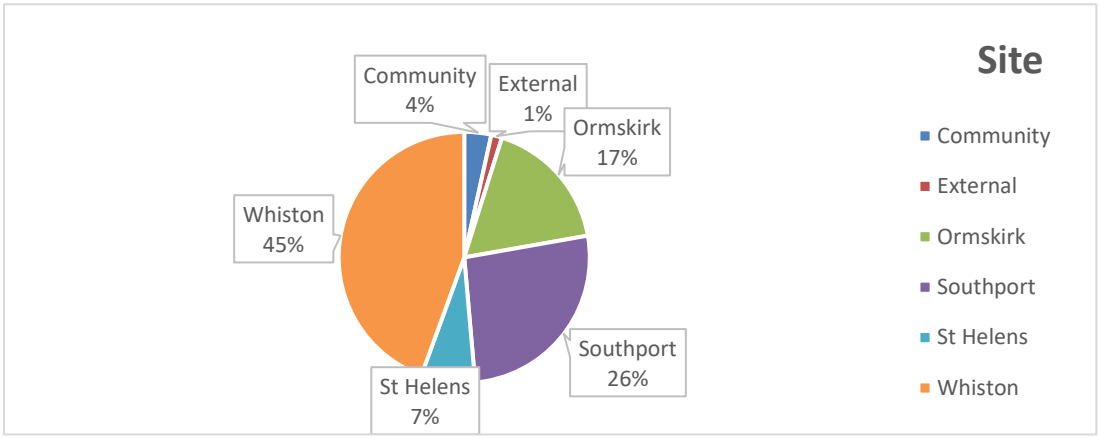
The Trust received 145 new complaints in Q3, there were 169 closed complaints in Q3 and 60 aligned to complaints that had breached the 60 day target. The Trust achieved a 65% compliance of complaints being responded to within 60 working days in Q3.

Quarterly comparison of 60 working day compliance	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3
MWL First stage complaint	142	115	161	145
Second Response Trust Target Less than 12 per Q	27	16	16	18
Response Compliance Trust Target 80%	64.6%	50.7%	71.6%	65%
MWL number of complaints breached 60 working timeframe	50	57	34	60

The charts below depict the specific Trust sites and divisional breakdown of the 145 first stage complaints received in Q3.



Corporate complaints relate to elements of the services provided at are not directly related to patient care.



External complaints relate to services commissioned by the Trust by third party providers.

The Trust received 18 second stage/reopened complaints in Q3. This is a very slight increase on Q2 as 16 complaints required a second response in Q2.

Site	Total Second Stage/Reopened
Community	3
Ormskirk	3
Southport	3
St Helens	1
Whiston	8
Total	18

4. Patient Advice and Liaison Service (PALS)

PALS Contacts	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
Number of contacts received	997	1131	1232	1112

*Figures at time of reporting from InPhase

PALS Contacts by Themes Q3

PALS Themes	C & CSS	Corporate /Other	M & UC	Surgery	W&C	Totals
Communications	34	97	180	96	39	446
Appointments	43	36	30	91	29	229
Patient Care/ Nursing Care	6	9	53	8	4	80
Admissions and Discharges	1	2	37	16	1	57
Clinical Treatment	3	7	21	10	12	53
Waiting Times	4	0	13	26	7	50
Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	2	23	7	3	3	38
Access to Treatment or Drugs	1	9	15	5	4	34
Values and Behaviours (Staff)	3	3	8	4	1	19
Facilities	1	10	3	1	1	16
Other (e.g. abuse/behaviour/Theft/Benefits)	0	6	3	2	1	12

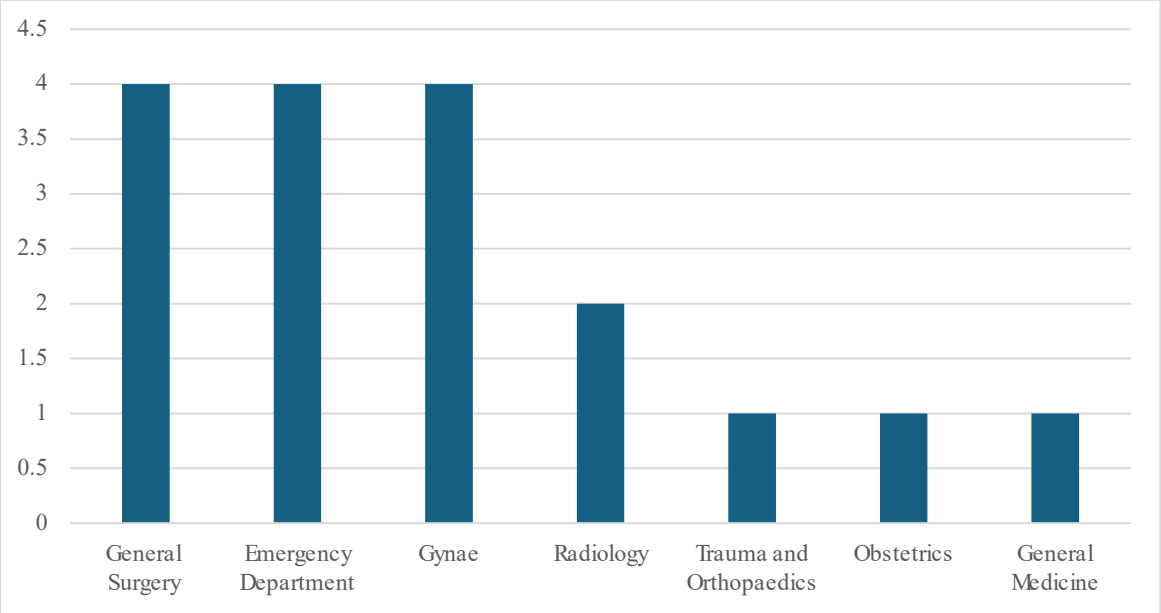
5. Ask Rob

Ask Rob data is being collected via InPhase from the middle of January 2025. Where these relate to patient specific concerns, we will be able to report on them from Q1 of 2026/27.

6. New Clinical Negligence Claims

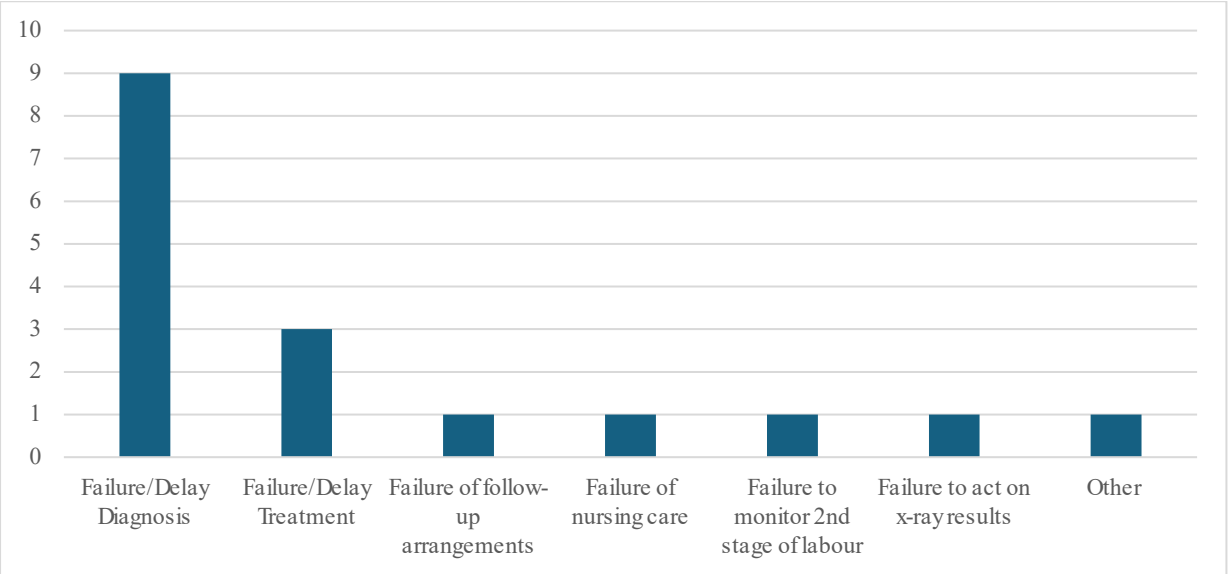
The Trust received 17 new claims in Q3, which is more consistent with Q1 (18) after a higher number in Q2 (24). 12 claims were received in relation to the Whiston and St Helens sites, and five related to Southport and Ormskirk. Ten of the claims were received in October, with three in November and four in December.

6.1 New claims by speciality



The highest number of claims by speciality were ED, Gynae (highest in Q2) and General Surgery (highest in Q4 and Q1 of 2025/26), although none had above four. There is also a birth injury claim for obstetrics. ED only had one claim in the previous quarter, although we would generally expect them to be one of the highest sources of claims due to the amount of activity.

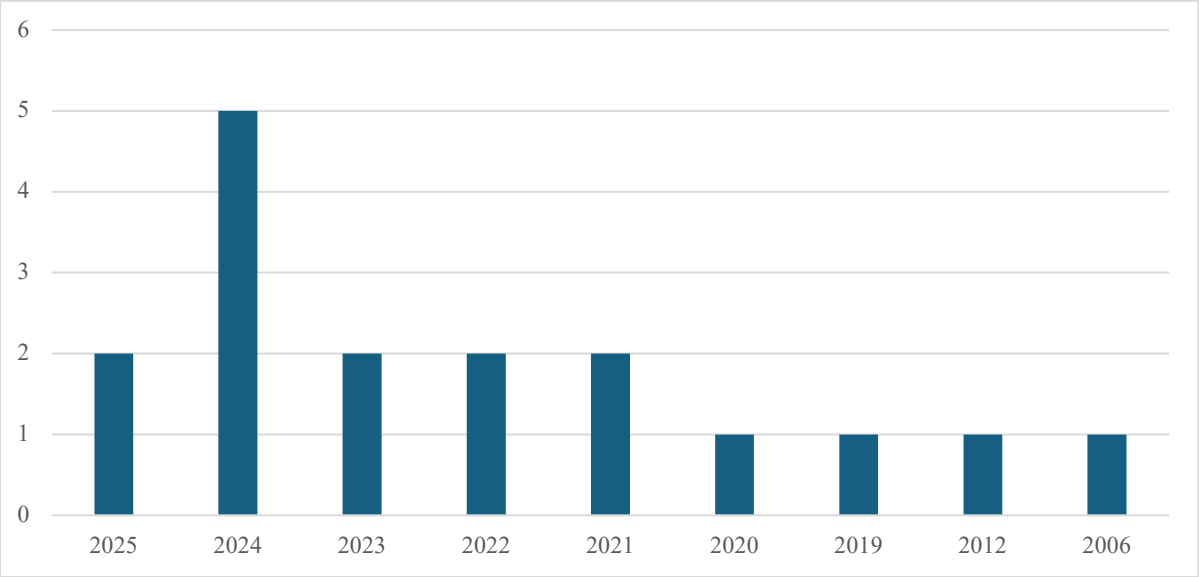
6.2 New claims by main reason



Failure/Delay in diagnosis is the largest cause of claims in Q3. This is consistent with other quarters and is generally the largest cause code for claims across the NHS. The nursing care claim relates to a fall, and the claim marked “other” relates to an allegation that we failed to remove sutures during post operative follow up.

