Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 27 May 2026
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(5 mins)*
10.05	2.	**Employee of the Month (May 2026)** *Purpose: To **note** the Employee of the Month presentations for May 2026*	Presentation	Chair *(10 mins)*
10.15	3.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.30	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	Chair *(5 mins)*
	5.	**TB26/032 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 29 April 2026*	Report	
	6.	**TB26/033 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				
10.35	7.	**TB26/034 Integrated Performance Report** 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*	Report	S O'Brien G Lawrence obo L Neary M Szpakowska G Lawrence *(20 mins)*

Committee Assurance Reports				
10.55	8.	**TB26/035 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 M Singh C Spencer obo L Knight C Spencer *(30 mins)*
Other Board Reports				
11.25	9.	**TB26/036 Aggregated Incidents, Complaints and Claims Report (Q4)** *Purpose: To **note** the Aggregated Incidents, Complaints and Claims Report for Q4*	Report	S O'Brien *(15 mins)*
11.40	10.	**TB26/037 Maternity and Neonatal Services Report** 10.1. Maternity and Neonatal Services Q4 Update *Purpose: To **note** the Maternity and Neonatal Services Report*	Report	S O'Brien *(15 mins)*
11.55	11.	**TB26/038 Draft Quality Account 2025/26** *Purpose: To **approve** the Quality Account 2025/26*	Report	S O'Brien *(15 mins)*
12.10	12.	**TB26/039 Learning from Deaths Quarterly Report (Q2 2025/26)** *Purpose: To **note** the Learning from Deaths Quarterly Report for Q2*	Report	S Dowson *(10 mins)*
12.20	13.	**TB26/040 2025/26 Board and Committee Effectiveness Review** *Purpose: To **approve** the updated Terms of Reference following the annual effectiveness review*	Report	A-M Stretch *(10 mins)*
12.30	14.	**TB26/041 Review of Trust Objectives for 2025/26** *Purpose: To **note** the Review of the Trust Objectives for 2025/26*	Report	R Cooper *(15 mins)*
Concluding Business				
12.45	15.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*

12.50	16.	**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 24 June 2026 at 09:30		**12.55 close**
15 minutes lunch break				

Chair: Steve Rumbelow

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 May 2026
Agenda Item	**TB26/000**			
Report Title	Employee of the Month (May 2026)			
Executive Lead	Steve Rumbelow, Chair			
Presenting Officer	Steve Rumbelow, Chair			
Action Required		**To Approve**	X	**To Note**

Purpose

To note the Employee of the Month winner for May 2026.

Executive Summary

The Employee of the Month winner for May is Margaret Duffy, Ward Manager of 14B at Southport Hospital. She was nominated by Louise Hill, Respiratory Directorate Manager.

As Ward Manager of one of the busiest and most complex wards on the Southport site, Margaret expertly manages patient flow, challenging clinical needs and competing priorities. She does this with calm authority and precision – often likened to the conductor of a symphony orchestra, bringing together people and processes to deliver safe, efficient and high-quality care. She is highly respected across MWL, known for her insight, her willingness to roll up her sleeves and the lasting difference she has made to patients, families and colleagues alike.

Since taking up the role in 2009, Margaret has demonstrated remarkable resilience and compassion, growing both personally and professionally alongside her team. Under her leadership, Ward 14B has steadily gone from strength to strength, achieving sustained improvement across the ward accreditation programme. The most recent inspection in March 2026 highlighted clear progress in documentation, infection prevention, patient experience and performance assurance, reflecting the positive culture and high standards now firmly embedded on the ward.

Mandatory training compliance has been consistently maintained at the highest level, placing the ward among the top performers in the Division. Ward 14B has not recorded a single pressure ulcer since May 2025 – a clear testament to Margaret's focus on patient safety, staff education and clinical excellence.

Communication and engagement also thrive under Margaret's guidance. This has been strengthened on the ward through effective governance structures, staff suggestion schemes and initiatives that ensure every voice is heard. She leads by example in identifying efficiencies and cost improvement opportunities, implementing changes that support sustainability, but don't compromise on patient care.

Margaret, as your nomination rightly states … every ward needs someone like you! You're an exceptional leader, dedicating an outstanding 40 years of service to the Trust and a shining example of everything MWL stands for. Thank you for being a role model to colleagues and future nurses. Please accept your certificate and wear your badge with pride, congratulations!

Financial Implications

Not applicable

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 May 2026
Agenda Item	**TB26/000**			
Report Title	Patient Story			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Yvonne Mahambrey, Quality Matron – Patient Experience Nadine McStein, Head of Nursing Quality, Urgent and Emergency Care			
Action Required		**To Approve**	X	**To Note**

Purpose

To inform the Board of Rachel's journey where she received collaborative regional care from the Ormskirk Maternity Unit, Southport Hospital Accident and Emergency Department (AED), the Liverpool Women's Hospital and the Walton Centre.

Executive Summary

Rachel contacted the Trust to express her thanks for the care that she received a year ago when she was 38 weeks pregnant with her daughter Betsy.

In March 2025, Rachel began to feel unwell and attended an antenatal assessment at Ormskirk Hospital and was transferred to the Emergency Department at Southport Hospital. Following scans, she was diagnosed with a sub arachnoid haemorrhage. This resulted in Rachel being transferred to the Walton Centre for further assessment and treatment. The safety of Rachel's daughter was also assessed through conversations between Ormskirk Maternity Services and the Liverpool Women's University Hospital. The decision was made for an obstetric team to attend the Walton Centre and deliver Betsy by a caesarean section under general anaesthetic as to support Rachel to have the necessary diagnostic investigations required to make a diagnosis.

Two weeks later Rachel was discharged from the Walton Centre, but within twelve hours returned to the Emergency Department with similar but quickly worsening symptoms. Following scans, Rachel was intubated and transferred back to the Walton Centre. During this time, as Rachel was breastfeeding, her husband was in the department with Betsy. He felt everything was being done to keep her safe and he always felt updated, consulted and reassured by the team looking after her.

Rachel underwent brain surgery at the Walton centre and now has a ventriculoperitoneal (VP) shunt and is physically well. As she celebrated Betsy's first birthday, she is feeling thankful to be given another chance to be a mum to her son and daughter, due to the collaborative and specialist care she received.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Patient Story.

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

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 29 April 2026
(Approved at the Trust Board on Wednesday 27 May 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
Steve Connor	SC	Non-Executive Director
Simon Dowson	SD	Chief Medical Officer
Neil Fletcher	NF	Associate Non-Executive Director
Neil French	NFr	Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Gareth Lawrence	GL	Chief Finance Officer
Sarah O'Brien	SO	Chief Nursing Officer
Mini Singh	MSi	Non-Executive Director
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer

In Attendance

Name	Initials	Title
Elsie Hayford	EH	Shadow Non-Executive Director (via MS Teams)
Wayne Longshaw	WL	Director of Integration (Agenda Item 10 via MS Teams)
Simon Regan	SRe	Designate Director of Corporate Services (Observer)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager
Marie Wright	MW	Halton Council Representative (Stakeholder Representative) (via MS Teams)

Apologies

Name	Initials	Title
Khalid Anis	KA	Associate Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Lesley Neary	LN	Chief Operating Officer

Agenda Item	Description
Preliminary Business	
1.	**Chair's Welcome and Note of Apologies**
	1.1. SR welcomed all to the meeting and in particular welcomed MSi who had joined the Trust as a Non-Executive Director and was attending her first Board meeting. 1.2. SR noted that WL would be attending the meeting to present Agenda Item 10 MWL Health Inequalities Strategy Annual Progress Review. Additionally, SR welcomed SRe who was observing the meeting, ahead of taking up post as the new Director of Corporate Services in June. 1.3. The following awards and recognitions were noted: 1.3.1. Professor May Ng, Consultant Paediatrician and Paediatric Endocrinologist, had her work on the international RADIANT diabetes study published in The Lancet Diabetes and Endocrinology. May recruited the first global participant into the trial, contributing to findings that show real promise for people living with type 1 diabetes. 1.3.2. Professor Greg Irving, Consultant GP at Marshalls Cross Medical Centre, had been awarded a prestigious National Institute for Health and Care Research (NIHR) Senior Investigator Award. This was one of the highest honours in UK health and care research and was only given to a small number of leading researchers across the country. 1.3.3. MWL reached an important milestone by completing the 1,000th robotic assisted surgical procedure. Based at Whiston Hospital, the robot has supported 1,000 procedures across General Surgery, Gynaecology and Urology. Apologies for absence were **noted** as detailed above
2.	**Employee of the Month**
	2.1. The Employee of the Month for April 2026 was Andrew Healey, Equality, Diversity, and Inclusion (ED&I) Manager, Whiston Hospital 2.2. SR read out the citation for AH and RC presented the Employee of the Month certificate and pin badge. **RESOLVED:** The Board **noted** Employee of the Month for April 2026 and congratulated the winner.
3.	**Declaration of Interests**
	3.1. There were no new declarations of interests made in relation to the meeting agenda items.

4.	**TB26/025 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 25 March 2026 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 25 March
5.	**TB26/026 Matters Arising and Action Logs**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. The following actions were closed: 5.2.1.1. Action Log number 30 (TB26/018 Integrated Performance Report 7.1 Quality Indicators) – SO advised that the availability of informal benchmarking of complaints response times had been explored, however this data was not readily available and would require scrutiny of individual Board papers for similar trusts. **Action closed.** 5.3. There were no other outstanding actions. **RESOLVED:** The Board **approved** the action log
Performance Reports	
6.	**TB26/027 Integrated Performance Report**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for March 2026 was presented.
6.1.	**Quality Indicators**
	6.1.1. SO and SD presented the Quality Indicators. SO highlighted the following: • The Trust was slightly above the NHS England (NHSE) Infection, Prevention and Control (IPC) threshold for 2025/26; however, the Trust was not an outlier in Cheshire and Merseyside (C&M). • Zero Never Events had been reported in March 2026. • The rate of complaint responses within 60 days had improved from 63.3% in February to 75% in March, however, this was still below the target of 80%. There would be a focus on sustaining this improvement.
6.2.	**Operational Indicators**
	6.2.1. GL, on behalf of LN, presented the operational indicators and highlighted the following:

	• Performance against the 28-day cancer target had improved to 81.3% in March 2026 compared to 74.9% in January 2026 (target 77%). This compared to 80.7% nationally and 80.5% for C&M. • The Trust 4-hour mapped waiting time performance for March 2026 was 79.5% compared to 77.2% in February 2026 (2025/26 YTD 78.2%) against the 78% interim national target. This compared to 77.1% nationally and 73.8% for C&M. • Performance against the discharges before noon target had improved to 20.8% in March 2026 from 19% in February 2026 (target 20%). • The validation period for Referral to Treatment (RTT) had been extended and performance was 63.4% for February 2026 and GL noted that it was anticipated that this would improve to circa 66.5% for March 2026. This exceeded the target that had been agreed with NHSE as part of the Q4 sprint. 6.2.2. GB commented that, despite improvements, bed occupancy remained high, noting that this had peaked at 151 additional patients at Whiston and Southport Hospitals and included patients in General and Accident (GA) beds, escalation areas and those waiting for admission in the Emergency Department (ED) and reflected on the impact this had on patient experience. RC responded that SO, SD and LN had been involved in discussions with the clinical teams about corridor care and the Trust's focus on eradicating this, however it would require considerable time and effort and included reviewing pathways and the re-configuration of bed bases. Discussions were taking place at Committee level to reduce reliance on corridor care so that it was eradicated. GB commented that this required a system-wide response. RC agreed and commented that, in his view, it was essential to ensure that all possible internal actions had been taken and, once this had been achieved, the Trust would be in a position to assert that further progress would require broader system changes and improvements. 6.2.3. SR commented that, whilst data was important, it was equally important to recognise the patients represented by the data as this would improve focus and enhance decision making. From a MWL standpoint, the focus remained on doing what was right for the patient.
6.3.	**Workforce Indicators**
	6.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for mandatory training was 89.5% (target 85%). • The compliance rate for appraisals was 90.1% (target 85%) and the new appraisal window for 2026/27 would open in May. The appraisal documentation had been updated to reflect the new MWL behavioural standards as well as the 2026/27 Trust Objectives that had been launched at the STAR Leadership Conference on 20 April 2026. • Sickness absence had reduced from 7.1% in February 2026 to 6.6% in March 2026 (target 5%). The Sickness Absence Improvement Plan had

	been shared and would be monitored through the Strategic People Committee (SPC) with an update to Executive Committee in July 2026. • In-month staff turnover in March was 1% (target 1.1%) compared to 0.6% in February. A slight variance had been reported between sites and in-month staff turnover at Southport and Ormskirk hospitals was 1.9%. This related to the Transfer of Undertakings (Protection of Employment) (TUPE) of Sefton Sexual Health as well as the migration of the Trust's hosted HR Commercial Services workforce from one Electronic Staff Record (ESR) system to another. Additionally, the national mutually agreed resignation scheme (MARS) leavers had also contributed to the slight increase of in-month turnover. • The average Time to Hire had deteriorated to 51 days in March from 49.4 days in February (target 40 days). This was drive by an extraordinary increase in activity through the onboarding of the Southport and Ormskirk NHSP workers to the Trust's Bank and there were currently 845 active candidates. However, the average time to hire for offers made in-month remained within target. It was noted that this metric would be included in the 2026/27 IPR. 6.3.2. SR noted that the Trust was currently taking on a significant number of new staff due to the expansion or commencement of new services and this would impact on the time to hire. MS advised that whilst not all employment checks were required under TUPE, it was a legal requirement to complete right to live and work checks which increased the burden on recruitment staff.
6.4.	**Financial Indicators**
	6.4.1. GL presented the financial performance indicators and noted that, as the Trust had submitted the financial accounts on 27 April in line with the national deadline, no figures had been included in the IPR. 6.4.2. The Trust had submitted a deficit of £10.7m which was in line with the 2025/26 plan as well as the forecast that had been discussed at the Finance and Performance (F&P) Committee and Board throughout 2025/26. 6.4.3. GL highlighted the following: • The Trust had successfully delivered the Cost Improvement Programme (CIP) of £48.2m recurrently. • The Trust had mitigated the elements of the risks in the plan which had been discussed during planning within the system. • The Trust had finished year end with £22.8m cash and, as discussed at F&P and Board, this had been anticipated due to timely payments around the capital programme. • The Trust had delivered £55m worth of assets which was in line with plan. 6.4.4. SR commented that it was vital for the Trust to deliver on its commitments to maintain credibility within the system and the current approach has ensured that 'we do what we say' and this was key to building confidence.

	6.4.5. GB reflected on the excellent performance and noted that the allocation of resources to ensure patient safety had not affected the consistent attainment of targets. Additionally, GB reflected on the consistent delivery of CIP against the plan every year and asked if it would be possible to review the cumulative results for the preceding five years. SR commented that these achievements were despite the structural deficit as a result of the transaction which had also been reduced. 6.4.6. SC reflected on GB's comments and added that divisional presentations at the F&P Committee reflected a strong organisational culture, where positivity about achievements was balanced with clear plans for ongoing progress. The practice appeared to be widespread throughout the organisation and supported continuous improvement. 6.4.7. CS commented that in some organisations CIP was viewed as having a negative impact on services, however, it was viewed positively within MWL. CS noted that she met regularly with the Triumvirates and the Divisional Directors were invited to participate in these meetings. The process was supported by clear ownership and the early identification of opportunities as well as a dedicated team that focused on benefits realisation and assisting staff to maximise outcomes. 6.4.8. SR commented that the Trust also ensured that CIP was overprogrammed to an appropriate level to facilitate successful delivery and this was essential to guarantee delivery of the CIP plan. 6.4.9. RC agreed with the comments and added that the clinicians and the Triumvirate all played a part in identifying and delivering the cost improvements and that this was viewed as part of their job. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB26/028 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. RC presented the Executive Committee Assurance report for the three meetings held in March 2026. It was noted that no meeting was held on 12 March due to the Executive Team Development Programme 7.1.2. Bank or agency staff requests that breached the NHS England (NHSE) cost thresholds were reviewed at each meeting, and the Chief Executive's authorisation recorded. Reports from the weekly vacancy control panel were also presented at every meeting. 7.1.3. The Committee had received the regular monthly assurance reports for:

- Nurse Safer Staffing
- Risk Management Council
- Financial Improvement Group

7.1.4. RC highlighted the following items from the report:

- The Committee had received an update on the lost to follow up review for Ophthalmology, following an incident where follow-up had been missed which had resulted in patient harm.
- The Committee had received the Outpatient Transformation Programme update and the ongoing work was noted.
- The Committee had received an update on the plans to transfer the Knowsley Urgent Community Response (UCR) Team to MWL on 01 May 2026 and work was underway to onboard the team. Additionally, work was taking place from a community perspective following the awarding of West Lancashire Community Services contract. There was a focus on community nursing and the current activity was being reviewed to understand the scope of the responsibilities managed by the team. There has been an increase in activity and careful consideration would be required to translate this to capacity. The Committee had approved five additional posts (circa 5% of the total whole-time equivalent (WTE)) to strengthen the service.
- The Committee had reviewed the business case detailing the proposals to create a single Dementia Team for MWL to ensure a consistent service across all sites.
- The Committee had received an update on the final preparations for the Transfer of Undertakings (Protection of Employment) (TUPE) of the Pathology Staff from Warrington and Halton Hospitals NHS Foundation Trust (NHSFT) to the East Pathology Hub.
- The Committee had reviewed the report which confirmed that Wrightington, Wigan and Leigh (WWL) NHSFT had withdrawn from providing a plastic surgery service and MWL was now the nearest alternative provider with capacity to take the referrals and work was ongoing to ensure that the appropriate infrastructure was in place.
- The Committee had received the Governance Mapping and Effectiveness Reviews – Councils and Groups which had been undertaken to ensure that there were standardised governance processes across Board, Committees, Councils and Groups. A similar piece of work was being undertaken to map the Divisional performance and accountability meetings.
- The Committee had received the draft Nursing, Allied Health Professional (AHP) and Midwifery Vision 2026-2029 and the new vision would be launched at the Star Conference.

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

- Cancer Nurse Specialist post – RC commented that that securing time-limited funding, especially from external sources, could present challenges when long-term objectives were being considered. Progress

	was being made, and it had been agreed to extend temporary funding for six months to facilitate the completion of the business case and finalise the relevant posts. • Community Nurse limited recruitment, pending contract activity and acuity negotiations • Funding for security enhancements for community premises following the recent attack at Newton Hospital as well as additional training for staff undertaking security duties as part of their role. 7.1.6. NF raised a concern about the uncertainty facing the Cancer Nurse Specialist staff in temporary roles, noting that this could prompt them to seek alternative employment. Additionally, NF asked about the future continuity of the service and whether any potential challenges had been identified. RC acknowledged the personal impact on staff occupying temporary positions and emphasised the importance of providing clarity and support. RC confirmed that the service would continue, noting that temporary funding had been approved for six months to allow time for a thorough review of the service. 7.1.7. GB reflected on the Dementia Service, noting the increasing vulnerability of legacy teams and highlighted the importance of patient experience. GB observed that the Trust was caring for a growing number of patients with delirium and dementia, which presented challenges for staff not routinely involved in dementia care. RC acknowledged that patient experience was a key driver and recognised the variations between sites. This would need to be addressed through comprehensive staff education to foster awareness and understanding across the workforce. Additionally, RC highlighted the need for a unified approach to patient experience within the Trust, and this included the appropriate metrics for ongoing evaluation. 7.1.8. GB reflected on the transfer of plastics surgery referrals from WWL NHSFT to MWL and asked whether the impact on the support services had been considered and whether additional consultants or nursing staff would need to be recruited. RC responded that, whilst the activity level was not excessive, it would be important to ensure that there was sufficient workforce capacity for effective service delivery. Staffing resilience has been a key area of focus and, whilst overall activity was manageable, staffing needs had been accounted for in the business case and service transfer plan. Plastic surgery generated a substantial volume of work, including some complex cases and the weighting would vary depending on the subspecialty areas. For high-volume, low-complexity procedures, it was essential to ensure that appropriate capacity and resources were properly allocated. Case complexity and demand fluctuated based on differing subspecialties within plastics. The remainder of the report was **noted.**
7.2.	**Audit Committee**

	7.2.1. SC presented the Audit Committee Assurance Report for the meeting held on 08 April 2026 and highlighted the following: • MIAA had issued five internal audit reports during the period February to March 2026, and substantial assurance had been received for Emergency Preparedness, Resilience and Response (EPRR). High assurance was received for Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme and Risk Management Core Controls. Substantial /high assurance had been received for Key Financial Systems Controls. • The fifth report was the Assurance Framework Opinion and the Trust had met the requirements. SC noted that for this an organisation either met or did not meet the requirements. • The Committee had received the Internal Audit Plan which was a risk based plan which linked to the Trust's strategic objectives and the Committee had been assured that the areas identified by Internal Audit were the key areas that required review. • The Head of Internal Audit had presented a verbal update and the Head of Internal Audit Opinion would be presented at the Committee meeting on 23 June. • The Committee had reviewed the MWL Audit Log and progress had been made on the implementation of internal and external audit recommendations. • The Committee had received the Audit Committee Annual Effectiveness Review which highlighted that the standard of Committee documentation was of a generally high standard. It had been agreed that a private meeting between the NEDs and internal and external audit would be arranged prior to each Committee meeting. 7.2.2. CS reflected on the strong and continuous relationship with MIAA and commented that MIAA had conducted an internal review to ensure that their processes were not impacted by this relationship and remained rigorous. 7.2.3. SC commented that the risk assessments were aligned with the Trust's strategic objectives, and whilst this might not be evident to Board members, the Audit Committee had been assured of the connectivity of these assessments and the Trust's boarder objectives. The remainder of the report was **noted.**
7.3.	**Charitable Funds Committee**
	7.3.1. SC presented the Charitable Funds Committee Report for the meeting held on 23 March 2026 and reflected on the amount of work that had been undertaken by the Head of Charity and the team during 2025/26. 7.3.2. SC highlighted the following: • The Committee had received the Head of Charity report which provided an overview of activity between November 2025 and March 2026, including a review of the MWL NHS Charity Strategy.

	• The Committee had received an update on the financial performance and financial position (fund balances), and it was noted that the balance was £1.483m at 30 January 2026. The Committee had been assured that funds were being spent for the benefit of patients. • The Committee had received the Legacies Update and Processes report which included a decision on the sale or rental of a property that had been included as part of a large legacy to the Spinal fund. Following a discussion the Committee had approved Option 2 in principle (renting of property), however, further investigation regarding the costs and returns was requested before a final decision was made. In response to SR's question, SC advised that it was a residential property. The remainder of the report was **noted.**
7.4.	**Quality Committee**
	7.4.1. GB presented the Quality Committee Assurance Report for the meeting held on 21 April 2026, noting the key quality performance indicators had already been discussed earlier in the meeting. 7.4.2. GB reported that the Committee had received the Annual Meeting Effectiveness Review and overall feedback was that the Committee continued to operate effectively in accordance with the Terms of Reference (ToR) and the timeliness of the distribution of papers had improved. GB suggested the adoption of a secure portal for the sharing of meeting papers. 7.4.3. GB highlighted the following points from the report: <u>Quality Committee Performance Report</u> 7.4.4. There had been a marked improvement in Complaints responses within 60 days and this remained an area of focus. 7.4.5. The mortality data for Southport and Ormskirk Hospitals required additional scrutiny and review by the Chief Medical Officer (CMO). <u>Draft Quality Account</u> 7.4.6. The Committee had reviewed the Draft Quality Account and GB noted that this would be presented at Trust Board for final approval. <u>Patient Experience Report</u> 7.4.7. The Committee received the Patient Experience Report and GB reflected on the level of patient experience data that was being gathered and presented. It would be important to determine how this information was integrated into the Trust's strategic decision making process. 7.4.8. The local maternity audits had indicated overall good performance; however, further improvements regarding birth choices and options for birthing partners to stay overnight was required at Ormskirk Maternity Unit. A solution was required for the beds and chairs at Whiston Maternity Unit. Additionally, the Committee had requested additional information regarding post-natal pain relief in the Q4 Maternity and Neonatal Services Report.

Care Quality Commission (CQC) Quarterly Report

7.4.9. The Committee had agreed that additional focus was required for the anticipated well-led visits, particularly for the NEDs.

7.4.10. The Quality Ward Rounds would include clinical services and there had been a request that support services, for example theatres, mortuary, Radiology, Pharmacy and Clinical Laboratory Services, were also included.

5 Star Accreditation

7.4.11. The Committee had received the 5 Star Accreditation report which provided an overview for 2025/26. GB reflected on the project that had taken place over the preceding three to four years.

7.4.12. It was noted that additional work was required regarding documentation, falls and IPC as these had been identified as recurring themes.

7.4.13. The report had highlighted the most improved wards, and GB highlighted the improvements in the Spinal Unit at Southport Hospital.

Patient Safety Report (Inc. Chair's Assurance Report)

7.4.14. The Committee had noted the recurring themes regarding falls training in the ED as well as pressure ulcers. A Tissue Viability Improvement Group was being introduced.

7.4.15. Never Events was a high priority on the Safety agenda and a successful audit day had taken place in March and outputs had indicated that robust plans were in place regarding checks and human factors.

Clinical Effectiveness Report

7.4.16. The Committee had requested that additional assurances were incorporated into future reports.

7.4.17. Pharmacy had been shortlisted for three awards (Ward dashboard, Homecare Prescriptions and AI Automation) in the Health Service Journal (HSJ) Awards.

7.4.18. The Trust currently had 547 Non-medical Prescribing (NMP) practitioners, and the Chief Nursing Officer (CNO) would present an update regarding the leadership of the NMPs.

7.4.19. An options appraisal for the Anaesthetic rotas at Southport and Ormskirk Hospitals was due to be tabled at the Executive Committee.

7.4.20. GB reported that the eradicating corridor care data would be an area of focus for Quality Committee with monthly and quarterly updates being presented. Additionally, the NEDs would be invited to visit the EDs at both Whiston and Southport Hospitals.

7.4.21. GB alerted to the Board that delays with clinical coding remained a challenge and risk mitigations were in place.

7.4.22. SD reported that the Antimicrobial Stewardship report, which had been developed in response to the national framework, outlined the Trust's action plan to address antimicrobial resistance which was a global challenge. Three

key areas, which were measurable and manageable, had been identified and updates would be presented at Quality Committee. The three priorities were:

- Transitioning patients from intravenous to oral antibiotics where appropriate.
- Conducting cultures to ensure targeted treatment, allowing for the use of narrower spectrum rather than broad-spectrum antibiotics.
- Addressing misconceptions around penicillin allergies, given that approximately 95% of individuals who believed they were allergic to penicillin were not, which often unnecessarily resulted in the use of broader-spectrum antibiotics.

7.4.23. SD highlighted that the Trust had been given the opportunity to select the priorities. MSi commented that the emphasis on prioritising actions that were integral to the Trust's current practices, rather than introducing additional ones, was commendable and that the measures reflected good clinical practice which if lapsed could be readily reintegrated. The priorities had been well chosen and practical and supported continuous improvement without imposing unnecessary complexity or additional systems. It would be important to reinforce that returning to strong foundational practices would be effective and sustainable for ongoing quality improvement.

7.4.24. SC reflected on a discussion at a previous F&P Committee about the challenge from the ICB regarding clinical coding and asked whether the issue noted in the report was a separate one. GL responded that this was a similar issue which related to the backlog, mainly for non-elective cases and a plan to clear this by the end of Q1 2026/27 had been presented at Executive Committee. Currently, there was sufficient capacity to manage the day to day activities. SR commented that clinical coding was an ongoing issue for all trusts, however, in his view, the Trust's performance was adequate, and this was demonstrated by interactions with the ICB.

7.4.25. GB asked if this was an area that could benefit from the use of Artificial Intelligence (AI). GL responded that currently robotic process automation (RPA) was used and that AI was being tested on elements, however, clinical coding required considerable interpretation of clinicians' documentation and ongoing communication with them to ensure that data was correctly coded. However, there were several areas, for example outpatients or day cases, where the use of RPA and AI was more effective due to the structured nature of the tasks. RPA was used exclusively in gastroenterology as the workflow was highly organised and well-suited for automation. MSi commented that this was where an integrated Electronic Patients Record (EPR) system would be beneficial as this would streamline the processes, however, if this was lacking difficulties might arise as the clinicians might not consistently input relevant information. Additionally, the resident doctors on the wards, might not recognise the financial implications of accurate coding as this would fall outside of their typical responsibilities and training. There was an opportunity to improve awareness among resident doctors regarding the importance and impact of proper documentation and coding.

	7.4.26. GB reflected on a recent article that she had read where a Trust had provided training for the resident doctors about the importance of accurate coding and documentation. The feedback received had noted an improved understanding of the link between coding and financial processes, including better note taking and coding efforts. GL reported that there was training available as well as a feedback loop with speciality teams to monitor the quality and outcomes of the data collected. 7.4.27. SR reflected on GB's comment about NEDs and members of the Executive team visiting EDs and the discussion at the recent Board Away Day about setting up a schedule for this and asked who would be leading on this. SO agreed to pick this up. **Action:** SO agreed to set up a schedule for NEDs and Executives to visit ED. **BY:** May 2026 The remainder of the report was **noted**.
7.5.	**Strategic People Committee**
	7.5.1. CS, on behalf of LK, presented the Strategic People Committee (SPC) Assurance report for the meeting held on 22 April 2026 and noted that some of the points noted had already been discussed in earlier reports to the Board and would not be repeated. 7.5.2. CS highlighted the following: • The compliance rate for appraisals had consistently exceeded the target of 85% throughout 2025/26 and the next appraisal window was due to open from 01 May. • The Committee had received the Workforce Operations Plan for M12 which was triangulated at the F&P Committee with the financial plan outturn. MWL was reporting a total workforce of 10,332.6 WTE which was 40.7 WTE above plan (0.4% variance to plan). This triangulated to the amount that Bank performance was over plan. It was noted this had been offset by a reduction in the use of agency staff. The plan had also provided assurance regarding the operational plans for 2026/27 to 2028/29 which outlined the actions being undertaken to support the divisions to have robust workforce plans to meet the necessary headcount reductions. Further reductions in the use of agency would require an increased focus on the substantive workforce and there were plans in place, including maintaining a clear baseline plan which would take into account any adjustments during the financial year for growth in services, shifts between service settings and commissioning changes. It would be important to ensure that there was an auditable summary included in the financial and workforce plans. • The Committee had received the Absence Taskforce Action Plan. Sickness absence had been included in the National Outcomes

	Framework and this highlighted the significance at a national level as performance in this area would affect the Trust's tiering in national assessments. The Committee had been assured that there was no complacency with the generation of ideas and operational strategies to address sickness absence. The Manager Toolkit, which provided robust workforce support and guidance on legal considerations, factual information, and appropriate levels of support, for all managers, had been presented. This represented a valuable contribution towards achieving sickness absence targets and further illustrated the commitment to innovation. • The Committee had received an update on the progress made against the 2025/26 Trust Objective of 'developing organisational culture and supporting our workforce' and it had been noted that the Team had reviewed their own performance rigorously, often marking themselves harshly. Despite this, most objectives were either achieved or showed significant progress toward their targets. This reflected that the Team consistently strived for improvement in the development and application of Key Performance Indicators (KPIs) to those areas traditionally regarded as soft targets. The remainder of the report was **noted**.
7.6.	**Finance and Performance Committee**
	7.6.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 23 April 2026. The Committee had reviewed the Finance and Performance CPR and monthly finance report, and CS noted that items discussed in other Board agenda items would not be repeated. 7.6.2. Other points to highlight from the report were: • The Committee had received the Finance Report for month 12 and it was noted that the Trust was expected to deliver against the 2025/26 plan and this included the successful delivery of CIP initiatives. • The Committee had received the contract risk update, and it was noted that this remained a risk for 2025/26 and 2026/27. This would be reviewed by the Committee until the risks had been resolved. • The CIP target for 2026/27 was £49.7m and it was noted that £52m of schemes had been identified to date with £44m fully developed or plans in progress. • The Committee had received the Urgent Care Performance Delivery Review and a year-end assessment regarding the system improvements outlined in the plan, including improvement, would be presented at a future meeting. • The Committee had received an overview of how the different teams supported each other in identifying CIP opportunities and translating these opportunities into benefit realisation.

	7.6.3. SR acknowledged the Trust's strong performance in developing CIP schemes and highlighted the importance of ensuring that all schemes were developed prior to the start of the financial year 7.6.4. The Committee had received Council Assurance Reports from the CIP Council, Procurement Council and Estates & Facilities Management Council with no issues escalated. The remainder of the report was noted. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
8.	**TB26/029 Corporate Risk Register**
	8.1. SO presented the quarterly Corporate Risk Register (CRR) report which provided an overview of the risks that had been escalated to the CRR via the Trust's risk management systems. 8.2. SO highlighted the following: 8.2.1. The current report reflected a snapshot of the risk registers on 06 April 2026 and reflected the risks reported and reviewed during March 2026. SO advised that she had reviewed LN's risks in her absence. 8.2.2. The total number of risks on the risk register was 1,015 compared to 1,067 in January. 8.2.3. 23 risks were reported on the CRR compared to 20 in January. 8.2.4. Seven risks were escalated to the CRR since to January. 8.2.5. Four risks had been closed or de-escalated from the CRR since January. • MWL Risk ID 33 (*If the end of 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*) – the old pharmacy robot had been dismantled and the new robot was now in place. • MWL Risk ID 263 (*if patients have duplicate hospital numbers, then there is a risk of causing patient harm*) – the risk score has been reduced as there were stronger mitigations in place. • MWL Risk ID1355 (*if the Trust cannot recruit, then there is a risk to the safe delivery of the paediatric cardiology service*) – the newly appointed Paediatric Cardiology consultant had started in post early April. • MWL Risk ID 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*) – the Trust had mitigated the gap arising from the non-delivery of the system-wide schemes.

	8.3. NF thanked SO for the explanation regarding the closing of MWL Risk ID 263 and asked whether this would impact on MWL Risk ID 1125 (***if** there are data quality errors and patient number mismatches due to legacy IT systems, **then** there is a risk to patient harm*). SO responded that, where two risks were similar, work had been undertaken to understand those risks and, where appropriate, to consolidate them. This work had been carried out by the relevant services. 8.4. CS asked whether there was a reason for not specifically addressing either urgent care or corridor care. SO responded that she would review this to identify if any actions had been initiated and if not, this would require further action. 8.5. SR commented that it would be important to have metrics in place to be able to assess progress as the Trust worked towards eradicating corridor care and anticipated that this assessment would become a measurement of exceptions rather than of routine occurrences. SO advised that there were several risks included on the risks register that related to urgent care and patient flow and whilst these related to corridor care it might be necessary to include a specific risk in the short term. MS commented that there was a cross over between the CRR and the Board Assurance Framework which might include these sub risks. SR noted that the objective was to eliminate corridor care entirely with rare exceptions being authorised by senior leadership. SD commented that the risk remained patient harm and by decreasing and ultimately eradicating corridor care this would minimise the risk. However, as this still remained an issue action was required. **Action:** SO to review the CRR to determine whether there were any actions to specifically address either urgent care or corridor care, and if not, to consider updating the CRR to address corridor care. **BY**: July 2026 **RESOLVED:** The Board **noted** the Corporate Risk Register
9.	**TB26/030 Board Assurance Framework**
	9.1. RC presented the Board Assurance Framework (BAF) and noted that each BAF risk had been reviewed by the lead Executive and updates provided in relation to closed and new actions. It was noted that the C&M Urgent and Emergency Care (UEC) Improvement Programme for 2026/27 included the action plan to eliminate corridor care, to decrease escalation capacity and improve patient flow was noted in BAF 3. 9.2. RC stated that the BAF served as an essential connection between the Trust's strategic planning and its overarching Strategy, facilitating alignment by systematically extracting and mapping the strategic objectives to delivery mechanisms. Each BAF risk was assigned a lead Executive who was responsible for ensuring that the risk was updated at each quarterly review.