6.3 Year to which claims relate

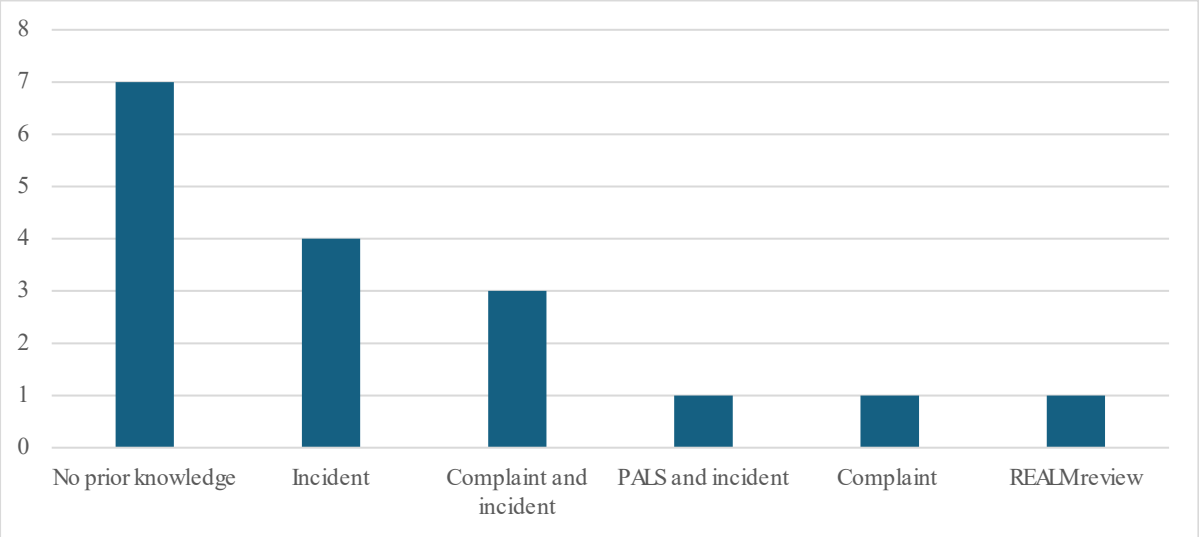
Although these claims were formally notified in Q3, the date of the incidents to which the claim relates can vary significantly. The graph shows the year in which the incident took place – where there is more than one incident the earliest that relates to this trust is used.



The claim from 2006 is the birth injury claim mentioned above.

6.4 Prior knowledge of issues causing claims

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



41.1% of the claims received had no previous investigation, which is less than the previous quarter. 52.9% had a formal investigation (incident or review) prior to being received.

All claims that have not been investigated at all are reviewed at Claims Governance Group to see if an investigation should take place. This happens two months after the claim has been accepted by NHS Resolution in order to allow clinician's comments to be obtained.

6.5 Lessons Learned/Actions taken from Closed Claims

The Trust closed 19 claims in Q3. Some of these concluded due to inactivity, but a number were settled, or the claimant has chosen not to pursue them. No matters reached trial in Q3.

There was one closed claim in Q3 that had provoked some significant learning and changes as a result of the claim investigation process:

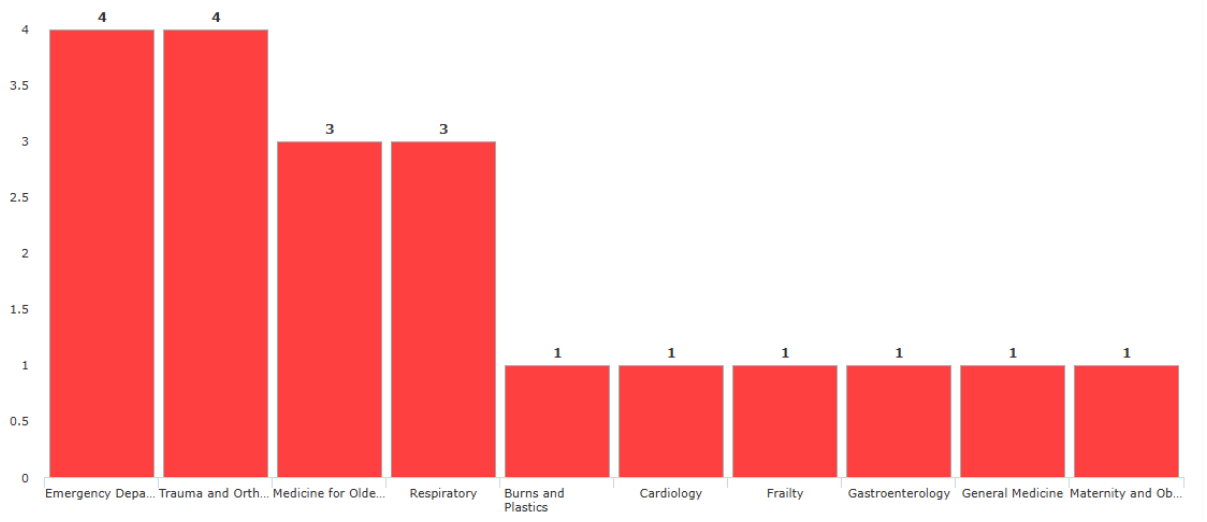
The claim related to the assessment, diagnosis, and treatment of a presumed flexor tendon injury. This led to a meeting between senior staff members of the radiology and surgical teams, which agreed that there were some issues with reporting. The outcome of the discussion was a mechanism by which specific consultants can request that ultrasound scans be performed by more specialist staff is now in place, and a group email has been distributed to the relevant team to enable case discussion in the absence of a formal MDT.

7. Inquests

7.1. New Inquests

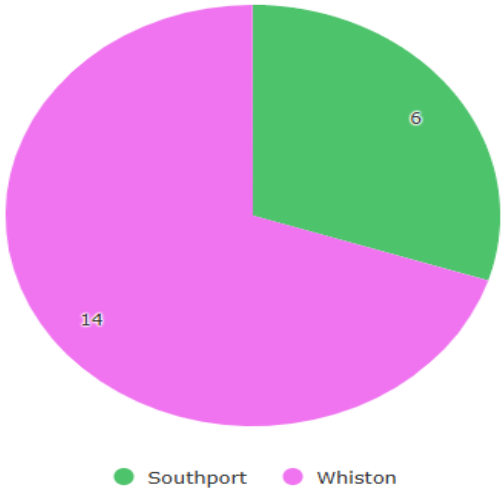
20 new inquests were opened in Q3. This is the same as Q2, but below the average number per quarter, which is around 30.

These inquests are broken down by department as follows:



ED received the most inquests, which is not unexpected and is consistent with Q2. Trauma and Orthopaedics had four inquests in Q3, which is double Q2. Medicine for Older People and Respiratory had one more in Q3 than the previous quarter.

And by site as follows:



7.2. Closed inquests

The Trust closed a total of 38 inquests in quarter 3. This is more than would normally conclude and may reflect the change in approach following the appointment of the new Senior Coroner for Sefton. We will keep this under review.

The Trust has not received any Prevention of Future Death (PFD) notices following the merger, and this continued in Q3. However, the Trust has been asked to provide some additional assurance to coroners in relation to three matters:

1. The accuracy of records on the EMIS system in relation to a community case. Changes are being made to allow better recording of signs of localised/systemic infection.
2. The process by which mental health providers are notified if a patient under their care has attended ED but hasn't waited to be seen as they already have an appointment. Discussions have been had between ED departments at the mental health liaison providers to formalise this process as part of the wider work the Trust is undertaking to implement its Mental Health strategy.
3. How information is communicated to care homes when a patient is discharged back there from ED. The need to print and provide written summary of treatment changes and plan of care to accompany the patient back to the care home has been reinforced to ED staff.

8. Recommendations

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	28 January 2026
Agenda Item	**TB26/009**			
Report Title	Learning from Deaths Q2 2025/26			
Executive Lead	Simon Dowson, Chief Medical Officer			
Presenting Officer	Simon Dowson, Chief Medical Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

This is the first report combining data from the legacy trusts in an integrated format.

Total number of SJRs	Q1 2025/26 (April – June)	51
Total number of SJRs	Q2 2025/26 (July – September)	48
Total received an SJR	Q1 2025/26 (April – June)	6
Total received an SJR	Q2 2025/26 (July – September)	0
Total outstanding for review	Q1 2025/26 (April – June)	45
Total outstanding for review	Q2 2025/26 (July – September)	48
Total Red SJRs	Q1 2025/26 (April – June)	0
Total Red SJRs	Q2 2025/26 (July – September)	0
Total Amber SJRs	Q1 2025/26 (April – June)	0
Total Amber SJRs	Q2 2025/26 (July – September)	0

All cases rated as Amber/Poor or Red will undergo more detailed review at divisional safety meetings with learning and additional actions fed back to the respective specialties.

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

The value of SJR is being reviewed in the context of an effective Medical Examiner Service and the use of the Patient Safety Incident Response Framework (PSIRF) for deaths where concerns are raised.

Financial Implications

None	
Quality and/or Equality Impact	
Learning from Deaths contributes to the Trust's continuous learning culture.	
Recommendations	
The Board is asked to note the Learning from Deaths Q1 and Q2 2025/26	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Reviews

Number of SJR requests Q3 October 2024 – December 2024

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
October 2024 22 (3 o/s)	15	1	3	0	0
November 2024 12 (5 o/s)	4	2	1	0	0
December 2024 25 (11 o/s)	9	2	2	1(80)	0

Number of SJR requests Q4 January 2025 – March 2025

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
January 2025 25 (8 o/s)	9	3	5	0	0
February 2025 20 (4 o/s)	11	2	2	1 (127)	0
March 2025 26 (6 o/s)	16	2	2	0	0

Number of SJR requests Q1 April 2025 – June 2025

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
April 2025 17 (14 o/s)	3				
May 2025 13 (11 o/s)	2				
June 2025 21 (20 o/s)	1				

Number of SJR requests Q2 July 2025 – September 2025

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
July 2025 17 (17 o/s)					
August 2025 20 (20 o/s)					
September 2025 11 (11 o/s)					

2. Key learning points

Update 28	**MCA and its use when concern over capacity** A person lacks capacity if they cannot understand, retain, use/weigh, or communicate the relevant information for the decision. The person needing to make the decision usually conducts the assessment, which should be proportionate to the decision's complexity. For important decisions, a formal, recorded assessment is required.	**Movement Disorder Review** Previous delays in movement disorder reviews have now been resolved due to the recruitment of additional consultants and the proactive identification of PD patients at the time of admission.