	9.3. RC reported that the Executive Committee was recommending the following amendments: 9.3.1. BAF 2 *(Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners)* – the risk score to be reduced to 15 to reflect the positive end to 2025/26 as well as there being a substantive and compliant plan for 2026/27. 9.3.2. BAF 3 *(Sustained failure to maintain operational performance/deliver contracts)* – the risk score to be reduced to 16 to reflect the positive end of year performance and the confidence in delivering the 2026/27 operational performance targets. 9.3.3. BAF 7 *(Major and sustained failure of essential assets or infrastructure)* – the risk score to be reduced to 8 to reflect the near completion of the estate's infrastructure works at Southport and Ormskirk Hospitals as this has substantially reduced the risk of a major and sustained failure of the estate on these sites. 9.4. GB reflected on the reduction of the risk score for BAF 7 and commented that despite the extensive work that had been undertaken on site, regular operations had continued. RC commented that this had been highlighted at the recent 5 Star Leadership Conference. Additionally, the ward refurbishment programme at Southport Hospital had commenced with one ward so far being completely renovated to enhance the layout and functionality for both patient care and staff efficiency. 9.5. GB reflected on her recent visit to Ormskirk Hospital and the improved use of space and commented on the improved experience for patients as well as the improved working environment. 9.6. SR reflected on CS and GB's earlier comments that some aspects of performance were slightly understated likely due to the high standards that the Trust aimed to maintain, and that this approach was commendable. **RESOLVED:** The Board **approved** the reduction in risk scores and changes Board Assurance Framework
10.	**TB26/031 MWL Health Inequalities Strategy Annual Progress Review**
	(*WL joined the meeting)* 10.1. WL presented the MWL Health Inequalities Strategy Annual Progress Review which provided an update on the 2025/26 Delivery Plan of the Trust's Health Inequalities Strategy as well as the draft plans for 2026/27. 10.2. WL reminded Board members of Trust's Health Inequalities Vision (*reducing health inequalities by ensuring equitable access to our services and*

promoting preventable support in the community) as well as the four objectives that the Trust had established namely:

- Being a provider of quality health care
- Being an active partner
- Being an employer of choice
- Being an anchor institution

10.3. WL presented the 2025/26 Delivery Plan (Appendix 1) and reported that most of the 2025/26 actions had been completed. Any actions highlighted in red or amber, reflected actions where targets had been missed or not achieved, and would be carried over to 2026/27. The draft 2026/27 Delivery Plan was included in Appendix 2 and this would be updated following discussions with the Chief Medical Officer (CMO), the Chief Nursing Officer (CNO) and the Chief People Officer (CPO).

10.4. SR thanked WL for the report and observed that, whilst there was a focus on digital inequality and digital illiteracy, there had not appeared to be any mention of digital poverty and how the Trust would address this as there was probably large sections of the community without access to digital services. WL thanked SR for his observation and responded that a representative from Edgehill University was presenting on this topic at the upcoming St Helens Partnership Board. It was noted that St Helens was an area of greater focus as the Trust had shared care records and this would allow for a more in depth review of the data to produce a map reflecting the digital poverty in the community. WL noted that, in his view, the changes in digital technology, which included the phasing out of analogue lines, would further exacerbate the situation and this would form part of the review that he would be undertaking with the CPO once he had received further information. A map, reflecting the digital poverty across the MWL footprint would be a useful tool, however, the Trust was reliant on its partners to create this.

10.5. SR commented that as the Trust's focus on digital exclusion was only a partial focus currently, the Digitally Enabled Services without Digital Exclusion theme should be updated for 2026/27 to reflect this. WL agreed with SR' suggestion and noted that this represented a gap that needed to be addressed. The Trust would be working with Edge Hill University to gain a greater insight and clarity into what needed to be resolved. One of the challenges was that the data could be somewhat imprecise and implementing changes often required extended timelines. WL agreed to update the revised action plan to include this.

Action:
WL to update the revised action plan for 2026/27 to include digital exclusion and the creation of a map reflecting digital poverty across the MWL footprint: **BY:** TBA

10.6. SO agreed with WL's comment that some aspects of digital poverty fell outside of the Trust's remit and involved broader partnerships, however, there were several notable examples to consider. For example, during the

	Covid-19 pandemic, local authorities in St Helens had provided digital devices to individuals, primarily children, who could not afford them and this assistance had greatly helped to manage the situation locally. The need to recognise children in need, including those affected by digital poverty had been one of the key learnings for local authorities during Covid-19. 10.7. SO commented, that in her view, it was vital for the Trust to educate staff about these issues and noted that there were staff members who had worked their entire careers in an acute hospital setting and might not fully appreciate the challenges of health inequalities faced in communities. The Trust had a programme in place which recognised the characteristics that contributed to health inequality. MWL's footprint included some of the country's most deprived boroughs and, whilst this was not a protected characteristic that led to health inequality, it was a systemic poverty experienced by local communities and it would be crucial for staff to recognise this reality and understand how to address it, with technology being a relevant example. SO commented that she believed that the Trust had a substantial educational responsibility in relation to this. 10.8. AMS agreed with SO's comments and mentioned she had discussed with WL the importance of training students to recognise health inequalities and their impact as future practitioners. Additionally, many long-serving staff members would need updates on this topic. 10.9. AMS reflected on the link between poverty and employment opportunities and commented that increased employment led to improved housing conditions and overall better health outcomes. AMS and WL had discussed the importance of focusing efforts on the Skills Hub which was due to open in St Helens in the near future to facilitate placements or employment as this would be crucial to addressing health inequalities. MSi asked if there were any plans to establish similar hubs at additional locations in the future. WL noted that St Helens had received funding as part of the previous government's Town Deal Fund which had allowed MWL to acquire and refurbish a building for a skills hub. The project was anticipated to start in June 2026 with a major recruitment campaign to fill healthcare assistant vacancies and the aim was to engage with the local community and provide them with opportunities to join MWL. WL reported that, whilst this initiative currently focused on a single location, the blueprint which would be developed over the coming months, would enable the Trust to expand and offer positions to a broader population. This project might shape the Trust's future approach to recruitment. This concept had been considered by SO and her colleagues nearly ten years ago and WL advised that he had been involved with the project over the preceding five years. A considerable effort has been required to secure premises, collaborate with partners, obtain funding, and refurbish the facility.

	10.10. WL commented that there were numerous health inequalities, however, the biggest challenge for health inequality was poverty in the communities served by the Trust. 10.11. CS reflected on WL's comment regarding the challenges in tracking certain outcomes with data and metrics and asked if there would be an opportunity within the plan to incorporate more specific metrics, possibly through staged KPIs, as several of the actions would take several years to complete. Additionally, CS asked how progress would be assessed in the medium and long terms. WL responded that currently the measurements included in the report were insufficient and advised that he was currently working with the Business Intelligence (BI) team to redevelop the health inequalities dashboard that was created last year and to establish a baseline with that data. Baselines and targets were being set and these should be available by the first quarter of 2026/27. The 2025/29 period would serve as the baseline, after which improvement targets would be set. These would focus on metrics such as Did Not Attend (DNA) rates. The intention was to disaggregate the figures by ethnicity, age, and deprivation indices to enable detailed tracking. For some indicators, changes would be observed relatively quickly, for example, a reduction in DNA rates among the lowest decile groups. However, shifts in life expectancy were generational and required a blended approach to measurement and, where possible, immediate responses would be provided including the monitoring of those on the waiting list. It would be possible to track whether the Trust's services were improving for those individuals currently on the waiting list, especially those with specific risk factors and this would demonstrate that these cases were being prioritised. Additionally, it would be possible to analyse employment patterns by examining the neighbourhoods and demographic characteristics of our workforce, utilising both lead and lag indicators where appropriate, however, the lag indicators might require extended periods to capture meaningful change. 10.12. WL advised that, as part of the ongoing review, the action plan remained in draft form so that, over the next few months, a comprehensive set of measurements could be included and the strategic approach refined. This approach would allow for greater assurance when monitoring and reporting progress. 10.13. SO reflected on WL's comments, noting that he had highlighted a key issue within the NHS, namely that meaningful impact on health inequalities often took ten to 30 years. Many initiatives were abandoned after only a year or two as priorities changed, so thoroughly understanding local communities and selecting two or three core priorities that were to be maintained on a long term basis would be essential. As a healthcare provider, it would be important to determine which factors could most effectively improve patient outcomes, for example clinic attendance rates or reducing waiting lists. Additional considerations relating to patient experience; diversity and reasonable adjustments were not consistently addressed, for example when

	supporting individuals with autism. Continuous improvement needed to be focussed on both operational processes and experiential outcomes. Additionally, collaboration was required with local partners to tackle major public health issues, for example, improving obesity in year 6 in St. Helens and Knowsley. These initiatives would have substantial long-term benefits, particularly regarding cardiovascular and cancer outcomes. 10.14. RC commented that the strategy had been developed by the Trust but could not be achieved in isolation. The data would allow the Trust to monitor improvements for the population that access Trust services, but that the health of those that did not engage at all would be missing. To bridge this gap, concepts such as "making every contact count" had been incorporated, for example, through the Cancer Life Diagnostic Network education which extended beyond health staff to community figures like hairdressers and pub employees, who facilitated broader engagement and early conversations. Using the skills hubs would enable a deeper outreach via voluntary sector organisations and community centres and would reach those individuals otherwise disconnected from traditional services. 10.15. RC commented that addressing digital poverty was another priority and noted that previously libraries provided access points for digital resources; there was also an opportunity to provide access in neighbourhood health hubs. Another consideration involved understanding where individuals sought advice in deprived areas as this was often not from doctors or nurses, but from pharmacists or other community members and connecting with these networks would be vital. There was evidence to support the effectiveness of community-based interventions, such as skin cancer promotion, and ongoing efforts with screening programmes highlighted the opportunities for greater integration across diagnostic pathways. RC commented that, in his view, neighbourhoods and community teams presented significant opportunities for collaboration and targeted intervention. 10.16. GB reflected on the discussions and noted that many people facing poverty lived in social housing and proposed connecting with housing organisations for broader outreach. Specifically, tenancy officers regularly visited residents of social housing and provided an opportunity to reach those that did not engage with health services. 10.17. SR commented that the Trust remained committed to contributing to the ten-year plan and recognised that this would be challenging and noted that the Trust had allocated funds to begin exploring opportunities in this area. 10.18. MSi asked whether staff would be the biggest expense in this initiative or if there were other significant contributing factors. SR responded that the biggest expense would be workforce and this needed to be done in collaboration with local authorities and other agencies such as housing providers. The approach would need to be aligned with the neighbourhood health agenda and SR commented that, with the shift towards joint efforts

and action, the Trust might be able to assume a leading role in these initiatives if it was positioned strategically.

10.19. MSi commented that there was an opportunity to utilise healthcare students in health outreach initiatives as they needed to gain an understanding of social deprivation and this would allow them to integrate such experiences into their educational frameworks. There were also placements for second-year students in schools which aligned with their educational goals. Regional collaboration with universities to support student engagement could be effectively arranged and interdisciplinary cooperation would fulfil multiple objectives and directly support organisational workforce development. Additionally, offering placement opportunities improved the organisation's appeal to prospective students.

10.20. MS advised that there was a focus on improving the Trust's education tracking provision and discussions were taking place with universities, mainly about increasing cohorts for medical students. There was continued collaboration with local colleges for the provision of practical experience for healthcare students as this hands-on exposure was essential as it had been observed that retention rates were affected by the disconnect between classroom learning and real-world application. Discussions regarding the education tariff were ongoing and there were still various infrastructural and resource considerations that needed to be addressed. MS advised that expanding student opportunities required careful planning and collaboration to ensure that there was adequate support for students as well as a good working environment and this piece of work was being led by SO and SD.

10.21. The team continually collected feedback and strived to deliver excellent experiences for all students, regardless of the site or working environment. A report outlining the future ambitions for the education service would be presented at Executive Committee in the next few months and MS advised that NED involvement would be welcome. Additionally, WL's involvement, due to his integration with neighbourhoods, would be important. In response to SR's question, MS assured that the strategy would include all students, not only medical students and that there was an emphasis on maintaining strong local partnerships. The Trust had a strong relationship with Edge Hill University and worked closely on recruitment of students, especially medical students.

10.22. SR commented that he respected the Trust's vision, particularly as it incorporated the term "equity" and reflected on a previous paper that WL had authored on this subject. It was encouraging to see that equity was emerging as a key element of the Trust's planning, however, it was essential that the meaning of this word was discussed as many individuals encountered the word "equity" without fully understanding its implications. Equity played a critical role in addressing health inequalities, and SR noted that this was linked to population health outcomes within communities. Effecting meaningful change would require identifying the actions necessary for

	specific groups to achieve equitable access to services and support through various approaches. This would require further discussion, as the concept of equalities was often referenced without sufficient consideration of the practical steps needed to achieve substantive change. RC commented that part of the work being done by the ED&I team included supporting teams and staff to understand the nuances of equity in service delivery. 10.23. SR reflected on the terminology used when discussing the MWL Health Inequalities Strategy and the progress plan and commented that, in his view, it should be referred to as a delivery plan with a focus on the specific actions and outcomes that the Trust aimed to achieve within the year. **RESOLVED:** The Board **noted** the MWL Health Inequalities Strategy Annual Progress Review *(WL left meeting)*
Concluding Business	
11.	**Effectiveness of Meeting**
	11.1. SR invited SRe to reflect on the effectiveness of the meeting. SRe commented that he had found the meeting interesting with a mix of assurance and challenge on the points raised and advised that he would likely reflect further once he had started in post. 11.2. Board members agreed that meeting had been effective.
12.	**Any Other Business**
	12.1. There being no other business, the Chair thanked all for attending and brought the meeting to a close 11.31. The next Board meeting would be held on **Wednesday 27 May 2026 at 09:30**

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

Trust Board (Public)

Matters Arising Action Log (updated 22 May 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 (24/04/2026) Recruitment was ongoing and planned into May 2026. An update would be provided at the Strategic People Committee in June 2026. Update (20/02/2026) The medical leadership structure recruitment is underway and an update will be presented to SPC in April. Update (23/01/2026) The CMO is about to commence recruitment to the new integrated medical leadership structure, and as part of this work the Trust had considered whether aspects of the current medical leadership structure or role design may be perceived as more attractive to male colleagues. This has included reviewing role expectations, the recruitment approach and any potential barriers or unintended impacts to ensure that our leadership opportunities are equitable, inclusive, and accessible to all. A further update once the process has concluded and if any recommendations have been identified will be shared with the Strategic People Committee (SPC).	MS / SD	~~Jan-26~~ ~~Apr-26~~ June-26		**Delegated to Strategic People Committee**
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		

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
31	25/03/2026	**TB26/019 Committee Assurance Reports** 8.1 Executive Committee	MG to circulate the Paper Free Work Programme that was in place for Board to be cited on the scope of work to reduce paper processes.	MG	~~May-26~~ Jun-26		
32	26/04/2026	**TB26/028 Committee Assurance Reports** 7.4 Quality Committee	SR reflected on GB's comment about NEDs visiting EDs and the discussion at the recent Board Away Day about setting up a schedule for this and including members of the Executive team and asked who would be leading on this. SO agreed to pick this up. Update (22/05/2026) SO in contact with NEDs to organise ED visits	SO	May-26		**Completed**
33	26/04/2026	**TB26/029 Corporate Risk Register**	SO to review the CRR to determine whether there were any actions to specifically address either urgent care or corridor care, and if not, to consider updating the CRR to address corridor care. Update (22/05/2026) Risk on corridor care on CRR, but three on RR. Risks being reviewed and consolidated.	SO	Jul-26		
34	26/04/2026	**TB26/031 MWL Health Inequalities Strategy Annual Progress Review**	WL to update the revised action plan for 2026/27 to include digital exclusion and the creation of a map reflecting digital poverty across the MWL footprint:	WL	TBA		

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
30	25/03/2026	**TB26/018 Integrated Performance Report** 7.1 Quality Indicators	SO to explore the possibility of conducting informal benchmarking of complaint response times against other C&M trusts.	SO	Apr-26	**24/04/2026** - SO advised that the availablity of informal benchmarking of response times had been explored, however this data was not readily available and would require scrutiny of individual Board papers for similar trusts. Action closed.	**Closed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 May 2026
Agenda Item	**TB26/034**			
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 31 key metrics. Quality has 10 metrics, Operations 11 metrics, Workforce 5 metrics and Finance 5 metrics.
Financial Implications
The forecast for 26/27 financial outturn will have implications for the finances of the Trust.
Quality and/or Equality Impact
The 10 metrics for Quality provide an overview for summary across MWL
Recommendations
The Trust Board is asked to note performance for assurance.

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

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

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Nov-25	96.4	100	90.7	Best 30%
FFT - Inpatients % Recommended	Apr-26	93.9%	90.0%	93.9%	Worst 40%
Nurse Fill Rates	Mar-26	94.5%	90.0%	96.1%	
C.difficile	Mar-26	12	97	109	
MRSA	Mar-26	1	0	4	
Falls ≥ moderate harm per 1000 bed days	Apr-26	0.11	0.00	0.11	
Stillbirths (intrapartum)	Apr-26	0	0	0	
Neonatal Deaths	Apr-26	2	0	2	
Never Events	Apr-26	0	0	0	
Complaints Responded In 60 Days	Apr-26	78.0%	80.0%	78.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Mar-26	80.4%	77.0%	71.2%	Worst 20%
Cancer 31 Days	Mar-26	96.7%	96.0%	93.9%	
Cancer 62 Days	Mar-26	86.3%	85.0%	79.3%	Best 20%
Ambulance Arrival to Vehicle Handover: % <45 mins	Apr-26	80.0%	100.0%	80.0%	
A&E Standard (Mapped)	Apr-26	77.9%	82.0%	77.9%	Worst 50%
% of Patients With No Criteria to Reside	Apr-26	24.1%	10.0%	24.1%	
Discharges Before Noon	Apr-26	20.1%	20.0%	20.1%	
G&A Bed Occupancy	Apr-26	96.9%	92.0%	96.9%	Worst 10%
18 weeks: % 52+ RTT waits	Apr-26	1.4%	1.0%	1.4%	Worst 40%
RTT % less than 18 weeks	Apr-26	66.8%	70.6%	66.8%	Best 40%
Diagnostic Waits: % <6 weeks	Apr-26	82.5%	95.0%	82.5%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Apr-26	89.6%	85.0%	89.6%	
Mandatory Training	Apr-26	89.6%	85.0%	89.6%	
Sickness: All Staff Sickness Rate	Apr-26	6.5%	5.0%	6.5%	
Staffing: Turnover rate	Apr-26	0.7%	1.1%	0.7%	
Average time to recruit (days) - All Staff	Apr-26	52	40	52	

Finance	Period	Score	Target	YTD	Benchmark
Delivery of CIP savings (000's)	Apr-26			3,313	
Reported Surplus/Deficit (000's)	Apr-26		-2,689	-2,688	
Cash Balances - Days to Cover Operating Expenses	Apr-26	1.0			
Capital Spend £ 000's	Apr-26		2,269	947	
Value of aged debt >90days overdue £000's	Apr-26			14,251	

Board Summary - Quality

Quality

HSMR
The HSMR for period Apr-25 to Nov-25 (latest data available) was 90.7 for MWL (92.1 for STHK and 107.7 for S&O). All individual diagnosis groups with an HSMR alert for this period have had patient details sent to be reviewed. The latest SHMI data for Oct-25 is 0.99.

FFT
Inpatients April positive score 93.86%, 0.14% below internal target of 94% (Most recent national average score February 2026 - 95%). Top themes aligned with negative ratings are staff attitude, environment and communication. All areas receive automated FFT reports for local action. CQC publication of the 2025 National Inpatient Survey results expected September 2026. Local surveys ongoing in line with the 2024 National Inpatient Survey action plan.

Nurse Fill Rates
Staffing fill rates above threshold. Bank and agency used if areas unsafe with controls in place.

Clostridium difficile infection
No updated data from last report. There is an agreement to run this data a month in arrears when required due to processing time from laboratory.

MRSA
No updated data from last report. There is an agreement to run this data a month in arrears when required due to processing time from laboratory.

Falls
There were 6 validated falls with harm in March 2026. April data yet to be validated for harm and learning reviews are currently underway for all falls with harm. A daily presence of falls practitioners continues in the Accident and Emergency departments to provide support and advice to colleagues for patients at risk of falls. Formal training which also included tissue viability has taken place on the Southport site and further sessions are planned for Whiston site. Ongoing work for Q1 includes the review and standardisation of the falls paperwork across MWL as well as review and standardisation of patient non- slip socks which will promote cost efficiency as well as consistent use across sites.

Stillbirths
There were no Stillbirths in April 2026.

Neonatal Deaths
Two cases of neonatal deaths before 28 days were reported in April – both relating to cases of extreme prematurity.

Never Events
No Never Events were reported in April 2026.

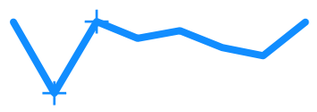
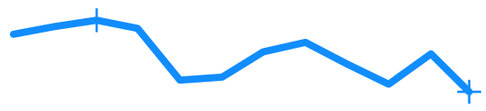
Complaints
In April there were 54 new first stage complaints received and in March there were 38. 18 of these complaints were received for the Southport and Ormskirk sites and the remaining 36 were received for Whiston site (inclusive of St Helens and Community Services). This illustrates a 42% increase on the previous month which was unusually quiet.
41 complaints were closed in April. 19 for S&O sites and 22 at Whiston and within the agreed Trust 60 working day target. April compliance is recorded at 78% which is a significant increase. Of the 41 closed in total, 32 were closed in time and 9 were closed out of time.
Figures are reported monthly and subsequently summarised in quarterly reports and complaints cases may be subject to change as per complainants wishes. Because of this, figures may also be subject to change and therefore minor variances can occur between reporting periods.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Nov-25	96.4	100	90.7	Best 30%	
FFT - Inpatients % Recommended	Apr-26	93.9%	90.0%	93.9%	Worst 40%	
Nurse Fill Rates	Mar-26	94.5%	90.0%	96.1%		
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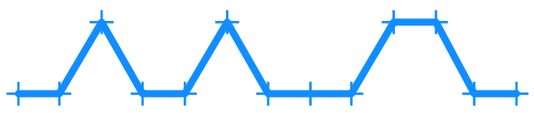
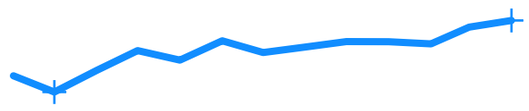
Never Events	Apr-26	0	0	0		
Complaints Responded In 60 Days	Apr-26	78.0%	80.0%	78.0%		

Board Summary - Operations

Operations

Urgent Care Pressures A&E
4-Hour performance decreased in April, achieving 73.8% (all types). The Trusts mapped 4-Hour performance achieved 77.9%, against the national target of 82%, which, whilst a reduction on the previous month, is the highest performance in C&M against Acute Trusts, and 3rd Highest within the North West region.
There are signs of operational improvement in selected areas (Ambulances triaged <15 and <30 minutes, Walk-in triage times, and discharges before noon) overall A&E performance continues to remain below the national standard, with high bed occupancy and increasing non-elective length of stay (LOS) continuing to impact front door performance.
4-hour and 12-hour improvement plans have been taken through the Medicine and UEC Divisional Performance Review meetings, and will be linked to the UEC workstream, within the Strategic Transformation Programme.

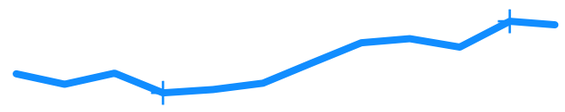
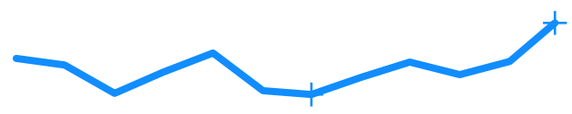
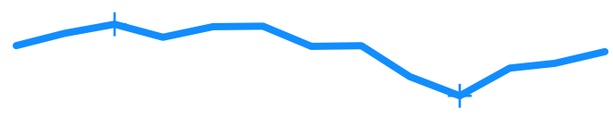
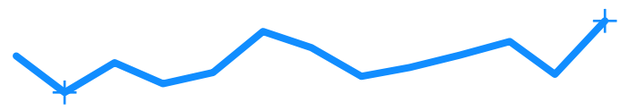
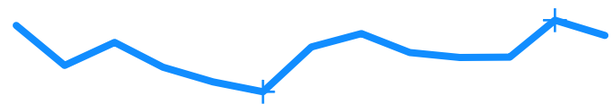
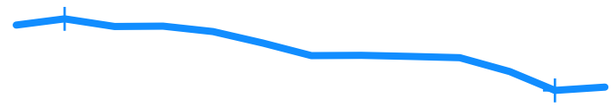
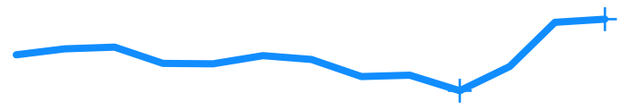
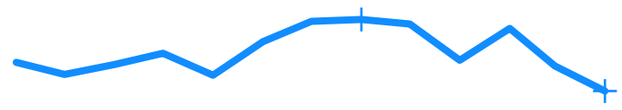
Patient Flow
Bed occupancy across MWL averaged 105.1% in April equating to 98.1 patients - an ongoing trend of high occupancy. There was a peak of 145 patients (64 at S&O, 81 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 1% lower than last April, with a 1% reduction in 1+ day LOS activity and also a 1% reduction in 0 day LOS activity. Average length of stay for emergency admissions remains high, at 9.4 at S&O and 8.2 at StHK, with an overall average of 8.6 days, the impact of non CTR patients being 24.1% at Organisation level, 3.7% higher than March and 2.4% higher than April 25 (21.3% S&O and 21.9% StHK).

Elective Activity
The total number of incomplete RTT pathways was 78,814 at the end of April 2026, with 26,204 pathways waiting 18 weeks or more. 1,110 incomplete pathways are over 52 weeks, representing 1.4% of the total RTT waiting list, against the national target of 1%. The number of 52-week waits has reduced compared with earlier months in the trend, the April position demonstrates that long waits remain a material concern and subject to continued specialty-level recovery in Trauma and Orthopaedics, Dermatology and General Surgery alongside validation and capacity optimisation.
The Trust reported 66.8% of incomplete RTT pathways waiting under 18 weeks at the end of April 2026, against the 92% constitutional standard, this was a 2.8% improvement against plan. This reflects continued pressure across waiting lists and capacity, with performance at 68.3% for Southport and Ormskirk and 66.2% for St Helens and Knowsley.

Cancer
Cancer performance continued to improve during March 2026, with all three headline cancer standards achieved at Trust level. The Trust delivered:
96.7% against the 31-day decision-to-treatment standard (target 96%);
86.3% against the 62-day urgent GP referral to treatment standard (target 85%);
and 80.4% against the 28-day Faster Diagnosis Standard (target 77%).
The data demonstrates sustained improvement in trajectory over recent months, particularly within the 62-day pathway where Trust performance improved from 78.0% in November 2025 to 86.3% in March 2026
Performance improvement has been supported through strengthened cancer pathway management, improved validation processes, earlier escalation of pathway risk, and closer operational coordination between cancer services, diagnostics and clinical specialties. Tumour site specific improvement plans, taken through Divisional Performance Reviews are in place, which set out the key actions being taken to achieve the 28 day and 62 day standards for 2026/27.

Diagnostics
Diagnostic performance in April deteriorated to 82.5% for MWL, failing to achieve the 95% target, with S&O achieving 74.6% and StHK 90.2%. MWL performance is ahead of national performance however (latest month March) of 78.8% and below C&M regional performance of 90.2% - one of the highest regions nationally. The Trust diagnostic waiting list has increased to 16,971 pathways in April, reflecting the increased demand through the March sprint initiatives, and continuing the upward trajectory seen over recent months. The deterioration also reflects a combination workforce fragility, reduced external support capacity and operational disruption across several key diagnostic modalities; specialty action plans have been produced within divisions and managed through the Trusts DMO1 working group.

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Mar-26	80.4%	77.0%	71.2%	Worst 20%	
Cancer 31 Days	Mar-26	96.7%	96.0%	93.9%		
Cancer 62 Days	Mar-26	86.3%	85.0%	79.3%	Best 20%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Apr-26	80.0%	100.0%	80.0%		
A&E Standard (Mapped)	Apr-26	77.9%	82.0%	77.9%	Worst 50%	
% of Patients With No Criteria to Reside	Apr-26	24.1%	10.0%	24.1%		
Discharges Before Noon	Apr-26	20.1%	20.0%	20.1%		
G&A Bed Occupancy	Apr-26	96.9%	92.0%	96.9%	Worst 10%	
18 weeks: % 52+ RTT waits	Apr-26	1.4%	1.0%	1.4%	Worst 40%	
RTT % less than 18 weeks	Apr-26	66.8%	70.6%	66.8%	Best 40%	
Diagnostic Waits: % <6 weeks	Apr-26	82.5%	95.0%	82.5%		

Board Summary - Workforce

Workforce

Mandatory Training
The Trust continues to exceed its mandatory training target, maintaining performance at 89.6% in April 2026 against a target of 85%. Targeted support remains in place to enable front-line clinical staff to access training, ensuring continued compliance and improvement.

Appraisals
Appraisal compliance is positively exceeding the 85% target at 89.6% in April 26. There is an expected downturn prior to this year's Appraisal Window which opens on 1st May 2026. Appraisal forms will be uploaded to the intranet by 1st May – following the launch of the new Trust objectives at the STAR Conference in April. Supportive toolkits and training will be available for managers to ensure staff are getting the most out of their appraisals, which will hopefully support the feedback from staff survey on the quality of appraisals.

Sickness Absence
Sickness absence reduced to 6.5% in April 2026 from 6.6% in March; however does remain above target of 5%. There's been a positive reduction since December 2025 (from 7.8%).
This continues to be a key priority area for the HR Team and for MWL.
Top 3 reasons for sickness absence:
Anxiety/stress/depression/other psychiatric illnesses
Cough/cold/flu
Gastro related
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.
The Absence Taskforce Group launched in early January 26 continues to work with the six areas identified as high risk for initial focused action, namley Surgery Medical Secretaries, Spinal Injuries Team, Ward 1B AMU, and Ward 1C AMU, Bevan 1 & 2. The group meets on a weekly basis to report on progress. This group is led by the AD of HR for LOD and HWWB and is reporting via People Performance Council for monitoring and Strategic People Committee by exception. Overall there has been a reduction in absence in all six areas since January when the Task Force was initially set up, with four areas showing a significant improvement. Once change has been embedded, next steps will be to work with additional teams based on a further deep dive.

Turnover
In-month turnover for April 26 is 0.7% against a target of 1.1%.

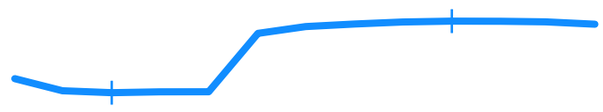
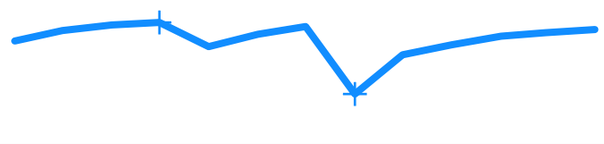
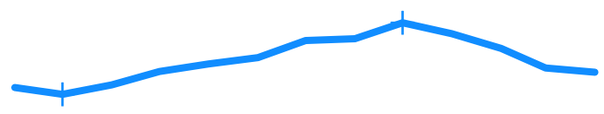
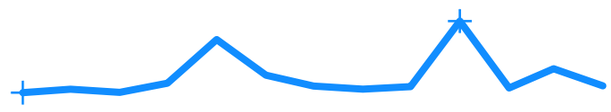
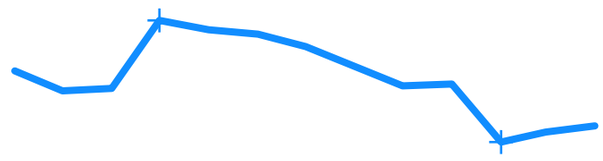
Time to Hire
Time to hire has been a particular challenge for us since the summer months, reporting 100.2 days in July 25. A recovery plan has been in place in recruitment and HWWB to drive it down.
In April 26, time to hire increased from 51 days to 52 days, exceeding the recovery plan target. This metric includes from advertising start date to checks complete which includes time spent with Recruiting managers for shortlisting, interview etc. The increase is attributed to exceptionally high volumes, including transition to an internal bank, TUPE transfers, and FY1 intake which is 3 times the usual volumes for the team at this time of year. Despite this, offers made in-month remain within target at 33.65 days against a 40-day target. The national average for TTH is 50 days.
Weekly (with higher frequency if required) meetings are taking place between Recruitment and HWWB, particularly as both teams are entering their busiest period of the year, to keep track of time to hire. Any concerns will be escalated through to the AD of HR team.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Apr-26	89.6%	85.0%	89.6%		
Mandatory Training	Apr-26	89.6%	85.0%	89.6%		
Sickness: All Staff Sickness Rate	Apr-26	6.5%	5.0%	6.5%		
Staffing: Turnover rate	Apr-26	0.7%	1.1%	0.7%		
Average time to recruit (days) - All Staff	Apr-26	52	40	52		

Board Summary - Finance

Finance

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

Surplus/Deficit – At the end of Month 1, the Trust is reporting an adjusted position of £2.7m deficit. Excluding deficit support funding, the adjusted position is £4.1m deficit, in line with plan. This includes the impact of the 2026/27 Agenda for Change pay award and industrial action costs which are mitigated within the overall position.

CIP - The Trust's CIP target for financial year 2026/27 is £49.7m, all if which is to be delivered recurrently. As at Month 1, the Trust has successfully transacted CIP of £3.3m year to date, in line with plan.

Cash - At the end of M1, the Trust's cash balance was £2.9m. As part of the plan submitted to NHSE, the Trust assumes the receipt of £16.8m deficit support funding by the end of the financial year. The Trust has also included £32.2m capital PDC funding 2026/27.

Capital - The Trust's capital plan for 2026/27 is £42.2m (including PFI lifecycle and lease remeasurements). Capital expenditure for the year to date [including PFI lifecycle maintenance and lease remeasurements] totals £0.9m, which is £1.7m below plan.

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Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Value of aged debt >90days overdue £000's	Apr-26			14,251		
Capital Spend £ 000's	Apr-26		2,269	947		
Cash Balances - Days to Cover Operating Expenses	Apr-26	1.0				
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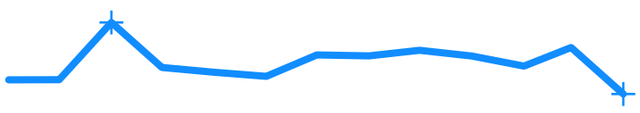
Delivery of CIP savings (000's)	Apr-26			3,313		

How to Interpret - Summary Table

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

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

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

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

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

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

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

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 May 2026
Agenda Item	**TB26/035 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in April 2026		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held during April 2026. No meeting was held on Thursday 16th April due to external diary commitments resulting in quoracy non-compliance. At each meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. The weekly vacancy control panel decisions were also reported.		
02 April 2026		
EPR Programme Team Retention	• The Committee received a paper seeking approval to retain the existing Electronic Patient Record (EPR) Programme team capacity on a short-term basis, pending confirmation of national funding. • The Director of Informatics outlined that this was not a request for expansion, but rather to maintain critical capability already in place at a key stage of the programme. • It was emphasised that the Trust must ensure strong clinical leadership at the appropriate level. • The Committee approved the continuation of the EPR Programme team for a period of three months.	Approval
Clinical Coding Backlog Progress Report	• The Director of Informatics introduced the paper looks to stabilise the Health Records function and address the current backlog of records requiring scanning and processing. • The Committee discussed the longer-term ambition to reduce reliance on paper records • The paper outlined a three-part approach. Part one: driving front-end digitisation, particularly within outpatient services. Part two: reducing	Approval

	unnecessary printing of electronically available information, and part three: engaging services to change behaviours contributing to paper volume. • The Committee Approved the proposed workforce actions.	
Dementia Team Proposal	• The Chief Nursing Officer introduced an updated paper that articulated the preferred service model. • The Committee discussed where the service should sit organisationally. It was agreed that the Dementia Team should be positioned within the medicine and urgent care division but with recognition that dementia care is "everybody's business" across the organisation. • The Committee Approved the Dementia Team proposal, including implementation of the revised nursing structure, reallocation of existing budget into the Medicine and Emergency Care Division and recruitment to stabilise the service.	Approval
Safe Staffing Report	• The Chief Nursing Officer presented an update on safe staffing across wards, including triangulated intelligence on fill rates, quality indicators, and emerging risks. • The Committee noted that some wards have experienced temporary closures due to infection prevention (IPC) issues. These closures have impacted staffing metrics and service stability at times. • A key theme of the discussion was the impact of staffing pressures on leadership capacity. The Committee noted that ward managers and coordinators are frequently pulled into clinical roles • The Committee agreed that there has been progress in triangulating workforce and quality data, highlighting good practice. However, the data also identified that there remains localised areas requiring support, which will be utilised inform improvement plans.	Assurance
Freedom of Information (FOI) Report	• The Director of Informatics presented a paper providing an update on Freedom of Information (FOI) performance, including compliance rates, operational challenges, and actions to improve responsiveness. • The Committee was updated on the work of the FOI Working Group, which has been established to improve coordination across teams, provide	Assurance

	clearer guidance on handling requests and identify opportunities to reduce duplication of effort. • The Committee reaffirmed the importance of maintaining focus on 20-day compliance requirements, continuing to improve internal processes and expanding proactive publication to reduce demand.	
Financial Improvement Group Update	• The Chief Finance and Performance Officer presented a verbal update relating to Financial Improvement Group (FIG) matters. • The meeting focused on reviewing progress against the Surgical divisional action log, workforce and financial pressures, and recovery plans across surgical specialities •	Approval
Summary from Vacancy Control Panel	• The Chief People Officer gave an update on activity and governance relating to the Vacancy Control Panel (VCP), including operational challenges, consistency of process, and workforce pressures across divisions. • The update on recent VCP activity, noting that 22 vacancies had been approved during the most recent cycle. • The Committee agreed that VCP remains a critical mechanism for workforce control and governance. However, improvements are required in consistency of attendance from divisions/departments, quality of submissions and visibility of workforce gaps.	Assurance
9 April 2026		
Temporary Workforce Report	• The Assistant Director (Workforce) presented the Temporary Workforce Utilisation report which provided an overview of bank and agency use for February and March 2026 • There had been a reduction in agency use for Agenda for Change (AfC) staffing groups from January-March 2026, there had, however, been a corresponding increase in requests for Bank staff. • The introduction of the One Bank model at Southport has been well received; 675 substantive colleagues and 200 bank only staff have been onboarded.	Assurance

	• The executive Committee noted the progress made	
Outpatient Digital Transformation Update	• The Deputy Director Strategy and Operations shared a presentation regarding the current status of the project. • Concerns were raised regarding the capacity to take the project forward whilst maintaining business as usual. • The Chief Executive requested clarification on the resources that would be required to take the digital transformation forward, how this differed from the resource that would be drawn down to deliver the preparation for a single EPR and what could be reprioritised to enure delivery of this piece of work within the 12 month timeframe. • The Director of Informatics took this action regarding resources required to deliver, to feedback at a future meeting.	Assurance
Rowlands Outpatient Tender	• The Chief Pharmacist presented the Outpatient Pharmacy Tender (Southport and Ormskirk sites) and noted the following. o The current contract ends on 17th May 2026 o 2 formal bids had been received from Rowlands Pharmacy (incumbent) and another organisation. o A robust tender review had identified Rowlands Pharmacy as the most favourable bid. • It was recommended to award the tender to Rowlands on a 3 year contract.	Approval
MWL Trust Strategy	• The Director of Strategy presented the draft MWL Trust Strategy which had been amended following feedback from Executive colleagues. • A discussion unfolded regarding improvements and the Director of Strategy took an action to update the MWL Trust Strategy with the suggested amendments.	Assurance
Board Assurance Framework Update	• The Chief Executive introduced the report. Three changes had been proposed: o BAF 2 reduce score to 15 o BAF 3 reduce score to 16 o BAF 7 reduce score to 8 • These proposals were agreed, but with the following changes to the rationale:	Assurance

	○ BAF 2 reduce risk score to 15 reflecting the positive end to 2025/26 and having a substantive and complaint plan for 2026/27. ○ BAF 3 reduce risk score to 16 reflecting the positive end of year performance and confidence in delivering the 2026/27 operational performance.	
Summary from Vacancy Control Panels	• The Deputy Chief Executive presented the report and noted the following: ○ 18 vacancies were considered, 14 were approved and 4 required further information. ○ 6 variations were considered, 2 were approved and 4 required further information.	Assurance
23 April 2026		
Service Transfer Updates Knowsley UCR and West Lancs Community Services Transfer	• The Director of Integration introduced the report which provided an update on the progress, risks and plans related to the transfer of Knowsley UCR • Staff will be TUPE'd across and onboarded to deliver the existing service model, with the intention of working with the team to maximise patient benefits as a result of pathway alignment. • Transfer is planned for 1st May 2026, and site visits are underway. Work is also underway to migrate the EMIS system.	Assurance
Strategic Programme Overview incl. Winter Summit Update)	• The Director of Strategy introduced the report along with the Strategic Programme Director, providing a project overview and an update following the winter summit. • MIAA will be undertaking a gap analysis around resource requirements; this will be brought back to the Committee once complete. • The Committee discussed the governance structure for the programme, going on to consider the requirement for appropriate project support for each of the workstreams, together with the correct level of admin support. • Feedback from the Winter Summit was discussed with several solutions and quality improvements identified. The Chief Executive stressed the need for some immediate actions along with medium	Assurance

	and long term planning for delivery and transformation	
Lost to Follow Up Update	• The Chief Nursing Officer introduced the report to provide the Lost to Follow Up update. • As at 15th April 2026 there remains 776 patients that require a review. This is a reduction of 259 patients since 25th March 2026. • It was acknowledged that there has been good engagement from the Divisions to clear the backlog. • A further update will be provided to the Committee on 7th May ahead of report to Quality Committee.	Assurance
Southport and Ormskirk Bed Moves Update	• The Chief Finance Officer introduced the report which provided an update on the ward moves at Southport. • The Committee discussed the works underway on Ward 10B, as part of the ward refurbishment programme for the Southport and Ormskirk sites. The aim is for completion of ward 10B in July. • The committee advised that the overall plan may involve movement of wards/departments to achieve the best configuration to support effective patient flow. There has been good engagement from teams to date	Assurance
Friends & Family Test Options	• The Chief Nursing Officer presented the report which provided current options following notice of withdrawal of patient experience services, namely the Friends & Family Test, by the current provider. • It was advised that the C&M procurement for patient experience services had not moved forward and therefore a local solution should be considered in the meantime; an alternative solution is required by August 2026. • It was advised that the Trust has met with North Cheshire and Mersey NHSFT (NCM) and would be meeting with East Cheshire Hospitals NHS Trust (ECH) to discuss efficiency at scale procurement opportunities.	Assurance
Model Emergency Department Self-Assessment	• The Chief Medical Officer presented the report, and the Committee reviewed the self-assessment, however, it was felt that some of the responses required further consideration.	Assurance

	• The Chief Medical Officer agreed to review the responses and provide feedback ahead of the submission date on 28th April 2026.	
EPR OBC	• The committee received an updated Outline Business case (OBC) however it was noted that NCM required some further amendments, specifically the financial changes to the OBC, therefore it was agreed the paper would be deferred from April's Trust Board and an Extra Ordinary Board would be convened during the first week of May.	Assurance
Health Inequalities Strategy Review Paper	• The Committee noted the Strategy and were asked to review and provide comments back to Director of Integration ahead of submission to the Trust Board. • The Deputy Chief Executive commented she had shared her feedback regarding the strategic aims. • The paper was approved for submission to board noting an additional action for Chief Nursing Officer, Chief Medical Director, and Chief People Officer to meet with the Director of Integration to agree 2026/27 objectives.	Assurance
Financial Improvement Group (FIG) Update	• The Committee noted the report and the financial updates from the Clinical Support & Community Division, focused on reviewing financial performance, CIPs and key operational risks. • A workforce update was received from the Medicine and Urgent Care Division, covering speciality level plans and the forthcoming TUPE of staff from Knowsley UCR.	Assurance
30 March 2026		
Maternity Patient Experience Survey 2025	• The Chief Nursing Officer presented the report which provided an update on the NHS Maternity Patient Experience Survey 2025 and associated action plan - there had been an overall improvement on the previous year. • Areas identified for further focus were post-natal pain, respect, timely discharge and partners being able to stay with patients. • It was advised that an additional national maternity survey had recently been received following investigations at 10 maternity units, across the country (MWL not being one of them).	Assurance

	• The Committee were pleased to note the ongoing improvements in maternity survey results.	
Theatre Safety Proposal	• The Chief Nursing Officer presented the report which provided a proposal from Health Innovation North West Coast (HINWC) to review theatre safety following a recent increase in Never Events. • HINWC would undertake a review to identify any themes and issues around Never Events and engage with staff to deliver a coaching academy. • The cost of the project is c.£33k; it was advised that CPD funds had been identified to cover these costs. • The Committee stressed the need for this project to link with Impact Service Improvement methodology and approved the report	Approval
EPR Outline Business Case (OBC)	• The Director of Informatics introduced the report which sought approval of the Acute and Community EPR Programme OBC. • The presentation provided an overview of progress to date, the changes that had occurred over time and the impact of those changes. • The Committee discussed the potential operational risks to switching EPRs during winter; the director of Informatics acknowledged the concerns but advised that they would use best endeavours to bring the implementation date forwards. • The Chief Executive raised concerns regarding the proposed timeline extension but felt this would not prevent the OBC being presented to the Trust Board for next level sign off in principle, as this detail would be worked through at Full Business Case (FBC) stage • The Executive Committee approved the EPR OBC for presentation at an extraordinary Trust Board meeting in early May.	Approval
Outpatient Transformation Update	• The Director of Strategy presented the report advising that it would now be possible to progress the GIRFT and Further Faster elements. • The committee discussed opportunities for automating transfer of patients onto newly configured systems. The Committee proposed identifying a speciality with an autonomous	Approval

	booking system, as this would allow the PBS central booking team to continue with business as usual (BAU) whilst testing automated transfer. Additional resource of a Band 5 for the duration of the project would be required to support the preferred option. • The Executive Committee approved the pilot of automated patient transfer, speciality to be determined, and approved the additional Band 5 resource for the duration of the project.	
May Trust Board Agenda	• The Committee reviewed the Trust Board agendas for May and noted the following amendments:	Assurance
Summary from Vacancy Control Panel	• The Chief Nursing Officer presented the summary from the Vacancy Control Panels held on 24th April and 28th April 2026. • The Committee considered whether changes to job plans would need to be discussed at Vacancy Control Panel, given they had already been approved at a senior level. It was agreed that this should be a separate discussion outside of the meeting.	Assurance
National NHS Uniform	• 90% of staff have ordered uniform – the reminders are being chased. The new uniform will go live in June 2026. Project is on track for delivery.	Assurance

Alerts:

None

Decisions and Recommendations:

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

- Continuation of the EPR Programme team for a period of three months.
- Clinical Coding backpay - The recruitment of 6 WTE Band 2 posts and extension of 4.4 WTE fixed-term roles.
- Outpatients Transformation Project - Additional Band 5 resource to be recruited for the duration of the project

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 May 2026
Agenda Item	**TB26/035 (8.2)**		
Committee being reported	Quality Committee		
Date of Meeting	19 May 2026		
Committee Chair	Minal Singh, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Minutes and Action Log	• The minutes of the Quality Committee meeting held in April 2026 were approved and the 7 actions due for update in May were all reviewed and updated.	Assurance
Quality Committee Corporate Performance Report (CPR).	• 0 Never Events reported for April 2026. • Sustained complaints performance against resolution within 60 day target. • Safeguarding Key Performance Indicators (KPI) all on target. • Venous Thromboembolism (VTE) screening remains under target • National Early Warning Score (NEWS) - observations in AED performance remains a focus. • 1 Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia March 2026. April data awaited. • Mortality data remains within satisfactory parameters. • Sepsis – Southport and Ormskirk sites report low noting small sample size with improvement work ongoing. • Stroke indicators against therapy domains to be further reviewed and reported back.	Assurance
Patient Safety Council Assurance Report	• Overall numbers of Incidents reported in March remains consistent. • IPC figures in relation to the number of notifiable infections overall, from a Northwest regional perspective, relatively favourable in comparison with peers.	Assurance

	• VIP monitoring -under 90% target, discussed through IV therapy group to support review of consistency of report. • Increase in number of falls – increase presence from subject matter experts in areas of focus. • Q3 HAPU reports a reduction in numbers. • Procedural documents for review reported an improving position.	
Patient Experience Council Assurance report.	• Assurance report for May received. • Closing of complaints within Trust standard (80%) noting increase in second stage complaints. • Increase in PHSO activity noting extended time of 12 months. • Ask Rob process working well with assurance provided on reporting process. To be added to the Trust Complaints policy. • Assurance provided on the increased activity through the patient portal noting rollout across Whiston and St Helens outpatient areas unable to progress and remains part of wider outpatient planning review. • Bi-annual report for Surgery received into the Council. • Patient story received demonstrating reasonable adjustments and multidisciplinary teamwork for a young patient with Learning Difficulties and Autism accessing urgent investigations on the Ormskirk Site. • Surgical Admissions Lounge opened on the Southport site improving patient flow by creating a dedicated space for elective admissions improving patient experience. • 1st October 2026 Trust moving away from Microsoft Publisher currently used for leaflets across MWL. Alternative apps being considered. • Assurance provided on Friends and Family Test and move to new provider – IQVIA will be the provider for the next 12 months whilst ongoing procurement considered across Cheshire and Mersey region. • Procedural documents for review reported a positive position.	Assurance
Clinical Effectiveness Council Assurance Report	• Assurance for May received. • Medicine Urgent Care Division exception report noted.	Assurance

	• National Joint registry – positive results noted with mortality within the 99.8% control limits-no concerns. • MWL HSMR -96.4 • Acute Kidney Injury-replacement for Advancing Quality (AQ) data still under discussion noting fluid balance collected via AMaT from April 2026. • Laboratory performance report noting Warrington Pathology service TUPED into MWL 1st May 2026 as part of the creation of the Eastern Hub Pathology Service. • Transfusion equipment highlighted for monitoring. • Learning From Deaths (LFD)-Q2 report due to Trust Board May– 200 structured judgement reviews completed. • Research Development and Innovation (RD&I)-Self-assessment against research readiness ongoing through SORT. • Procedural Documents for review noted.	
Patient Safety Report	• Overall number of Incidents reported in March were as expected noting slight increase in numbers of falls but reduction in falls with harm – targeted improvement works ongoing. • 1 Severe harm reported in March -review ongoing. • 1 Medication incident downgraded to low harm from moderate harm following review. • Reduction in Pressure Ulcers reported with work to increase resource and consistent information across Websites -2 validated Hospital Acquired Pressure Ulcers (HAPU) with lapses in care February. • Local Safety Standards for Invasive Procedures (LOCSIPP) development -directory across MWL ongoing. Seeking new list of Clinical Directors to support the work. • 0 Patient Safety Incident Investigation (PSII) commissioned and 0 PSIIs closed in March.	Assurance
Quarterly Safeguarding Report	• Q3 feedback noted positively with level 3 adult training as only area of noncompliance. • Children in care initial health assessments and turnaround timeframes -noncompliance due to external factors. Q4 data submitted and awaited.	Assurance

	• Deprivation of Liberties (DOLS) -Now digital across all sites at MWL in Q4. Local Authorities challenges re DOLs with draft guidance developed with no immediate changes to Trust process although improvements made to the completion of form 1. • Contacts to the safeguarding team now included in the report. • Decrease in MARAC referrals noted – no themes. • Domestic abuse staff members – 20 cases reported. • Child Protection medicals – 15 undertaken in Q4. • Section 42 enquiries – 20 received (reduction from previous numbers reported) with consistent themes i.e. discharge, poor communication and poor documentation. • Learning Disability and Autism practitioner appointed to vacancy. • Detentions reported-looking to expand the Merseycare Service Level agreement for Mental Health Act Legal Administration across MWL – briefing paper to executive committee. • 0 Child deaths reported. • Allegations- common themes detailed in report. • Training – improvement seen year to date. • 2025/27 Commissioning standards submitted to ICB-All areas of Key Lines of Enquiry (KLOE) reported positively (Green). • Safeguarding Annual report to Committee in June.	
Infection Prevention and Control Quarterly Report	• Q4 Report received. • Healthcare Associated Infections (HEI) with exception of Klebsiella, all above thresholds noting rates remain lower than those report for comparable Trusts across Cheshire and Mersey. Robust IPLR's continue to support organisational learning with fast track reviews. • MRSA Bacteraemia – 4 cases year to date (2 cases less than 2025) noting 2 cases in Q4. • 109 Clostridium Difficile in year which is 12 above the threshold (5 less than 2025) -MWL remains below Cheshire & Mersey rate. • MSSA -No external objective noting Trust target of 10% reduction. MWL report noted 79 cases in year a reduction of 11 cases.	Assurance

	• Q4 reports dip in VIP monitoring – improvement work ongoing through peer review audits. • Blood stream infection monitoring and key improvement actions noted inclusive of prompt identification and management of sepsis with key improvement actions noted. • 47 outbreaks in Q4 at MWL (27 IN Q3), majority of outbreaks related to norovirus. • MIAA for Trusts arrangements for norovirus outbreak-Substantial assurance received. • Latest HSMR for septicaemia (100) and is below national target. • Noted increase in contact tracing for Tuberculosis, measles, and other notifiable conditions. • Blood stream infections improvement plan of the 31 actions 1 area red (external review of IV access). • Point prevalence for antimicrobials – documentation 64% and prescribing 74.6% with improvement work ongoing. Antimicrobial policies under review. • IPC Level 1 e-learning compliance 90.7%, Level 2 e-learning compliance for clinical staff 85.1% at the end of Q4 (82.9% in Q3) which is above the Trust target of 85% minimum.	
Maternity and Neonatal Services Quarterly Report	• Q4 report received. • Maternity Incentive Scheme (MIS) year 7 - extensive validation completed by NHSR and formal confirmation of compliance to all 10 safety actions received. • MIS year 8 – launched April 2026 with significant changes. There are now 6 safety actions condensed from 10 with the majority amalgamated into the new 6 rather than being removed. • Q4 maternity Mersey Internal Audit (MIAA) reviewed all 10 MIS Safety actions – high level of assurance received. • Maternity and Neonatal dashboard current areas of focus: Transfers to neonatal unit annual rate of 6.5% (6% target)-all cases reviewed and deemed appropriate. Introduction of TC will improve this rate and ensure minimalization of separation of mothers and babies wherever possible.	Assurance

	• Instrumental births – December 2025 increase in instrumental births -no themes noted following reviews and identified as natural variation. Rates reduced since the December increase. National average is 10-15% based on 1:8 women experiencing an instrumental birth. End of Year position was 9.8% and below national average. • 5 Perinatal mortality cases. 4 cases following review identified no care issues, 1 following review suggesting increase in scan opportunities over weekend and bank holiday periods. • 2 PMRT cases in Q4-No issues identified. • 2 serious incidents – 2 hr maternity divert Ormskirk site due to short term medical staffing issues – 1 woman diverted to triage at Whiston site who was reviewed and discharged. 1 baby underwent therapeutic cooling as part of the COMET trial– no care issues identified reported to Maternity and Newborn Safety Investigations (MNSI) as per criteria. • Saving babies lives – Q4 data validated -96% overall (1% decrease to Q3). Local Maternity and Neonatal System (LMNS) happy with progress and actions in place for elements 2 and 5. • 10 maternity complaints completed in Q4 and 9 formal complaints received. Themes noted and no breaches. 1 neonatal complaint completed in Q4 and 1 received. • 0 New claims in Q4 and therefore no claims to triangulate against the claims scorecard. • 25 Maternity Red Flags Whiston site relating to a delay of 15 minutes or more between presentation and triage– full reviews completed all patients safe and no adverse outcomes. • Maternity workforce – aligned to Birthrate+ (BR+) funded establishment recommendations. The maternity service had proposed a full BR+ workforce review in Q4 or Q1 however BR+ underwent a national review and a decision to await the outcomes to ensure the new methodology would be used.	

	• Obstetrics workforce -fully established. 1 Consultant on secondment and currently covered by a fixed term appointment. • Neonatal medical staffing aligned to British Association of Perinatal Medicine (BAPM) standards. • Neonatal nursing workforce. Whiston site currently 3.45 wte below the recent workforce calculator. Action plan in place. • 11 Neonatal closures in Q4 on Whiston site, 0 at Ormskirk site – unit remained open to emergency admissions. No transfers were required during the closure periods for mothers or babies. • National Inpatient Survey 2025 – against 48 questions significantly improved in 6 questions. Areas of improvement related to focussed work that had been undertaken in antenatal care and discharges from the postnatal wards. Revised action plan produced in collaboration with Maternity and Neonatal Voices Partnership (MNVP) and patient engagement teams to strengthen communication, support and family involvement. Targeted work includes undertaking local surveys which has identified positive results. • Recruitment to 3rd (MNVP) lead completed with focus on neonatal services. • 3 year delivery plan – 11 ongoing deliverables. • Maternity pathway changes – refined pathways implemented to support configuration of services across MWL with 2 pathways remaining under review- continued Joint Oversight Scrutiny (JOS) monitoring by LMNS. Next meeting will be July 2026 and hoping that following this meeting enhanced support will be stopped.	
Effectiveness of the Meeting	• Meeting quorate and within timeframe.	Assurance
AOB	• Nil	
Alerts:		
•		
Decisions and Recommendation(s):		
The Trust Board is asked to note the report.		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 May 2026
Agenda Item	**TB26/035 (8.3)**		
Committee being reported	Strategic People Committee		
Date of Meeting	20 May 2026		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
Committee Performance Report (CPR)	Core Mandatory Training compliance is above the 85% target at 89.6% for April 2026. Appraisals - 89.6% against the 85% target. There is an expected downturn trend in compliance prior to this year's Appraisal Window which opens on 1st May 2026. Appraisal forms have been uploaded to the intranet – following the launch of the new Trust objectives at the STAR Conference in April. Supportive toolkits and training is available for managers to ensure staff are getting the most out of their appraisals, which will hopefully support the feedback from staff survey on the quality of appraisals. Sickness Absence - decreased further in April to 6.5%. A new C&M Sickness Absence policy will commence our local consultation process with trade unions, this will see the trust align its approach to managing sickness with other trusts within the region. Vacancy Rate - increased to 8.1%, slightly above the 8% target. The most significant gaps in workforce are in Admin and Clerical roles and Senior Heath Care Assistants. Work is continuing with Nursing colleagues to review its Band 2 and Band 3 workforce and the recruitment of existing staff. Areas experiencing high vacancy levels and identified safer staffing risks are able to advertise posts, subject to approval from the Heads of Nursing. Within Administrative and Clerical services, a number of vacancies have arisen following approved MARS applications and subsequent staff departures. Time to hire increased from 51 to 52 days, exceeding the recovery plan target.	Assurance

	This increase remains due to exceptionally high volumes of onboarding new starters, predominately due to the transition to an internal bank, TUPE transfers and the Foundation Doctor in-take. The trust has 500 active vacancies and 845 active candidates, however the offers made in-month remain within target at 34 days against the 40 day target. Turnover – below target at 0.7% Health, Work & Wellbeing (HWWB) - Pre-Employment screening days received to clear is 2 days and withing target.	
Workforce Operations Plan M12	The Committee received an update on the M1 workforce plan. The report highlighted the following: • As at M1 MWL are reporting a total workforce of 10,338.4WTE which is 68.11WTE below plan. This is a -0.7% variance to plan. • This was driven by positive performance below plan for substantive (106.7WTE below plan) and agency (25.88WTE below plan) workforce offset by negative performance above plan for bank (64.5WTE above plan). The report also provided assurance regarding the actions being undertaken to support the divisions to have robust workforce plans to meet the necessary headcount reductions. There was an ask from the Committee to consider assurance levels around process and delivery in future reports. The Committee noted the update.	Assurance
Mutually Agreed Resignation Scheme Update	The Committee received a report on MARS applications and decisions following the scheme opening on 1 February 2026 and closing on 16 March 2026 (six weeks). **MARS Numbers and Decisions** • 183 - Applications received • 36 – Approved • 147 – Declined • 0 - outstanding For the 147 declined applications, the primary reasons were the requirement to replace posts on a like-for-like basis or material impact on front-line patient care. The Committee noted the update.	Assurance

HR Commercial Services Objectives 2026/27	The Committee received a report outlining the proposed HR Commercial Services Objectives for 26/27. The report reflect detailed the objectives which are ongoing as BAU from 2025/26 and new objectives to reflect local and national programmes of work in particular: • The NHSE Target operating model, Transforming People Services and the 10 year plan • State of readiness for the implementation of the new national workforce system as a shared service provider • Cheshire & Merseyside blue print collaboration • NHSE plans for the national expansion of the Lead Employer Model • Opportunities for national collaboration on automation It was noted that opportunities for HR Commercial Services are live and in discussion and on that basis there may be a requirement to revisit these objectives later in the year to reflect our ambition for growth. The Committee approved the objectives; however there was feedback that the measurements needed to be reconsidered to ensure they were objective, measurable and tangible.	Approval
MWL Behavioural Standards Framework	The Committee received an update on the progress of the launch and embedding of the new Behavioural Standards. In April 2025, senior leaders across the organisation met at the start of the year STAR conference. At this conference, several High Impact Actions were identified, including work to improve behaviours across MWL. There was agreement at the conference that behaviours were a key enabler in achieving MWL's vision of five-star patient care and the culture it aspires to. This work links to other High Impact Actions and is reflected in the results of the Staff Survey which have informed the plan and provides a real opportunity to show we have listened to genuine feedback from staff across MWL. A draft framework was developed by a senior level working group, consisting of Deputy Directors of Informatics (x2), Finance and HR, Divisional Director of Operations for CSS and Senior OD Manager (replaced by Head of L&OD), which was tested at the STAR conference in December 2025. The paper included the full Behavioural Standards which successfully launched at the STAR conference in April 26 along with tools to support its embedding and use across MWL in the	Assurance

	form of a 'How to Guide'. The Committee were provided with a delivery plan and future actions which are being developed in consultation with our Communications Team linking the roll out to our staff survey engagement plans. The Committee noted the update.	
Assurance Reports from Subgroup(s)	The following assurance reports were received and noted: • People Performance Council • HR Commercial Services Council	Assurance
Alerts:		
Time to Hire exceeded the recovery plan target and increased from 51 to 52 days.		
Decisions and Recommendation(s):		
Decisions: Approval of HR Commercial Services Objectives **Recommendations:**		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	27 May 2026
Agenda Item	**TB26/035 (8.4)**		
Council being reported	Finance & Performance Committee		
Date of Meeting	21 May 2026		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
MWL FC26/096 – CFO narrative Update on emerging news.	• Update on system performance for M1 2026/27 discussed. • System Turnaround support remains in place for Q1 2026/27 and the Trust will continue to be invited for monthly meetings with system and region partners.	Assurance
MWL FC26/097 – Finance Report M12 2025/26	• The committee received the submitted M12 financial position which is a deficit of £10.7m including £30.2m deficit support funding in line with plan. • At M12 agency costs equate to £12.5m (1.8% of total pay costs), which is a significant improvement on prior year. • The Trust had a closing cash balance of £22.8m due to increased capital creditors and receipt of deficit support funding. • The revised capital delivered in year totals £54.6m which includes PFI Lifecycle and IFRS16 Lease Remeasurement. • The Trust is working with external auditors on the audit of these accounts which will be presented to Audit Committee in June before the final submission to NHSE.	Assurance
MWL FC26/098 – Committee Performance Report Month 1 2026/27	**Urgent care** • A&E performance was 77.9% in March, ahead of the national (76.9%), and ahead of C&M at 74.7%. • Long waits in emergency department continued to be a challenge – 18.8% waited over 12 hours in April, improvement plans have been developed. • Ambulance Handover 45 – improvement in performance to 80% of patients arriving by ambulance being handed over within 45 minutes.	Assurance

	• No Criteria to Reside (NCTR) patients accounted for 24.1% of inpatients which was an increase from March. **Elective** • 18 Week performance in April was 66.8%, a 2.8% improvement against plan following the sprint exercise in March. • The Trust had 1110 52-week waiters at the end of April, specialty level recovery plans in place. • Diagnostic 6-week performance for April was 82.5% which remained ahead of national performance at 78.8% and below C&M performance at 90.2%. The target remains at 95%. • Cancer performance in March was 80.4% for the 28-day standard (target 77%) and increased to 86.3% for the 62-day standard (target 85%). • Bed occupancy averaged 96.9%	
MWL FC26/099 – Finance report Month 1	• The approved MWL financial plan for 26/27 is a deficit of £16.7m excluding deficit support funding (DSF). Including DSF the plan is a balanced plan. • The Trust is reporting a M1 deficit of £4.1m (excluding deficit support funding) in line with plan. • Deficit support funding has been confirmed for Q1, future funding will be confirmed based on delivery of plan on a quarterly basis. • Our position takes account of all variable activity. However, contracts (for 2026/27) are still not finalised, and negotiations continue. • The Trust's 2026/27 CIP target is £49.7m. At M1, the Trust has delivered £3.3m in line with plan. • At M1 agency costs equate to £0.7m (1.3% of total pay costs), which is a continued improvement on prior year. • The Trust had a closing cash balance of £2.9m. • Aged debt has decreased (debt greater than 90 days at £14.3m in M1. • The revised capital plan for the year totals £42.2m which includes PFI Lifecycle and IFRS16 Lease Remeasurement. M1 spend is £0.9m and plans are in place to deliver the programme for the year.	Assurance
MWL FC26/099a – CIP Programme And MWL FC26/102 – Womens and Childrens CIP Update	• Trust CIP target for 2026/27 is £49.7m. To date £54.9m schemes have been identified with £47m fully developed or plans in progress. • Trust PMO supporting in aligning CIP plans with transformation workstreams to support further delivery of targets • Womens & Childrens Division reported their progress on CIP delivery in 2026/27 schemes including work to further develop ideas. The	Assurance

	Division have identified £3.4m across 60 schemes for 2026/27.	
MWL FC26/100 – Contract Update	• Update provided and discussed on current contract queries/disputes and progress to resolve. • System changes resulting in longer timescales for resolving issues.	Assurance
MWL FC26/101 – Elective Care Recovery Performance Delivery Review	• The Committee received an update on Elective Care at the Trust and the actions ongoing to improve care against the key performance indicators. • The Committee discussed the work ongoing to deliver and further develop improvement plans and associated trajectory for the key performance metrics.	Assurance
Assurance Reports from Subgroups:	• MWL FC26/104 – CIP Council • MWL FC26/105- Capital Planning Council Update • MWL FC26/106 - IM&T Council Update • MWL FC26/107 – Estates & Facilities Management Council Update	Assurance
Alerts		
None		
Decisions and Recommendation(s):		
The Board note the report		

Title of Meeting	**Trust Board**	**Date**	27 May 2026
Agenda Item	**TB26/036**		
Report Title	Aggregated Incidents, Complaints and Claims Report – Q4 2025/26		
Executive Lead	Sarah O'Brien, Chief Nurse		
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 4 2025-26

Executive Summary

Incidents

- A total of 7,940 incidents were reported across MWL in Q4 2025/26.
- Of these, 5,921 were patient safety incidents.
- 49 patient safety incidents were classified as moderate harm or above.
- The most frequently reported patient safety incidents in Q4 were:
    - Pressure Ulcers, including those not acquired under Trust care, were the highest reported Trust wide (950)
    - Accidents including slips, trips, falls, and collisions were the second highest reported incidents in Q4 (868)

Complaints, PALS & Ask Rob

- The Trust received 157 first stage complaints in Q4.
- The Trust received 20 stage 2/reopened complaints in Q4.
- The Trust closed 180 complaints in Q4.
- 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 1157 PALS contacts in Q4
- The Trust received 87 Ask Rob Concerns in Q4 (32 in Q3)

Claims & Inquests

- In Q4 the Trust received 21 new claims. 25 were closed
- The Trust received 21 new inquests, and 27 inquests concluded
- No Prevention of Future Death (PFDs) were issued during that period

Financial Impact

None as a direct consequence of this paper

Quality and/or Equality Impact

Not applicable

Recommendations

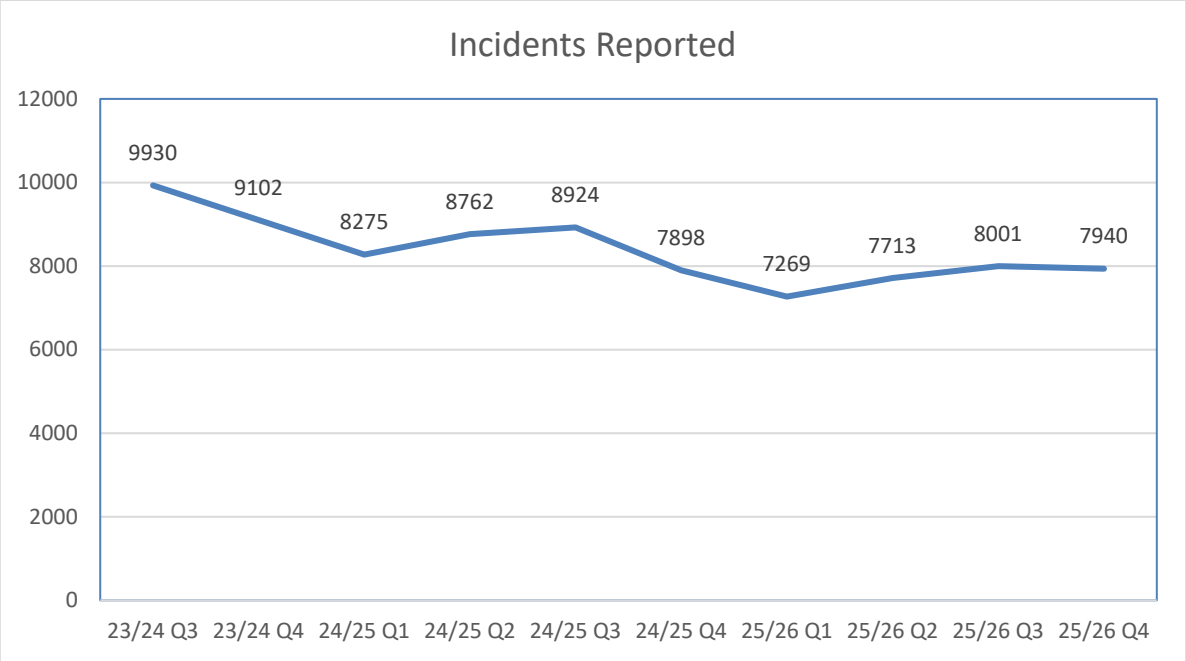
The Board is asked to note the report

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

1. Introduction

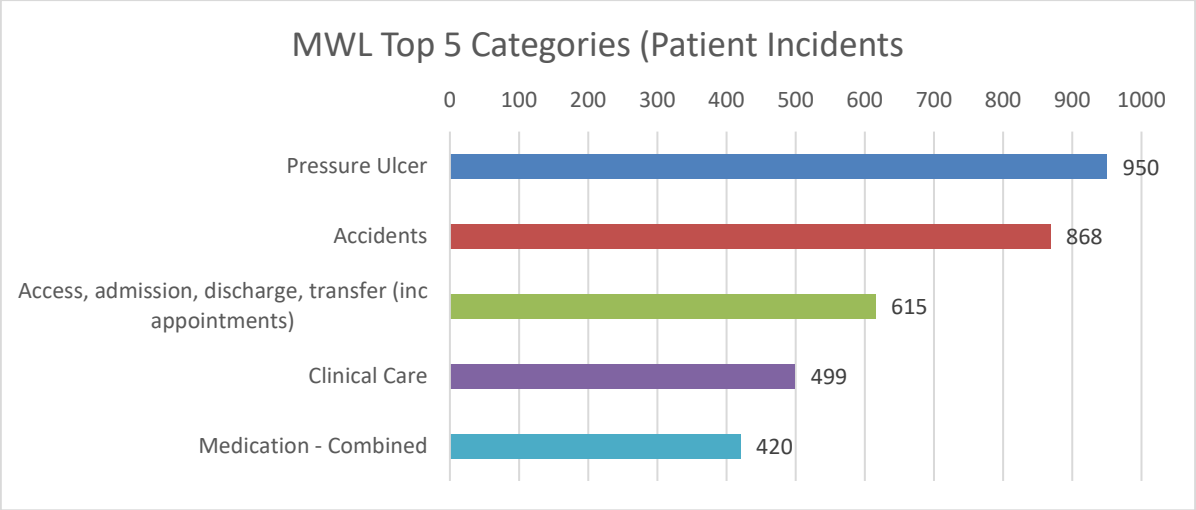
This paper includes reported incidents, complaints, PALS contacts, claims, and inquests during Quarter 4 2025/26, highlighting any trends, areas of concern and the learning that has taken place. In March 2025 the Trust moved to a new Incident Reporting System, InPhase, which brought all sites onto one reporting platform to record incidents, complaints, PALS, claims and inquests.