Update 27	**Hypoglycaemia in a non-diabetic patient** The presence of hypoglycaemia in a non-diabetic patient who is not taking insulin / oral hypoglycaemic agents should prompt early clinical review. In patients with sepsis or those with severe frailty, hypoglycaemia is likely to be a poor prognostic sign. Its presence should alert the medical team to deterioration in the patients condition, which should prompt a clearly documented decision to either escalate treatment or consider palliation.	**Acute agitation** Patients with acute agitation should be appropriately assessed and managed by the treating team. The Trust delirium guideline can be used to advise on the appropriate steps to take. Where symptoms are prolonged or do not respond to treatment, specialist advice should be sought from the Mental Health Liaison Team (inpatient core 24 referral via Careflow) or discuss with a geriatrician.
Update 26	**Sepsis of uncertain origin** When patients preset with sepsis of uncertain origin, it is essential to do a thorough assessment to identify the source of their infection as this allows antibiotics to be tailored appropriately. Assessment should include a skin survey, including removal of any wound dressings / compression bandages. It is also important to consider whether there are any indwelling devices (including prosthetic joints, pacemakers, etc, that may have become infected.	**Careflow Alerts** It is important to review all careflow alerts when patients are admitted to hospital. MRSA/VRE/CPE alerts should trigger review of antibiotic prescribing to ensure that there is appropriate cover for resistant organisms. Failure to do so risks delay to appropriate antibiotic prescription.
Update 25	**Know your Pathways** Trust pathways have been developed following local and national guidance of significant events and learning within the healthcare environment. It is imperative that staff familiarise themselves with what pathways are available within their field of practice, then follow them accordingly. They are there to protect our patients and you.	**Communication with families / carers** At times of high emotion and distress, it may be that families and carers do not take in what is happening to their loved one and may not be able to comprehend a poor prognosis, this is even more challenging over the phone. Staff must remain aware of verbal of physical cues from families / carers suggesting key messages haven't been fully appreciated, so the communication can be reinforced accordingly
Further updates can be found on the intranet Learning from Action		

Learning into Action

- Following each quarterly submission to Board, examples of learning are reported and shared throughout the organisation to ensure that all staff are given the opportunity to determine how this could impact on their practice and try and make things better. The leaning is shared at team brief and via all Trust councils. The learning also appears on the intranet. http://nww.sthk.nhs.uk/about/learning-into-action

Top learning points for Q4 2024/25

- Failure of DNACPR
- Failure to administer medication appropriately
- Failure to recognise a deteriorating patient
- Delay in requesting/ obtaining an investigation
- Failure to escalate
- Patient care affected by lack of staff
- Suboptimal communication

3. **Deaths subject to Patient Safety Incident Investigation**

Closed Q2 2025/2026

Date of Death	Cause of Death	Lessons Learned
removed	removed	Gaps and missed opportunities identified in the care of the patient. Multiple factors contributed to the delay in reviewing, escalating, and handing over the patient's urgent abdominal x-ray. These included fragmented communication, inconsistent handover practices, and a reliance on system status indicators rather than direct image access. Urgent inpatient plain film x-rays are reclassified as 'inpatient' so the urgency of the x-ray then defaults to the narrative. The narrative entered on the Careflow system to facilitate an urgent abdominal x-ray request is critical.
removed	removed	Clear process in place for the escalation of surgical patients who are deteriorating in the hospital whilst the surgical team are busy in theatres. Reinforce importance of Vital PAC observations being completed at the correct intervals.
removed	removed	1. The increase in the need for supplementary care not escalated 2. Patient was not placed on a low-rise bed which should have been in place on admission.

		3. Patient was not in an observable side room and was in room 5. Patient should have been moved to an observable side room when cognitive impairment identified. 4. Falls alarm was working throughout the shift and then did not activate when patient stood up. 5. Fall in ED not handed over to ward 6. Lying and standing blood pressure deficit was not escalated 7. Accuracy of the 4AT assessments and the documentation to support the implementation of the Dols 8. Medication review not completed post fall 9. Risk assessments not completed in change of condition (confusion)

10. Action plan to address back log of SJRs

No.	Action	Lead	Due by	comments
1	Recruitment of new reviewers	LFDs Lead	Ongoing	These roles are not remunerated. Three new recruits from ED (who get time back) so far. All started reviews as of Jan. CDs of all departments asked for nominations of interested persons.
2	Review of outstanding SJRs to see if any can be eliminated	LFDs Lead	End of Q4 2025/2026	See update below
3	Collaborative working with medical examiners to hopefully reduce the amount of SJRs and to prevent future backlog recurring	LFDs Lead	End of Q4 2025/26	In progress. Ongoing at S&O who share ME scrutiny with Mortality Steering Group in necessary cases to avoid duplication, the intention is to extend this process to all of MWL ME scrutiny better than an SJR (and involves concerns from families).
4	Targeted reviews to specific staff members	Consultant Lead	Ongoing	

Generic Update:

All Trust deaths have been scrutinised by a Medical Examiner since 2024 when this became statutory. This process acts as a time sensitive review of deaths which feeds into coroner and patient safety services where appropriate offering significant assurance. These cases do not necessarily benefit from duplicate SJR but learning needs to be shared with the Mortality Steering Group for distribution. Links with patient safety teams are established for this regular feedback.

Current SJRs are pulled as per the National Quality Board (NQB) criteria (from 2017).The LFD Lead has tried to reduce numbers of SJR triggered explained for each category:

Categories of death that require for SJR – potential for reduction of cases:

- **Cardiac arrest** – discussions with resuscitation team members who review every ward cardiac arrest. If anything concerning, referral made to MSG for an SJR. Only review previous 12 hours before cardiac arrest. Continue these SJR allocations until robust, real-time reviews reliable enough for exclusion.

- **Post operative** – elective surgical deaths all require SJR. Emergency surgical deaths where lifesaving potentially do not, unless specific complication during/from surgery and not underlying indication for the surgery that caused death. Difficult to separate these until after review so all kept in allocations for now. Exclude cases that have triggered PSIR/II and share learning.

- **Learning disability and Autism (LeDeR)** – Contact with LD leads and LeDeR team to see if more detailed scrutiny from LeDeR could be shared, declined. LeDeR team ask for our SJR as part of their scrutiny (which involves a more detailed, specific review alongside family discussions). Our own LD teams perform mortality review also but value an SJR still being completed. There is also an ME scrutiny. I question the value here of an SJR but have kept them in allocations.

- **Concern** – any significant concerns thought to have contributed to death need alerting to the patient safety team in a timely manner. Exclude and investigate through the Patient Safety Incident Response Framework (PSIRF) This change is supported by the Associate Medical Director for Patient Safety.

- **CQC Alert** – low numbers. Continue

- **Diagnosis group** – HSMR and SHMI notifications of any outliers. Continue

- **External request** – have been several years old and usually get shared from other Trusts who have already done an SJR and shared the outcome with us. No repeat SJR. If concerns, manage through patient safety.

- **Internal request** – usually through the ME office. Should agree to share their scrutiny and specific concerns which can be used as a Medical Case Review and graded by the Mortality Steering Group accordingly and brought to mortality meeting. Again, if patient safety concerns raised, and not reached threshold for coroner involvement, should go through patient safety team and learning shared.

Title of Meeting	**Trust Board**			**Date**	28 January 2026
Agenda Item	**TB26/010**				
Report Title	National Quality Board Nurse Establishment Reviews				
Executive Lead	Sarah O'Brien, Chief Nursing Officer				
Presenting Officer	Sarah O'Brien, Chief Nursing Officer				
Action Required	X	**To Approve**		**To Note**	

Purpose

To inform Board of the outcomes and recommendations following completion of bi-annual establishment review using the Safer Nurse Care Tool (SNCT) in line with National Institute for Health and Care Excellence (NICE) Guidance and National Quality Board (NQB) recommendations.

Executive Summary

This paper aims to provide assurance that Mersey and West Lancashire NHS Teaching Hospitals (MWL) has arrangements in place to review the nursing and midwifery establishments in line with regulatory requirements.

The paper details the outcome of the bi-annual establishment reviews for November 2025 for acute inpatient wards based on the configuration and clinical pathways currently in place, providing the assessment of current staffing levels, using a nationally recognised nurse to patient ratio methodology (SNCT), and is based on the established bed capacity only.

The safe staffing reviews used a triangulated approach aligned to NQB recommendations which included a check on right staff, right skills, right place and time, with relevant workforce information and the patient safety, patient experience and clinical effectiveness indicators for each specific clinical area (NQB Safe sustainable and productive staffing, 2016)

Furthermore, the Trust has been undertaking a process since 2024 to determine the correct ratio of band 2 and band 3 Healthcare Assistants (HCAs) using a Banding Resolution Framework agreed with the Trade Unions and approved by the Trust Executive team in 2024. It was agreed that the establishment review in November 2025 would include a determination of the correct ratio of band 2 and band 3 HCAs per inpatient ward and other clinical areas using the evidence-based approach of the SNCT. The recommended ratios for band 2 and band 3 HCAs are presented in this paper for approval.

Financial Implications

B2-3 budget uplift in Divisions from 01 April 2026

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to:

1. Note the assurance regarding Trust compliance with the NQB recommendations
2. Approve continuation of current nurse staffing establishments
3. Note the areas for further review during the next safe staffing review in May 2026

4. Approve the recommended Band 2 and Band 3 ratios for each clinical area and note the associated risks with implementation of these ratios. 5. Note the ongoing operational pressures requiring additional escalation beds and the potential impact this has on safe staffing across the Trust	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

The purpose of this paper is to present the findings of the nurse staffing inpatient ward establishment review which was undertaken in November 2025 (data collection commenced in September 2025) for all 48 inpatient wards across MWL.

There is a plethora of evidence that registered nurse staffing levels correlate with level of care, mortality and morbidity both directly and indirectly. Furthermore, recurrent short staffing results in increased staff stress and reduced staff wellbeing, leading to higher sickness absence (needing more bank and agency cover), and more staff leaving.

NHS providers are expected to have the right people, with the right skills, in the right place at the right time to achieve safer nursing and midwifery staffing in line with the recommendations of the National Quality Board (NQB, 2016). The NQB states that providers:

- Must deploy sufficient suitable qualified, competent, skilled, and experienced staff to meet treatment needs of patients safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required and keep them safe at all times.
- Must use an approach that the reflects current legislation.
- Boards should carry out a strategic staffing review at least annually

This paper provides Board with assurance that the Trust has a clear validated process for monitoring and ensuring safe staffing levels in line with national guidance and regulatory expectations.

It presents the outcomes of the establishment review conducted in November 2025 and any related recommendations pertaining to nurse staffing establishments.

2. Background

The aim of the establishment review is to consider nurse staffing and skill mix across inpatient areas against patient acuity using the SNCT which is a nationally recognised and evidence-based tool. Other factors relevant to MWL that have influenced the review include:

- Recognising that the establishment alignment post transaction, is ongoing and to make recommendations for consideration of any required changes to the wards funded establishments.
- Standardising our approach to nurse staffing establishments to ensure nationally mandated reviews, latest staffing guidance for clinical wards from NICE guidance, NHSi guidance (Developing Workforce Safeguards 2018) and the RCN nursing workforce standards (2021) are incorporated in the reviews.

- Recognise the National ongoing work that has been undertaken by the Trust to review the requirement for specific skillset across the Healthcare Assistant (HCA) workforce and align services to reflect the ratios required for band 2 and band 3 workers.

3. Methodology

The Safer Nursing Care Tool (SNCT:2023) data collection was undertaken throughout the month of September/October 2025. The SNCT is a NICE-endorsed evidence-based tool currently used in the NHS to identify safe staffing levels for:

- adult inpatient wards in acute hospitals
- adult acute assessment units
- children and young people's inpatient wards in acute hospitals

A national safe staffing tool for community nursing has been developed and is being piloted across the NHS. MWL have agreed to introduce this tool during 2026.

The SNCT calculates clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses in their safe staffing decisions. The tools:

- Provide organisational level metrics to monitor impact on the quality of patient care and outcomes
- Give a defined measure of patient acuity and dependency
- Are able to support benchmarking activity in organisations when used across trusts
- Embrace all the principles that should be considered when evaluating decision support tools set out in the relevant NHSE/I 'Safe, sustainable and productive staffing' resources
- Include staffing multipliers to support professional judgement
- Provide accurate data collection methodology

The data collection tool was reviewed in 2023 by the Shelford Group (original developers of SNCT) and updated to reflect the care needs for patients who needed additional support to maintain their safety and this was captured as levels 1c and 1d. SNCT care level 1c reflects patients requiring continuous observation as per local policy to maintain patient safety, with 1d highlighting the need for continuous monitoring of patients who pose a significant risk to themselves or others if left unsupported, and this safe care can only be safely delivered by 2 members of staff. This change to the tool was necessary because across the trust, we continue to see an increase in the complexity of patients being admitted who require additional care to maintain their safety particularly in relation to cognitive impairment. MWL adopted the updated version of SNCT in 2024.

Once the data had been collated, the information and findings were validated by the specialty matrons, to give assurance that the information was captured accurately.

The Divisional Nurse/Midwife/AHP Directors reviewed the information gathered, and using professional judgement, signed off divisional submissions and approved any additional requirements across their respective services for inclusion in the full staffing establishment paper. These submissions were then reviewed by the Chief Nurse who met with the Divisional leads to scrutinise the data and recommendations prior to her final approval.

The establishment review currently does not take into consideration the use of escalation beds. However, it is recognised that additional temporary staffing has been utilised regularly to safely manage the opening of additional beds in times of extreme bed pressures.

4. Care Hours Per Patient per Day (CHpPD)

CHPPD produces a single comparable figure that represents both staffing levels and patient requirements, unlike actual hours or patient requirements.

CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is reported as a total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix.

$$\textbf{Care Hours per Patient Day} = \frac{\text{Total hours of nurses and midwives plus total hours of care support workers}}{\text{Total number of inpatients}}$$

CHpPD was reported as 7.5 for Whiston and St Helens sites, overall figure for Southport and Ormskirk sites in September 2025 was 8.7. The national benchmark is 7.0.

Variations in CHpPD have been identified as due to different working arrangements. This breakdown identifies the following variances that still require harmonisation across sites:

- Differences in baseline staffing levels in some areas
- Inconsistencies in skill mix requiring alignment across sites, including band 6 provision.
- Differences in break allowance during 12-hour shifts. (Consultation to harmonise this commenced in November 2025)
- Variations in the provision of hostess and housekeeper roles.
- Differences in ward layouts across sites.
- HCA Band 2-3 ratio variances

5. Establishment review outcome summary by Division

Below summarises the current position of the nursing establishments following the divisional review in November 2025.

Medicine and Urgent Care Division:

There are no recommended changes to current establishments from this review, but Board is asked to note the following areas that require further consideration / evaluation ahead of the next establishment review:

- In February 2025 the Trust Executive Committee approved an establishment uplift of an additional **41.8 WTE** B2 HCA investment on the Whiston site for the top 5 user wards for supplementary care. This additional resource has supported the Division to cease HCA agency use but additional anticipated benefits identified in the Divisional Business case of February 2024 have not yet been realised.
- SNCT highlights high level of patient need and requirement for additional HCA on days and nights for wards 10A and 7B at Southport and this triangulates with unregistered nursing fill rate in monthly staffing reports, 12-month average of 132% (115% days to 170% nights).
- It is recommended that further evaluation is required of the additional HCA investment and the ETOC (Enhanced Therapeutic Observations) pilot before there is a recommendation to increase the established HCA numbers on these wards and this will be included as part of the Divisions next Establishment Review in May 2026.
- The staffing of NIV (Non-invasive Ventilation) beds needs a formal review and will be picked up in the May establishment review.

Surgical Care Division:

There are no recommended changes to current establishments from this review, but Board is asked to note:

- Following the completion and approval of January 2025 establishment reviews for inpatient areas the surgical division realigned existing funding between the wards which in total was a reduction of 1.15 RN and an increase in HCA 1.32 wte across the division.
- Due to the 3-month lead time for any amendments to rosters to go live, these changes were not reflective until the roster period commencing 22 September 2025 and therefore SNCT data collection was limited against new roster templates. The division will maintain scrutiny against these templates, monitoring any amendments, patient safety alerts and staffing challenges until the next establishment review which will enable us to provide a robust review against these live templates.
- **Theatres and Critical Care:** SNCT data collection is designed for inpatient areas and assessment units only. As such, additional departments/specialties such as Theatres and Critical Care require establishment reviews, which are currently underway. This will be completed by the Division by the next establishment review

Clinical Support Services and Community Division

There are no recommended changes to current establishments from this review.

Women and Children's Division

There are no recommended changes to current establishments from this review, but Board is asked to note the following:

- **Maternity -** there is an existing requirement regarding triage midwives that the Division have identified resource from Community Team that can be realigned
- Birth Rate Plus Workforce review to be completed by Q4 2025/26 and some requirements are anticipated from this based on new national requirements
- **Paediatrics -** Full detailed review of paediatric services across MWL including Chobs is required as there are differing staffing ratios across sites. This will be completed as part of a future establishment review.

Trust wide, a review of 'headroom' allowance within the nursing establishments is overdue and will be picked up in the May 2026 establishment review process. Additionally, the CNO is planning to lead some improvement work in 2026 regarding utilisation of HCA across all inpatient wards as it is evident there is variation in approach to HCA use with a heavy reliance on the use of bank shifts for HCAs.

6. HCA 2/3 Banding Resolution Framework

Nationally, a formal grievance raised by UNISON in December 2017 relating to banding of HCA's resulted in protracted negotiations for many trusts including MWL. In 2024 the trust approved a Banding Resolution Framework. This supported the backpay for B2 HCA workers who could provide evidence of performing clinical duties going back to April 2018 as a maximum and staff had to indicate their preferences for a band 2 or band 3 role going forward. The process has been challenging and protracted but the trust is now ready to consult with affected staff about their future role. To do this, it is necessary to understand the requirements for each clinical area of band 2 and band 3 HCA roles.

It was agreed at Executive Committee, that the future requirements for Band 2 and 3 HCA's would be determined as part of the November establishment reviews. Consequently, the overall request for band 3 HCAs across the Trust has increased from an average of **19% Band 3 to 71%.** Please note the proposed overall ratio for in-patient areas only for band 3s to Band 2 is **64%:36%.** This recommendation benchmarks with other trusts regionally and nationally.

A full breakdown of ratios requested by each division is presented in Appendix 1, 2, 3, 4.

Table 1 – Highlights the current Band 2/3 WTE with a percentage of Band 3 at 21.78% versus the proposed Band 2/3 WTE with a percentage increase to 75.70% (Trust Wide Ratio)

Board is asked to approve these recommended ratios so that the necessary consultation can commence with affected staff.

T*able 1*

Division	Current Band 2	Current Band 3	Total	% Band 3	Proposed Band 2	Proposed Band 3	Total	% Band 3	Cost of Uplift
CSS & Community	129.24	105.12	234.36	44.85	69.53	167.26	236.79	70.64	81,096
Medicine	614.43	74.23	688.66	10.78	205.18	484.28	689.46	70.24	535,111
Surgery	353.79	69.56	423.35	16.43	66.60	356.75	423.35	84.27	521,577
Women & Children's	66.20	75.20	141.40	53.18	21.52	119.88	141.40	84.78	58,302
Corporate	-	2.00	2.00	100	-	2.00	2.00	100	-
Total	**1,163.66**	**326.11**	**1,489.77**	**21.89**	**362.83**	**1,130.17**	**1,493.00**	**75.70**	**1,196,086**

7. Risks

Agreeing appropriate nurse staffing establishments is a fundamental responsibility for trust boards to ensure safe, clinically effective care. However, recruiting the required numbers of staff is an ongoing risk that the trust continues to mitigate and the monthly staffing reports to the Executive Committee provide assurance regarding fill rates and triangulation with quality indicators. The key risks to safely staffing clinical areas in line with board approved establishments are:

- Absence for work attributed to sickness.
- Operational demand and requirement to open escalation beds
- Attrition rate for HCA workforce.
- Harmonisation of establishments across MWL sites to reduce variation.
- Ongoing requirements for Enhanced Therapeutic Care (supplementary care).

Band 2 and Band 3 HCA Ratios

If Board approve the recommended HCA band 2 and band 3 ratios the trust then needs to consult staff and fill these posts, but Board is asked to note that this process will be complex and is expected to take a long time to fully enact. The risks to filling the recommended band 2 and band 3 ratios are:

- Clinical areas require more band 3 staff than will be available from the framework process
- Current high level of band 2 vacancies
- Some staff may be required to move from their existing clinical area
- Financial impact of the increase in band 3 ratios (savings schemes will be developed to offset additional costs)

It is anticipated that the process to fill the HCA ratios may take as long as 24 months to complete and the impact on safe staffing will need to be mitigated and monitored through the monthly safe staffing reports to Executive Committee.

8. Recommendations

Trust Board is asked to:

1. Note the assurance regarding trust compliance with the NQB recommendations
2. Approve continuation of current nurse staffing establishments
3. Note the areas for further review during the next safe staffing review in May 2026
4. Approve the recommended Band 2 and band 3 ratios for each clinical area and note the associated risks with implementation of these ratios.
5. Note the ongoing operational pressures requiring additional escalation beds and the impact this has on safe staffing cross the trust

Appendix 1

CSS & Community

Purple column indicates Band 3 Ratio's

Key
No difference between Current % and Target
Current % of B3 FTE over Target
Current % of B3 FTE under Target