2. Incidents



MWL Q4 incidents reported	
5,921	**Incidents affecting patients**
642	**Incidents affecting staff**
1,323	**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)**
52	**Incidents affecting visitors, contractors or members of the public**
2	**Martha's Rule / Call for Concern**

Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon. The system to support this commenced across Southport sites between January and April 2024, and officially trust-wide on 2 April 2026.



There were 7,940 incidents reported across MWL during Q4, which remains consistent with Q3 (8,001). Patient related incidents accounted for **74.6%** of these cases (5,922).

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 Q4, with 950 cases, which is consistent with Q3 (952)
- **Accidents** – including slips, trips, falls, and collisions – were the second highest reported patient events (868) which is an increase on the previous quarter (831 in Q3).

2.1. Incidents by harm category

The table below illustrates incidents by harm for Quarter 4 2025/26.

In Q4 there was 1 incident recorded as fatal harm across all sites which is a decrease on the previous quarter. The percentage of severe and fatal incidents against the total of all patient incidents is 0.12% for Q4 2025-26 compared with 0.22% for Q3. This will continue to be monitored in the coming quarters.

The fatal incident reported in Q4 relates to a radiology discrepancy with a missed 'subtle thin left acute subdural haematoma' which is subject to an expanded learning review and the case was submitted to the Radiology Events and Learning Meeting (REALM) to determine any further learning.

MWL	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4
Moderate	37	35	33	54	67	38	45	49
Severe	15	9	9	6	14	14	6	6
Death	0	2	4	2	4	4	7	1
Total	52	46	46	62	85	56	58	56

2.2. PSII incidents and Learning

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

Q4 2025/26 – Discussed at Patient Safety Panel	Total
Patient Safety Incident Reviews	30
Learning Reviews including Expanded Reviews	5
MDT / AAR	0
Patient Safety Incident Investigations (PSII) / (including MNSI)	0
StEIS reportable incidents	3

There were 3 StEIS reportable incidents recorded for Q4 2025-26. Two of these were surgical related never events which are currently under review, and the third was a Maternity Divert for a 2 hour period at Ormskirk Hospital due to senior medical cover issues, with one patient diverted to Whiston, meeting the criteria for reporting on StEIS.

2.3. Duty of Candour

The duty of candour process has been commenced or completed for all incidents where harm has been confirmed as moderate or above. The investigation and validation of some Q4 reported incidents is still ongoing. In accordance with policy, Duty of Candour will be initiated following confirmation of harm.

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

3. Complaints

The Trust received 157 new complaints in Q4, there were 147 closed complaints in Q4 and 63 aligned to complaints that had breached the 60-day target. The Trust achieved a 64.8% compliance of complaints being responded to within 60 working days in Q4. Compliance has improved across the quarter, with 77% of complaints answered in March 2026 completed within target timescales. The aim is to sustain this improvement going forward.

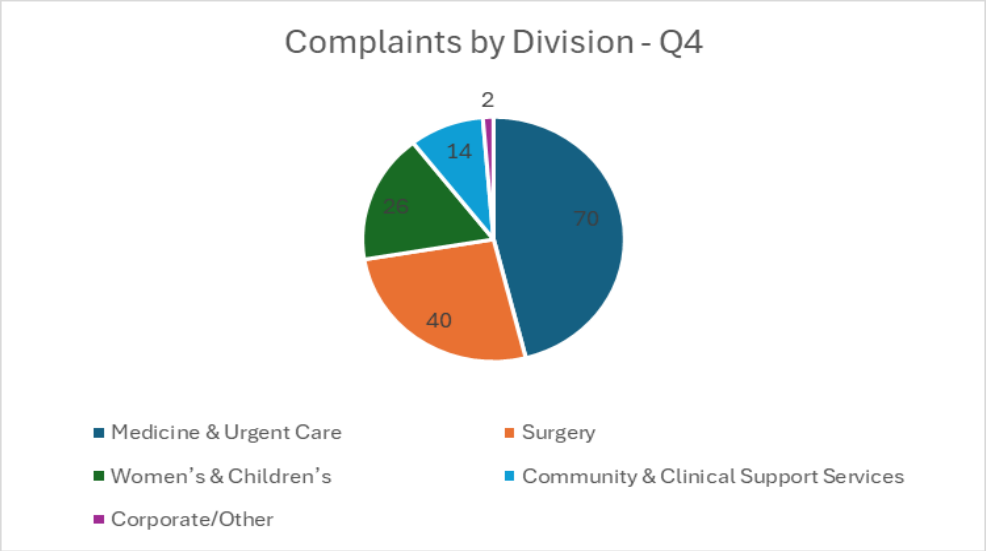
	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	**2025/26 Q1**	**2025/26 Q2**	**2025/26 Q3**	**2025/26 Q4**
MWL First stage complaint	109	122	144	142	115	161	146	157
Second Response Trust Target Less than 12 per Q	14	13	12	27	16	16	19	20
Response Compliance Trust Target 80%	74.76%	57.44%	62.9%	64.6%	50.7%	71.6%	60.7%	64.8%
MWL number of complaints breached 60 working timeframe	28	52	54	50	57	34	77	63

Closed Complaints	**Q4 24/25**	**Q1 25/26**	**Q2 25/26**	**Q3 25/26**	**Q4 25/26**
Not Upheld	12	22	17	20	16
Partially Upheld	79	89	86	127	90
Upheld	16	24	17	22	41
Total	**107**	**135**	**120**	**169**	**147**

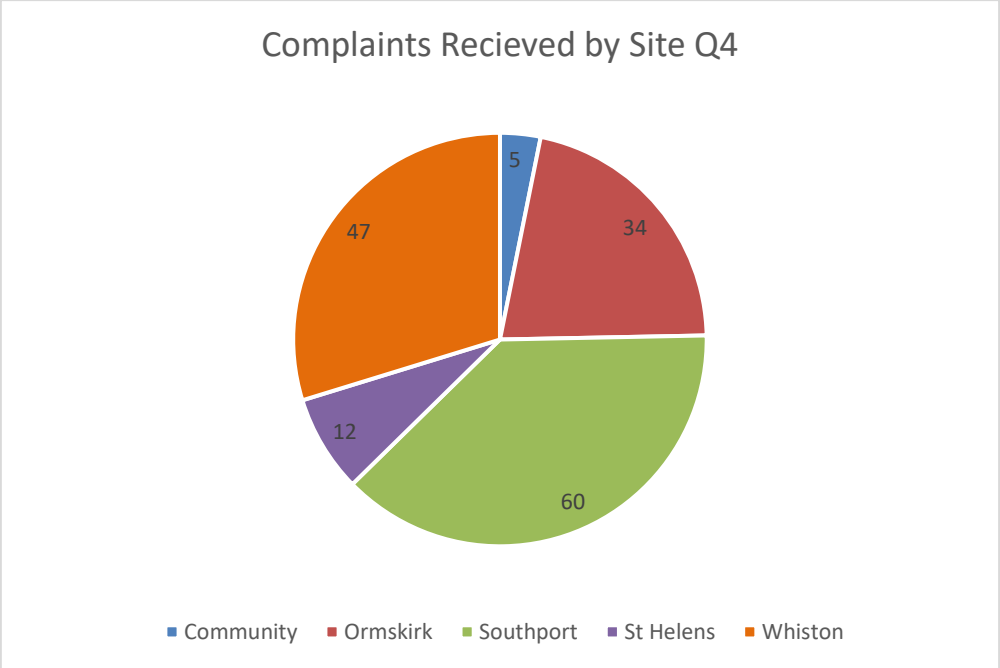
Themes of Closed Complaints (Top 5)	**24/25 Q3**	**24/25 Q4**	**25/26 Q1**	**25/26 Q2**	**25/26 Q3**	**25/26 Q4**
Clinical Treatment	69	63	61	54	66	73
Patient Care (Nursing)	18	20	19	17	21	27
Values & Behaviours	14	6	2	5	6	13
Communication	21	14	14	21	22	20
Admission & Discharge	0	1	9	4	9	25

Figures correct at time of reporting from InPhase

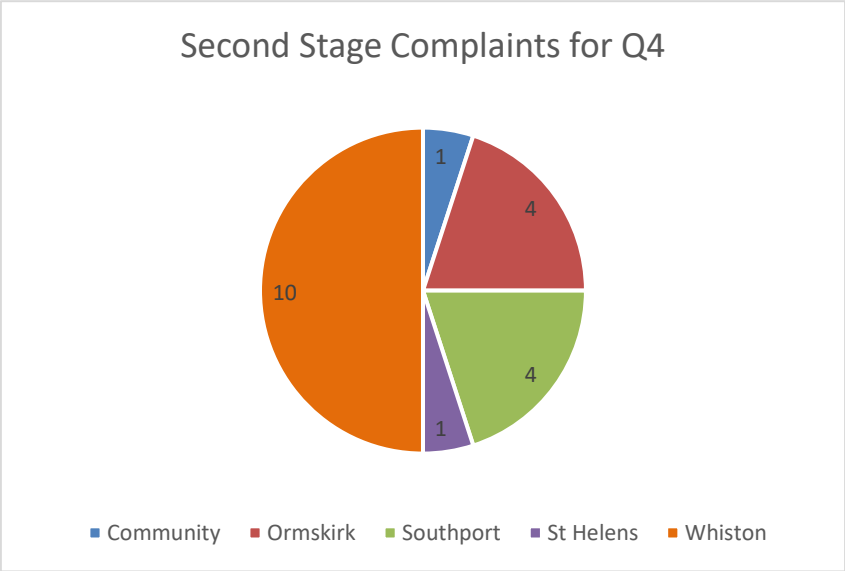
The charts below depict the specific divisional breakdown of first stage complaints received in Q4.



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



The Trust received 20 2nd stage/reopened complaints in Q4. This is a slight increase on Q3 as 19 complaints required a second response in Q3.



4. Patient Advice and Liaison Service (PALS)

PALS Contacts	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Number of contacts received	997	1131	1232	1112	1157

Figures at time of reporting from InPhase

PALS Contacts by Themes Q4

PALS Themes	C&CSS	Corporate /Other	M&UC	Surgery	W&C	Total
Communications	40	96	230	143	49	558
Appointments	27	32	36	91	17	203
Patient Care/ Nursing Care	0	5	42	5	5	57
Admissions and Discharges	2	5	27	30	3	67
Clinical Treatment	4	9	21	19	14	67
Waiting Times	4	4	17	27	4	56
Trust Admin/ Policies/ Procedures (Inc. Patient Record Management)	1	15	1	1	1	19
Access to Treatment or Drugs	1	8	17	8	2	36
Values and Behaviours (Staff)	1	2	5	0	5	13
Facilities	1	16	7	0	0	24
Other (e.g. abuse/behaviour/Theft/Benefits)	0	2	5	1	0	8

5. Ask Rob

The Ask Rob process has been reviewed since the previous quarter. This is now following a more formal governance process with the contacts being formally logged on the Trust's reporting system Inphase. The concerns are being responded to formally via the exec office. Few have escalated to the Trust formal complaint process. However, it is to be noted there is a significant increase in the number of contacts since the process is now being reported formally on Inphase.

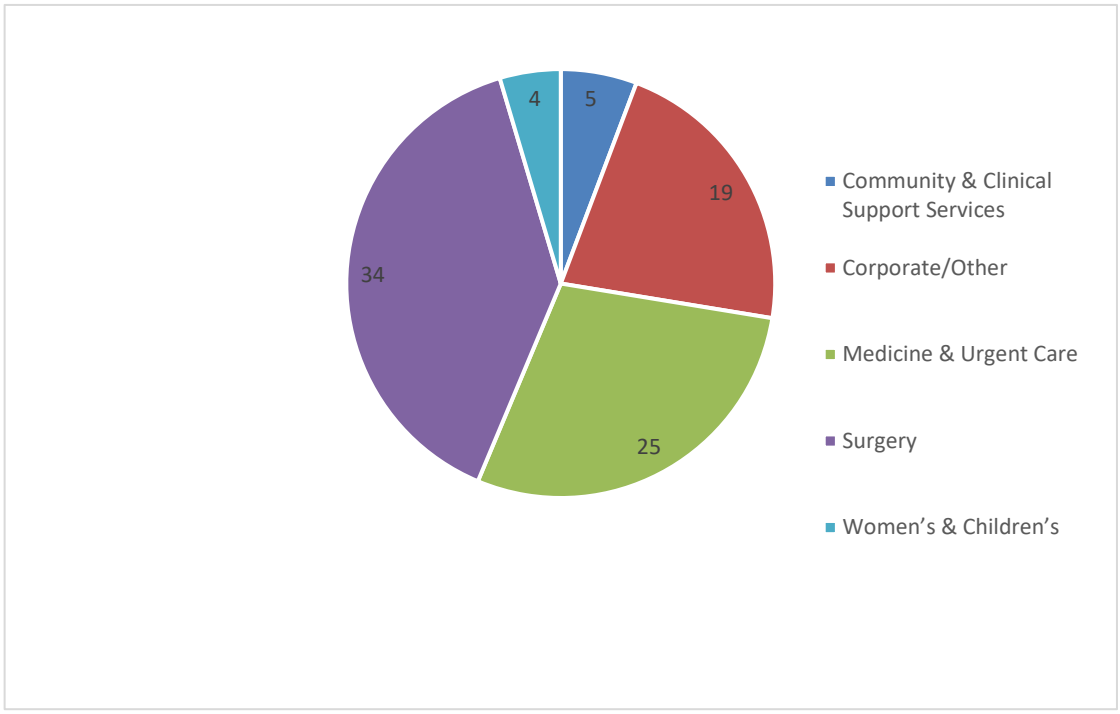
In Q4 there where 87 Ask Robs concerns received this is a 172% increase on the previous quarter. However this increase is reflects more accurate recording of Ask Rob queries, rather than an overall increase in volume.

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

The top five themes for Ask Rob contact in Q4 were:

1. Communication (main theme)
2. Facilities
3. Waiting Times
4. Appointments
5. Patient/Nursing Care.

The chart below displays the Ask Rob concerns received by division in Q4.



6. PHSO

The table below displaces the number of PHSO case the Trust currently has on going in Q4 and into Q1 of 26/27.

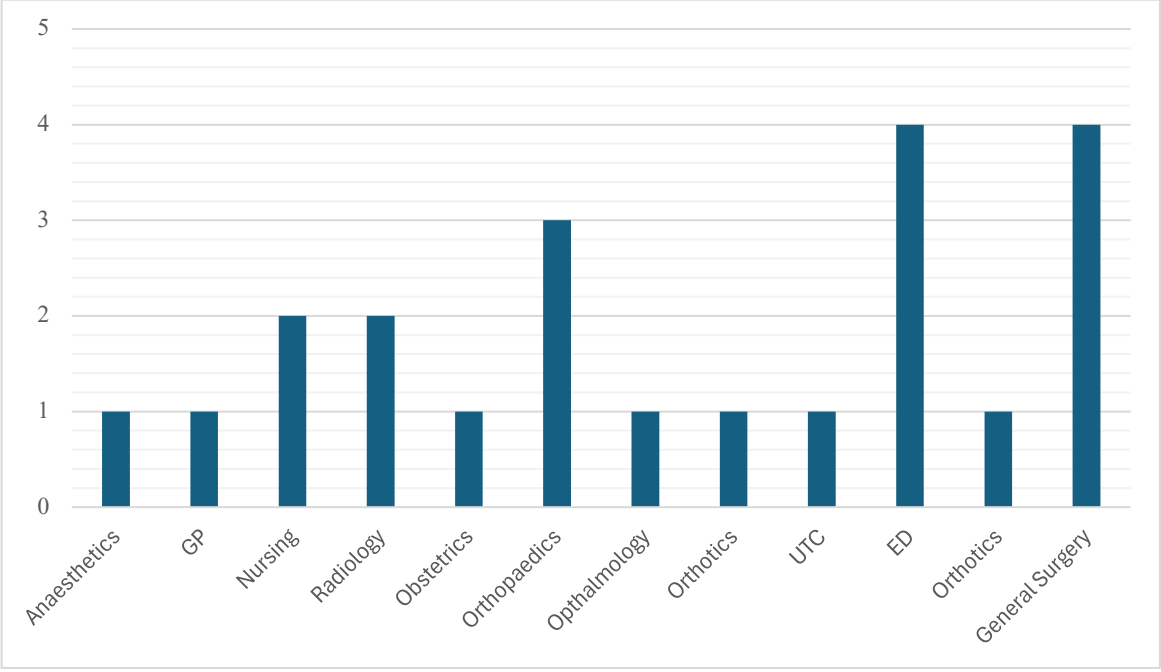
Current PHSO cases open to April 2026:

PHSO formal investigation	3
PHSO proposal to investigate	1
Primary investigation enquiry / Prelim enquiries open	13
Awaiting final outcome report	1
Total	18

7. New Clinical Negligence Claims

The Trust received 21 new claims in Q4, which is slightly more than the previous quarter and Q1, but less than quarter Q2 (24). This is an annual total of 80 claims, which is an average of 20 per quarter, and indicates a fairly consistent pattern across the year. 15 of the claims related to legacy STHK sites/services, and 6 related to legacy S & O. 6 were received in January, 7 in February, and 8 in March.

7.1. New claims by speciality



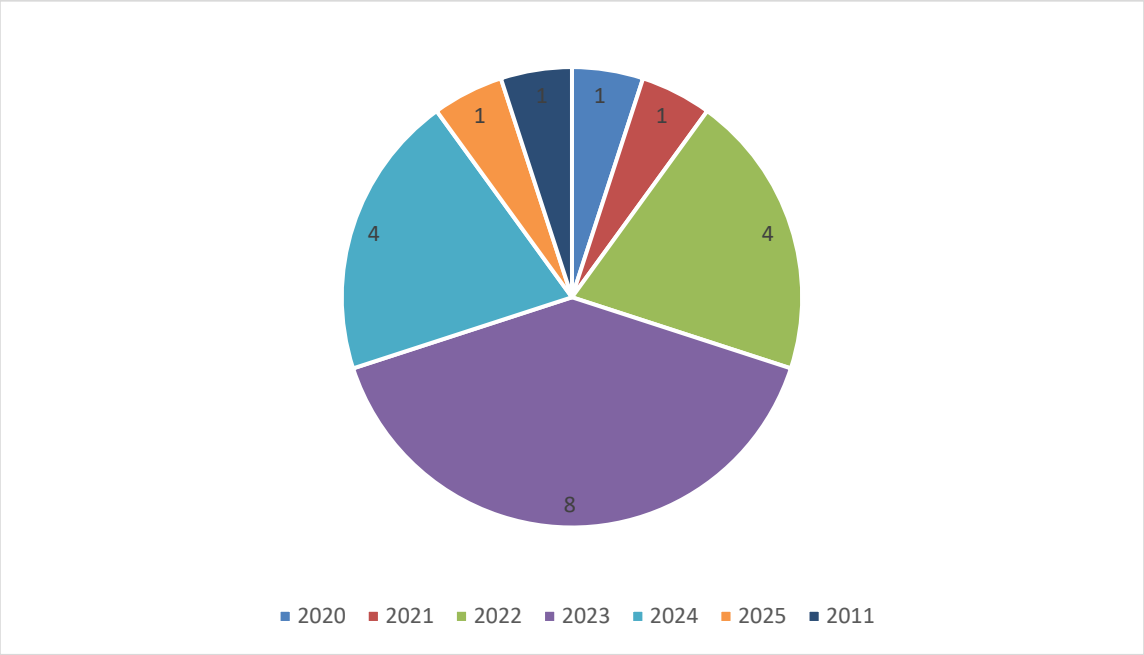
The highest number of claims by speciality were ED (highest in Q3), and General Surgery (highest in Q4 and Q1 of 2025/26), although none had above 4. The GP claim relates to the GP practice run by the Trust on the St Helens site.

7.2. New claims by main reason

Failure/Delay in diagnosis is the largest cause of claims in Q4. This is consistent with other quarters and is generally the largest cause code for claims across the NHS. The 2 nursing claims relate to falls.

7.3. Year to which claims relate

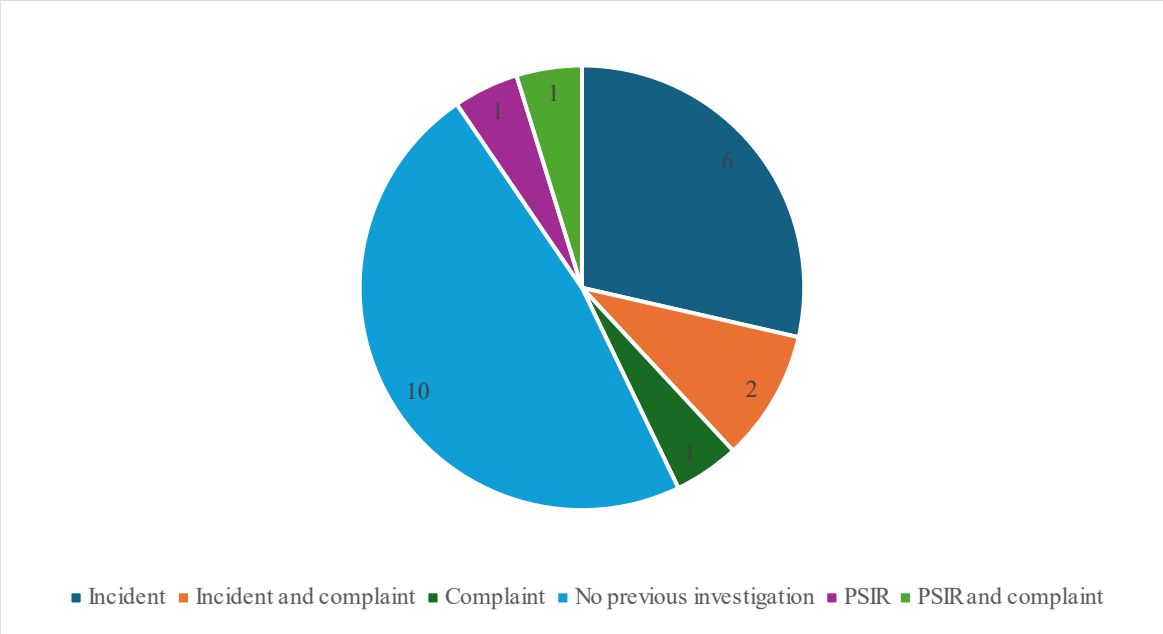
Although these claims were formally notified in Q4, the date of the incidents to which the claim relates can vary significantly. The graph shows the year in which the incident took place – where there is more than one incident the earliest that relates to this trust is used. Sometimes the date of knowledge (the point at which the claimant became they could bring a claim) is later than the date of incident. This can explain some of the delays in claims being brought.



The claim from 2011 relates to a birth injury.

7.4. 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.



47.6% of claims had not been investigated in some format prior to them being received (10 from 21). 8 had undergone an incident investigation of some sort, and 2 had undergone a full PSIR process.

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 2 months after the claim has been accepted by NHS Resolution in order to allow clinician's comments to be obtained. Although review of the claims for this quarter is not yet complete, 1 matter has been referred back for a full investigation.

7.5. Lessons Learned/Actions taken from Closed Claims

The Trust closed 25 claims in Q4. 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 Q4.

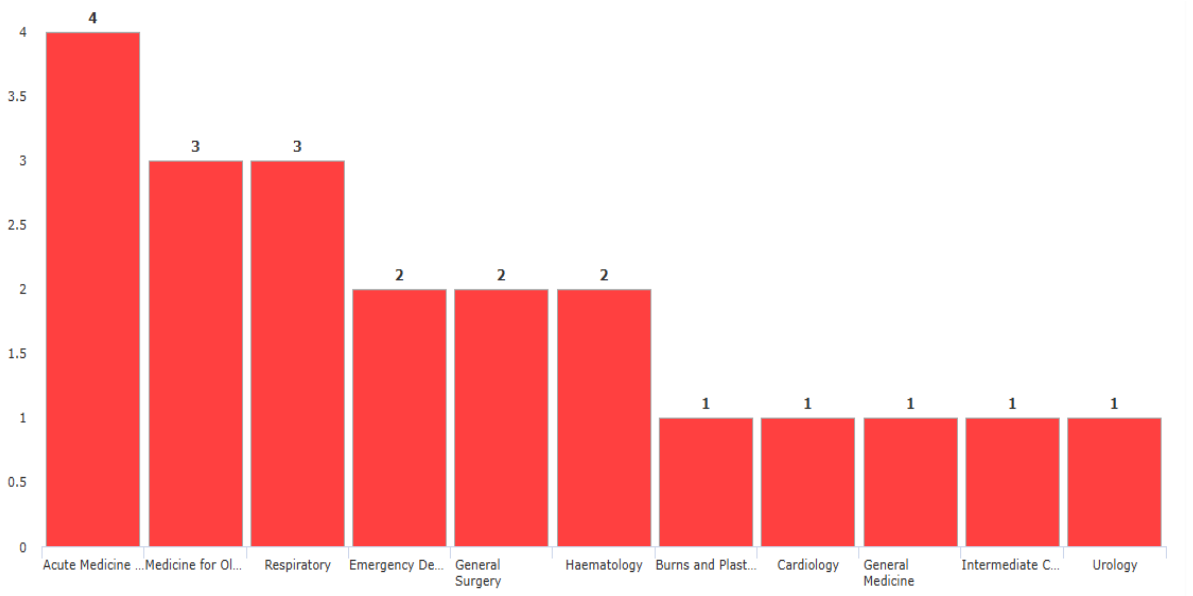
There was one closed claim in Q4 that had provoked some significant learning and changes as a result of the initial investigation process. The claim concerned knee surgery, and the use of an inappropriate technique to try and repair an injury. The investigation recognised that, although there are different techniques that can be utilised, a move to an MDT approach would ensure that the approach used is appropriate. This has now been actioned.

8. Inquests

8.1. New Inquests

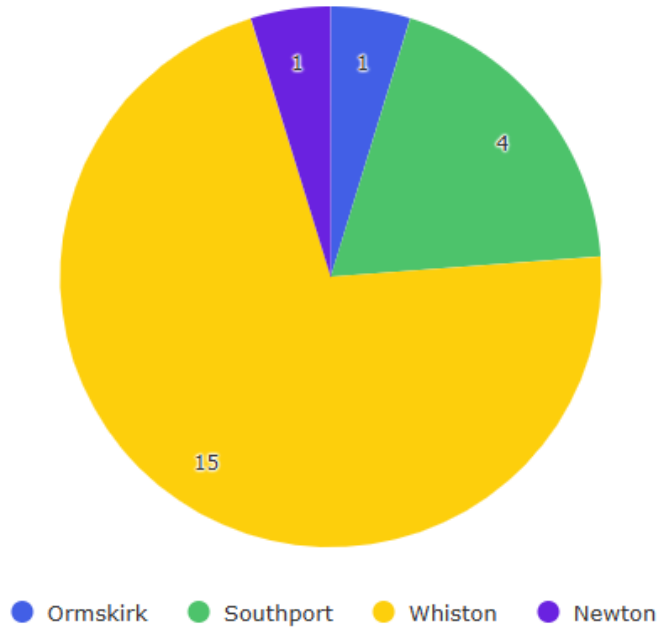
21 new inquests were opened in Q4. This is one more than the previous quarter, and Q2. This is less than we would historically expect, with average numbers around 30 per quarter.

These inquests are broken down by department as follows:



Acute medicine has the most inquests, whereas ED which had the most in the previous quarter. Medicine for older people and respiratory both had 3 inquests, which would not be particularly surprising given the nature of the patients they treat. For example, for any death where industrial disease (such as mesothelioma) is suspected, the coroner will automatically open an inquest

And by site as follows:



The Newton case related to a patient who was transferred from Whiston for rehabilitation but had to be readmitted following a deterioration. The Ormskirk case involves a patient who had an apparent

adverse reaction to a platelet transfusion. They were transferred to the Emergency Department at Southport but declined to wait to be seen.

8.2. Closed inquests

The Trust closed a total of 27 inquests in quarter 4. This is around the number we would normally expect.

The Trust has not received any Prevention of Future Death (PFD) notices following the merger, and this continued in Q4. We have not been asked to provide any additional assurances to the coroner, although the senior coroner for Sefton has raised her concern over the length of time it is anticipated it will take the Trust to obtain a fully electronic patient record system.

9. Recommendations

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

Title of Meeting	**Trust Board**		**Date**	27 May 2026
Agenda Item	**TB26/037**			
Report Title	Maternity and Neonatal Services Quarter 4 2025/26 Report			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Sue Orchard, Director of Midwifery			
Action Required		**To Approve**	X	**To Note**

Purpose

This report provides the Board with an overview of performance, quality, safety, workforce, and patient experience across Maternity and Neonatal Services for Quarter 4 2025/26.

Executive Summary

Alert

- During Q4, five reportable perinatal deaths occurred (all stillbirths), an increase compared with Q3. All cases have been reviewed through multidisciplinary processes, reported to MBRRACE, and are progressing via PMRT, with no care themes identified to date.
- 11 temporary neonatal service suspensions at Whiston due to workforce pressures (with emergency care maintained throughout)
- Patient feedback highlighted variability in postnatal pain relief following operative birth and ongoing challenges in supporting partner overnight stay, particularly at Whiston.

Advise

- The Trust achieved full compliance with MIS Year 7, with embargo lifted in April 2026, and is preparing for transition to the revised MIS Year 8 framework from Q1 2026/27.
- Instrumental birth rates, including a temporary increase at Ormskirk, have stabilised with no sustained trend identified.
- Quality improvement activity remains strong, including implementation of neonatal transitional care at Whiston, a reduction in neonatal medication incidents, sustained high compliance with Saving Babies' Lives Care Bundle V3, and continued progress against the Three-Year Delivery Plan.
- Workforce planning remains a priority, particularly in neonatal nursing at Whiston, where establishment review and business case development are underway.

Assure

- Safe staffing standards were maintained, with 100% compliance for one-to-one care in labour and supernumerary delivery suite coordination across both sites.
- Consultant obstetric presence and neonatal medical staffing remain compliant with national guidance, supported by agreed rota solutions.
- Training compliance is high across maternity and neonatal services, with active management of any gaps. The Trust continues to demonstrate robust governance, learning from incidents and feedback, strong executive and Board oversight, and sustained progress in delivering safe, compassionate, and high-quality maternity and neonatal care.

Financial Implications

Awareness of potential future investment into the Maternity and Neonatal Services.

Quality and/or Equality Impact

Not applicable	
Recommendations	
The Board is asked to note the Maternity and Neonatal Services Quarter 4 2025/26 Report	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

This standardised report template has been developed by the Cheshire and Mersey Local Maternity and Neonatal System (LMNS) and includes the key issues identified within Maternity and Neonatal Services.

1. Maternity Incentive Scheme (MIS)

The Maternity Incentive Scheme (MIS) Year 7 Board declaration template was completed and submitted prior to the 3 March 2026 deadline. MWL declared compliance to 9 out of 10 safety actions alongside a supporting action plan and mitigation in response to this non-compliance of SA1, Element 1c. This related to a single data omission in one case.

The Trust received formal confirmation on 25 March from NHSR that the organisation had achieved all 10 safety actions with the embargo lifted on 13 April as all Trusts findings had been published.

MIS Year 8 official launch scheduled for 23 April 2026.
The format of the Maternity (Perinatal) Incentive scheme has changed from previous years. There are now 6 safety actions compared to the previous number of 10 with the majority being condensed into the 6 new actions.

- Safety action A: workforce and capacity, Obstetric, short-term locums, midwifery, anaesthetic, neonatal nursing and medical, planned caesarean section capacity mapping and workforce governance and forward planning that includes, anaesthetic and perioperative teams
- Safety Action B: Training. This includes minimum quarterly compliance oversight reports (ideally SPC charts) monitored against a trajectory towards 100% and working towards maintaining equal to / greater than 90% throughout the year.
- Safety Acton C: Learning from reviews and investigations including notification of all required events, seeking parents' views, external MDT reviews, sharing information with families, offering meetings with relevant specialists and thematic reviews and actions.
- Safety Action D: Service user voice and equity
- Safety Action E: Care bundles: Saving babies Lives, Maternal care and Neonatal pulse oximetry testing including homebirths
- Safety Action F: Board oversight, Governance, Culture and leadership

The service is currently reviewing the information, requirements and timeframes and provide an overarching report to the Executive team once completed.
This Q4 report refers to MIS year 7 safety actions and the new MIS year 8 safety actions will be adopted in the Q1 26/27 reports going forward.

In Q4 an MIAA review was undertaken of the MIS Year 7 governance processes and submitted evidence for all 10 safety actions. The findings identified a high level of overall assurance with a strong system of internal control. There was 1 low level control design recommendation relating to the failsafe actions for SA1 as a result of a single data inputting error.

2. Quality and Safety

2.1 Clinical Outcomes/ Dashboard

Maternity and Neonatal Dashboards

Performance is monitored via our local and regional dashboards. Regional and local clinical dashboards are monitored via local governance and presented via the IPR at Quality Committee.

Current areas of focus:

- **Intra-uterine deaths occurring prior to the onset of labour.** In Q4 there were five in-utero deaths before the onset of labour. This was an increase from Q3 which reported one stillbirth that was a known severe congenital abnormality that was incompatible with life.
  The cases will be described in further detail within the perinatal mortality section of this report.

- **Neonatal Death elsewhere.** There was one neonatal death in Q4 of a baby born on the Whiston site, who died elsewhere. Following a planned caesarean section the baby became unwell and required transfer to a level 3 neonatal unit and was subsequently transferred to the Children's Hospital, where the baby was diagnosed with congenital cardiovascular abnormalities that were inoperable. Review of the antenatal screening for the case, indicated that all appropriate pathways were followed.

- **Term Transfers to the NNU.** Q4 saw a consistently high rate of admission of term babies to the NNU. January had the highest rate of admission of 8.9% which reduced to 6.8% in March. The annual rate for the financial year was 6.5%, which is higher than the target rate of 6.0%. All admissions are reviewed and were appropriate.
  The maternity and neonatal services have been working together to introduce a transitional care service on 2E, that is aimed to reduce the number of admissions / transfers to the NNU and prevent mothers and babies being separated. During Q4 2025/26 the services undertook staff training and orientation programmes with a plan to commence transitional care service in April 2026.

- **Instrumental Birth Rates.** Instrumental birth rates have been reviewed by site during Q4 following a demonstrated a higher rate of forceps and ventouse deliveries in December on the Ormskirk site, which appears to be an isolated increase. Subsequent months show a consistent reduction in forceps use and stabilisation of rates. Whiston rates demonstrate expected month to month variation, with no sustained upward trend identified. Instrumental birth rates continue to be monitored through routine governance processes focus on appropriate clinical decision-making and safe birth outcomes.

2.2 Perinatal Mortality

For the Q4 2025/26 reporting period, there were five reportable perinatal deaths.

Q4 2025/26	Total		
January	3		3 Stillbirths on Whiston site • 29+3/40 Intrauterine fetal death • 27+4/40 Intrauterine fetal death • 30/40 Intrauterine fetal death
February	0		
March	2		2 Stillbirths on Whiston site: • 24/40 Intrauterine fetal death • 37+5 Intrauterine fetal death

All cases have undergone a multidisciplinary review, and the PMRT process has commenced. The care provided in each case was reviewed and assessed using the MBRRACE categorisation framework.

January 2026: 3 Stillbirths

Case 1) Whiston site – Stillbirth: Low risk at booking, attended maternity triage at 29+3 gestation with reduced fetal movements. CTG performed which was assessed as reassuring however the woman was identified as requiring a growth scan which was arranged. Due to the bank holiday period, this scan could not be arranged within the recommended 72 hours. The woman contacted triage the day before her arranged scan and was advised to attend however she declined. A fetal death in-utero was diagnosed when the woman attended the following day.
The maternity service is working with the ultrasound department to increase the availability of scans outside of routine working hours to facilitate additional urgent scans, particularly on Bank Holiday weekends.

Case 2) Whiston site – Stillbirth: At 27+4 weeks gestation a woman with an IVF pregnancy attended maternity triage with a watery vaginal loss. The fetal heart was not audible via auscultation, and an in-utero death was confirmed via ultrasound scan. No issues with care and treatment were identified at the initial review.

Case 3) Whiston site – Stillbirth: Low risk at booking. Attended maternity triage at 30 weeks gestation via ambulance with vaginal bleeding. Placental abruption suspected and an USS was confirmed a fetal death in utero. Placental abruption confirmed at birth. Findings of the initial review identified no care issues which may have contributed to the outcome.

March 2026: 2 Stillbirths

Case 4) Whiston site – Stillbirth: Premature pre labour rupture of membranes diagnosed at 22+6 weeks gestation. Appropriately transferred to a maternity unit with a level 3 NNU at the time of diagnosis but subsequently discharged by the receiving Trust. At 24/40 the woman reattended maternity triage with a small vaginal bleed, declined transfer to another unit and the fetal heartbeat could not be auscultated. Fetal death diagnosed on ultrasound scan. The initial review identified minor issues that did not impact on the outcome of the case.

Case 5) Whiston site – Stillbirth: Assessed as high risk at booking due to a previous caesarean section. Attended maternity triage with reduced fetal movements at 37+5 weeks gestation. Fetal heart was not detected and a fetal death was diagnosed via ultrasound scan. At birth of the baby, significant entanglement of the umbilical cord was identified fully occluding vessels. Findings of the initial review identified no care issues which may have contributed to the outcome.

All cases were reported to MBRRACE, and the Perinatal Mortality Review Tool (PMRT) process is underway.

There were two ongoing PMRT cases which occurred in Q3 that were reviewed in Q4.

Intrapartum stillbirth – October 2025 40+1 weeks' gestation:

Fetal diagnosis of anencephaly was made at 13+2 weeks, with an appropriate referral to fetal medicine unit. The parents made an informed decision to continue with the pregnancy. Multidisciplinary team involvement in place throughout the pregnancy, and supportive care arranged with a dedicated children's hospice.
The baby was born with no signs of life.

Following birth, the findings in addition to the known anencephaly confirmed via placental histology abnormalities in the umbilical cord structure with significant vascular malperfusion of the placenta.

The review identified no issues that would have affected the outcome:

Neonatal Death – October 2025, 40+6 weeks gestation: Low risk at booking and continued with a planned home birth.
During labour, transfer to the obstetric unit was required following the onset of vaginal bleeding and identification of a fetal bradycardia. Rapid transfer was facilitated by Northwest Ambulance Service (NWAS). On arrival at the obstetric unit, a prompt obstetric assessment was undertaken with immediate transfer for a Category 1 caesarean section. Baby born in poor condition and despite extensive resuscitation efforts, sadly died.

A PMRT report was completed prior to the completion of the MNSI report and whilst the coroner's investigations are ongoing.

The cause of death at the review was confirmed as placental abruption, although this may change once the findings of the coroner's postmortem are made available.

2.3 Serious Incidents

Never Events

No never events occurred in this reporting period.

Serious Reportable Incidents

Serious incidents (SIs) are reported and evidenced on the regional dashboard which is updated monthly. Serious incidents are additionally detailed within the patient safety report presented at Quality Committee.

In Q4 2025/26 there were 2 StEIS reportable incidents within the Maternity service.

- In February 2026 there was a Maternity unit divert on the Ormskirk site. This was undertaken by a short-term medical staffing issue. The unit diverted for 2 hours and one women required diverting to triage at Whiston during the divert period.
- In March 2026, one term baby was born at the Whiston site with low cord gases and required therapeutic cooling following randomisation to the COMET trial. The criteria for MNSI referral and StEIS reporting was met due to cooling.
  The neonatal service has enrolled in COMET (Cooling in mild encephalopathy Trial). This is a national trial where babies with an Apgar Score <5 at 10 minutes, require resuscitation at 10 minutes of age or have a cord pH <7.0mmol or Base deficit >16mmol, with evidence of mild HIE on examination between 1 and 6 hours of age, but not meeting the diagnosis of moderate or severe HIE, are randomised to either therapeutic cooling or the standard care arms of the study. Any babies recruited to the cooling arm of the study meet the MNSI reporting criteria but not all are accepted.

Both incidents undergoing investigation processes with governance oversight to identify any learning.

2.4 Maternity and Neonatal Safety Investigations

The Maternity and Neonatal Serious Incident (MNSI) team conducts independent investigations into incidents within Maternity Services that meet defined criteria, including maternal deaths, stillbirths, and neonates requiring therapeutic cooling.

Cases referred by the Trust are triaged by MNSI according to the following criteria:

- Results of the baby's MRI
- Concerns raised by the family regarding the care provided
- Concerns raised by the Trust regarding the care provided

All investigations accepted by MNSI are reported on STEIS as serious incidents. Cases that are not accepted are returned to the Trust for investigation through a full multi-disciplinary team (MDT) review, which includes an external representative from the Cheshire and Merseyside system.

To support effective communication and oversight, the Trust receives a monthly update on cases reported to MNSI, including the progress of ongoing investigations. Draft case reviews are shared with the Trust for accuracy verification prior to finalization and are subsequently shared with the woman and family.

Cases to Date April 2019 to March 2026	Ormskirk	Whiston	Total
Total Referrals	**18**	**58***	**76**
Referrals / Cases Returned to the Trust / Rejected	7	21	28
Total Investigations Accepted	11	36	47
Total HSIB Investigations Completed	11	34	45
Current Active Cases	0	2	2

* The case that occurred in Q4 that has been referred to MNSI has not yet been accepted for investigation. It occurred at the end of the quarter and the MNSI triage process is ongoing.

MNSI Case Update

Ormskirk Site:

A case reported in Q2 2025/26 for a baby born by a category 2 caesarean section that required therapeutic cooling has been finalised and received by the Trust in Q4. The baby's MRI at 7 days of age reported no evidence of hypoxic ischaemic encephalopathy however the placental histology indicated evidence of acute chorioamnionitis.

The review identified several areas for learning with the below actions undertaken.

- Review of risk assessments for fetal growth restriction based on recommendations for fetal growth restriction within SBLCB v3.2 and provision of 150mg aspirin.
- Review of communication tools between the obstetric team and the neonatal team when called to theatre if concerns regarding the fetal heart rate. Assessing using skills drills.
- Standardisation of resuscitation documentation tools

Whiston Site:

There was one new MNSI case referral in March, Q4 2026/27.

Case1) Diagnosis of a small for gestational age baby and the mother diagnosed with preeclampsia. Following an emergency caesarean section, the baby initially required respiratory resuscitation and transfer to the Neonatal Unit. The Baby was recruited to the COMET trial and was randomised to the cooling arm of the study leading to transfer to a level 3 neonatal unit and the requirement to report to MNSI. The case is still undergoing the MNSI triage process.

The two cases, reportable to MNSI that occurred in Q3 2025/26 within the Whiston Maternity Service, are still ongoing at the end of Q4. The final reports are expected to be received by the Trust early in Q1 2026/27

2.5: Neonatal Medication Incidents

During the Q4 reporting period, there were four medication incidents reported within the Neonatal Units (NNU) of MWL. The majority of medication incidents during this quarter were categorised as prescribing errors. All incidents were reviewed and categorised as no harm. Appropriate action was taken on all occasions as the incidents were escalated and rectified.

The number of incidents reported at Whiston has decreased significantly, aligning with the introduction of the new prescription booklet however, it is also worth considering whether incidents may have been underreported this quarter.

Number of medication incidents				
Location	**Q1**	**Q2**	**Q3**	**Q4**
Ormskirk	3	7	7	4
Whiston	8	15	13	0
Total	**11**	**22**	**20**	**4**

Category	**Q1**	**Q2**	**Q3**	**Q4**
Medication - storing	0%	0%	10%	25%
Medication - prescribing	45.5%	31.8%	35%	50%
Medication - administration	54.5%	63.7%	50%	25%
Medication - delivery	0%	4.5%	5%	0%
Medication - preparing	0%	0%	0%	0%

Key observations during this period:

- Unintentional omission or delay of medicines. Not anticipated to have long term consequences.
- Parenteral nutrition (PN) prescribed incorrectly as there was a discrepancy between the intended therapy and the prescribed regimen. The error was identified prior to preparation/administration during the pharmacist clinical check and no harm occurred.

Recommendations:

Location	Action	Update	Due date
Ormskirk/Whiston	**Introduction a new prescription booklet for NNU** *specifically for neonatal Unit use. multi-disciplinary input from the clinical director, ward manager, senior neonatal nurses, advanced neonatal nurse practitioners and pharmacy. This new chart will include a gentamicin prescription page within it, similar to the chart used at Whiston, to aid prescribing and drug monitoring*	03/02/2025 – prescription booklet live at Ormskirk 04/2025 – Whiston to move to same prescription booklet, undergoing their governance process 10/2025 – Whiston currently piloting the prescription booklet with consultant paediatrician and NNU ward manager leading the trial 11/2025 – prescription booklet is approved for use at Whiston	Complete – Ormskirk Complete - Whiston
Ormskirk/Whiston	**Introduction BBraun drug library on NNU** *to aid administration of medication and reduce the number of related incidents*	02-2026 – Ormskirk go live, no issues identified 05-2026 – meeting arranged for Whiston to go live	Complete - Ormskirk July 2026 - Whiston

Ormskirk/Whiston	**Introduction IV drug monographs** *and moving away from using Medusa as considered not fit for purpose on an NNU. These monographs have had multi-disciplinary input from pharmacy, advanced neonatal nurse practitioners, and senior neonatal nurses*	10/2025 – 28 drug monographs ratified and in use	Ongoing
Ormskirk/Whiston	**Introduction of Numeta G13% and G16% PN guideline** *to help reduce the risk of compounding errors, infection and medication errors associated with PN. It will replace ITH ordering of PN for Ormskirk making it more cost effective and will allow babies to receive lipid soon after birth and improve long term growth outcomes.*	09/2025 – implementation of Numeta at Ormskirk 30/01/2026 – presented the implementation of standardised parenteral nutrition at Ormskirk at the NWODNN Annual Conference 04/26 – the neonatal fluid and electrolyte guideline has been harmonised to facilitate Whiston NNU moving to use Numeta 05/26 – guideline going to MWL guideline meeting for ratification	Complete – Ormskirk June 2026 - Whiston

- Neonatal education and staff induction contributions from pharmacy to continue across MWL

2.6 Saving Babies Lives (SBL) Care Bundle

Compliance with all elements of the Saving Babies' Lives Care Bundle Version 3.2 remains a requirement for Safety Action 6 for MIS Year 7.

	Whiston Assessment 7	Ormskirk Assessment 7	MWL Assessment 1	MWL Assessment 2	MWL Assessment 3
Review Quarter	Q1		Q2	Q3	Q4
Assurance review	10/06/25		30/09/25	30/12/25	09/04/2026
Element 1	100%	100%	100%	90%	100%
Element 2	100%	100%	70%	95%	95%
Element 3	100%	100%	100%	100%	100%
Element 4	100%	100%	100%	100%	100%
Element 5	96%	96%	96%	100%	92%
Element 6	100%	100%	83%	100%	100%
Total	99%	99%	88%	97%	96%

The LMNS remain satisfied with the ongoing progress of MWL in implementing the Saving Babies' Lives Care Bundle, with monitored action plans focused mainly on audits and documentation.

Element 1: Reducing Smoking in Pregnancy
Compliance has reached 100%, representing an improvement from 90% in the previous quarter. This progress reflects sustained effort across both sites to ensure that all recommendations are adhered to including the compliance with training staff in very brief advice around the impact of smoking in pregnancy.

Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
Overall compliance has been sustained at 95% but there have been changes in how compliance is measured. GROW 2.0 has now been successfully implemented, aligning the maternity services at MWL with the recommendation that electronic Growth surveillance systems should be utilised and is expected to support improved detection rates moving forward.
The proportion of small for gestational age pregnancies detected at Whiston fell below the 45% compliance threshold at 42.1%. All cases are reviewed and there were not themes identified. The

implementation of the electronic charts GROW 2.0 should improve recognition of growth issues and improvements in compliance.

Element 3: Raising Awareness of Reduced Fetal Movements
100% compliance is being maintained through ongoing audit processes and continued policy harmonisation.

Element 4: Effective Fetal Monitoring in Labour
100% compliance has been sustained throughout the year through ongoing audit processes and continued policy harmonisation.

Element 5: Reducing Preterm Birth
Compliance has reduced from 100% to 92% this quarter.

The areas where compliance was not achieved were:

- The proportion of mothers delivering between 22 and 33 weeks' gestation who received a full course of antenatal corticosteroids within one week prior to birth was 58% at Whiston and 33% at Ormskirk, with an overall MWL rate of 45.5% which falls below the compliance threshold of 53%. The number of cases are small denominators. 7/12 women at Whiston and 1/3 women at Ormskirk received timely corticosteroids. This related to women receiving one dose but delivering prior to the administration of the second dose.
- The proportion of mothers delivering between 22 and 29 weeks' gestation who received magnesium sulphate within 24 hours prior to birth was 100% at Ormskirk and 0% at Whiston, with a combined MWL rate of 50%, which is below the compliance threshold of 85%. The 0% compliance at Whiston was one woman who required an emergency CS due to a bradycardia and here was no time for administration.

The services have reviewed the cases where compliance was not achieved and for future submissions the services are going to submit detailed narrative and exception reporting information to the evidence submissions. In the cases reviewed the optimisation recommendations were not achievable.

Element 6: Management of Pre-existing Diabetes
100% compliance is being maintained through ongoing audit processes and continued policy harmonisation.

2.7 Care Quality Commission CQC Review

The most recent maternity service CQC inspection was December 2023 that rated services as:

- **Ormskirk**: Good overall and for being well-led. It was rated requires improvement for safe.
- **Whiston:** Good overall and good for safe and well-led

Ormskirk areas for improvement

Three **MUST** do actions were identified to comply with its legal obligations which were:

- Ensure all staff are up to date with mandatory training including but not limited to pool evacuation.
- Ensure staff accurately complete and document modified early obstetric warning scores and newborn risk assessments, record CTG assessments and fresh eyes in order to identify and escalate women, birthing people and babies at risk of deterioration.
- Ensure there are sufficient numbers of staff deployed to keep women, birthing people and babies safe.

Actions the service **should** take to improve were:

- Ensure that records are maintained for all discarded medicine used for epidurals.
- Ensure all staff receive supervision and annual appraisals.
- Consider making electronic records accessible to women and birthing people.
- Ensure incidents are reviewed in a timely manner.
- The service should develop a maternity-specific strategy and vision.

Whiston areas for improvement

Three areas were identified as **should** actions for improvement which were,

- Ensure a vision and strategy is developed for the service that incorporates recommendations from the Ockenden report.
- Continue to monitor and take action to ensure baby observations are completed in line with national and trust guidance.
- Ensure staff discarding or witnessing epidural infusions sign the controlled drug register and record the actual amount administered.

Audit data demonstrates an overall trend of improvement in compliance for MEOWS, NEWS, fresh eyes and epidural wastage demonstrating embedded practice, with the findings and any improvement actions discussed and devised locally with relevant stakeholders through risk and governance meetings, with oversight from the divisional leadership teams.

In relation to ensuring enough staff are available, a robust rolling recruitment programme is in place to ensure timely recruitment into vacancies which may arise during the year. The service has minimal Midwifery vacancies.

A Maternity EPR across MWL has been undertaken and Maternity will be a standalone system. A PID was developed and the BadgerNet project formally launched on 1 May 2025 with expected timeline for implementation in November 2026

The CQC have refined their assessment and will use a single assessment framework. The five domains of safe, effective, caring, responsive and well led will remain. However, the key lines of enquiry will be replaced by a series of quality statements and will use six evidence categories to help them understand the quality of care being delivered for each quality statement which includes:

- People's experience of health and care services
- Feedback from staff and leaders
- Feedback from partners – people representing organisations that interact with the service or organisation that is being assessed.
- Observation by CQC inspectors, specialist professional advisors and Healthwatch
- Processes (including incidents, waiting times, audits, policies and procedures)
- Outcomes focusing on the impact of care processes on individuals, with data taken from patient level data sets and national clinical audits.

Preparedness for CQC inspections continues across the service with each service completing a self-assessment in relation to the quality standards and collating supporting evidence. Regular updates are in progress with monitoring at the Divisional Management Group

2.8 Antenatal and Newborn Screening Quality Assurance

Work continues on implementing the 38 recommendations from the successful Screening Quality Assurance visit in early 2025. The final feedback session is scheduled to take place on 4 June 2026. After this meeting any remaining outstanding actions or concerns will be handed to the public health commissioning team who will monitor and follow up.

Recommendations Status Overview

Status	Number	Notes
Closed	**20**	Fully actioned and closed.
On Track for Next Meeting	**2**	Expected to be closed at the upcoming meeting.
Progressing on Schedule (Jun 04 closure target)	**11**	On track to meet standard closure timeline.
Progressing on Schedule (Extended Apr 2026 target)	**3**	On track for extended closure target.
Behind Target	**2**	1. **NIPE guideline Rec 34** – completed, pending review and submission for June 4th meeting. Agreed with NHSE. 2. **Radiography guidelines** (n=2) in **Rec 8** – Radiography team have indicated that these guidelines may not be harmonised and ratified before the June 4th deadline. This has been raised with NHSE SQAS team who have confirmed that they can be followed up after the deadline by the public health commissioning team.
Total Recommendations	**38**	

Key areas of focus include for actions not yet closed are:

- Ongoing work from Sonography leads to close outstanding actions for cross site guidelines and SOPS.
- Guideline Harmonisation. Cross site screening team meeting arranged for Early May 2026 to continue work plan for this.
- Ongoing monitoring of all screening KPI's with particular reference to SCT-S02, NHSP-S02, NIPE S02/3/4/5 and NBS S06 which are listed in the recommendations document as areas for improvement.

The updated action plan is presented as Appendix 1

2.9 Safety Champions

Safety Action 9 outlines the standards and evidence requirements for Maternity and Neonatal Safety Champions. The purpose of the Safety Champion role is to ensure effective communication from 'floor to Board', with a focus on improving safety, outcomes, and the overall experience of women, babies, and families. Monthly Safety Champion meetings are held to support this aim and includes the Board, non - executive, maternity and neonatal safety champions and MNVP leads.

There is a schedule for Safety Champion Walkarounds for 2026, providing opportunities for frontline clinical and non-clinical staff, as well as women and their families, to raise any safety concerns to safety champions including the Board and Non – Executive safety champions. Feedback from these walkarounds is discussed at the Maternity Safety Champion meetings. The feedback proforma has been updated to record whether safety actions have been identified and where these have been escalated for action or oversight.

Non-Executive and Executive Safety Champions also undertake regular walkarounds, with their observations and feedback reported at the Maternity Safety Champion meetings to ensure transparency and Board-level visibility.

The Maternity Safety Champions review the Perinatal Quality Surveillance Model (PQSM) tool on a monthly basis, with findings reported to the Board as part of the CPR.

2.10 Complaints and Claims.

Maternity:

There were ten Maternity complaints completed in Q4. (3 complaints were upheld and 7 partially upheld)

Learning and Actions from Closed Complaints included:

- Need to minimise distractions and ensure timely documentation of findings of clinical tasks to reduce risk of transcription errors (e.g. birth weight or fundal height)
- Ensure clear, compassionate, and non-judgemental communication at all times with a heightened awareness of vulnerable postnatal periods

There is one complaint received in Q3 that remains open at present, the delay is awaiting the completion of a debrief with the woman to provide feedback from the incident investigation, to which the complaint is related. This is scheduled for April.

There were nine formal complaints received in Q4 for Maternity. The complaints primarily highlight issues with clinical care, perceived appointment delays and the values and behaviours of staff. Patients reported a lack of sensitivity and empathy by some professionals they encountered.

Maternity	January 2026		February 2026		March 2026		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of complaints	2	0	3	2	1	1	6	3

All open complaints are on track to complete within timescales (Total 8 ongoing complaints at end of Q4)

Neonatal:

One ongoing complaint from Q3 was closed in Q4 as partially upheld.

Learning and Actions from Closed Complaints

- Ensure expected timescales for appointments are shared at referral to manage expectations and reduce anxiety

There was one formal complaint received in Neonatal services at ODGH. The complaint relates to professional behaviour. A response has been drafted and is awaiting executive review.

Neonatal	January 2026		February 2026		March 2026		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of complaints	0	0	1	0	0	0	0	0

Claims

In Q4 2025/26, there were no new claims where letters for allegations were received for the Maternity Service.

In addition, there have been 14 cases where there has been an initial enquiry concerning case, with no letter of claim outlining allegations yet received.

There have been no claims closed in Q4 2025/26 and 4 potential claims closed.

The claims scorecard is produced annually in September, and it now contains the data for both MWL sites for the years 2015/16 until the end of 2024/25. The scorecard is expected to be updated with data for 2025/26 by NHS Resolution in Q2 2026/27.

The details for the combined scorecard are:
The Top 5 injuries by volume for obstetrics:
1 Psychiatric/psychological damage
2 Stillborn
3 Fatality
4 Unnecessary Pain
5 Brain Damage

The Top 5 Causes by volume within the scorecard were:
1 Failure or delay in treatment
2 Failure/delay diagnosis
3 Fail to monitor first stage of labour.
4 Fail to monitor second stage of labour.
5 Failure to make a response to abnormal fetal heart rate.

There were no claims to triangulate against the scorecard in Q4.

2.11 Midwifery Red Flags

The NICE Safe Midwifery Staffing Guidance recommends the use of nationally recognised Midwifery Red Flag indicators as part of safe staffing and quality assurance processes. The recognition and prompt reporting of Midwifery Red Flag events are vital to maintaining safe, effective, and compassionate care. These indicators act as early warning signs that staffing levels or workload pressures may be impacting the quality or safety of care provided to women, birthing people, and their babies.

A Midwifery Red Flag event is considered as a potential early indicator warning sign. These incidents must be reported to the Maternity Shift Leader and Bleep holder to identify and address and identify any immediate actions.

The following red flags should be documented using the Incident Reporting System:
- Delayed or cancelled time-critical activities.
- Missed or delayed care (e.g., a delay of 60 minutes or more in washing and suturing).
- Missed medication during admission to hospital or midwifery-led unit (e.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 15 minutes or more between presentation and triage.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and the commencement of the induction process.
- Delayed recognition of and response to abnormal vital signs (e.g., sepsis, reduced urine output).
- Any instance where one midwife is unable to provide continuous one-to-one care and support to a woman during established labour.

Theme	Total for Q4 2025/26							
	January 2026		February 2026		March 2026		Total	
	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk
Delayed or cancelled time critical activity	0	0	0	1	0	0	**0**	**1**
Missed or delayed care	0	0	0	0	0	0	**0**	**0**
Missed medication	0	0	0	0	0	0	**0**	**0**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**	**0**
Delay of 15 minutes or more between presentation and triage	11	0	2	0	8	0	**21**	**0**
Delay of 30 minutes or more between presentation and triage	4	0	0	0	0	0	**4**	**0**
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**	**0**
Delay of 2 hours or more between admission for induction	0	2	0	1	0	0	**0**	**3**
Delay in transfer to delivery suite for ARM	0	0	0	0	0	0	**0**	**0**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**	**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0	**0**	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**	**0**
TOTAL	**15**	**2**	**2**	**2**	**8**	**0**	**25**	**4**

During the reporting quarter, 25 Midwifery Red Flags (MRFs) were recorded on the Whiston site, all relating to delays between presentation and triage, representing an increase compared with the previous quarter. A full review of each MRF occurred with the results showing that all patients remained safe and there were no adverse outcomes. Themes were considered and any dates with multiple MRF's we provided supportive conversations and refresher training to the midwives to ensure appropriate escalation and redeploy staffing if required.

The Whiston Triage telephone system remains an important safeguard, particularly during times of heightened acuity. In Quarter 4, the team handled 4895 telephone calls which is an increase from last quarter.
However, the requirement to prioritise answering the telephone can generate MRFs, as call handling must take precedence. This presents additional challenge during periods of high demand, where balancing telephone triage with in-person care can be difficult. Alongside the calls 1,776 face-to-face attendances occurred which is an increase of over 100 attendances. This varied with between 5 and 30 attendances each day. Even with this increased attendance the compliance for the 15-minute triage was 99.3%.

There were no delays in the initial commencement of induction of labour in this quarter, with all Induction of labour procedures commencing within two hours of arrival. This is the second quarter with no MRF induction delays.

The Delivery Suite Shift Coordinator continues to be a key component of the intrapartum safety system, functioning in line with national guidance, including the standards outlined in the Ockenden Report. The position is always maintained as supernumerary, providing continuous leadership, effective oversight, and coordination within the unit. Ongoing monitoring through monthly audits, reported to the Maternity Governance Meeting, consistently shows full compliance. Furthermore, records from the Maternity Bleep Holder offer additional assurance, with four-hourly checks confirming that the supernumerary status is upheld.
All Midwifery Red Flag events are consistently documented, examined, and escalated through the appropriate governance frameworks. Key learning points are routinely shared through ward meetings, safety huddles, ensuring that insights are effectively embedded into practice and that a culture of continuous improvement is sustained. Specific one to one work continuous with staff with multiple MRF's or if there has been any lack of escalation.

All MRF incidents are formally recorded as incidents and reviewed. Learning outcomes are shared via ward meetings, safety huddles, and through Trust-wide communication to support continuous improvement and maintain safe standards of care.

3. Workforce
Maternity workforce is a requirement of MIS Safety Action 5, with neonatal staffing relating to Safety Action 4.

The Women's and Children's Division was formally established in April 2024, structured around a dedicated divisional triumvirate consisting of:

- Divisional Director of Operations
- Divisional Director of Midwifery
- Divisional Medical Director

The Division encompasses Maternity, Gynaecology, Paediatric, and Neonatal services across two sites.
Across the two legacy sites, there is a variation in the percentage uplift used to determine required staffing levels. A staffing review has been undertaken to identify the appropriate uplift, considering sickness, annual leave, training, and maternity leave. The completed findings will be presented to the executive team to enable standardisation across the maternity service.

The Maternity Service has commenced discussions regarding the next required Birthrate+ (BR+) workforce review for 2025/26, meeting the expectation that a systematic, evidence-based process to calculate the midwifery staffing establishment will be undertaken. A meeting with the Birthrate+ team took place in September 2025 to agree the requirements for MWL and work was planned to ongoing during Q3 and Q4 to collate the required data from within the service with a report initially anticipated by the end of the financial year as the first workforce review undertaken collaboratively as MWL. However, the BR+ assessment has not yet commenced to allow consideration of the findings of a national review published in February 2026 to ensure alignment with the most up-to-date and strengthened approach to workforce planning for Maternity services.

The independent review confirms that BR+ remains a credible and robust approach to midwifery workforce planning, supporting safe and sustainable maternity services. However, it identifies that the model does not fully reflect the increased complexity of modern maternity care, including higher clinical acuity, expanded safeguarding and Perinatal Mental Health needs, and growing administrative demands. Targeted updates are recommended to better capture contemporary roles, care pathways and skill mix; however, no clear timescales for these changes have yet been agreed. The review also highlights the need for aligned system-level action, including updated national guidance, clearer standards for specialist roles, and sustained workforce investment.

Ormskirk Maternity Service:

The latest BR+ assessment, received in January 2022, recommended a funded establishment of 105.63WTE for the provision of direct midwifery care. This recommendation included a 25% uplift to account for annual leave, sickness, and study leave, based on 2,387 births and forward bookings for 2020/21. The reporting timeframe of January to March 2026 identified the funded establishment as being above this recommended figure at 113.39 WTE. This includes a funded establishment for direct clinical care reflective of an increased uplift of 30% that was approved following the BR+ assessment to reflect the average midwife unavailability's for sickness, study leave, annual leave and maternity leave. In addition, funding was provided for designated staff for elective caesarean lists and some externally funded posts.

The BR+ report identified that 9.51WTE was recommended as the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical whole time equivalent. The current funded non-direct care equates to 15.82wte. The contracted establishment is currently 14.9wte and below the funded establishment due to vacancies for 0.1WTE Matron, (temporary reduction of hours with a plan to return to full time hours) and vacancies for 0.22WTE infant feeding midwife and a 0.6WTE Band 6 MSW retention midwife. The current funded establishment relates to 12% of the total clinical establishment which is above the BR+ recommendations of 9% and is due to additional funding from Ockenden and externally funded posts.

The staffing position at the end of March 2026 identified that the unit was not in deficit to the BR+ funded establishment recommendations for direct or non-direct maternity care. 4.6WTE newly qualified midwives have been recruited and are due to commence in the Trust in May. Taking these in to account and staff leaving within the month, the vacancy rate was 0.44% (0.55WTE) across all clinical midwifery posts

The Midwife to birth ratio for this reporting period has been recorded as

Month	Midwife to Birth ratio
January 26	1:21
February 26	1:21
March 26	1:21

There has been 100% compliance noted for the provision of 1-1 care in labour and 100% compliance with a supernumerary Delivery suite shift coordinator at the start of the shift for this 3-month reporting period.

Whiston Maternity Service:

The last BR+ report which was received by the Trust in October 2022 reviewed the acuity of the women who used maternity services.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and recommended that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 15.19 WTE (inclusive of uplift of 0.8WTE for Digital Midwives in 25/26) and aligns to the recommendations and therefore no variance is noted. In addition, the non-direct care band 7 posts include three fixed term externally funded posts (1.8WTE) which are included in the contracted figures but not in the funded establishment. If external funding ceases, there will be a requirement to complete a business case for these roles as they are required within the service as they are fundamental in supporting improving outcomes for vulnerable women and babies, and providing retention support to the workforce

The BR+ report identified that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 168.22 WTE. Agreement to substantively over establish to cover maternity leave is maintained and the service is therefore in line with the recommendations of the BR+.

The staffing position at the end of March 2026 identified that the unit was not in deficit to the BR+ funded establishment recommendations for direct or non-direct maternity care

Proactive recruitment has occurred to ensure those who have been promoted, reduced hours, submitted notice of retirement or are leaving the organisation are being replaced. At the end of Q4 the service had 4.22WTE MW vacancies and 1.2WTE vacancies, all which have been recruited to with checks underway for start dates in Q1.

Midwife to birth ratio for this reporting period has been recorded as:

Month	Midwife to Birth ratio
January 2026	1:26
February 2026	1:23
March 2026	1:29

MWL use the formula and methodology provided by Birthrate Plus to produce the calculation.

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernumerary Delivery suite shift coordinator for this 3-month reporting period.

Obstetric Workforce.

Obstetric Staffing relates to Safety Action 4 of MIS Year 7

The Whiston and Ormskirk sites are fully recruited to the funded Consultant establishment. However, one Consultant based at the Ormskirk site is currently on secondment to Manchester Foundation Trust in Urogynaecology, creating a temporary vacancy with ongoing recruitment. One Consultant vacancy is currently being covered by a fixed-term appointment.