Team	Sum of B2 FTE	Conditional Offer B2	Booked Start Dates B2	Vacancies B2	FTE Budget B2	Sum of B3 FTE	Conditional Offer B3	Booked Start Dates B3	Vacancies B3	FTE Budget B3	Sum of Total FTE	Sum of Pipeline FTE	Sum of FTE Budget	Target % of B3 FTE	% of B3 FTE	Difference	WTE Difference	Required B2	Required B3	B2 Change to B3	Cost of Change
409 355375 Duffy Suite Intermediate Care Team	2.09	2.20	0.00	0.00	16.51	12.76	0.00	0.00	0.00	2.00	14.85	2.20	18.51	30.00%	68.94%	-38.94%	- 7.21	12.96	5.55	3.55	4,636.67
409 355453 Newton Intermediate Care Team	17.24	0.00	1.00	0.91	17.18	5.00	0.00	0.00	0.00	6.00	22.24	1.91	23.18	30.00%	21.57%	8.43%	1.95	16.23	6.95	0.95	1,244.97
409 355903 Seddon Suite Trauma Rehab Team	4.03	0.00	0.00	2.77	18.73	11.23	0.00	0.00	0.00	0.00	15.25	2.77	18.73	20.00%	59.94%	-39.94%	- 7.48	14.98	3.75	3.75	4,888.53
Division Total	23.36	2.20	1.00	3.68	52.42	28.99	0.00	0.00	0.00	8.00	52.35	6.88	60.42	**26.90%**			- 12.73	44.17	16.25	8.25	10,770.17
409 355111 Lilac Centre & Cancer Services Admin Team	0.00	0.00	0.00	0.00	0.00	4.75	0.00	0.00	0.00	4.75	4.75	0.00	4.75	100.00%	99.93%	0.07%	0.00	-	4.75	-	-
409 355433 COPD St Helens Team	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00	2.00	2.00	0.00	2.00	100.00%	100.00%	0.00%	-	-	2.00	-	-
409 355444 Sexual Health St Helens Team	0.00	0.00	0.00	0.00	0.00	1.75	0.00	0.00	0.00	4.20	1.75	0.00	4.20	100.00%	41.59%	58.41%	2.45	-	4.20	-	-
409 355456 Marshalls Cross Medical Centre Team	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00	1.00	0.00	1.00	100.00%	100.00%	0.00%	-	-	1.00	-	-
409 355461 Urgent Treatment Centre Team	0.00	0.00	0.00	0.00	0.00	1.80	0.00	0.00	0.00	1.80	1.80	0.00	1.80	100.00%	100.00%	0.00%	-	-	1.80	-	-
409 355462 IV Therapy St Helens Team	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00	1.00	0.00	1.00	100.00%	100.00%	0.00%	-	-	1.00	-	-
409 355464 Newton Hospital OPD Team	0.00	0.00	0.00	0.00	0.00	0.43	0.00	0.00	0.00	0.43	0.43	0.00	0.43	100.00%	99.23%	0.77%	0.00	-	0.43	-	-
409 355471 St Helens Central DN Team	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00	2.00	2.00	0.00	2.00	100.00%	100.00%	0.00%	-	-	2.00	-	-
409 355472 St Helens North DN Team	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00	1.00	0.00	1.00	100.00%	100.00%	0.00%	-	-	1.00	-	-
409 355473 St Helens South DN Team	0.00	0.00	0.00	0.00	0.00	3.40	0.00	0.00	0.00	3.40	3.40	0.00	3.40	100.00%	100.00%	0.00%	-	-	3.40	-	-
409 355474 St Helens OOH DN Team	0.92	0.00	0.00	0.00	0.92	3.37	0.00	0.00	0.00	3.37	4.29	0.00	4.29	100.00%	78.63%	21.37%	0.92	-	4.29	0.92	1,200.60
409 355475 St Helens Haydock & Newton DN Team	0.00	0.00	0.00	0.00	0.00	1.60	0.00	0.00	0.00	2.00	1.60	0.00	2.00	100.00%	80.00%	20.00%	0.40	-	2.00	-	-
409 355476 St Helens Contact Cares Nursing Team	0.00	0.00	0.00	0.00	0.00	0.43	0.00	0.00	0.00	0.00	0.43	0.00	0.00	100.00%	100.00%	0.00%	-	-	0.43	0.43	561.15
409 355486 Community Matrons Team	0.00	0.00	0.00	0.00	0.00	1.60	0.00	0.00	0.00	1.60	1.60	0.00	1.60	100.00%	100.00%	0.00%	-	-	1.60	-	-
409 355701 Radiography Whiston Team	13.69	0.00	0.00	0.00	19.98	24.03	0.00	0.00	0.00	22.03	37.72	0.00	42.01	70.00%	57.21%	12.79%	5.37	12.60	29.41	7.38	9,626.99
409 355901 OPD St Helens Team	0.80	0.00	0.00	0.00	22.81	17.00	0.00	2.00	0.00	0.00	17.80	2.00	22.81	100.00%	83.30%	16.70%	3.81	-	22.81	22.81	29,767.05
409 355902 OPD Whiston Team	0.80	0.00	0.00	0.00	10.92	10.60	1.00	1.00	1.00	4.20	11.40	3.00	15.12	100.00%	89.95%	10.05%	1.52	-	15.12	10.92	14,250.60
409 357504 Sexual Health Sefton NC Team	0.00	0.00	0.00	0.00	0.00	3.97	0.00	0.00	0.00	4.70	3.97	0.00	4.70	100.00%	84.54%	15.46%	0.73	-	4.70	-	-
409 357527 Radiology Southport Team	0.00	0.00	0.00	0.00	1.07	9.86	0.00	0.00	0.00	9.42	9.86	0.00	10.49	100.00%	93.99%	6.01%	0.63	-	10.49	1.07	1,396.35
409 357528 Community Diagnostic Centre Team	0.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.00	0.60	0.00	3.00	0.00%	0.00%	0.00%	-	3.00	-	- 3.00	- 3,915.00
409 357709 Intermediate Care Team	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00	1.00	0.00	1.00	100.00%	100.00%	0.00%	-	-	1.00	-	-
409 357715 Spinal Injuries Team	8.57	4.00	1.00	4.00	18.14	17.56	0.00	0.00	0.00	20.89	26.13	9.00	39.03	75.00%	44.99%	30.01%	11.71	9.76	29.27	8.38	10,939.16
409 357778 General Outpatients Southport & Ormskirk Team	0.00	0.00	0.00	0.00	2.98	10.91	0.00	0.00	0.00	3.33	10.91	0.00	6.31	100.00%	172.85%	-72.85%	- 4.60	-	6.31	2.98	3,888.90
Division Total	**25.38**	**4.00**	**1.00**	**4.00**	**76.82**	**121.05**	**1.00**	**3.00**	**1.00**	**97.12**	**146.44**	**14.00**	**173.94**	**85.46%**			22.95	25.36	149.01	51.89	67,715.80
409 355716 Microbiology Team	0.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00	0.00	2.00	0.00	100.00%	0.00%	100.00%	-	-	2.00	2.00	2,610.00
	48.74	**6.20**	**2.00**	**7.68**	**129.24**	**150.04**	**3.00**	**3.00**	**1.00**	**105.12**	**198.78**	**22.88**	**234.36**	**70.64%**			10.22	69.53	167.26	62.14	81,095.96

Appendix 2

Medicine & UEC

Purple column indicates Band 3 Ratio's

Key
No difference between Current % and Target
Current % of B3 FTE over Target
Current % of B3 FTE under Target

Team	Sum of B2 FTE	Conditional Offer B2	Booked Start Dates B2	Vacancies B2	FTE Budget B2	Sum of B3 FTE	Conditional Offer B3	Booked Start Dates B3	Vacancies B3	FTE Budget B3	Sum of Total FTE	Sum of Pipeline FTE	Sum of FTE Budget	Target % of B3 FTE	% of B3 FTE	Difference	WTE Difference	Required B2	Required B3	B2 Change to B3	Cost of Change
409 355380 Bevan Court 1 Team	4.25	1.00	0.00	2.80	24.37	18.15	0.00	0.00	0.00	1.00	22.39	3.80	25.37	70.00%	71.53%	-1.53%	0.39	7.61	17.76	16.76	21,870.50
409 355366 Bevan Court 2 Team	15.35	1.00	1.80	5.00	27.50	7.64	0.00	0.00	0.00	2.00	22.99	7.80	29.50	60.00%	25.90%	34.10%	10.06	11.80	17.70	15.70	20,488.50
409 355413 Ward 1A Team	16.84	0.00	0.61	3.84	29.46	7.68	0.00	0.00	0.00	0.00	24.52	4.45	29.46	60.00%	26.07%	33.93%	10.00	11.78	17.68	17.68	23,067.18
409 355308 Ward 1B AMU Team	8.20	0.00	0.00	0.00	18.00	9.99	0.00	0.00	0.00	1.00	18.19	0.00	19.00	80.00%	52.56%	27.44%	5.21	3.80	15.20	14.20	18,531.00
409 355307 Ward 1C AMU Team	7.28	0.00	0.00	0.00	19.60	13.64	0.00	0.00	0.00	0.00	20.92	0.00	19.60	70.00%	69.59%	0.41%	0.08	5.88	13.72	13.72	17,904.60
409 355434 Ward 1D Cardiology Team	5.00	0.00	0.00	0.00	16.85	10.44	0.00	0.00	0.00	1.00	15.44	0.00	17.85	60.00%	58.49%	1.51%	0.27	7.14	10.71	9.71	12,671.55
409 355408 Ward 1E CCU Team	0.00	0.00	0.00	0.00	6.18	4.20	0.00	0.00	0.00	0.00	4.20	0.00	6.18	100.00%	67.96%	32.04%	1.98	0.00	6.18	6.18	8,064.90
409 355439 Ward 2A Haematology Team	2.07	0.61	0.00	0.70	8.87	4.98	0.00	0.00	0.00	0.00	7.05	1.31	8.87	80.00%	56.11%	23.89%	2.12	1.77	7.10	7.10	9,260.28
409 355437 Ward 2B Respiratory Team	6.92	0.00	0.00	0.00	17.66	10.67	0.00	0.00	0.00	1.00	17.59	0.00	18.66	60.00%	57.16%	2.84%	0.53	7.46	11.20	10.20	13,305.78
409 355438 Ward 2C Respiratory Team	6.92	2.00	1.80	0.00	18.66	9.21	0.00	0.92	0.00	0.00	16.13	4.72	18.66	60.00%	54.31%	5.69%	1.06	7.46	11.20	11.20	14,610.78
409 355395 Ward 2D Respiratory Team	4.72	0.00	0.92	0.00	14.23	10.01	0.00	0.00	0.00	0.00	14.73	0.92	14.23	60.00%	70.37%	-10.37%	1.48	5.69	8.54	8.54	11,142.09
409 355452 Ward 3C General Medicine Team	16.35	4.00	0.00	0.00	29.45	6.75	0.00	0.00	0.00	0.00	23.09	4.00	29.45	60.00%	22.91%	37.09%	10.92	11.78	17.67	17.67	23,059.35
409 355436 Ward 3D Gastroenterology Team	4.80	0.00	0.00	0.00	16.45	9.63	0.00	0.00	0.00	1.40	14.43	0.00	17.85	60.00%	53.93%	6.07%	1.08	7.14	10.71	9.31	12,149.55
409 355382 Ward 5A COE Team	11.43	1.00	0.00	0.00	29.50	11.32	0.00	0.00	0.00	0.00	22.75	1.00	29.50	60.00%	38.37%	21.63%	6.38	11.80	17.70	17.70	23,098.50
409 355383 Ward 5B COE Team	9.13	3.00	0.00	0.00	27.50	14.13	0.00	0.00	0.00	2.00	23.27	3.00	29.50	60.00%	47.91%	12.09%	3.57	11.80	17.70	15.70	20,488.50
409 355387 Ward 5C HASU Step Down Team	9.20	1.00	0.00	0.00	21.28	12.04	0.00	0.00	0.00	1.00	21.24	1.00	22.28	60.00%	54.04%	5.96%	1.33	8.91	13.37	12.37	16,140.24
409 355381 Ward 5D Acute Stroke Team	4.40	0.00	0.00	0.00	24.03	16.05	0.00	0.00	0.00	0.00	20.45	0.00	24.03	60.00%	66.81%	-6.81%	1.64	9.61	14.42	14.42	18,815.49
409 357358 Ward 7A Team	10.31	0.00	0.00	0.00	14.57	4.16	0.00	0.00	0.00	0.00	14.47	0.00	14.57	60.00%	28.55%	31.45%	4.58	5.83	8.74	8.74	11,408.31
409 357359 Ward 7B DMOP Team	15.96	0.00	0.00	0.00	18.73	0.60	0.00	0.00	0.00	0.00	16.56	0.00	18.73	60.00%	3.20%	56.80%	10.64	7.49	11.24	11.24	14,665.59
409 357332 Ward 9A Team	8.56	0.00	0.00	0.00	15.78	8.52	0.00	0.00	0.00	0.00	17.08	0.00	15.78	60.00%	53.99%	6.01%	0.95	6.31	9.47	9.47	12,355.74
409 357315 11A Unit Team	5.00	0.00	1.00	0.00	7.92	6.24	0.00	0.00	0.00	5.50	11.24	1.00	13.42	60.00%	46.50%	13.50%	1.81	5.37	8.05	2.55	3,330.36
409 357314 Ward 11B Southport Team	11.24	0.00	0.00	0.00	18.78	7.20	0.00	0.00	0.00	0.00	18.44	0.00	18.78	60.00%	38.34%	21.66%	4.07	7.51	11.27	11.27	14,704.74
409 357300 Ward 14B Southport Team	13.47	0.00	0.00	0.00	18.78	2.79	0.00	0.00	0.00	0.00	16.25	0.00	18.78	60.00%	14.84%	45.16%	8.48	7.51	11.27	11.27	14,704.74
409 357312 Ward 15A General Med Team	12.80	0.00	0.00	0.00	18.73	1.80	0.00	0.00	0.00	0.00	14.60	0.00	18.73	60.00%	9.61%	50.39%	9.44	7.49	11.24	11.24	14,665.59
409 357313 Ward 15B Stroke Team	8.67	0.00	0.00	0.00	19.54	10.16	0.00	0.00	0.00	0.00	18.83	0.00	19.54	60.00%	52.00%	8.00%	1.56	7.82	11.72	11.72	15,299.82
409 357316 Ward 1 Escalation Team	3.64	0.00	0.00	0.00	5.40	0.00	0.00	0.00	0.00	0.00	3.64	0.00	5.40	100.00%	0.00%	100.00%	5.40	0.00	5.40	5.40	7,047.00
409 357328 Emergency Assessment Team	13.75	0.00	0.00	0.00	18.78	6.56	0.00	0.00	0.00	0.00	20.31	0.00	18.78	80.00%	34.93%	45.07%	8.46	3.76	15.02	15.02	19,606.32
409 357357 FESS Team	17.49	0.00	0.00	0.00	18.73	2.92	0.00	0.00	0.00	0.00	20.41	0.00	18.73	60.00%	15.59%	44.41%	8.32	7.49	11.24	11.24	14,665.59
Division Total	**253.73**	**13.61**	**6.13**	**12.34**	**525.33**	**227.47**	**0.00**	**0.92**	**0.00**	**15.90**	**491.20**	**33.00**	**541.23**	**63.41%**			**114.81**	**198.03**	**343.20**	**327.30**	**427,122.59**
409 355303 A&E Nursing Team	9.88	0.92	0.00	1.00	44.57	23.59	0.00	0.00	1.00	0.00	33.47	2.92	44.57	100.00%	55.16%	44.84%	19.98	0.00	44.57	44.57	58,163.85
409 355388 Virtual Ward Hub Team	0.00	0.00	0.00	0.00	0.00	0.80	0.00	0.00	0.00	0.00	0.80	0.00	0.00	100.00%	0.00%	100.00%	-	0.00	0.80	0.80	1,044.00
409 355392 Rheumatology OPD Nursing Team	0.00	0.00	0.00	0.00	0.80	3.80	0.00	0.00	1.00	3.00	3.80	1.00	3.80	100.00%	126.32%	-26.32%	1.00	0.00	3.80	0.80	1,044.00
409 355801 Catheter Lab Team	0.00	0.00	0.00	0.00	1.20	0.80	0.00	0.00	0.00	0.00	0.80	0.00	1.20	100.00%	66.67%	33.33%	0.40	0.00	1.20	1.20	1,566.00
409 355396 Endoscopy Unit Whiston Team	3.00	0.00	0.00	0.00	15.23	14.51	0.00	0.00	0.00	5.80	17.51	0.00	21.03	100.00%	68.98%	31.02%	6.52	0.00	21.03	15.23	19,875.15
409 355426 Diabetes Nursing Team	0.00	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	100.00%	100.00%	0.00%	-	0.00	1.00	1.00	1,305.00
409 355429 Dermatology Team	0.00	0.00	0.00	0.00	0.00	2.20	0.00	0.00	0.00	4.80	2.20	0.00	4.80	100.00%	45.83%	54.17%	2.60	0.00	4.80	0.00	-
409 355602 Transfer Lounge Team	2.59	1.00	1.00	0.00	4.37	0.00	0.00	0.00	0.00	0.00	2.59	2.00	4.37	0.00%	0.00%	0.00%	-	4.37	0.00	0.00	-
409 357326 A&E Nursing Southport Team	4.16	0.00	0.00	1.00	10.73	12.04	0.00	0.00	0.00	16.10	16.20	1.00	26.83	100.00%	44.88%	55.12%	14.79	0.00	26.83	10.73	14,002.65
409 357329 Ambulatory Care Team	0.00	0.00	0.00	0.00	4.22	6.16	0.00	0.00	0.00	1.15	6.16	0.00	5.37	100.00%	114.71%	-14.71%	0.79	0.00	5.37	4.22	5,507.10
409 357336 Medical Discharge Lounge Team	0.80	0.00	0.00	0.00	2.78	0.00	0.00	0.00	0.00	0.00	0.80	0.00	2.78	0.00%	0.00%	0.00%	-	2.78	0.00	0.00	-
409 357369 Medical Day Unit Team	0.00	0.00	0.00	0.00	0.00	3.47	0.00	0.00	0.00	3.47	3.47	0.00	3.47	100.00%	99.90%	0.10%	0.00	0.00	3.47	0.00	-
409 357519 A&E Paediatric Team	0.00	0.00	0.00	0.00	0.00	8.32	0.00	0.00	0.00	8.32	8.32	0.00	8.32	100.00%	100.00%	0.00%	-	0.00	8.32	0.00	-
409 357755 Endoscopy Unit Southport Team	0.00	0.00	0.00	0.00	0.00	7.55	0.00	0.76	0.00	12.77	7.55	0.76	12.77	100.00%	65.05%	34.95%	4.46	0.00	12.77	0.00	-
409 357760 Dermatology Outpatient Team	0.60	0.00	0.00	0.00	4.20	4.31	1.00	0.00	0.00	2.92	4.91	1.00	7.12	100.00%	74.53%	25.47%	1.81	0.00	7.12	4.20	5,481.00
Division Total	**21.03**	**1.92**	**1.00**	**2.00**	**89.10**	**88.53**	**1.00**	**0.76**	**2.00**	**58.33**	**109.56**	**8.68**	**147.43**	**95.18%**			**48.79**	**7.15**	**141.08**	**82.75**	**107,988.75**
	274.76	**15.53**	**7.13**	**14.34**	**614.43**	**316.00**	**1.00**	**1.68**	**2.00**	**74.23**	**590.76**	**41.68**	**688.66**	**70.24%**	**46.57%**	**23.67%**	**163.59**	**205.18**	**484.28**	**410.05**	**535,111.34**