Cross-site working continues for specialist clinics, including fetal medicine, multiple births, and pelvic health services, with close collaboration between the Delivery Suite and Clinical leads in navigating temporary pathway changes.

Current challenges continue within the middle-grade rota, primarily due to part-time working arrangements and maternity leave and as such has engaged use of locums.

Consultant obstetrician presence on the Delivery Suite aims to improve safety and enhance training by providing 24/7 or extended consultant cover, particularly for high-risk births. Based on the number of births per annum, Safer Childbirth and the Royal College of Obstetricians and Gynaecologists (RCOG) define minimum hours for consultant presence per week. Birth numbers at the Ormskirk site (<2500 per annum) allow for local professional judgement, which has been agreed at 74.5 consultant hours per week. In contrast, the Whiston site should achieve a minimum of 98 consultant hours per week, with ongoing plans to progress towards full consultant presence of 168 hours per week. Obstetric units with more than 6000 births per annum are expected to provide continuous consultant obstetrician presence. Currently on the Whiston site the rota for senior clinical presence is supplemented by SAS obstetricians during periods when a resident consultant obstetrician is not available, ensuring continued senior decision-making to support patient safety on the Delivery Suite.

Neonatal service

A transformation programme is currently underway across Cheshire & Merseyside, with a renewed focus on implementing changes to the existing commissioned capacity.

The Division submitted a paper to the Executive Team proposing a potential cot reconfiguration across MWL. The paper summarised both the current and potential cot arrangements and the associated staffing requirements, based on ODN intelligence. The Neonatal Nursing Workforce Tool staffing establishment highlighted that the ward manager should not be included in the clinical staffing numbers to ensure effective leadership and staff support, consistent with other neonatal units in the Cheshire & Merseyside area. Currently, 0.4 WTE of the ward manager's time is included in clinical staffing establishments.

Further discussions with the ODN provided updated 2024/25 capacity and demand data and guidance on the network approval process for cot reconfiguration. Additional review is ongoing

Neonatal medical workforce

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 1st May 2025 and remains currently compliant to date.

Neonatal nursing:

Ormskirk neonatal nursing service:

The neonatal unit on the Ormskirk site is funded and meets the BAPM Neonatal Nursing Standards utilising the Neonatal workforce calculator within the MIS reporting period which has been shared with the ODN.

Following successful recruitment into vacant posts, all appointed candidates commenced in Q4. The department currently has a vacancy of 0.11WTE against funded establishment.

Whiston Neonatal nursing service:

Safety Action 4 requires the neonatal unit to meet the BAPM neonatal nursing standards. An action plan continues to be updated and monitored via the risk register. The action plan has been shared with the LMNS and Neonatal Operational Delivery Network (ODN).

A staffing review of the Neonatal Unit in Q4 has identified the following vacancies:

- 2.76 WTE Band 4 - vacancy.
- 0.48 WTE Band 3 - following Trust agreement for uplift of Band 2 roles.
  A plan to review the nursing establishment for 2026 includes the Band 4 roles in line with service need.

The Neonatal Unit position due to Band 6 nurse unavailability improved at the end of Q4 due to the return of LTS nurses and the conclusion of an ongoing investigation.

The neonatal unit on the Whiston site completed the Q4 2025/6 workforce calculator tool which was submitted to the ODN in April 2026. The tool identified that there is now a deficit of 3.45 WTE registered nurses based on activity levels. The tool includes a separate tab for Transitional Care staffing although transitional care on the ward to full BAPM standards had not been commenced in Q4 2025/6. An action plan has been developed which includes the requirement to review the nursing establishment, undertake a business case and review the neonatal cot configuration. The Neonatal Nurse workforce summary and associated action was presented to Trust Board, ODN and LMNS in November 2025 and continues to be monitored via the risk register. The action plan is presented as Appendix 2.

Transitional care has commenced at Whiston at the beginning of Q1 2026/2027.

Qualified in Speciality (QIS) trained staff across MWL.

There is a mandatory requirement that 70% of the neonatal workforce hold Qualified in Specialty (QIS) status. A programme is in place to support staff in achieving this qualification.
The pathway to QIS requires:

1. Completion of the Foundation in Neonates (FIN) course
2. Completion of the QIS course

Both courses require a secondment to a Level 3 unit for 4–6 weeks (longer for part-time staff). Staff release is managed individually to ensure safe service provision.

Due to a national shortage of QIS-qualified nurses, developing internal staff is essential. Ensuring an optimised workforce supports nurses while undertaking the programme.

Ormskirk Site:
The compliance for FIN course is 82% with all new starters having either commenced or are booked onto the course.

The current QIS compliance on the Ormskirk site is 80%, with an ongoing plan in place to ensure training targets are maintained. Three staff members will commence QIS training in 2027 following consolidation of FIN programme.

Whiston Site:
FIN compliance has improved in Q4 2025/6 to 69% with three Band 5 staff who are completing the course which increase compliance to 84%.

Seven Band 5 staff nurses are QIS-qualified. This number has reduced from 9 in Q3 due to 2 staff members gaining promotion from Band 5 to Band 6.
Six of these individuals progressed through the structured FiN-to-QIS development programme, supported by targeted training and mentorship within defined timeframes. This represents a significant achievement for the unit, further highlighted by the career progression of 2 further Band 5 team members who have been promoted to Band 6 roles.

QIS compliance 54.8% this is due to new starters (non-QIS) commencing on the unit. One nurse commenced QIS training in September 2025 has completed the course in March 2026 and awaits final results which will increase QIS compliance to 57.9%. There are also three Band 5 nurses who have commenced the course in March 2026. QIS compliance fluctuates each quarter due to staff turnover and promotional opportunities, and training trajectories support the aim of maintaining and exceeding the 70% requirement.

FiCare Accreditation:

FiCare (Family Integrated Care) is a recognised model in neonatal units that actively involves parents in the day-to-day care of their babies. The model aims to:

- Empower parents to participate in care activities such as feeding, bathing, and developmental support.
- Provide structured education and training to build parental confidence and competence
- Ensure staff support to guide parents safely.
- Improve infant outcomes, including growth, developmental progress, and shorter hospital stays
- Enhance parental bonding and psychosocial wellbeing.

Units can be assessed through staged FiCare accreditation which measures how well the unit has embedded the FiCare principles into daily practice.

Ormskirk: Currently Stage 1 Green; Stage 1 reassessment passed July 2024; Stage 2 assessment was due early 2025 however there is currently a review of the FiCare framework and until completed there is no date for reassessment scheduled. There is no change at present to this position.
Whiston: Stage 1 achieved December 2023; FiCare sustainability visit January 2025 confirmed embedded practice; working towards Stage 2 accreditation with an updated action plan submitted to the ODN.

Neonatal UNICEF Baby Friendly Initiative (BFI) Accreditation:

The UNICEF Baby Friendly Initiative is an internationally recognised programme that promotes best practice in supporting breastfeeding, parent-infant bonding, and responsive care. Accredited services demonstrate:

- Promotion and support of exclusive breastfeeding where possible

- Encouragement of skin-to-skin contact and early bonding between parents and babies
- Staff training in evidence-based practices to support feeding and attachment
- Implementation of robust policies and procedures to embed family-centred care in everyday practice

UNICEF accreditation provides external assurance that the maternity and neonatal services are delivering care aligned with international standards, complementing other initiatives such as Family Integrated Care (FiCare).

Ormskirk: Achieved Stage 2 BFI accreditation in February 2025. Working towards Stage 3 but no date confirmed for assessment.
Whiston: Currently working towards BFI accreditation, with a date for assessment yet to be confirmed. plan is in place for all staff to complete BFI training, and a nurse is being supported to undertake the BFI Train the Trainer course to enable future internal delivery and sustainability of training. 75% of nursing staff have received the 2-day BFI training with the exception of staff that are on maternity leave and on LTS, Neonatal Educators have booked all new starters on the BFI 2-day course to support attendance.

Professional Development opportunities

One member of staff is currently completing the PNA (Professional Nurse Advocate) course, and 1 member of staff is completing the PMA (Professional Midwife Advocate) course at Whiston.

The NNU Ward Manager at Whiston is completing the NHSE Rosalind Franklin Leadership Programme.

Neonatal Transitional Care (NTC):

The Ormskirk site has a NTC service in place with NTC pathways in place. However, this is not funded as per BAPM compliance. However, NHSP is utilised to support if the activity on the Unit is above the average occupancy of 70% in order to remain compliant to BAPM standards.

Neonatal transitional care has been launched at Whiston in Q1 2026/7. By delivering Neonatal Transitional Care (NTC), we are able to provide care via a multi-disciplinary approach between Maternity and Neonatal Teams on both sites, to parents and their babies who previously would have been separated on admission to the Neonatal Unit.

3.1 Sickness Including COVID

Sickness	January 26	February 26	March 26
Ormskirk Maternity	10.20%	9.11%	7.34%
Whiston Maternity	7.64%	9.91%	7.01%
Ormskirk Neonatal	7.21%	5.18%	8.05%
Whiston Neonatal	15.12%	15.17%	9.83%

Sickness is being managed according to the MWL policy, with monthly oversight and support from HR. During Q4 there has been a resolution to a number of ongoing HR investigations which has impacted on sickness absence in the Neonatal Unit on Whiston site.

3.2 Maternity Continuity of Carer

The current MCoC position and expansion at both legacy sites remains on hold, as previously agreed at Executive level. The plan to deliver a Maternity Continuity of Carer model at full scale, in line with national guidance, has been updated with revised timescales while awaiting further national guidance. This model utilises a mixed-risk approach, providing enhanced midwifery care to women and babies of Black, Asian, and mixed ethnicity, and those living within the lowest 10% decile of deprivation.

The Northwest Regional Maternity Team has provided interim direction, advising that the focus should be on delivering antenatal and postnatal continuity for these priority groups. To support this the service has recruited dedicated community-based Maternity Support Workers utilising external funding on a 12-month fixed term basis who commenced in Q4 2025/26 and will be focusing on the geographical areas within the lowest decile of depravation across the MWL footprint

During the Community Midwifery Service alignment across MWL, and the wholescale review of the MCoC plan, the current MCoC teams from the legacy organisations continue to remain operational:

- Ormskirk Sapphire Team provides continuity for women living out of area on a shift-based model.
- Whiston Amethyst Team continues to provide continuity for the most vulnerable women, although they are currently unable to provide the intrapartum element, with intrapartum support delivered by the Delivery Suite. To support the current model, fixed-term funding has been provided to recruit dedicated Maternity Support Workers to enhance care for women of Black, Asian, and mixed ethnicity and those in the lowest 10% decile.
- Whiston Homebirth Team provides full continuity of care for women choosing home birth, which can be offered at any stage of the antenatal pathway. The formal alignment provides an opportunity to develop a dedicated MWL Homebirth Team across the geographical area, which could also support women choosing to birth at Lowe House freestanding MLU once estate works are complete and CQC registration achieved. It is anticipated that a dedicated homebirth team will be a recommendation of the NW Regional Homebirth charter when published in Q1 2026/27 and remains a priority for MWL

The MCoC Action Plan has been revised and refreshed following the alignment of the MWL Community Midwifery Service and is presented to the committee as Appendix 3.

3.3 Maternity Suspension of Services.

During the reporting period there was one suspension of Maternity Services on the Ormskirk site for a period of 2 hours due to a short-term medical staffing issue. In line with requirements, this has been STEIS reported and an after-action review is ongoing.

3.4 Neonatal Suspension of external services

Ormskirk site			**Whiston site**	
Q4 25/26	No of closures		Q4 25/26	No of closures
January 26	0		January 26	6
February 26	0		February 26	3
March 26	0		March 26	2
Total closures	**0**		**Total closures**	**11**

During Q4, there were 11 neonatal suspensions of services across MWL, all of which occurred on the Whiston site. Throughout each period of temporary closure, the Neonatal Unit remained open

to emergency admissions, with clear plans in place to stabilise and transfer babies requiring neonatal admission where necessary. No transfers were required during these periods.

Importantly, the neonatal service suspensions did not impact maternity care pathways, and no antenatal women were required to transfer to an alternative provider for birth as a result of these closures.

3.5 One to One Care in Labour

Maternity Services aim to achieve 100% one-to-one care for women in established labour. Compliance with this standard is monitored and reported through the Safe Staffing Report and the monthly dashboard.
For Q4, there were no occasions in which one-to-one care in labour was not provided.

3.6 Maternity and Neonatal Safety Training

Maternity and Neonatal Safety Training is mandatory education for all maternity team members, including obstetric doctors, anaesthetists, midwives, maternity support staff, and neonatal nurses, to ensure the safety of mothers and newborns.

Key Areas of Training:

1. Fetal Surveillance
2. Management of Obstetric emergencies (PROMPT)
3. Neonatal life support (NLS): Immediate care, resuscitation, and stabilisation of newborns.

This training is the gold standard when delivered in the staff member's current unit, providing hands-on learning with local multidisciplinary teams. All staff groups are expected to maintain a minimum compliance level of 90%, in alignment with national standards.

While rotational medical staff groups may face compliance challenges at certain points throughout the year, all are supported to achieve the standard alongside local teams. Rotational medical teams, although may have completed training at their previous Trusts, are prioritised for MWL training within three months of commencing in role.

Ormskirk Site:

Rolling Annual Compliance at MWL as of 31 March 2026		
Fetal Surveillance	Consultant Obstetrician	92.3%
	Other Obstetric Doctors	100.0%
	Midwives	97.6%
PROMPT	Consultant Obstetrician	92.9%
	Other Obstetric Doctors	81.8%
	Midwives	96.1%
	MSW	100.0%
	Consultant Anaesthetist	75.0%
	Other Anaesthetic Doctors	93.3%
NLS	Midwives	92.9%
	Neonatal Consultants	90.0%
	Other Neonatal Doctors	87.5%
	Neonatal Nurses	88.0%
	ANNP	100%

Whiston Site:

Rolling Annual Compliance at MWL as of 31 March 2026		
Fetal Surveillance	Consultant Obstetrician	90.0%
	Other Obstetric Doctors	100.0%
	Midwives	99.4%
PROMPT	Consultant Obstetrician	95.0%
	Other Obstetric Doctors	79.3%
	Midwives	97.2%
	MSW	93.6%
	Consultant Anaesthetist	92.8%
	Other Anaesthetic Doctors	48.0%
NLS	Midwives	99.4%
	Neonatal Consultants	91.0%
	Other Neonatal Doctors	97.6%
	Neonatal Nurses	94.7%
	ANNP	100.0%

4. Patient Experience

Maternity

The 2025 NHS Annual CQC Maternity Survey for MWL gathered feedback from women giving birth in February 2025, was published in December 2025. 396 service users were invited to take part and 141 completed the survey (36%). This was slightly lower than the average response rate for all Trusts (39%). 90% participants were white ethnicity which reflects the ethnicity of users to our service overall and 95% had English as their main language.

The 2025 survey included 4 new questions not previously asked before. In comparison to the 2024 survey, MWL showed no statistical difference in results for 48 questions, however significantly better in 6 questions. Areas of improvement related to experience of antenatal care following focused work being undertaken in the previous year and being discharged home without delay from the postnatal ward. MWL was notably a positive outlier for treating women and families with kindness, compassion, respect and dignity, women and their families being involved in decisions about care and ensuring that concerns raised to our multidisciplinary teams during labour and birth are taken seriously and acted upon, though challenges remain in partner involvement whilst on the postnatal ward.

Survey results have been triangulated with other patient feedback sources to target ongoing improvements, and a revised action plan has been co-produced with the Maternity leadership team, MNVP, and patient engagement teams, focusing on ongoing opportunities to strengthen communication, support, and family involvement. The ongoing 2024 action plan has been reviewed, with any outstanding or ongoing actions carried forward into the newly developed action plan.

As part of ongoing improvement work, maternity matrons, supported by the Patient Experience team, developed local surveys on the Tendable platform to address identified areas of concern. This initiative proved successful following the 2024 survey results. This approach provided timely feedback directly to the service, demonstrating that improvements were being embedded effectively.

The surveys have been reviewed and updated to reflect areas requiring improvement identified in the 2025 survey.

MWL Overall Score	**Jan 2026**	94.97%
	Feb 2026	98.16%
	March 2026	92.96%

Across the six questions, results demonstrate consistently high levels of overall satisfaction and provide assurance regarding the quality of care delivered. The findings indicate that recently implemented service improvements (specifically the introduction of a standardised closing statement to confirm understanding of advice provided via the maternity triage telephone line) have had a positive and measurable impact on patient satisfaction.

Notably, an ongoing area of focus remains ensuring partners are able to stay as much as they wish during the inpatient stay. Further work is required to reduce variation and ensure an equitable offer across both sites. Currently, partner overnight stay is supported at the Ormskirk site, with extended visiting hours offered at Whiston while work continues to improve facilities, including the procurement of suitable chairs, to support full implementation.

Question	**Jan 2026**	**Feb 2026**	**March 2026**
Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	100%	97.14%	100%
Do staff introduce themselves?	100%	100%	100%
Do you think that your healthcare professional did everything they could to help manage your pain in hospital after the birth?	100%	90%	94.44%
Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay as much as you wanted them to?	77.78%	100%	83.33%
Thinking about the last time that you contacted the maternity triage line, did you feel that you got the advice that you needed?	100%	100%	100%
Do you feel safe and cared for?	100%	100%	94.44%

Qualitative feedback from various sources, including FFT, compliments and concerns was reviewed across all areas. FFT scores, comments, and identified themes are shared monthly with clinical leads, who then disseminate this information to their teams. The feedback is also displayed on Quality and Safety boards within the clinical areas and reported through the Maternity Governance meeting, ensuring visibility, accountability, and continuous improvement in patient experience.

Maternity Q4 Friends and Family Feedback (Positive %, Very Good/Good Response)

Response rates for friends and family test fluctuate for the service. The qualitative narrative suggests that although there are four touch points in Maternity, women and families often provide an overarching response of experience of maternity care as one submission within areas feedback.

The Community Midwifery Matron has recently met with the Trust Patient Experience Team to review low response rates within the postnatal community setting, which were identified as being related to technical issues with QR codes not functioning correctly. As a result, the FFT has been streamlined into a single QR code for this touchpoint across the MWL footprint, allowing women to select their locality of care via a drop-down option. A new poster has been developed and disseminated to managers and clinical leads for implementation across community midwifery teams, with the aim of improving accessibility and increasing response rates.

Ormskirk:

Area	Jan 26	Feb 26	March 26	Trust Target
Antenatal	100%	No Responses	No Responses	95%
Birth/Delivery	100%	94%	95%	93%
Maternity Ward	94%	86%	89%	92%
Postnatal Community	No Reponses	100%	No Responses	91%

Whiston:

Area	Jan 26	Feb 26	March 26	Trust Target
Antenatal	100%	81%	100%	95%
Birth/Delivery	91%	97%	92%	93%
Maternity Ward	88%	88%	72%	92%
Postnatal Community	100%	100%	100%	91%

Qualitative feedback across all service areas has been reviewed. Postnatal feedback during this period highlighted themes primarily relating to care following caesarean section and the timeliness of pain relief. Some comments also reflected variability in experience overnight. With an increase in the number of women experiencing operative birth there is a requirement to support effective pain control and enhanced surgical recovery.

These themes have been discussed directly with ward teams. Actions have focused on reinforcing expectations around timely analgesia administration, particularly overnight, and ensuring clear handover and escalation where pain is not adequately controlled. Ongoing monitoring through walkarounds and patient feedback will be used to assess the impact of these actions, with direct feedback to date not highlighting a recurring concern.

Neonatal Q3 Friends and Family Feedback (Positive %, Very Good/Good Response)

Area	October 25	November 25	December 25	Trust Target
Neonatal Ormskirk	100%	100%	100%	94%
Neonatal Whiston	No responses	100%	100%	94%

Feedback posters have been developed in partnership with the Corporate Patient Experience Team and displayed within the Neonatal Unit at Whiston. These include a QR code to support parent

engagement and encourage families to share their experiences, generating valuable feedback to inform and support ongoing service improvement.

Following the introduction of Transitional Care, the NNU Senior Nursing Team is working closely with the Corporate Patient Experience Team to capture feedback and to develop a bespoke Transitional Care satisfaction survey.

MNVP

The MNVP continues to be actively embedded within maternity governance and service improvement arrangements. Monthly MNVP meetings are established, with attendance from maternity and neonatal leadership and external MNVP representation. These meetings provide a mechanism for triangulating service user feedback and ensuring this informs divisional quality discussions.

MNVP feedback is directly contributing to the December 2025 Survey Action Plan, particularly in relation to postnatal pain management and information-giving around induction of labour. These themes are being tracked through existing action plans and fed into quality and safety forums for oversight.

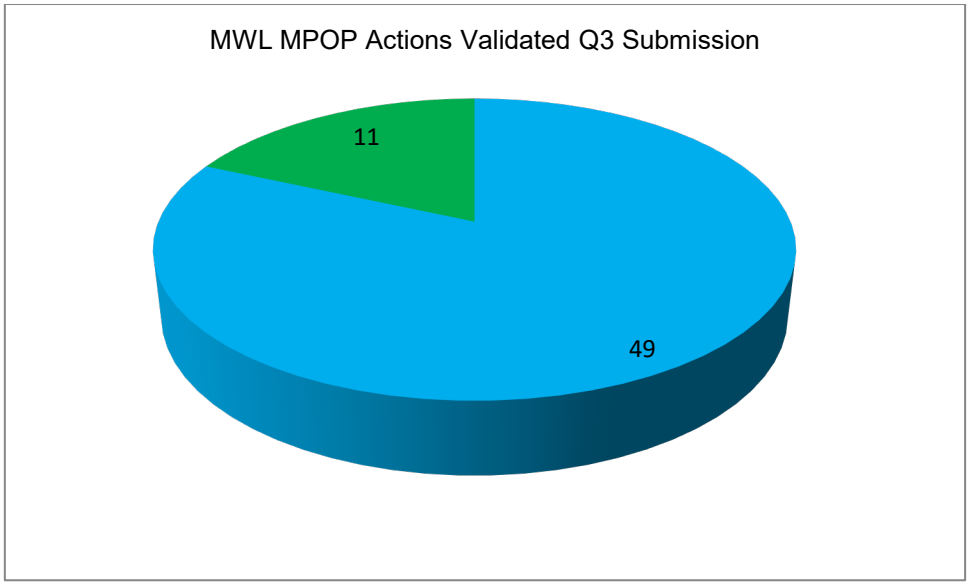
Recruitment to the further expand the MNVP capacity is progressing with interviews scheduled in Q1.

5. NHSE: Three-Year Delivery Plan for Maternity and Neonatal Services

While most women report positive experiences with NHS maternity and neonatal services in England, independent reviews have highlighted cases where families have experienced unacceptable care, trauma, and loss. The publication of NHSE's Three-Year Delivery Plan for Maternity and Neonatal Services in March 2023 consolidated learning and actions from national reports, including the Ockenden final report. This plan ensures accountability across the system, encourages the spread of best practices, and supports a cross-system approach to improving care for service users.

The NHS England Regional Maternity Team has established a process via the Maternity Provider Oversight Panel (MPOP) to review progress against the deliverables in the Three-Year Delivery Plan. Implementation is assured through quarterly provider submissions of evidence via the Local Maternity and Neonatal Systems (LMNS), with an additional annual site visit for each provider. Quarterly LMNS assurance meetings commenced in 2024 to review evidence and monitor progress.

We are currently in Year 3 of the Three-Year Delivery Plan. The LMNS validated evidence for the Q3 submission, which was shared with the Trust in March 26 and highlighted ongoing progress against MWL actions. 49 deliverables have been BRAG rated as complete by the LMNS and 11 are ongoing which relate to maternity workforce fill rates monitored via provider workforce returns.



Q4 MPOP submission as provided to the LMNS in April 2026 is presented to the Quality Committee in Appendix 4.

6. Maternity pathway changes

Following an expert clinical review by the Local Maternity and Neonatal Service, which identified areas of clinical risk, a Trust decision was made requiring temporary changes to some high-risk pathways which included women with the following conditions identified at booking requiring transfer and birth on the Whiston site:

- Type 1 diabetes
- Parity of five or more
- Multiple pregnancies
- BMI greater than 40 at booking
- Previous PPH greater than 1500mls
- Women receiving care under the maternal medicine criteria (Categories B-D)

The temporary maternity pathway changes were implemented on 4 September 2025. Following the National Maternity team review in October 25 and receipt of the report was in November an action plan has been developed and shared with the LMNS.

Agreement was made to refine the pathways which has continued to be monitored by the clinical workstreams, clinical pathways project board and the LMNS Joint Oversight Scrutiny Team to align and support the delivery of services across MWL.

The pathways for women with a BMI greater than 40 at booking, parity of five or more, PPH and women receiving maternal medicine care have been revised and implemented. Type 1 diabetes and multiple pregnancy pathways are still under review which are providing care to women in the most appropriate place

7. Recommendations

The Board is asked to note the report.

8. Summary of Appendices

- Appendix 1: Screening QA Action Plan
- Appendix 2: Neonatal Nursing Workforce Action Plan
- Appendix 3: Revised and Updated MCoC Action Plan
- Appendix 4: MPOP Tool (Three Year Delivery Plan)

Appendix 1

	Recommendation		Action/evidence required	Responsible Lead	Timescale	Progress	BRAG Rating
Governance and leadership - Programme leadership, management and co-ordination.							
1	Complete the planned work for ANNB screening governance across the whole trust footprint, making sure that ANNB screening is visible to senior leadership and that escalation processes are documented and available for staff	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Organisational structure chart (that is signed off) Escalation process (that is signed off)	DoM, DDoMs, Quality and Safety Matrons.	3 Months - July 2025	**Submitted to SQAS on Tuesday 19/8/25 & 22/08/2025**	Rec Closed
2	Update the terms of reference of the ANNB Steering Group to reflect the trust's joint footprint and include standing agenda items and consistent reporting from all sites, including risks and incident management	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening	Terms of reference signed off by the ANNB Steering Group	ANNB Steering Group Chair	3 Months - July 2025	**Submitted to SQAS 27/10/2025**	Rec Closed
3	Improve links between maternity and the newborn hearing screening programme to make sure that issues and risks are shared		Escalation process (that is signed off) Minutes from meetings	ANNB Hearing Screening Manager ANNB Steering Group Chair ANNB Hearing Screening	6 months October 2025	**Quarterly meetings now in place for 26-27**	Rec to be closed at next meeting
Governance and leadership - Incident, risk management and escalation							
4	Document the process for the escalation and management of screening incidents (and share this with staff)	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Escalation and management process (that is signed off)	Quality & Safety matron ANNB Screening Coordinators (both sites)	3 Months - July 2025	Updated version sent to NP 05/01/2026	Rec Closed
5	Make sure guidelines refer to managing safety incidents in NHS screening programmes and the link to the NHSE screening incident assessment form (SIAF) is updated	Managing safety incidents in NHS screening programmes updated 2024	Guideline (that is signed off)	ANNB Screening Coordinators (both sites) Quality & Safety matrons	12 Months April 2026	Needs all guidelines to link into the trust incident guideline	Progressing on Schedule
Governance and leadership – Heath Inequalities							
6	Make sure that the screening health inequality audit is presented within the trust and that there is a monitored action plan to address findings	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025	Minutes of meetings Action plan including timescales	ANNB Screening Coordinators (both sites)	6 months October 2025	*Action plan to be submitted as evidence - emailed to LR this week, scheduled for presentation at next audit meeting - can be closed with submission of action plan and agenda for audit meeting with HEA included*	Rec Closed
7	Make sure women have consistent access to translation services for ANNB screening services cross-site. Including when face to face interpreters and telephone translation services are not available and in alternative formats to written information	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Guideline (that is signed off) which should include how the provider identifies women who need alternative formats to written information. Interpreting services when English is not the first language and neither face to face interpreters or telephone translation services are available. Plan to audit the process within 12 months.	Maternity Matron for Outpatients	12 Months April 2026	Ormskirk site - telephones not availabile in scan rooms. Work underway, with approved bid funded to purchase Ipad to meet this.	Progressing on schedule
Governance and leadership – Policies and Guidelines							
8	Make sure that current clinical practice complies with national policy and guidelines, policies and SOPs are appropriately updated to reflect this, including, SCT pathway for abnormal paternal results, updated NIPE pathway for testes, NIPE timeframe for hip scans	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Audit of current clinical practice against guideline. Guidelines (that are signed off)	ANNB Screening Coordinators (both sites)	12 Months April 2026	1. List of requirements from Nicola Poplett 2. List of guidelines across both sites 3. Screening team cross site meeting to develop action plan for guidelines to be merged and updated	Progressing on schedule

9	Make sure harmonised guidelines clearly reflect any site-specific differences and pathways	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Guidelines (that are signed off)	ANNB Screening Coordinators (both sites)	12 Months April 2026	1. List of requirements from Nicola Poplett 2. List of guidelines across both sites 3. Screening team cross site meeting to develop action plan for guidelines to be merged and updated	Progressing on schedule
10	Implement a trust wide governance plan for audit of ANNB screening	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	List of planned audits	Quality & Safety matrons, Maternity Matron for Outpatients	12 Months April 2026	LR meet with Carmel / Sue to put together documentation of the audit schedule.	Progressing on schedule
Governance and leadership – Communication and feedback							
11	Demonstrate that feedback (including complaints) from service users, including those with protected characteristics or from underserved groups is used to develop and/or improve service delivery for antenatal and newborn screening	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	User feedback findings action plan discussed at the ANNB Steering Group	ANNB Screening Coordinators (both sites)	12 Months April 2026	LR to arrange meeting with PALS to establish any current feedback received. LR to work with PALS / MNVP to develop screening specific patient feedback questionnaire if needed.	Progressing on schedule
Infrastructure – workforce and training							
12	Ensure there is resilience in the service to maintain delivery of screening functions when key members of staff, including the LCO, are absent	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Business continuity plan (that is signed off). Job description/structure chart/guideline that outlines the functions of the respective roles if relevant.	Maternity Matron for Outpatients	3 months July 2025	**Submitted to SQAS 27/10/2025**	Rec Closed
13	Make sure there is resilience in the ultrasound service by implementing a collaborative and sustainable workforce plan across all sites, this could also include utilising cross-site training opportunities	Section 7a screening service schedule 2 no: 16 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021	Workforce plan / business continuity plan (that is signed off)	Ultrasound Service Manager	6 months October 2025	To meet this recommendation we need to submit a collaborative and sustainable workforce plan that is a cross-site plan, including joint training / cross site cover / harmonised working practices as examples	To be reviewed at 12 month meeting for closure agreed by NHSE
14	Implement and monitor a process for ongoing training and continuing professional development for health professionals involved in screening	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21, 22 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Training log / completion of NHS Screening e-Learning resource (with dates)	Maternity Matron for Outpatients ANNB Screening Coordinators (both sites)	12 Months April 2026	SA/CK - to request Midwifery Study day compliance from Education lead midwives for 2025	Rec Closed
Identification of cohort (antenatal)							
15	Make sure that weekly checks are in place for the timely identification of the complete antenatal cohort at Ormskirk	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Tracking process which shows weekly (as a minimum) tracking	ANNB Screening Coordinator Ormskirk site	3 months July 2025	**Carmel sent directly to Nicola 21/8/25**	Rec Closed
16	Make sure processes are documented for the failsafe of the antenatal screening programmes	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Documented processes (that are signed off)	ANNB Screening Coordinators (both sites)	3 months July 2025	**Confirmation to be given at October board that this is ratified**	Rec Closed
17	Make sure processes are documented for the management of screen positive results for women who miscarry or terminate their pregnancy, and they are followed up as required	Section 7a screening service schedule 2 no: 15, 16, 17, 18 2024 - 2025 Antenatal screening pathway requirements specifications 2021	Documented processes (that are signed off). Tracking system. Letter templates.	ANNB Screening Coordinators (both sites)	6 months October 2025	Letter templates deveolped and added to AN screening guideline, not yet ratified as other amendments also pending. Unratified documents sent to NP	Rec Closed
Sickle cell and thalassaemia screening							
18	Monitor the action plan to meet the acceptable threshold for standard/key performance indicator SCT-S02/ST2 - the proportion of pregnant women having antenatal sickle cell and thalassaemia screening for whom a screening result is available before or at 10+0.	Section 7a screening service schedule 2 no: 18 2024 - 2025 Sickle cell and thalassaemia screening pathway requirements specification 2021 Standards 2018 SCT-S02	Action plan that is agreed and monitored by the ANNB Steering Group. Action plan that is agreed and monitored by the ANNB Steering Group.	Maternity Matron for Outpatients ANNB Screening Coordinators (both sites)	12 Months April 2026	12 month template for Q4,1,2,3 plus 24-25 annual summary for SCT 2, NIPE standards and NBS	Progressing on schedule

19	Make sure staff providing counselling to women/couples at risk of sickle cell and thalassaemia undertake the accredited genetic risk assessment and counselling module	Section 7a screening service schedule 2 no: 18 2024 - 2025 Sickle cell and thalassaemia screening pathway requirements specification 2021 Standards 2018 SCT-S02	Confirmation of completion of accredited genetic risk assessment and counselling module	ANNB Screening Coordinators (both sites)	12 Months April 2026	CK has now completed GRAC - evidence will be sent to SQAS as soon as module is signed off by KCL	Rec closed
20	Implement a documented process for the fast track of women and/or couples known to be at risk of having a baby with a haemoglobin condition and for women with assisted pregnancies	Section 7a screening service schedule 2 no: 18 2024 - 2025 Sickle cell and thalassaemia screening pathway requirements specification 2021	Documented process (that is signed off)	ANNB Screening Coordinators (both sites)	3 Months July 2025	Draft guideline - NP comments on other aspects of SCT. Appendix 9 - replaced with NHSE pathway	Rec closed
Infectious disease in pregnancy screening							
21	Improve awareness of staff and the promotion to women of the 'negative now' message in IDPS testing	Section 7a screening service schedule 2 no: 15 2024 - 2025 Infectious diseases in pregnancy screening pathway requirements specifications 2021	Documented process (that is signed off) Minutes of meetings	ANNB Screening Coordinators (both sites)	6 months October 2025	Unratified guidelines sent to NP before 4/12/25	Rec closed
22	Make sure that there is an agreed process for the establishment of a formal IDPS MDT when this is required	Section 7a screening service schedule 2 no: 15 2024 - 2025 Infectious diseases in pregnancy screening pathway requirements specifications 2021	Documented process (that is signed off)	ANNB Screening Coordinators (both sites)	6 months October 2025	Unratified guidelines sent to NP before 4/12/25	Rec closed
23	Make sure each woman who declines the initial offer of IDPS screening (HIV, Hepatitis B and/or syphilis) is identified, tracked and re-offered screening by 20 weeks of pregnancy or within 2 weeks if booked after 20 weeks gestation	Section 7a screening service schedule 2 no: 15 2024 - 2025 Infectious diseases in pregnancy screening pathway requirements specifications 2021	Documented process (that is signed off)	ANNB Screening Coordinators (both sites)	6 months October 2025	CK to send unratified IDPS guidelines to NP as confirmation. Closure confirmed by NP 2/1/26	Rec Closed
Fetal anomaly screening							
24	Make sure processes are documented including site specific variations across the trust, for booking ultrasound appointments, undertaking a clinical review when a baby is born unexpectedly with on of the physical conditions screened for, IT downteim for maternity ultrasound, induction of new/agency sonographers, ensuring women scanned in EPAU do not miss the opportunity for first Trimester screening.	Section 7a screening service schedule 2 no: 15, 16, 17, 18, 19, 20, 21 2024 - 2025 Antenatal and newborn screening pathway requirements specifications 2021	Documented processes (that are signed off) including: Booking ultrasound appointments Undertaking a clinical review when a baby is born unexpectedly with one of the physical conditions screened for. IT downtime for maternity ultrasound Induction of new or agency ultrasound staff performing FASP scans Ensure women scanned in EPAU do not miss the opportunity of screening if they are within or approaching the eligible date range for first trimester screening	Screening Support Sonograhpers / Lead sonographers	3 months July 2025	1. USS booking process - with KL - comments sent from NP. 2. IT down time sent from both sites -requires email confirmation from KL/DS when approved 3. Local induction process - with KL/CD/DS - comments sent back from NP. 4.EPAU - LR to send ratified SOP 5. Clinical review for babies born upexpectedly with one of the physical conditions. Add to USS guideline as well as maternity guideline.	Extended due to accepted complexity of recommendation. 1.updated and ratified doc to be sent from Whiston site 2. updated and ratified doc to be sent from Whiston site 3.updated and ratified doc to be sent from both sites or joint doc 4. LR to send completed doc 5. Update required
25	Make sure the SSS at Whiston is supported in carrying out the functions of the role including capacity to provide feedback on 6-monthly DQASS reports to individual practitioners	Section 7a screening service schedule 2 no: 16 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021 Fetal anomaly screening programme handbook 2024	Rostered time. Feedback to individual ultrasound practitioners.	Ultrasound Service Manager Obstetric Lead sonographer (both sites)	6 months October 2025	SSS have emailed confirmation to NP	Rec closed
26	Audit the FASP screening pathway including quadruple rate, inadequate samples (FA4) and repeat 20-week scans. The audit should be included on the organisation's audit schedule with an agreed timeline and the findings and associated actions shared into the ANNB Steering Group	Section 7a screening service schedule 2 no: 16 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021 Fetal anomaly screening programme handbook 2024	FASP Audit Schedule. Minutes from ANNB steering group.	Ultrasound Service Manager Obstetric Lead sonographer (both sites)	12 Months April 2026	LL / SA / CK / DS / KL to meet and create an AMAT audit schedule for this. CK to send audit schedule to NP when completed. CK also to provide update at end of March.	Progressing on schedule