Appendix 3

Surgery

Purple column indicates Band 3 Ratio's

Key
No difference between Current % and Target
Current % of B3 FTE over Target
Current % of B3 FTE under Target

Team	Sum of B2 FTE	Conditional Offer B2	Booked Start Dates B2	Vacancies B2	FTE Budget B2	Sum of B3 FTE	Conditional Offer B3	Booked Start Dates B3	Vacancies B3	FTE Budget B3	Sum of Total FTE	Sum of Pipeline FTE	Sum of FTE Budget	Target % of B3 FTE	% of B3 FTE	Difference	WTE Difference	Required B2	Required B3	B2 Change to B3	Cost of Change
409 355010 Ward 3A Plastics Team	1.00	0.00	0.00	0.00	13.60	12.16	0.00	0.00	0.00	3.35	13.16	0.00	16.95	80.00%	71.74%	8.26%	1.40	3.39	13.56	10.21	13,324.05
409 355011 Ward 4D Burns Team	0.00	0.00	0.00	0.00	10.73	4.68	0.00	0.00	0.00	0.00	4.68	0.00	10.73	100.00%	43.62%	56.38%	6.05	-	10.73	10.73	14,002.65
409 355074 Ward 4F T&O Team	6.41	0.00	0.00	1.00	11.48	1.60	0.00	0.00	0.00	1.00	8.01	1.00	12.48	100.00%	12.82%	87.18%	10.88	-	12.48	11.48	14,981.40
409 355075 Ward 3B T&O Team	10.92	0.00	0.00	0.00	17.78	5.80	0.00	0.00	0.00	1.00	16.72	0.00	18.78	70.00%	30.88%	39.12%	7.35	5.63	13.15	12.15	15,850.53
409 355076 Ward 3Alpha T&O Team	3.00	0.00	1.00	0.00	13.30	7.00	0.00	0.00	0.00	1.00	10.00	1.00	14.30	70.00%	48.95%	21.05%	3.01	4.29	10.01	9.01	11,758.05
409 355101 Ward 4A General Surgery Team	5.88	0.00	0.00	0.00	16.10	8.80	0.00	0.00	0.00	0.00	14.68	0.00	16.10	70.00%	54.66%	15.34%	2.47	4.83	11.27	11.27	14,707.35
409 355102 Ward 4B General Surgery Team	0.00	0.00	0.00	0.00	14.07	12.68	0.00	0.00	0.00	3.60	12.68	0.00	17.67	100.00%	71.76%	28.24%	4.99	-	17.67	14.07	18,361.35
409 355103 Ward 4C General Surgery Team	2.60	0.00	0.00	1.00	14.70	12.20	0.00	0.00	0.00	1.40	14.80	1.00	16.10	70.00%	75.78%	-5.78%	0.93	4.83	11.27	9.87	12,880.35
409 357745 Orthopaedic Rehab Team	14.16	0.00	0.00	5.74	22.86	4.92	0.00	0.00	0.00	0.96	19.08	5.74	23.82	30.00%	20.65%	9.35%	2.23	16.67	7.15	6.19	8,072.73
409 357746 Elective Orthopaedics Team	1.00	0.00	0.00	0.00	4.69	2.76	0.00	0.00	0.00	2.76	3.76	0.00	7.45	100.00%	37.05%	62.95%	4.69	-	7.45	4.69	6,120.45
409 357748 Ward 14A Team	15.12	0.00	0.00	1.70	19.17	6.84	0.00	0.00	0.00	4.49	21.96	1.70	23.66	50.00%	28.91%	21.09%	4.99	11.83	11.83	7.34	9,578.70
409 357749 Short Stay Surgical Unit Team	2.56	0.00	0.00	0.00	16.15	14.04	0.00	0.00	0.00	3.88	16.60	0.00	20.03	70.00%	70.09%	-0.09%	0.02	6.01	14.02	10.14	13,234.01
Division Total	**62.65**	**0.00**	**1.00**	**9.44**	**174.63**	**93.48**	**0.00**	**0.00**	**0.00**	**23.44**	**156.13**	**10.44**	**198.07**	**70.98%**			**47.10**	**57.49**	**140.58**	**117.14**	**152,871.62**
409 355142 Theatres St Helens Team	5.80	0.00	0.00	0.00	22.49	14.24	0.00	0.00	0.00	0.00	20.04	0.00	22.49	100.00%	63.32%	36.68%	8.25	-	22.49	22.49	29,349.45
409 355143 Acute Pain Team	3.00	0.00	0.00	0.00	7.90	0.00	0.00	0.00	0.00	0.00	3.00	0.00	7.90	0.00%	0.00%	0.00%	-	7.90	-	-	-
409 355158 Theatres Materials Mgmt Team	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00%	0.00%	0.00%	-	-	-	-	-
409 355168 Theatres Whiston Team	10.67	0.00	0.00	0.00	54.85	44.39	0.00	0.00	0.00	2.00	55.06	0.00	56.85	100.00%	78.08%	21.92%	12.46	-	56.85	54.85	71,579.25
409 355321 Ward 4E ICU Team	1.00	0.00	0.00	0.00	11.55	8.88	0.00	0.00	0.00	0.00	9.88	0.00	11.55	100.00%	76.88%	23.12%	2.67	-	11.55	11.55	15,072.75
409 357711 Critical Care Team	2.92	0.00	2.00	0.00	5.01	3.60	0.00	0.00	0.00	6.49	6.52	2.00	11.50	100.00%	31.30%	68.70%	7.90	-	11.50	5.01	6,538.05
409 357713 Critical Care Outreach Team	0.00	0.00	0.00	0.00	0.40	0.80	0.00	0.00	0.00	0.80	0.80	0.00	1.20	100.00%	66.67%	33.33%	0.40	-	1.20	0.40	522.00
409 357718 Pre-Op Assessment Team	0.00	0.00	0.00	0.00	0.00	2.40	0.00	0.00	0.00	2.40	2.40	0.00	2.40	100.00%	100.00%	0.00%	-	-	2.40	-	-
409 357720 Theatres General Team	5.31	0.00	0.00	0.00	12.13	14.93	0.00	0.00	0.00	13.59	20.24	0.00	25.72	100.00%	58.06%	41.94%	10.79	-	25.72	12.13	15,829.65
409 357730 Theatres Southport Team	7.27	0.00	0.00	0.00	12.94	9.35	0.00	0.00	0.00	6.00	16.61	0.00	18.94	100.00%	49.35%	50.65%	9.59	-	18.94	12.94	16,886.70
Division Total	**36.96**	**0.00**	**2.00**	**0.00**	**127.27**	**98.59**	**0.00**	**0.00**	**0.00**	**31.28**	**135.55**	**2.00**	**168.55**	**95.02%**			**52.06**	**7.90**	**169.65**	**236.51**	**308,648.47**
409 357768 Maxillofacial Team	0.00	0.00	0.00	0.43	0.43	0.00	0.00	0.00	0.00	0.00	0.00	0.43	0.43	100.00%	0.00%	100.00%	0.43	-	0.43	0.43	561.15
409 355006 B&P Holbrook Unit Team	0.00	0.00	0.00	0.00	1.60	2.60	0.00	0.00	0.00	0.00	2.60	0.00	1.60	100.00%	162.50%	-62.50%	1.00	-	1.60	1.60	2,088.00
409 355008 Plastics Trauma Team	0.00	0.00	0.00	0.00	1.71	1.51	0.00	0.00	0.00	0.00	1.51	0.00	1.71	100.00%	88.11%	11.89%	0.20	-	1.71	1.71	2,231.55
409 355015 PSDU St Helens Team	0.00	0.00	0.00	0.00	1.35	1.00	0.00	0.00	0.00	0.00	1.00	0.00	1.35	100.00%	74.07%	25.93%	0.35	-	1.35	1.35	1,761.75
409 355016 PSDU Southport Team	1.00	0.00	0.00	0.00	1.21	0.00	0.00	0.00	0.00	0.00	1.00	0.00	1.21	0.00%	0.00%	0.00%	-	1.21	-	-	-
409 355024 Ophthalmology Rennie Eye Clinic Team	4.69	0.00	0.00	0.00	9.32	3.84	0.00	0.00	0.00	0.75	8.53	0.00	10.07	100.00%	38.13%	61.87%	6.23	-	10.07	9.32	12,162.60
409 355077 Trauma Coordinators Team	0.00	0.00	0.00	0.00	1.80	1.80	0.00	0.00	0.00	0.00	1.80	0.00	1.80	100.00%	100.00%	0.00%	-	-	1.80	1.80	2,349.00
409 355078 Fracture Clinic Team	1.00	0.00	1.00	0.00	2.00	1.00	0.00	0.00	0.00	0.00	2.00	1.00	2.00	100.00%	50.00%	50.00%	1.00	-	2.00	2.00	2,610.00
409 355086 Breast Surgery Team	0.00	0.00	0.00	0.00	3.11	2.69	0.00	0.00	0.00	0.00	2.69	0.00	3.11	100.00%	86.60%	13.40%	0.42	-	3.11	3.11	4,058.55
409 355087 Stoma Nurse Specialist Team	0.00	0.00	0.00	0.00	0.60	0.60	0.00	0.00	0.00	0.00	0.60	0.00	0.60	100.00%	100.00%	0.00%	-	-	0.60	0.60	783.00
409 355088 Surgical PreOp Team	0.00	0.00	0.00	0.00	0.00	6.40	0.00	0.00	0.00	6.60	6.40	0.00	6.60	100.00%	96.97%	3.03%	0.20	-	6.60	-	-
409 355095 Urology Suite Whiston Team	0.80	0.00	0.00	0.00	3.20	2.20	0.00	0.00	0.00	1.00	3.00	0.00	4.20	100.00%	52.38%	47.62%	2.00	-	4.20	3.20	4,176.00
409 355097 Sanderson Suite Surgery Team	0.60	0.00	0.00	0.00	16.41	13.20	0.00	0.00	0.00	2.00	13.80	0.00	18.41	100.00%	71.70%	28.30%	5.21	-	18.41	16.41	21,415.05
409 357747 Day Case Team	0.00	0.00	0.00	0.00	0.73	2.72	0.00	0.00	0.00	2.10	2.72	0.00	2.83	100.00%	96.11%	3.89%	0.11	-	2.83	0.73	952.65
409 357753 Fracture Clinic Southport Team	0.60	0.00	0.00	0.00	2.40	2.80	0.00	0.00	0.00	0.91	3.40	0.00	3.31	100.00%	84.59%	15.41%	0.51	-	3.31	2.40	3,132.00
409 357760 Pain Service Team	0.00	0.00	0.00	0.00	0.00	0.60	0.00	0.00	0.00	0.60	0.60	0.00	0.60	100.00%	100.00%	0.00%	-	-	0.60	-	-
409 357774 ENT & Eye Team	0.00	0.00	0.00	0.00	6.02	6.48	0.00	0.00	0.00	0.88	6.48	0.00	6.90	100.00%	93.91%	6.09%	0.42	-	6.90	6.02	7,856.10
Division Total	**8.69**	**0.00**	**1.00**	**0.00**	**51.46**	**49.44**	**0.00**	**0.00**	**0.00**	**14.84**	**58.13**	**1.00**	**66.30**	**98.17%**			**15.65**	**1.21**	**65.09**	**45.59**	**59,494.95**

Appendix 4

Women's & Children's

Purple column indicates Band 3 Ratio's

Key
No difference between Current % and Target
Current % of B3 FTE over Target
Current % of B3 FTE under Target

Team	Sum of B2 FTE	Conditional Offer B2	Booked Start Dates B2	Vacancies B2	FTE Budget B2	Sum of B3 FTE	Conditional Offer B3	Booked Start Dates B3	Vacancies B3	FTE Budget B3	Sum of Total FTE	Sum of Pipeline FTE	Sum of FTE Budget	Target % of B3 FTE	% of B3 FTE	Difference	WTE Difference	Required B2	Required B3	B2 Change to B3	Cost of Change
409 355054 Ward 3E Gynaecology Team	3.20	0.00	0.00	1.00	12.19	6.60	0.00	0.00	2.60	0.53	9.80	3.60	12.72	100.00%	72.33%	27.67%	3.52	-	12.72	12.19	15,907.95
409 355348 Ward 3F Paediatrics Team	1.31	1.17	0.80	0.00	11.00	4.34	0.00	0.00	0.00	0.00	5.65	1.97	11.00	100.00%	39.45%	60.55%	6.66	-	11.00	11.00	14,355.00
409 357511 Paediatric Ward Ormskirk Team	0.00	0.00	0.00	0.00	0.00	9.88	0.00	0.00	0.00	9.77	9.88	0.00	9.77	100.00%	101.13%	-1.13%	-0.11	-	9.77	-	-
409 357742 Surgical & Gynae Assessment Team	0.00	0.00	0.00	0.00	3.17	6.49	0.00	0.00	0.00	3.95	6.49	0.00	7.12	100.00%	91.20%	8.80%	0.63	-	7.12	3.17	4,136.85
Division Total	**4.51**	**1.17**	**0.80**	**1.00**	**26.36**	**27.31**	**0.00**	**0.00**	**2.60**	**14.25**	**31.82**	**5.57**	**40.61**	**100.00%**			**10.70**	**-**	**40.61**	**26.36**	**34,399.80**
409 355043 Gynaecology OPD Whiston Team	0.40	0.40	0.00	0.00	2.43	1.80	0.00	0.00	0.00	0.00	2.20	0.40	2.43	100.00%	74.07%	25.93%	0.63	-	2.43	2.43	3,171.15
409 355044 Gynaecology OPD St Helens Team	0.00	0.00	0.00	0.00	1.94	8.60	0.00	0.00	0.00	9.00	8.60	0.00	10.94	100.00%	78.61%	21.39%	2.34	-	10.94	1.94	2,531.70
409 355045 Community Midwifery Whiston Team	0.00	0.00	0.00	0.00	0.00	4.00	0.00	0.00	0.00	5.60	4.00	0.00	5.60	100.00%	71.43%	28.57%	1.60	-	5.60	-	-
409 355046 Womens OPD Team	1.00	0.00	0.00	0.00	5.07	3.40	0.00	0.00	0.00	0.00	4.40	0.00	5.07	80.00%	67.06%	12.94%	0.66	1.01	4.06	4.06	5,293.08
409 355047 Delivery Suite Whiston Team	4.63	2.00	1.00	2.52	11.55	1.40	0.00	0.00	0.00	0.00	6.03	5.52	11.55	0.00%	12.12%	-12.12%	-1.40	11.55	-	-	-
409 355052 Infant Feeding Team	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	1.00	1.00	0.00	1.00	100.00%	100.00%	0.00%	-	-	1.00	-	-
409 355053 Ward 2E Maternity Team	1.00	0.00	0.00	0.00	5.62	20.75	0.00	0.00	0.00	19.56	21.75	0.00	25.18	100.00%	82.39%	17.61%	4.43	-	25.18	5.62	7,334.10
409 355343 Ward Paediatric Day Case Team	0.00	0.00	0.00	0.00	0.00	2.80	0.00	0.00	0.00	3.51	2.80	0.00	3.51	100.00%	79.77%	20.23%	0.71	-	3.51	-	-
409 355345 Neonatal Unit Team	1.00	0.00	0.00	0.00	3.48	2.00	0.00	0.00	0.00	0.00	3.00	0.00	3.48	0.00%	57.47%	-57.47%	-2.00	3.48	-	-	-
409 355349 Ward Childrens Observation Team	0.61	0.00	0.00	0.00	2.68	0.92	0.00	0.00	1.15	0.00	1.53	1.15	2.68	100.00%	77.24%	22.76%	0.61	-	2.68	2.68	3,497.40
409 357517 Paediatric Clinic Team	0.00	0.00	0.00	0.00	0.00	1.20	0.00	0.00	0.00	1.60	1.20	0.00	1.60	100.00%	75.00%	25.00%	0.40	-	1.60	-	-
409 357518 Childrens Community Outreach Team	0.00	0.00	0.00	0.00	0.00	0.80	0.00	0.00	0.00	0.80	0.80	0.00	0.80	100.00%	100.00%	0.00%	-	-	0.80	-	-
409 357537 Gynaecology Clinic Team	0.00	0.00	0.00	0.00	0.00	2.41	0.00	0.00	0.00	1.85	2.41	0.00	1.85	100.00%	130.45%	-30.45%	-0.56	-	1.85	-	-
409 357541 Maternity Ormskirk Team	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	100.00%	100.00%	0.00%	-	-	-	-	-
409 357547 Delivery Suite Ormskirk Team	1.80	0.00	0.00	0.00	0.00	2.64	0.00	0.00	0.00	5.48	4.44	0.00	5.48	0.00%	48.18%	-48.18%	-2.64	5.48	-	5.48	7,151.40
409 357548 Maternity Assessment Ormskirk Team	0.00	0.00	0.00	0.00	0.00	4.24	0.00	0.00	0.00	5.48	4.24	0.00	5.48	100.00%	77.37%	22.63%	1.24	-	5.48	-	-
409 357549 Maternity Ward Ormskirk Team	3.40	0.00	0.00	0.00	5.48	8.00	0.00	0.00	0.00	5.48	11.40	0.00	10.96	100.00%	72.99%	27.01%	2.96	-	10.96	5.48	7,151.40
409 357551 Antenatal Clinic Ormskirk Team	0.40	0.00	0.00	0.00	1.59	1.80	0.00	0.00	0.00	1.59	2.20	0.00	3.18	100.00%	56.60%	43.40%	1.38	-	3.18	1.59	2,074.95
Division Total	**14.24**	**2.40**	**1.00**	**2.52**	**39.84**	**68.76**	**0.00**	**0.00**	**1.15**	**60.95**	**83.00**	**7.07**	**100.79**	**78.64%**			**10.36**	**21.52**	**79.27**	**18.32**	**23,902.38**
Division Total	**18.75**	**3.57**	**1.80**	**3.52**	**66.20**	**96.07**	**0.00**	**0.00**	**3.75**	**75.20**	**114.82**	**12.64**	**141.40**	**84.78%**			**21.05**	**21.52**	**119.88**	**44.68**	**58,302.18**

Title of Meeting	**Trust Board**			**Date**	28 January 2026
Agenda Item	**TB26/011**				
Report Title	Home Birth Services – Risk, Benchmarking and Improvement Programme for Northwest Region				
Executive Lead	Sarah O'Brien, Chief Nursing Officer				
Presenting Officer	Sarah O'Brien, Chief Nursing Officer				
Action Required		**To Approve**	X	**To Note**	

Purpose

To inform the Board of national concerns regarding home birth services and to outline the proposed Northwest regional approach to risk assessment, benchmarking, and service improvement.