27	Make sure contact details are updated with National Congenital Anomaly and Rare Disease Registration Service (NCARDRS), that data is submitted timely and all aspects of the process are documented	Section 7a screening service schedule 2 no: 16, 17 2024 - 2025 Fetal anomaly screening pathway requirements specification 2021	Documented processes (that are signed off). Feedback to ANNB Steering Group.	Ultrasound Service Manager Obstetric Lead sonographer (both sites)	3 Months July 2025	Email to NP to confirm that NCARDRS backlog is clear and all is up to date - and send unratified guideline - sent by LL 13/1	Rec closed
Diabetic eye screening							
28	Implement and monitor a process to track all eligible women into DESP including women from out of area (Whiston), and report into the ANNB Steering Group	Section 7a screening service schedule 2 no: 22 2024 - 2025 Diabetic eye screening pathway requirements specification 2021	Confirmation of a tracking process Attendance at ANNB Steering Group by DES representative	Diabetic Specialist Midwife (both sites)	3 Months July 2025	DESP tracker now in use, annonymised version sent to NP 13/1/2026	Rec closed
Newborn hearing screening							
29	Make sure that the NHSP local manager completes outstanding local manager designated tasks and attends the ANNB Steering Group	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Confirmation that local manager tasks are up to date Attendence at ANNB Steering Group by local representative	ANNB Hearing Screening Manager (both sites)	3 Months July 2025	LG to send email to NP with confirmation that we are now up to date with management tasks.	Rec Closed
30	Make sure that NHSP processes are fully documented in guidelines and standard operating procedures (SOPs)	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Guidelines and policies (that are signed off).	ANNB Hearing Screening Manager (both sites)	12 Months April 2026	SOP's updated and ratified through Bridgewater Board. - Requested for documentation of NHS Number missing in a separate SOP - Laura to discuss with Bridgewater. Alison to send through to NP for review	Progressing on schedule
31	Make sure aetiological investigation data for babies with PCHI is added onto S4H	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Provide updates at ANNB Steering Group	ANNB Hearing Screening Manager (both sites)	6 months October 2025	Agreement for retrospective entry for five years, now in place. NHSP work inputting ongoing, progression on schedule.	on schedule - deadline extended to end of April, in agreement with NHSE
32	Implement and monitor a plan to meet the acceptable threshold for standards NHSP-S01 (KPI NH1), NHSP-S02, NHSP-S03 and NHSP-S05 (KPI NH2)	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021 Standards 2022 NHSP-S01 Standards 2022 NHSP-S02 Standards 2022 NHSP-S03 Standards 2022 NHSP-S05	Action plan that is agreed and monitored by the ANNB Steering Group as well as through audiology directorate processes. Submission of data for standard/key performance indicators for NHSP-S01 (KPI NH1), NHSP-S02, NHSP-S03 and NHSP-S05 (KPI NH2).	ANNB Hearing Screening Manager (both sites)	12 Months April 2026	NP and CO'N to discuss template for 12 month progression of standards. 12 months required will be Jan to Dec 2025 (Q4,1,2,3)	Progressing on schedule
33	CHIS to make sure that notification of babies with missing results to NHSP is timely to ensure all eligible babies are included and the upper age parameter meets national guidance	Section 7a screening service schedule 2 no: 20 2024 - 2025 Newborn hearing screening pathway requirements specification 2021	Documented CHIS processes, in line with national guidance, for babies with incomplete/no screening results.	Senior CHIS Manager	3 Months July 2025	CHIS evidence submitted via email directly to NP	Rec Closed
Progressing on schedule							
34	Implement and monitor a process to support the continuing professional development of practitioners undertaking NIPE.	Section 7a screening service schedule 2 no: 21 2024 - 2025 Newborn and infant physical examination screening pathway requirements specification 2021 Newborn and infant physical examination programme handbook 2024	Training log / completion of NIPE e-Learning resource each year (with dates).	ANNB Screening Coordinators (both sites)	6 months October 2025	NIPE CPD process developed for discussion at next NIPE working together meeting in December. Guideline completed, will be sent to NHSE when approved by NIPE Working Group.	Rec to be closed on receipt of approved guideline - with Carmel
35	Implement and monitor a plan to meet NIPE standards NIPE-S02, NIPE-S03, NIPE-S04 (KPI NP4) and NIPE-S05 (making sure that only NIPE defined reportable conditions are documented for referral on S4N)	Section 7a screening service schedule 2 no: 21 2024 - 2025 Newborn and infant physical examination screening pathway requirements specification 2021 Standards 2024 NIPE-S02, NIPE-S03, NIPE-S04/NP4, NIPE-S05	Action plan that is agreed and monitored by the ANNB Steering Group. Submission of data for standard/key performance indicators for NIPE-S02, NIPE-S03, NIPE-S04 (KPI NP4) and NIPE-S05. Quarterly data quality report from S4N.	ANNB Screening Coordinators (both sites)	12 Months April 2026	12 month template for Q4,1,2,3 plus 24-25 annual summary for SCT 2, NIPE standards and NBS	Progressing on schedule

36	Audit the process for NIPE referrals to ensure that secondary check by medical staff does not cause delays in the referral pathway	Section 7a screening service schedule 2 no: 21 2024 - 2025 Newborn and infant physical examination screening pathway requirements specification 2021 Newborn and infant physical examination programme handbook 2024	Share audit findings at the ANNB Steering Group Submission of data for standards/key performance indicators for NIPE-S03, and NIPE-S04 (KPI NP4)	ANNB Screening Coordinators (both sites)	6 months October 2025	Is secondary check still happening - if so, is it having an impact on referrals? SA to confirm via email that practice on the ward was to refer to Paediatrics due to access issues, not competence.	Rec Closed
Newborn blood spot screening							
37	Implement and monitor a plan to meet the acceptable threshold for standard NBS-S06 (KPI NB2) - the proportion of first blood spot samples that require repeating due to an avoidable failure in the sampling process	Section 7a screening service schedule 2 no: 19 2024 - 2025 Newborn blood spot screening pathway requirements specification 2021 Standards 2021 NBS-S06	"Action plan that is agreed and monitored by the ANNB Steering Group Submission of data for standard/key performance indicator for NBS-S06 (KPI NB2)	Maternity Matron for Community Midwifery	12 Months April 2026	12 month template for Q4,1,2,3 plus 24-25 annual summary for SCT 2, NIPE standards and NBS	Progressing on schedule
38	CHIS to develop a process to notify GPs of missing NBS results/ unscreened babies at 1 year old	Section 7a screening service schedule 2 no: 19 2024 - 2025 Newborn blood spot screening pathway requirements specification 2021 Standards 2021 NBS-S06	Documented processes (that are signed off)	Senior CHIS Manager	6 months October 2025	Monthly report now set up, should be running within the next month at which point documentary evidence will be provided and rec can be closed.	Progressing on schedule - deadline extended as work on NHSE side also required

Appendix 2

MWL (Whiston Site): Neonatal Nursing Workforce Action Plan – December 2025
CNST MIS Safety Action 4 - YEAR 7 MIS

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the requires standard?

Requirement	Status	Actions	Lead	Target Date	Completed date	BRAG Rating
The Trust is required to formally record in the Trust Board minutes compliance to BAPM nurse staffing standards annually using the Neonatal Nursing workforce calculator For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any previously developed action plans to address deficiencies. The agreed action plan should be monitored via a Risk Register.	The neonatal workforce calculator for Q2 25/26 demonstrates that there is a shortfall in the current neonatal workforce based on the activity/acuity on the Whiston neonatal unit and therefore it no longer meets British Association of Perinatal Medicine (BAPM) nurse staffing standards.	Neonatal workforce tool completed and submitted to the ODN identifying a nursing deficit	Neonatal/ Paediatric matron	October 25	October 25	
		Risk Register updated to reflect non-compliance with BAPM standards and associated patient safety, staffing and resilience risks. Risk score 15	Neonatal/ Paediatric matron	Nov 25	Nov 25	
		Complete nursing establishment review	DDOM/ DDDOM/ matron	Nov 25		
		Revise the timescales for implementation of neonatal transitional care based on the need to safely staff the unit, utilising the funded neonatal transitional care establishment monies	Neonatal/ Paediatric matron	31/03/26	April 2026	
		Development of a business case to address staffing deficits to increase funded establishment in line with BAPM standards and most recent Neonatal workforce calculator data	Paediatric Directorate Manager/ Matron, Finance Business Partner and DDON	March 26		
		Review MWL cot configuration and associated staffing paper and submit to executive team and ODN	DDO/ DDOM/ / Finance business partner	January 26		
		Submit nursing workforce action plan to LMNS and ODN	Neonatal/ Paediatric matron & Head of Midwifery	Nov 25		
		Submit action plan via quarterly maternity and neonatal progress updates and CNST update paper to Quality Committee and Trust Board	DDOM	Nov 25		

Requirement	Status	Actions	Lead	Target Date	Completed date	BRAG Rating
		Progress monitoring via updates in quarterly maternity and neonatal papers to Quality committee, Trust Board, LMNS and ODN	DDOM/ Paediatric Matron	Quarterly		
		Monthly progress monitoring through Paediatric Clinical Governance & W&C Divisional Management Group	Neonatal/ Paediatric matron	Nov 25		

KEY TO STATUS BRAG RATING			
	Risk to completion		**Work On-going**
	Action on Track		**Completed action**

Appendix 3

Maternity Continuity of Carer Action Plan
Revised and update December 2025

		Action	Responsible person	Expected date of Completion	Progress	BRAG
	Agree the vision					
1		Share new vision with staff. Clear details of next steps for working towards MCoC being the default model of care offered to all women across MWL adopting a mixed risk model of care.	DoM/DDoMs	July 2022	Roll out of MCoC at full scale remained paused. Action suspended	
2		Agree safe staffing level for traditional model, proceeding only when safe to do so	DoM/DDoMs	June 2026	The Trust has ceased further rollout of MCOC.Revised plans will be considered following full establishment of staff and Trust Board consideration of BR+ workforce findings once complete. Awaiting BR+	On hold
	Safe Staffing					
3		Undertake a new BR+ assessment	DoM/DDoMs	March 2026	BR+ assessment as MWL commissioned – awaiting commencement	
4		Trust agreement of safe staffing levels for the maternity service based on new BR+ workforce recommendations and reconfiguration of teams across MWL.	Trust Board	August 2027	BR+ findings will be reported to Trust Board in upon completion for review of next steps for MWL.	
5		Review staffing establishment based on MCOC workforce tool incorporating current BR+ recommendations to determine staffing levels required for implementing MCOC at full scale	DoM/DDoMs	July 2027	Utilisation of National MCOC workforce tool to determine staffing required for MCOC using current BR+ staffing recommendations of the traditional model of care once new MWL report received.	

6		Proceed with MCOC only when staffing is safe to do so	DoM/DDoMs	September 2026		On hold
7		Continue rolling programme of recruitment for current vacancies	DoM/DDoMs	Completed		
8		Agreement by Executive team required to increase the maternity establishment based on BR+ and MCoC workforce modelling as required	Trust Board	July 2026		
9		Current recruitment plans revised to align with Continuity of carer becoming the default model of care; including updating Job adverts and job descriptions.	DoM/DDoMs	July 2026		
	Planning					
10		Review booking and community activity including 'Cross boundary movement' to determine the number of women who can receive MCoC	Community Matron	May 2026	Activity to reviewed and undertaken via BR+ including bookings undertaken of women from allocated GP practices	
11		Confirm staffing numbers required across all clinical areas including core staff and individual MCOC teams required prior to implementation.	DoM/DDoMs	August 2026		On hold
12		Agree the number of women expected to receive MCOC when offered as the default model of care	DoM/DDoMs / Community matron	June 2026	To be re-reviewed following BR+ as MWL	On hold
13		Review patient booking service processes required to support MCOC and action accordingly.	Community Matron	February 2026	BadgerNet deployment is underway with a target go-live of February. Process mapping for booking commenced to align with the new digital system. Issues relating to two EPR and separate BadgeNet systems will prevent MWL MCoC at full scale as a single maternity service.	
14		Confirm location of the initial MCOC teams in order to progress to full scale implementation. Allocation will be based on National principles and Standards and include the highest areas of Black, Asian and Mixed ethnicity populations and postcodes of the lowest deciles to ensure women who are most likely to experience adverse outcomes are prioritised.	DoM/DDoMs / Community matron	September 2026		
15		IT support to extract analyse and provide data on which to base the MCOC teams. I.e postcode linked to areas of deprivation and ethnicity.	BI analyst	September 2026		

16		Ensure that 75% of BAME women and women from the most deprived 10% of areas are prioritised into a MCoC team.	Community matron	September 2026	Formal align community Midwifery services across MWL footprint in readiness for a whole scale re-review of MCoC. BadgeNet systems will prevent MWL MCoC at full scale as a single maternity service	
17		Determine the provision of an enhanced model of MCoC that provides extra support for women from the most deprived 10% of areas	Community matron	September 2025	In post	
18		Midwifery deployment plan into MCoC, to facilitate a phased scale up to default position of care whilst maintaining safe staffing levels	DoM/DDoMs / Maternity Matrons	August 2026		
19		Realignment of Maternity rosters	E – Resourcing Team leader/ Maternity Matrons	September 2026	Establishment reviews to be completed following BR+ assessment. In the interim MWL community midwifery services have been aligned and are under review for team allocations as one service in readiness for BadgerNet.	
20		Implement 4 MCOC teams	Community Matron	September and October 2023	On Hold as per National Review	
21		Ensure co production of action plan with MVP	DoM/DDoMs	September 2026		
	Training					
22		Revise mandatory training programme to include MCOC updates	Practice development midwife	August 2026		On hold
23		Training programmes to share best practice and build confidence managing mixed risk caseloads	Practice development midwife	August 2026		On hold
24		Each midwife, core and MCoC team midwives will have a personal training needs analysis programme based on findings of the competency assessment framework which will identify any clinical skills needed to provide care for women throughout the pregnancy journey and across a range of settings, and also for providing care to women from diverse ethnic	Maternity managers/ matrons	September 2026		On hold

		backgrounds and those living in the most deprived communities.				
25		Plans to be developed to identify and allocate the time and resources needed to upskill midwives who are required to work in unfamiliar environments.	Maternity matrons	ongoing		On hold
26		Consider use of a buddy scheme and PMA role to support staff	Maternity matrons	January 2023		On hold
	Communication and Engagement					
27		Agree long and short term communication plans for all stages for transformation including: - Updating staff on progress - Celebrate benefits of MCoC model for staff and women - Sharing feedback from staff and women under the care of MCoC teams - Utilisation of use of social media. - Continued engagement with Maternity Voice Partnership to raise awareness, obtain feedback and co design patient information - Newsletters - Information on Trust website	DoM/DDoMs and Clinical Director	September 2026		On hold
28		Develop GP communications and agree content with GP forums and CCG/ ICS	Clinical Director	October 2026	Previous engagement but updates required once MCoC has been reviewed and Trust plans agreed.	On hold
29		Develop regular maternity service communication meetings / briefings/ workshops and communication blog	Maternity matrons/ comms team	July 2026		On hold
30		Develop regular meetings with MCOC teams	Maternity matrons	September 2026		On hold
31		Development of patient information leaflets	Maternity matrons/ MVP chair	September 2026		On hold
32		Liaison with staff side	DoM/DDoMs Maternity matrons	July 2026	Reinstatement of meetings with staff side and HR once Trust position agreed.	On hold
33		Consider requirement for staff consultation in order to fully implement MCoC	Head of Midwifery	July 2026		On hold
	Skill Mix					

34		Develop a MCoC competency assessment	Practice development midwife /Maternity matrons	Sept 2026		On hold
35		Identify individual gaps in experience, knowledge and skills for individuals utilising the competency assessment framework with individual meetings	Practice development midwife /Maternity matrons	June 2026		On hold
36		Devise personal development plans in place for all Midwives allocated to a MCoC team or core team	Practice development midwife /Maternity matrons	June 2026		On hold
37		Ensure preparedness of Band 7 DS coordinators to support programme of change with workshops and engagement sessions	Maternity matrons	June 2026		On hold
38		Development of an orientation package for new MCoC teams and new team members	Maternity matrons	June 2026		On hold
39		Ensure appropriate use of Maternity support workers.	Maternity matrons	October 2026	Review of MSW responsibilities in community once recruitment complete	On hold
	Team building					
40		Time for team building once teams established	Maternity matrons	September 2026 and continuing		On hold
	Linked Obstetrician					
41		Agree named link Consultants for each MCoC Team	Clinical Director	September 2026		On hold
42		Ensure a robust referral process to an obstetrician process Is in place	Clinical Director	Completed	Current processes in place which will be updated prior to the implementation of the new teams and allocated linked consultants	
	Standard Operating Procedure					
43		Development of an SOP that outlines roles and responsibilities to support delivery of MCoC.	Quality and Safety Matron	September 2026		On hold

	Governance					
44		Risks will be identified and managed within the Trust Governance Framework with the development of a risk log	Quality and Safety Matron	ongoing		On hold
45		Development of an MCoC SOP	Quality and Safety Matron	September 2026		On hold
46		Review escalation policy in view of implementation of MCoC	Quality and Safety Matron	September 2026		On hold
47		Evaluation of the process of availability of data collection and reporting mechanism	Digital midwives	September 2026		On hold
48		Ensure process for extraction of MSDS National Data Collection is appropriate	Business Intelligence manager	July 2026		On hold
	Pay					
49		Utilise the MCoC toolkit to review midwifery pay for staff working in a MCoC team as no midwife should be financially disadvantaged in a MCoC as identified in the NHSE/I toolkit	DoM/DDoMs/ Senior management accountant	June 2026		On hold
50		Work with staff, HR and unions to agree on appropriate uplift or on call payments, considering LMNS wide agreement where appropriate or possible with presentation to the Board for consideration.	DoM/DDoMs	June 2026		On hold
	Estates and Equipment					
51		Identify initial numbers and cost of additional equipment required for staff working in a MCOC team based on full rollout being mindful that additional teams may be required dependant on WTE of midwives allocated per team.	Community matron	June 2026		On hold
52		Identify and source suitable clinical venues required for the provision of MCoC within the community environment as midwifery care will not be in GP practices	Community matron	September 2026	Provision of Lowe House but further estates needed across MWL.	On hold
53		Ensure adequate IT systems and connectivity are fit for purpose to enable appropriate off site access	IT project manager	September 2022		On hold
	Review Process					

54		Quarterly review of action plan by Trust Board	DoM/DDoMs	June 2026	Via Quality Committee Paper	
55		Determine LMNS and national action plan review dates	LMNS CoC lead			

North West Region Maternity Performance Oversight Panel Support Tool

Objective	Deliverables	Q3 25/26 Provider Update / Rationale for BRAG	Q3 25/26 LMNS Assured?	Q3 25/26 LMNS BRAG Rating	Q3 25/26 LMNS Rationale for BRAG	Q4 25/26 Provider BRAG Rating	Q4 25/26 Provider Update / Rationale for BRAG	Q4 25/26 LMNS Assured?	Q4 25/26 LMNS BRAG Rating	Q4 25/26 LMNS Rationale for BRAG
	Is PCSP training included in the TNA?	No change since Q2. TNA in date until March 2027	Y	Blue	LMNS assured - TNA in date until March 2027	Blue	No change from Q3			
	Are Personalised care audits being undertaken regularly?	Annual Audit Plan previously uploaded	Y	Blue	LMNS assured - Trust has uploaded an Audit Plan as evidence	Blue	No change from Q3			
	Is the trust in a position to roll out MCoC	The current MCoC position and expansion at both legacy sites remains on hold, as previously agreed at Executive level. The plan to deliver a Maternity Continuity of Carer model at full scale, in line with national guidance, has been updated with revised timescales while awaiting further national guidance. This model utilises a mixed-risk approach, providing enhanced midwifery care to women and babies of Black, Asian, and mixed ethnicity, and those living within the lowest 10% decile of deprivation. Updated action plan uploaded to evidence file . The Northwest Regional Maternity Team has provided interim direction, advising that the focus should be on delivering antenatal and postnatal continuity for these priority groups. To support this the service in the recruitment process for dedicated community based Maternity Support Workers utilising external funding on a 12-month fixed term basis. It is anticipated that they will be in post by the end of Q4 2025/26 and will be focusing on the geographical areas within the lowest decile of depravation. All areas of the remaining traditional community service operate in small geographical teams offering antenatal and postnatal continuity.	P	Green	The LMNS note that the Trust has advised that the Northwest Regional Maternity Team has provided interim direction, advising that the focus should be on delivering antenatal and postnatal continuity for these priority groups. To support this the service is in the process of recruiting dedicated community based Maternity Support Workers utilising external funding on a 12-month fixed term basis. It is anticipated that they will be in post by the end of Q4 2025/26 and will be focusing on the geographical areas within the lowest decile of depravation. All areas of the remaining traditional community service operate in small geographical teams offering antenatal and postnatal continuity	Blue	3 MSW's appointed.			
	Number of EMCoC teams operating in line with national guidance?	During the Community Midwifery Service alignment across MWL, and the wholescale review of the MCoC plan, the current MCoC teams from the legacy organisations continue to remain operational: • Ormskirk Sapphire Team provides continuity for women living out of area on a shift-based model. • Whiston Amethyst Team continues to provide continuity for the most vulnerable women, although they are currently unable to provide the intrapartum element, with intrapartum support delivered by the Delivery Suite. To support the current model, fixed-term funding has been provided to recruit dedicated Maternity Support Workers to enhance care for women of Black, Asian, and mixed ethnicity and those in the lowest 10% decile. • Whiston Homebirth Team provides full continuity of care for women choosing home birth, which can be offered at any stage of the antenatal pathway. The formal alignment provides an opportunity to develop a dedicated MWL Homebirth Team across the geographical area, which could also support women choosing to birth at Lowe House freestanding MLU once estate works are complete and CQC registration achieved.	P	Green	The LMNS note the following Trust update: During the Community Midwifery Service alignment across MWL, and the wholescale review of the MCoC plan, the current MCoC teams from the legacy organisations continue to remain operational: • Ormskirk Sapphire Team provides continuity for women living out of area on a shift-based model. • Whiston Amethyst Team continues to provide continuity for the most vulnerable women, although they are currently unable to provide the intrapartum element, with intrapartum support delivered by the Delivery Suite. To support the current model, fixed-term funding has been provided to recruit dedicated Maternity Support Workers to enhance care for women of Black, Asian, and mixed ethnicity and those in the lowest 10% decile. • Whiston Homebirth Team provides full continuity of care for women choosing home birth, which can be offered at any stage of the antenatal pathway. The formal alignment provides an opportunity to develop a dedicated MWL Homebirth Team across the geographical area, which could also support women choosing to birth at Lowe House freestanding MLU once estate works are complete and CQC registration achieved	Green	No change from Q3			
	Number of EMCoC teams planned to be rolled out in line with national guidance?	This is based upon the mapping completed prior to the two legacy Trusts coming together from MWL there will be a total of 15 teams.	P	Green	The LMNS note the following Trust update: This is based upon the mapping completed prior to the two legacy Trusts coming together from MWL there will be a total of 15 teams	Green	No change from Q3			
	Has the trust achieved UNICEF BFI accreditation?		Y	Green	The Trust has confirmed ongoing audits are undertaken and regular communication is in place with UNICEF. Plan remains in place for Q4 assessment, but no confirmed date at present					
Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adhers to the Accessible Information Standard?	This may change one the re-review is complete alongside an updated BR+ assessment. Trajectories to be reviewed once re-review and mapping is completed.	Y	Blue	LMNS assured - Policy review date 31.12.2026	Blue	No change from Q3			
	Is data collected and disaggregated based on population groups?		Y	Blue	LMNS assured - MSDS data uploaded as evidence	Blue	No change from Q3			
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	The Northwest Regional Maternity Team has provided interim direction, advising that the focus should be on delivering antenatal and postnatal continuity for these priority groups. To support this the service in the recruitment process for dedicated community based Maternity Support Workers utilising external funding on a 12-month fixed term basis. It is anticipated that they will be in post by the end of Q4 2025/26 and will be focusing on the geographical areas within	Y	Blue	LMNS assured - Governance TOR have MNVP as supplementary members (co-opted as required). 15 steps report uploaded August 2025 for both sites with actions. Patient Experience Survey Executive Committee paper 12th Dec 2024 noted - MNVP work plan included in this paper.	Blue	No change from Q3			
	Date of last BR+	BR+ has been commissioned, with data collection to commence in Q4,	Y	Green	BR+ has been commissioned, with data collection to commence in Q4. BR+ will be across MWL	Green	Data collection date pushed			

Objective 4: Grow our workforce	Funded to BR+ establishment	No change since Q2. Biannual Staffing Paper Jul-Dec 2025 currently being drafted to be presented to QC in Feb 2026, as part of the Maternity And Neonatal Update papers.	Y	Blue	LMNS assured - reviewed staffing as part of SAS MIS Y7	Blue				
	Planned Date of Next BR+	BR+ has been commissioned, with data collection to commence in Q4. BR+ will be across MWL	Y	Green	BR+ has been commissioned, with data collection to commence in Q4. BR+ will be across MWL	Green	Data collection date pushed back			
	Bi-Annual workforce plan for maternity and neonates including obstetrics in place?	No change since Q2. Q2 Maternity and Neonatal Update paper uploaded into evidence file to demonstrate ongoing review	Y	Blue	LMNS assured - Trust has declared compliance with SAS MIS Y7	Blue	No change from Q3			
	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	MWL is not currently supporting any RTP Midwives- as there has not been a request to do so. The Preceptorship Policy references (Page 5) that this policy also relates to Midwives who have completed RTP programme or anre Internationaly Educated- with a bespoke package dependant on the individualised needs of the Midwife	Y	Blue	LMNS assured - MWL is not currently supporting any RTP Midwives- as there has not been a request to do so. The Preceptorship Policy references (Page 5) that this policy also relates to Midwives who have completed the RTP programme or are Internationaly Educated- with a bespoke package dependant on the individualised needs of the Midwife	Blue	No change from Q3			
	MW Vacancy Rate (please provide additional narrative to support data)	Q3 PWR Data to be uploaded on receipt	Y	Blue	LMNS assured - Nov 25 PWR vacancy rate = 0.5%	Green	PWR vacancy rate 3.39%			
	MW Leaver Rate (please provide additional narrative to support data)		Y	Green	Nov 25 PWR leaver rate = 4.5% - just above national average	Green				
	MW Turnover Rate (please provide additional narrative to support data)		Y	Green	Nov 25 PWR turnover rate = 6.9% - just above national average	Green	PWR turnover rate 8.18%			
	MW Sickness Rate (please provide additional narrative to support data)		Y	Green	Nov 25 PWR sickness rate = 6.4% - in line with national average	Green	PWR sickness rate 7.09%			
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)		Y	Blue	LMNS assured - 0 vacancies reported	Green	Consultant vacancy 5.99%			
	MSW Vacancy Rate (please provide additional narrative to support data)		Y	Green	Following review of the Nov 25 PWR data, the LMNS noted a very high MSW vacancy rate for MWL. However, the Trust confirmed that this is due to a data inputting error and that the will ensure that the data is correct for the next submission. The Trust also advised that for month 10, the total support workers in maternity vacancy was 16.91. This is broken down into 15.48 Band 2 and 1.43 Band 3. The Trust are currently concluding a Band 2/3 review and there have been some delays in recruiting band 2 pending this conclusion which has now been completed	Green	MSW vacancy 22.14%			
	Is there a retention midwife in post? (please provide additional narrative to support data)	Midwives remain in post- no change. Lauren Griffiths and Ashley Latham.	Y	Blue	LMNS assured - confirmation received from Trust that post remains filled	Blue	No change from Q3			
Objective 5: Value and retain our workforce	Does the trust have a retention improvement action plan?	Ongoing. No change since Q2	Y	Blue	LMNS assured - June 2025 MWL Retention plan noted	Blue	No change from Q3			
	Is there a plan in place to reduce workforce inequalities?	No change since Q2	Y	Blue	LMNS assured - note MWL EDI Operational Plan 2022-2025	Blue	No change from Q3			
	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	Trust awarded bronze status under the BAME Assembly Anti-Racism Framework	Y	Blue	LMNS assured - Trust awarded bronze status under the BAME Assembly Anti-Racism Framework	Blue	No change from Q3			
	Do the trust have a mechanism to identify and address issues highlighted in student and trainee feedback surveys?	NETS Survey 2025 closed- awaiting results. S3 Midifery responses submitted	Y	Blue	LMNS assured - Trust positive outliers with NETS for Midwifery and Obstetrics	Blue	No change from Q3			
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	Mersey West Lancashire has been awarded the National Multi-Professional Preceptorship Quality Mark. This reflects the successful aligning of preceptorship programmes across sites and the commitment to supporting preceptorship across the whole trust. Midwifery have led the way launching a cross-site preceptorship programme reflecting the national Midwifery preceptorship Framework in October 2024. Moving forward further work is planned with our nursing and AHP colleagues to create a combined preceptorship policy whilst retaining the specific standards required to support Midwives in their transition to practice.	Y	Blue	LMNS assured - MWL has been awarded the National Multi-Professional Preceptorship Quality Mark. This reflects the successful aligning of preceptorship programmes across sites and the commitment to supporting preceptorship across the whole trust. Midwifery have led the way launching a cross-site preceptorship programme reflecting the national Midwifery preceptorship Framework in October 2024. Moving forward further work is planned with our nursing and AHP colleagues to create a combined preceptorship policy whilst retaining the specific standards required to support Midwives in their transition to practice.	Blue	No change from Q3			

	Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor?	No change since Q2	Y	Blue	LMNS assured - Trust has confirmed that an offer of support is available to all newly appointed midwives via NW Coast Leadership Academy	Blue	No change from Q3			
	Does the trust have a leadership succession plan which reflects the ethnic background of the wider workforce? .	No change since Q2	Y	Blue	LMNS assured - note MWL EDI Operational Plan 2022-2025	Blue	No change from Q3			
	Does the trusts TNA aline with the core competency framework?	No change since Q2	Y	Blue	LMNS assured - TNA Maternity Specialist Training noted	Blue	No change from Q3			
Objective 6: Invest in skills	Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervison?	No change since Q2. 6 month aggregated audit covering Q1/2 uploaded. Will declare complaince with SA4 in MIS year 7	Y	Blue	LMNS assured - Consultant cover noted both sites LMNS aware Trust will declare compliance with MIS Y7	Blue	No change from Q3			
	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	No change since Q2. MIS Year 7 SA4 Audit Short Term Locum uploaded- demonstrating ongoing complaince	Y	Blue	LMNS assured - MIS Year 7 SA4 Audit Short Term Locum uploaded- demonstrating ongoing complaince	Blue	No change from Q3			
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, including time to engage stakeholders, and MNVP leads?		Y	Blue	LMNS assured - Job plan dated June 2025 cover 25/26 both sites	Blue	No change from Q3			
	Have senior leaders attended national leadership programmes, including board maternity and neonatal safety champions?		Y	Blue	LMNS assured - DoM RCM Leadership Programme noted. Team still working through perinatal leadership actions from programme	Blue	No change from Q3			
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	No change since Q2- ongoing	Y	Blue	LMNS assured - Quality paper 16th Sept 2025 noted	Blue	No change from Q3			
	Is there a clear and structured route for the escalation of clinical concerns? i.e. (Each Baby Counts: Learn and Support escalation toolkit).	No change since Q2. Policy in date until October 2028	Y	Blue	LMNS Assured - Trust has confirmed MWL SOP for Clinical escalation uploaded expires 02/10/28	Blue	No change from Q3			
	Is there a Freedom to Speak Up Guardian?	No change since Q2. F2SU Guardians remain in post	Y	Blue	LMNS assured - MWL confirmed the FTSU guardians remain in place	Blue	No change from Q3			
	Is there a FTSU training module for staff?	Using ESR National Training as per CSTF	Y	Blue	LMNS assured - Trust uiing ESR National Training as per CSTF	Blue	No change from Q3			
Objective 8: Learn and improve	Has the trust implemented PSIRF?	No change since Q2	Y	Blue	LMNS assured - MNSG presentation noted. PSIRF plan approval noted	Blue	No change from Q3			
	Is there a formal structure to review and share learning? (with agreed timescales)	No change since Q2	Y	Blue	Timescales included in PSIRF policy which is due for review Sept 2026 and has been uploaded	Blue	No change from Q3			
	Has the organisation established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care?	No change since Q2	Y	Blue	LMNS assured - PSIRF plan approval noted	Blue	No change from Q3			
	Has the organisation adopted a single point of contact process for families where ongoing dialogue is required with the trust?	The single point of contact remains currently the incident investigator with support from the central safety team members in liaising with patients and families to ensure family voices are heard, they can help direct any safety reviews and are kept up to date with the outcomes of the reviews. The Central Safety Team are currently undergoing a workforce review and the liaison role is recognised as part of this.	Y	Green	The single point of contact remains currently the incident investigator with support from the central safety team members in liaising with patients and families to ensure family voices are heard, they can help direct any safety reviews and are kept up to date with the outcomes of the reviews. The Central Safety Team are currently undergoing a workforce review and the liaison role is recognised as part of this	Green	No change from Q3			
	Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?	No change since Q2	Y	Blue	LMNS assured - PSIRF plan approval noted	Blue	No change from Q3			
	Is there a process of triangulation of outcomes data, staff, and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well?	Divisional Update to Patient Experience Committee uploaded. Trust will declare complaicne with SA7 MIS Y7	Y	Blue	LMNS assured - Divisional Update to Patient Experience Committee uploaded. Trust will declare complaicne with SA7 MIS Y7	Blue	No change from Q3			
Objective 9: Support and oversight	Does the organisation share open and honest information on the safety, quality, and experience of their services?	No change. Q2 Papers to PSC and Exec Committee uploaded	Y	Blue	LMNS assured - Paper to Quality Committee noted 16th Sept 2025 and Womens and childrens Division Patient Safety Council Report 9 Oct 2025 (Q1 data)	Blue	No change from Q3			
	Does the organisation regularly review the quality of maternity and neonatal services?	No Change. Q2 Paper to QC Uploaded	Y	Blue	LMNS assured - Paper to Quality Committee noted 16th Sept 2025 and Womens and childrens Division Patient Safety Council Report 9 Oct 2025 (Q1 data)	Blue	No change from Q3			
	Have maternity safety champions been appointed, including NED?	Acting NED remians in role undertaking requirements	Y	Blue	LMNS assured - Acting NED remains in role undertaking requirements	Blue	No change from Q3			
	Has the quadumverite been appointed?	No change since Q2	Y	Blue	LMNS Assured - Quad remains in place	Blue	No change from Q3			
	Are MNVPs involved in the development of the organisations complaints process?	No change since Q2	Y	Blue	LMNS assured - Evidenced through MNVP Action Plan and TOR	Blue	No change from Q3			
	Are the MNVPs involved in the quality safety and surveillance group that monitors and acts on trends.	No change since Q2	Y	Blue	LMNS assured - Trust has confirmed TOR Quality Governance Group 25/26 has MNVP as supplementary member to be co-opted as required	Blue	No change from Q3			
	Is FTSU data reported to board and acted upon?	No change since Q2	Y	Blue	LMNS assured - Quality Committee agenda received as evidence	Blue	No change from Q3			