Executive Summary

Following the issuance of a Prevention of Future Deaths (PFD) report by the Senior Coroner for Manchester North after the deaths of Jennifer Cahill and her baby, Agnes Cahill, NHS England (NHSE) has requested an urgent national review of home birth services. The issues identified related to the operational delivery of homebirth care, care planning and risk assessment processes, and arrangements for governance and oversight.

In response, the Northwest Regional Maternity Team has initiated a regional benchmarking and standard-setting programme to address variation, strengthen governance, and improve safety and quality across home birth services.

MWL has completed a regional scoping exercise, identifying areas of good practice alongside opportunities for further alignment and improvement

Areas of good practice included:

- Introduction of community specific safety huddles held every morning seven days per week that feature home birth-specific discussions including, on-call arrangements, equipment checks and updates and reviews of women planning home birth
- A dedicated fortnightly home birth review meeting in place, attended by the Consultant Midwife, community managers, and midwives.
- Standardised home birth equipment and bags stocked to enable maternal and neonatal emergencies in the community, supported by a robust checking and oversight process.
- A strong culture of learning and education within the community midwifery service. Ensuring all midwives undertaking first on-call duties are Resuscitation Council UK (RCUK) Newborn Life Support (NLS) trained, regular community specific obstetric emergency drills in conjunction with other stakeholders including North West Ambulance Service NHS Trust (NWAS).
- Risk assessments at every antenatal contact including a birth planning assessment at 36 weeks gestation agreed with the woman alongside a risk assessment at the onset of labour.
- There is an MWL Standard operating procedure for referral pathways to the consultant midwife for care planning for birth outside guidance. Individualised care-planning and comprehensive risk assessments co-produced with women and shared with all relevant care providers.

Areas for Further Consideration include:

- Harmonisation of clinical guidance which was under development and will be ratified at January Governance and quality meetings.
- Exploration of a dedicated home birth team covering the MWL community footprint.
- Consideration of aligning a dedicated Obstetric Consultant for women choosing birth at home or birth outside national guidance discussions

The maternity service assures the Trust Board that the guidance and processes in place to support women in their choice to birth at home, have risk assessments, care planning, delivery of appropriate care, necessary equipment and robust checks to ensure equipment is adequate and fit for use alongside training and community specific training involving key stakeholders e.g NWAS to ensure the delivery of a safe service.

A regional Rapid Task and Finish (RT&F) Group has been established to develop a Northwest Home Birth Charter, setting minimum regional standards by 01 April 2026.

Once the charter is developed MWL will complete a formal gap analysis against the minimum regional standards and develop an improvement plan to address any identified areas for further development which will be shared with the Board.

Financial Implications
Not applicable

Quality and/or Equality Impact
Not applicable

Recommendations
Trust Board is asked to note the Home Birth Services – Risk, Benchmarking and Improvement Programme for Northwest Region.

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

Briefing Paper: Home Birth Services – Risk, Benchmarking and Improvement Programme for Northwest Region

Following the issuance of a Prevention of Future Deaths (PFD)[1] report by the Senior Coroner for Manchester North after the deaths of Jennifer Cahill and her baby, Agnes Cahill, following a homebirth, NHS England has requested an urgent national review of homebirth services.

A letter dated 26 November 2025 was received by the Trust outlining concerns arising from this case. These included issues related to the operational delivery of homebirth care, care planning and risk assessment processes, and arrangements for governance and oversight. While reaffirming that trusts remain responsible for offering homebirth as a choice for women, NHS England emphasised the need for prompt action where concerns are identified, to ensure services remain safe, effective, and of high quality.

This case, together with findings from national maternity service reviews and Maternity and Newborn Safety Investigations (MNSI), has identified significant concerns across multiple aspects of homebirth service provision. These include, but are not limited to:

- Variability in homebirth service models across trusts
- The nature, quality, and depth of multidisciplinary (MDT) risk assessment undertaken
- The quality and consistency of care planning discussions with women
- The adequacy of risk communication and documentation, particularly for women choosing care outside national guidance, including explicit discussion of the risk of death
- Provision of balanced information to support informed decision-making
- Training, competence, experience, and ongoing exposure of staff attending homebirths
- Emergency response arrangements, including ambulance response times, extrication from the home environment, and timely transfer to obstetric units

At present, there are no nationally agreed minimum or best-practice standards for homebirth services. In the absence of national direction, the Northwest Regional Maternity Team has determined that it is essential to establish a shared regional understanding of risk and agree minimum regional standards. The rationale for adopting a regional approach is to reduce unwarranted variation in homebirth service provision across trusts, enable greater standardisation of service offers where appropriate, and promote a shared visibility and understanding of risk across the region. This approach supports consistency in quality, safety, and governance, ensuring that women and families receive equitable, high-quality care regardless of provider, while strengthening regional oversight and assurance arrangements.

A Northwest Regional Homebirth Scoping Tool has been developed and was issued to all 17 maternity providers in the region. Informed by both national and regional concerns, the tool was designed to establish a baseline regional risk profile, identify provider-level gaps in service provision and governance, and inform the development of minimum regional standards to ensure consistency, safety, and quality across the region.

A review of the current MWL homebirth provision was undertaken in December 2025, led by the Deputy Director of Midwifery, Consultant Midwife, and Community Midwifery Matron to inform the tool which was submitted on 22 December 2025.

The review identified areas of good practice alongside a few potential improvement opportunities, including variability in operational arrangements following service alignment.

[1] Jennifer Cahill and Agnes Cahill: Prevention of future deaths report - Courts and Tribunals Judiciary (https://www.judiciary.uk/prevention-of-future-death-reports/jennifer-cahill-and-agnes-cahill-prevention-of-future-deaths-report/)

Areas of Strength within MWL

The legacy Whiston community midwifery service introduced an innovative approach to community-specific virtual safety huddles in 2024. These huddles were formally rolled out to the legacy Ormskirk teams following alignment of community midwifery services in April 2025.

Key features include:

- Virtual huddles held each morning, seven days per week
- Huddles are documented and recorded
- A structured forum for sharing safety messages, operational planning, and service updates
- Home birth-specific discussions including - Daily on-call arrangements, Equipment checks, review of women planning home birth

The Northwest Regional Maternity Team and the Maternity Safety Support Programme identified these huddles as innovative and good practice during recent visits to MWL.

In addition, a dedicated fortnightly home birth review meeting is in place, attended by the Consultant Midwife, community managers, and midwives. All anticipated planned home births are discussed, reviewed, and updated.

The service uses standardised home birth equipment, with Baby Lifeline bags deployed across all areas of the service. These are stocked to manage maternal and neonatal emergencies in the community, supported by robust checking and oversight processes.

There is a strong culture of learning and education within the community midwifery service. Priority is given to:

- Ensuring all midwives undertaking first on-call duties are RCUK NLS trained
- Facilitating community-specific obstetric emergency drills in conjunction with other stakeholders including NWAS
- Participation in Trust-wide mandatory PROMPT training

All women including women who have chosen a birth at home have continual risk assessments at every antenatal contact throughout their pregnancy pathway which is documented with the health records. A birth planning assessment is undertaken at 36 weeks gestation and agreed with the woman and a further risk assessment is undertaken at the onset of labour.

Care Planning for Birth Outside Guidance

For women choosing to give birth outside national guidance, an MWL-wide Standard Operating Procedure (SOP) is in place which sets out a clear referral pathway to the Consultant Midwife. Referrals are triaged, and individualised care-planning appointments are arranged based on a comprehensive risk assessment. The rationale for the woman's choice is explored, alongside discussion of alternative birth settings. Multidisciplinary input is sought as part of the care-planning process, with additional stakeholder advice obtained where required, including from the Trust Legal Team, the Nursing and Midwifery Council (NMC), and the Northwest Ambulance Service (NWAS). Enhanced personalised care and support plans are co-produced with women, formally agreed prior to dissemination, and shared widely with all relevant care providers via multiple platforms. The risks associated with choosing to birth outside guidance are clearly communicated and documented and, where appropriate, include explicit discussion of the risk of maternal and neonatal morbidity and mortality.

Areas for Further Consideration

Following the formal alignment of community services, areas have been identified for consideration to strengthen and standardise the home birth provision across MWL, including:

- Harmonisation of clinical guidance. The guideline has been harmonised and is pending approval at the joint guidelines meeting followed by ratification at the maternity Governance and Quality meeting in January 2025
- Exploration of a dedicated home birth team covering the MWL community footprint. Currently a dedicated homebirth team is in place at our whiston site with a traditional model of service delivery provided by the community team of a day and the on-call midwives out of hours.
- Consideration of aligning a dedicated Obstetric Consultant for home births and birth outside national guidance discussions

Regional Improvement Programme and Next Steps

The findings from the regional scoping exercise will directly inform the development of minimum regional standards and guide subsequent local improvement planning.

A Northwest Regional Home Birth Rapid Task and Finish (RT&F) Group has been established, with the first meeting taking place on 6 January 2026. MWL is represented by the Consultant Midwife and Community Midwifery Matron.

The RT&F Group will meet weekly to review national recommendations and develop an evidence-based Northwest Home Birth Charter, establishing agreed minimum regional standards by 01 April 2026.

Once the Charter is agreed, MWL will be required to complete a formal gap analysis against the minimum regional standards and develop a time-bound improvement plan to address any identified areas for development. Progress against this plan will be monitored quarterly through the established Maternity Provider Oversight Process (MPOP), with the first formal reporting submission scheduled for August 2026.

This programme of work aims to ensure that women and families receive consistent, high-quality, and balanced information to support informed decision-making regarding homebirth, while reducing inequity arising from variation in service provision across the region.

The Board is asked to note the information and associated timeline. It is proposed that ongoing assurance will be provided to the Quality Committee through the Maternity and Neonatal Quarterly Updates, with oversight of the improvement plan once developed. Any emerging risks will be escalated appropriately and recorded on the Trust Risk Register.

To: Trust Chief Nurses
Trust Directors of Midwifery

cc. ICB Chief Nurses
ICB Directors of Midwifery

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 November 2025

Dear colleagues,

Urgent review of homebirth services following Prevention of Future Deaths report

We are writing to bring to your immediate attention the Prevention of future deaths report issued by the Senior Coroner for Manchester North after the tragic deaths of Jennifer Cahill and her child Agnes Cahill following a homebirth. The report raises a number of concerns and we are asking you to urgently review the safety and quality of your homebirth services.

We would like you to consider the following issues which were highlighted in this case:

The operational running of your service: including how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multi-disciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth.

Care planning and risk assessment: including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period.

Governance and oversight: including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continual improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care.

Trusts have a continuing responsibility to offer homebirth as a choice for women. Where this review identifies concerns, please take prompt action to address them to ensure your homebirth service remains safe and high quality. While no formal response is required, we expect that the outcome of the review be reported to your Trust board and that you contact your regional NHS England team immediately if you identify any safety concerns requiring urgent attention.

Yours sincerely,

Kate Brintworth
Chief Midwifery Officer for England

Claire Mathews
Regional Chief Midwife, North West
NHS England