	Objective 10: Standards to ensure best practice	Is the organisation on track to implement version 3 of the Saving Babies' Lives Care Bundle by March 2024?	Complaince for MWL 97% as of 2 Jan 26 with next submission in Feb 26.	Y	Blue	LMNS assured - Trust achieved an overall compliance rate of 97% for Q3	Blue	No change from Q3			
		Is the organisation on track to adopt the national MEWS and NEWTT-2 tools by March 2025?	Ongoing audits as per audit plan	Y	Blue	LMNS assured - NEWWT-2 launched 31st Aug 25. MEWS is up and running electronically. Ongoing audits to be undertaken as per audit plan	Blue	No change from Q3			
		Does the organisation regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services?	Continued updtes in QC Papers	Y	Blue	LMNS Assured - Quality Committee Septmber 2025 uploaded as evidence.	Blue	No change from Q3			
		Has the organisation completed the national maternity self-assessment tool? .	No change since Q2	Y	Blue	LMNS assured	Blue	No change from Q3			
	Objective 11: Data to inform learning	Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities?	No change since Q2	Y	Blue	LMNS assured - Quality Committee Report details triangulation of data of outcomes, dashboard, addressing health inequalities through implementation of SBL, MCoC.	Blue	No change from Q3			
		Does the organisation have a system that ensures high-quality submissions to the Maternity Services Data Set?	No change. MWL will declare complaince with SA2 MIS Year7	Y	Blue	LMNS assured - MWL will declare complaince with SA2 MIS Year7	Blue	No change from Q3			
		Does the organisation have robust processes in place to ensure referrals to NHSR, MNSI, and the National Perinatal Epidemiology Unit?	No change since Q2	Y	Blue	LMNS assured	Blue	No change from Q3			
	Objective 12: Make better use of digital technology in maternity and neonatal services	Does the organisation have a digital maternity strategy and digital roadmap?	No change since Q2	Y	Blue	LMNS assured - strategy noted	Blue	No change from Q3			
		Is the digital strategy and roadmap being implemented?	BadgerNet project underway	Y	Blue	LMNS assured - BadgerNet project underway	Blue	No change from Q3			
		Does the organisation have an EPR system that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set?	Currently evaluating delivery milestone due to delay in UAT. For formal update to Exec Committee in Jan 2026	Y	Blue	LMNS assured - BadgerNet project underway	Blue	No change from Q3			
		BRAG Rating									
		Action is complete									
		Action is on track									
		Action mainly on track with some minor issues (mitigation in comments)									
		Action not on track wit major issues (mitigation in comments)									

Title of Meeting	**Trust Board**		**Date**	27 May 2026
Agenda Item	**TB26/038**			
Report Title	Draft Quality Account 2025/26			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Sarah O'Brien, Chief Nursing Officer			
Action Required	X	**To Approve**		**To Note**

Purpose

The purpose of this report is for the Trust Board to approve the draft of the Mersey and West Lancashire Teaching Hospitals NHS Trust Quality Account for 2025-26 prior to finalisation of the document for publication.

Executive Summary

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality and standard of services they provide. They are required by the Government to help NHS Trusts, including providers of hospital acute services, community health services and mental health services, maintain focus and improve the quality of care for patients. By producing a Quality Account, trusts are able to demonstrate their commitment to continuous evidence-based quality improvement and to explain their progress to patients and their families, the public and those who have an interest in the services that the Trust provides.

There is a standard format Quality Accounts should follow as set out by NHS England in the 2020 document titled *Detailed requirements for quality reports 2019/2020.*

The account should have 3 Parts:

Part 1	Statement on quality from the Chief Executive
Part 2	Priorities for improvement looking forward Statements relating to quality of NHS services provided.
Part 3	Other information Review of quality performance
Annex 1	Statements from commissioners, local Healthwatch organisations and overview and scrutiny Committees
Annex 2	Statement of directors' responsibilities for quality account

Please note: the Quality Account is no longer subject to review by external auditors and will be a desktop review with the presentation days having been stood down as part of the business continuity arrangements by Cheshire and Merseyside Integrated Care Board (ICB) including Healthwatch.

Executive colleagues were requested to review and comment against the draft account and support any outstanding areas of data and narrative within their line of accountability prior to submission of the draft to the Quality Committee. Further updates have been actioned since the Quality Committee and the document has been shared to Commissioners and Healthwatch with feedback awaited.

Following approval at Trust Board, the Quality Account will go through full proofread and finalisation for publication on 30 June 2026.

Financial Implications

No direct costs arising from this report.
Quality and/or Equality Impact
The Quality Account provides a review of the Trust's quality objectives and provides an overview of how quality is maintained across the Trust.
Recommendations
The Trust Board is asked to approve the draft Quality Account prior to submitting for publication 30 June 2026.

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

Draft Quality Account 2025-26

Contents

Part 1

1.1 Statement on Quality from the Chief Executive of the Trust

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) is pleased to present the Trust's third annual Quality Account, which demonstrates our ongoing commitment to ensuring we provide the highest quality of care to our patients and the communities we serve.

This is my second introduction to the annual Quality Account since my appointment as Chief Executive of MWL, on 1st December 2024. MWL is a fantastic organisation, with a longstanding history of outstanding care, and a trusted reputation in our local communities and I am truly honoured to be Chief Executive here. I've been part of MWL for ten years now and over that time, I have had the absolute pleasure of working alongside so many amazingly talented staff.

In July 2025 we welcomed Professor Sarah O'Brien as the Trust's new Chief Nursing Officer. Sarah is no stranger to the organisation, starting her career at St Helens and Knowsley Teaching Hospitals as a staff nurse. She spent 18 years at the Trust in various roles including Diabetes Research Nurse, Diabetes Nurse Consultant and Deputy Director of Nursing before working across commissioning, local government and integrated care system over the last 10 years.

Dr Simon Dowson also joined MWL as the Chief Medical Officer in November 2025.He has spent the last 17 years at Mid Cheshire Hospitals NHS Foundation Trust in various roles, his most recent being Deputy Chief Medical Officer. In addition to his leadership responsibilities, Simon will also continue his clinical practice working alongside paediatric colleagues at Ormskirk Hospital.

Our vision to provide 5 Star Patient Care remains the Trust's primary objective so that patients and their carers receive services that are safe, person-centred and responsive, aiming for positive outcomes every time. The mission and vision have remained consistent and embedded in the everyday working practices of staff throughout the Trust, where delivering 5 Star Patient Care is recognised as everyone's responsibility. The vision is underpinned by the Trust's values, behaviours and five key action areas – care, safety, pathways, communication and systems.

2025-26 continued to present many challenges for staff with ongoing demands on an already stretched workforce. Every part of the NHS is under significant pressure at the moment and the areas of Merseyside and West Lancashire are no exception. My focus has, and will be, on making sure that we continue to look after our patients and our staff to provide the highest standards against this challenging backdrop.

In March 2026, following a rigorous and thoroughly detailed process including a 10-week pre-consultation engagement period and 13-week public consultation the joint committee of the NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria Integrated Care Boards, made the decision to relocate the Children's A&E from Ormskirk to Southport Hospital. It is estimated that delivering this decision could take a minimum of 3 years, allowing the time needed to plan safely, invest appropriately, and work through the practical implications. Throughout this period, we

remain fully committed to working closely with our staff, patients, and local communities to ensure everyone is actively involved, kept informed, and able to shape how these changes are developed and introduced.

One of my proudest moments during the year was attending our first LGBT+ Clinical Conference at Edge Hill University. It was inspiring to join colleagues and learn directly from the excellent national speakers. At MWL, I am committed to nurturing kindness, openness, and inclusivity, and it motivates me every day to witness so many teams working hard to strengthen our inclusive practice. I believe even small changes in listening, communication, and support can make a significant difference not only to the care we provide but also to the culture of our organisation.

I was, however, extremely disappointed that during the year there were five never events, relating to wrong site nerve block, implant discrepancy and insulin incident. Actions have been taken following these as part of the Trust's commitment to learning from incidents and these are outlined in more detail in the report.

The Trust has delivered a comprehensive programme of quality improvement clinical audits throughout the year, with several actions taken as a result of the audit findings. Delivery of the quality improvement and clinical audit programme is reported to the Quality Committee via the Clinical Effectiveness Council.

We continue to roll out and update the ward accreditation programme, to ensure it is fit for purpose. During the year we have assessed all adult inpatient areas and have included specialist areas, A&E, ICU and paediatrics. The aim is to continue to roll this programme out to all other areas including theatres, maternity and community services in 2026-27.

We continue to work with our local Healthwatch partners to improve our services. Healthwatch representatives are key members of the Patient Experience Council, who report to the Trust Board's Quality Committee, and the Equality and Diversity Steering Group which reports to the People Performance Council. This ensures effective external representation in the oversight and governance structure of the Trust. Meetings have continued to be held virtually to maximise attendance.

The Trust has a Patient Participation Group, which met quarterly throughout the year and patients have continued to share their experiences of care via patient stories for the Board and Patient Experience Council.

We are extremely grateful to our volunteers who make a unique and valuable contribution to patients and carers, relatives, visitors, and staff. The skills and support they provide has a positive impact for people who use our services, including our staff, and the community. An incredible 308 volunteers have contributed to our 5 hospital sites during 2025-26.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the challenges faced during the year. It also outlines our quality improvement priorities for 2026-27.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2025-26 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate. We trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and patient-centred services we have continued to deliver during the ongoing challenges in 2025-26.

I remain extremely proud of all our staff who continue to give the best of themselves to care for the people who need us. I would like to thank all our staff and volunteers for everything they continue to deliver during the most challenging times we face.

Rob Cooper
Chief Executive
Mersey and West Lancashire Teaching Hospitals NHS Trust

1.2 Celebrating Success during 2025-2026

Our staff make our organisation and to celebrate the outstanding work they undertake. This important event gives us the opportunity to put the spotlight on the extraordinary dedication and compassion of our staff and recognise the difference this makes to individuals and families within the local community.

The winners are acknowledged below with the detail of the nominations.

Special Recognition Award	Following the tragic incident in Southport in July 2024, the Trust joined with the local community to recognise staff from Southport and Ormskirk Hospitals who responded with 'the highest levels of professionalism, compassion, and courage'. Presenting the Special Recognition Award Steve Rotherham, Mayor of the Liverpool City Region, shared his heartfelt thanks with all those involved, saying that the town of Southport will be forever grateful. Reverend Martin Abrams was invited to accept the award on behalf of all the staff involved, and our guests took to their feet to honour their colleagues with an emotional standing ovation.
Outstanding Contribution Award	**Richard Fraser – Former Chairman** Richard Fraser who was recognised with the Outstanding Contribution Award following just over ten years at the Trust. Richard retired in April 2025 after a decade of dedicated service. Presenting the award, Rob Cooper, Chief Executive, expressed our deepest thanks to Richard for his invaluable support and guidance, his advocacy across the region for our hospitals, and his tireless efforts to ensure our staff get the recognition they deserve.
Lifetime Achievement Award	**Ann Marr OBE – Former Chief Executive** After serving the NHS for over 40 years and leading our Trust for an incredible 21 years, former Chief Executive Ann Marr OBE who retired in 2024 was the proud recipient of our first ever Lifetime Achievement Award. Presenting the award, Rob Cooper, Chief Executive, shared his heartfelt thanks and admiration

	for all that Ann achieved, highlighting her integrity, compassion, determined spirit, and unwavering commitment to 5 Star Patient Care. Joining him on stage Ann took the opportunity to express her deep fondness for our organisation, telling staff that she missed seeing them every day, but knows they'll continue to make her proud.
Excellence in Clinical Care	**Ward 2C Respiratory Whiston Hospital** This forward thinking team deliver expert care to those with significant respiratory illness. Always looking for ways to develop their service, a recently established day care unit offering rapid diagnosis and ongoing treatment has had an enormous impact on patient experience and been praised by CQC for improving the quality of care.
Excellence in Quality Improvement	**Radiology Department Whiston Hospital** This outstanding department is committed to supporting clinical teams by providing timely and accurate diagnostic services. Named the highest performing CT unit in the country, the team is always looking at ways to advance their service, utilising the latest data insights and technology to improve pathways, reduce turnaround times and aid faster diagnosis
Excellence in Patient Safety	**Dementia & Delirium Team S&O Hospitals** This team are passionate about providing a safe and comforting environment for some of our most vulnerable patients. Creating and encouraging a dementia friendly culture, that reaches beyond Southport and Ormskirk hospitals and into the local community they deliver comprehensive training and embed best practice to ensure patients' cognitive needs are always central to their care
Excellence in Support Services	**Estates and Facilities Department MWL** From opening new theatres to building therapy units, or even meeting the ever-

	growing need for more and more car parking, this team always prioritises the needs of patients and staff across the entire Trust. Thanks to their hard work and high standards, in the past 12 months our hospitals received top marks in the national patient-led assessment of the care environment making MWL best in the North-West.
Patient Experience Award	**Prosthetics Department and Laser Suite Team Whiston and St Helens Hospital** When life delivers significant challenges through illness or injury, this team of highly knowledgeable experts use their extensive skills and innovative techniques to rebuild and transform the lives of their patients. Always empathetic and compassionate, their unwavering dedication, alongside a remarkable attention to detail, provides exceptional results of the highest standard.
St Helens Star People's Choice Award	**Diabetes Department Whiston and St Helens Hospital** This award is voted for by the readers of the St Helens Star and highlights the appreciation that patients and their families have for the excellent care they receive. Patients say this specialist service is a lifeline when living with diabetes. Innovative, research-based and high quality, this knowledgeable team consistently help to improve day-to-day life for those they treat and have received exceptional feedback for their unwavering support and expertise. They are regularly recognised as being one of the leading departments in the country.
Stand up for Southport People's Choice Award	**Paediatric Department Ormskirk** This award is voted for by the readers of Stand Up for Southport and highlights the appreciation that patients and their families have for the excellent care they receive.

	This multidisciplinary team embodies the Trust's values each and every day. Caring for some of our youngest patients, often with complex conditions and needs, they go above and beyond to provide the highest standards of clinical and holistic care in some of the most difficult and challenging situations. They have been hailed as heroes by patients, families and carers.
Employee of the Year	**Debbie Warburton** Debbie understands that delivering 5 star patient care starts with the welfare of her team. An outstanding member of our Trust, her unwavering commitment to creating a kind, open and inclusive culture is exemplary. Always a positive role-model, she leads by example and has made great improvements to the quality, safety and the overall experience for patients and staff on her ward.
Team of the Year	**Urology Department MWL** This award recognises the outstanding performance of a team that has continuously delivered an undeniably first-class service. One of the leading urology services in the region, this team are pioneers in their field. They work tirelessly to deliver innovative solutions, transform pathways and provide outstanding clinical care for patients right across MWL. The Trust receives exceptional feedback from patients who describe this team as 'the NHS at its best'.

1.3 Our Challenges

In 2025-26 the Trust began the year responding to the serious incident at Newton Hospital on the 30th December 2025. While legal proceedings are ongoing and restrict what can be said publicly, our focus has remained on the safety and wellbeing of those directly affected, and of all who work across the Trust.

From an operational point of view, we experienced high demand across all services, and this has been felt at every site and in every team. Whether in our Emergency Departments, Urgent Treatment Centre, community services or on our wards, the hard work and the resilience of staff continues and the commitment to our patients is what underpins everything we do.

Infection Prevention Control (IPC) in respect of reportable healthcare associated infections, outbreaks, incident management and lessons learned from these remains a key focus and aligned to the Trust's Quality Objectives for 2026-27, including a key focus on reduction of avoidable hospital onset MSSA and to reduce the incidents of MRSA and improve our Aseptic Non-Touch Technique (ANTT) compliance.

Part 2 – Priorities for improvement and statements of assurance from the board.

2.1 Quality objectives for improvement during 2026-27

The Trust's quality objectives for 2026-27 are listed below with the reasons why they are important areas for quality improvement. The views of stakeholders and staff were considered prior to the Trust Board's approval of the final list. The consultation included an online survey that was circulated to staff and stakeholders.

The consultation was undertaken using an electronic survey with 81 responses received. There was a high level of agreement with the proposed objectives, four receiving over 85% positive responses and three receiving 73%. The proposed objective which received the most support was 'focus on eradicating corridor care' with 90% positive responses.

Further suggested objectives for coming years included:

-Community Discharge
-Medication Safety
-Digital Improvements
-Focus on mental health
-Staffing levels
-Sustainability and the Environment

No	Objective	Lead Director	Measurement
1. 5 STAR PATIENT CARE – Care We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families			
1.1	Transitional Care – Keeping Mothers and Babies Together	Chief Nursing Officer	• Implement comprehensive and uniform transitional care service across MWL, in line with the Maternity Incentive Scheme (MIS) action plan
1.2	Ensure improvement and sustainability of nutritional & hydration standards for patients	Chief Nursing Officer	• Achieve 95% of adult inpatients screened for malnutrition on admission using the MUST tool • 90% of the highest risk patients (with a MUST score or 2+ or AKI Stage 2 or above) have a fluid

			balance chart in place and accurately completed
1.3	Eradicate corridor care and patient boarding	Chief Nursing Officer	• No patients to be cared for in a non-clinical space (using national definition of corridor care) by 31 March 2027 • Achieve 95% of appropriate patients triaged in the emergency departments within 15 minutes in line with the national standard • Achieve 80% of observations completed within tolerance
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**			
2.1	All patients with a working diagnosis of sepsis receive antibiotics in line with the NICE guidance	Chief Medical Officer	• Administration of Antibiotics within 1 hour of diagnosis for high-risk patients • Administration of Antibiotics within 3 hours of diagnosis for moderate risk patients
2.2	Safer Surgery Every Time: embed WHO 5 Steps, NatSSIPs2 (safety checklists) and PSIRF consistently across all surgical sites	Chief Medical Officer	• 0 Never Events in 2026/27 • Audit compliance with WHO 5 Steps and NatSSIPs2 (safety checklists) across theatres and peri-operative pathways • Evidence PSIRF learning loops embedded within Surgical Governance
2.3	Increase Infection Prevention Control awareness and adherence to best practice standards	Chief Nursing Officer	• Eliminate methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia infections resulting from lapses of care • Deliver the improvement plan to reduce avoidable hospital onset MSSA bacteraemia • Achieve minimum aseptic non-touch technique (ANTT) practical training compliance of

			85% for Level 2 across MWL (practical) • 90% compliance with visual infusion phlebitis (VIP) monitoring
3. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**			
3.1	Improve patient feedback	Chief Nursing Officer	• Using existing sources (FFT, Patient Surveys, Complaints/PALs trends etc.) set a baseline and trajectories for improvement and action plans in Q1 • Deliver the year one action plans and produce quarterly progress reports against the improvement trajectories

Part 2.2 Statements of assurance from the Board

The following statements are required by the regulations and enable comparisons to be made between organisations, as well as providing assurance that the Trust Board has considered a broad range of drivers for quality improvement.

2.2.1 Review of services

During 2025-26, the Trust provided and/or sub-contracted £948m NHS services.

MWL has reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2025-26 represents 96% of the total income generated by MWL for 2025-26

2.2.2 Participation in Clinical Audit

Annually NHS England publishes a list of national clinical audits and clinical outcome review programmes that it advises Trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing and new items.

During 2025/26, 63 national clinical audits and four national confidential enquiries covered NHS health services that Mersey and West Lancashire Hospitals NHS Trust provide. During that period the Trust participated in 98% of the national clinical audits and 100% of the national confidential enquiries, of the national clinical audits and national confidential enquiries which the organisation was eligible to participate in.

The national clinical audits that Mersey and West Lancashire Teaching Hospitals NHS Trust participated in during 2025-26 are listed in appendix 1.

The national confidential enquiries that MWL was eligible to participate in during 2025-26 are as follows:

Name of Study	Status during 2025-26	MWL Position
Blood Sodium	Data Collection	Report published Dec 25 Gap Analysis Stage
Emergency procedures in children and young people	Data Collection	Report published Dec 25 Gap Analysis Stage
Acute Limb Ischaemia	Data Collection	Report published Nov 25 Gap Analysis stage

Acute illness in people with a Learning Disability	Data Collection	Awaiting National report - due out Summer 2026

The reports of 249 local clinical audits were reviewed by the provider in 2025-26 and MWL has taken and intends to take the following actions to improve the quality of healthcare provided.

Audit of standards relating to neonatal and maternity transitional care service

This audit was undertaken to look at Transitional Care which is a service given to new mothers following the birth of a baby who would otherwise need to be admitted to the Neonatal Unit in Ormskirk Hospital.
It is a supportive care model designed for newborns who require more than standard care but do not need intensive monitoring in a neonatal unit.

The audit achieved full assurance and will be re-audited to ensure the high standards are maintained.

Appropriate admission – Admitted due to correct criteria	100%
Admission sheet complete	100%
Baby reviewed daily & documented by Medical Staff	100%
Care documented correctly in BadgerNet	100%
Medical/Nursing notes updated daily	100%
BadgerNet discharge complete	100%
Transitional Care discharge checklist complete	100%
Discharge checklist signed by NNU nurse/Midwife	100%

Annual Audit of Consent Documentation

Every year we audit our compliance with the Trust consent policy and review the standard of documentation on consent forms.

The results of the audit are presented at our speciality audit meetings to share learning and discuss improvement required.

	Whiston Site	S&O Site
Patients surname	100%	100%
Patients first name	100%	100%
Date of birth	100%	100%
Sex	100%	100%
NHS or hospital number	100%	100%
Name of procedure / treatment	100%	100%
Intended benefits of the procedure	100%	100%
Significant unavoidable or frequently occurring risks	100%	100%
Type of anaesthesia / sedation	98%	62%
Patient signature	100%	100%

Patient printed name	78%	79%

An audit of practice around targeted muscle reinnervation (TMR) in patients with limb amputation within the Burns and Plastics department at Mersey and West Lancashire Teaching Hospitals NHS Trust

Targeted muscle reinnervation is a relatively newer technique for managing severe neuropathic pain in patients who have undergone limb amputation. The Burns and Plastics department at Whiston is increasingly receiving referrals from all around the North West from amputees with severe post-operative limb pain and increasingly performing this procedure to improve pain. The aim of this audit was to examine our current approach to patient selection, intraoperative technique, timing of surgery, and perioperative pain management, as our patient cohort continues to grow

Our practice

- Set up an Amputation multi-disciplinary team (MDT) in 2023 as part of Limb Reconstruction Service
- Includes Plastic surgeons, Orthopaedic Surgeons, Vascular (as needed), Limb Rehabilitation Specialists from Clatterbridge and Aintree, Prosthetists, Therapists, Amputation Specialist Nurses
- TMR, Regenerative Peripheral Nerve Interface, Phantom Limb Pain, Residual limb revisions for redo myodesis, bony adjustments, soft tissue coverage free flaps and lipomodelling
- Interface training sessions prior to each MDT
- Links with Chronic Pain Specialists
- Commenced TMR surgery
- Small numbers reflect global practice
- Referrals for residual limb pain (around 1 per limb reconstruction clinic).

Conclusions

- This is a complex patient group who have endured years of pain
- TMR reduces mean pain scores
- Pain score in Phantom Limb Pain reduced from a mean of 9/10 to 6.4/10
- Pain score overall reduced from a mean of 9.4 to 5.8
- One patients pain score did not change – this could reflect patient selection
- One patient's analgesia requirements were not improved which may reflect choice of technique and learning curve
- 1 patient with TMR experiences no pain at all now
- The primary TMR has no postoperative pain compared to a score of 10 preoperatively
- No patient's pain score worsened
- No neuromas have recurred

As per NICE guidance – more evidence required for primary TMR in formal research setting.

Operationally:

- We have created a standardised preoperative assessment and outcome set tool for prospective assessment and to aid audit
- We will quantify in greater detail effect on pain, sleep and prosthetic usage
- We will continue MDT assessment, planning and follow up for these patients
- We will standardise perioperative anaesthetic management to optimise pain relief which is linked to long term improvement of pain symptoms
- We will collate long term follow-up
- Set up a local / national registry to collect demographic and outcome data
- Potential to set up an Randomised Control Trial with other local units (Alder Hey/ Manchester) to allow primary TMR

2.2.3 Participation and Recruitment in Clinical Research

Background/ Introduction

In August 2025 the Department of Health released a policy paper “Transforming the UK clinical research system”, part its vision is to foster cutting-edge research and innovation to encourage breakthroughs in life sciences, thus ensuring a healthier population, allowing patients to access novel treatments and providing a health system that is more accessible, efficient and sustainable to build an NHS fit for the future.

Research and innovation are central to improving outcomes and tackling the major health challenges in our region.

Here at MWL, we are dedicated to providing high quality research to people that use our services. During 2025–26 our Trust continued to play a vital role in advancing research that directly benefits patients, supports our workforce, and contributes to the wider health and care system.

Over the past year we have been adapting to the changing research landscape, which includes working towards the government’s ambitious vision to reduce the setup time for clinical trials to fewer than 150 days. In addition, in 2025, there was a change to the National Institute for Health Research (NIHR) Research Delivery Network (RDN) funding model. A portion of an NHS Trust’s research funding allocation is now linked to actual research activity, which is weighted by type and complexity of study. Another proportion of funding is linked to performance metrics, such as meeting recruitment timelines and other key performance indicators defined for the UK clinical research delivery system. This aligns with the Government’s policy targets (e.g., set-up and first-participant recruitment timelines).

In the context of the NIHR RDN funding, the recruitment weighting used to calculate workload and funding across different clinical study types is shown in the table below:

Design	Weighting Score per participant
Interventional	175
Observational	86
Large Interventional	29
Large Observational	1

Activity/Performance

In 2025-26, 879 patients were recruited to research studies at MWL. This is a reduction compared to the previous year; however, it must be noted that this is partly due to the new NIHR performance metrics, where a higher weighting criterion is applied to interventional, drug trials and commercial studies, all of which have lower recruitment numbers.

Historically we have set our own internal annual recruitment target. In 2025-26 we recruited 879 participants against a target of 1400, this was an ambitious target and did not take into consideration, the NIHR performance metrics which were introduced part way through the year. Taking this into consideration adjustments will be required when setting the target for 2026-27.

In line with the new the recruitment weighting metrics we are pleased to report that we have increased the proportion of both our interventional and observational studies compared to the previous year; interventional from 7.25% in 2024/25 to 19.5% in 2025/26 and the observational studies from 29% in 2024/25 to 50.6% in 2025/26.
Interventional research refers to clinical studies where participants are assigned to groups to receive an intervention or placebo, allowing researchers to assess the efficacy and safety of the intervention.
Observational research is a non-experimental method where researchers systematically observe and record behaviours or phenomena in their natural settings without manipulating variable.

The number of research studies open to recruitment at the Trust during 2025-26 was 118, compared to 104 in 2024-25. The number of studies that were issued with confirmation of capacity & capability (MWL NHS Permission) in 2025-26 was 33, compared to 27 in 2024-25, which was an increase from the previous year.

During 2025-26 the MWL had 16 active commercial studies on its portfolio which remains stable compared to the previous year, this included studies in which patients were followed up after concluding their treatment. This demonstrates our ongoing commitment to focusing on commercial research, it also allows our patients the benefit of earlier access to new treatments and technologies.

The Diabetic Foot Ulcer study, open at the Southport and Ormskirk sites involved working in collaboration with our colleagues from Mersey Care, which is encouraged

to allow patients from the community the opportunity to take part in research that would usually be out of their reach.

Primary Care Research

At MWL we are in a unique position of having a GP practice (Marshall Cross Medical Centre) based within St Helens Hospital. We are pleased to report that in April 2025 we were successful in securing NIHR funding for Research Nurse support at the practice. This has been a huge success story.

The Research Nurses have worked hard to increase research activity and are embedding a research culture to a previously research naive area. Since April 2025 they have opened 9 studies and have put in a forward plan to ensure the growth and the facilitation of research at the practice.

Professor Greg Irving, Consultant GP at Marshalls Cross Medical Centre, has been awarded a prestigious NIHR Senior Investigator Award. This is one of the highest honours in UK health and care research and is given to only a small number of leading researchers across the country. He was also successful in securing NIHR strategic funding to be part of the National Neighbourhood Health Implementation Programme (NNHIP). This is a flagship national initiative led by the Department of Health and Social Care and NHS England to accelerate neighbourhood-based models of care. This project responds directly to the Research Delivery Networks strategic commitment by focusing on how research delivery is normalised within neighbourhood health systems - how it is adopted, implemented, embedded, integrated, and sustained in everyday neighbourhood working.

Good news stories

MWL first site in the UK to consent a patient to an important research study

Whiston Hospital recorded the achievement on a commercially sponsored study investigating a new treatment for ulcerative colitis.

The patient consented to take part in the study after 129 days of the 150 day metric introduced by the Department of Health and Social Care as part of the UK government's commitment to reduce the set-up time for clinical trials to less than 150 days. Not only did we meet the 150 day metric, we also recruited the first patient in the UK to the trial.

This study offers patients the opportunity to take part in cutting edge research, this includes patients from the Southport and Ormskirk sites who are also screened for eligibility and offered the opportunity to take part in the study.

MWL were also the top recruiters in the UK to several other important research studies.

Update on Commercial Research Delivery Centres (CRDCs)

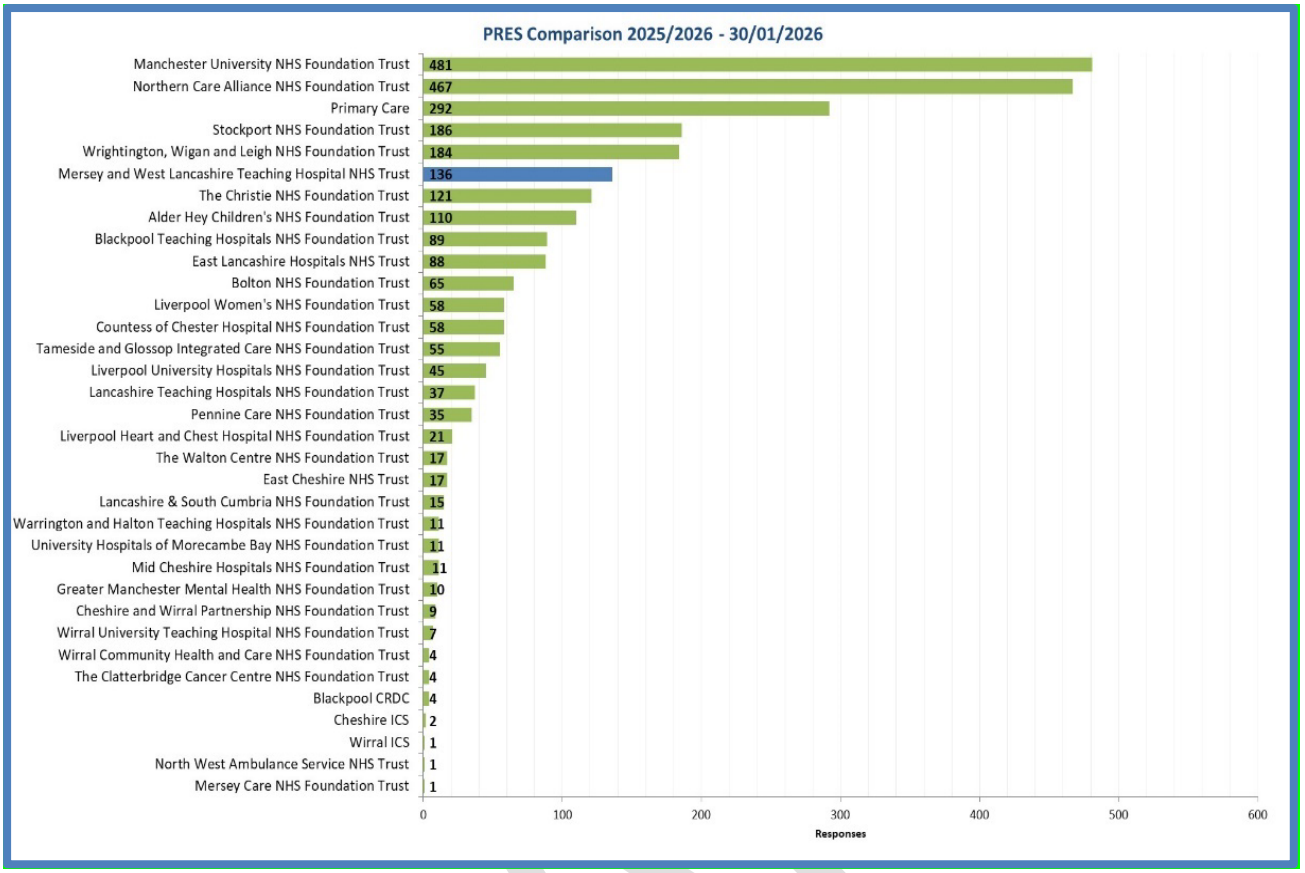
We are an active partner in the Cheshire & Merseyside CRDC and are committed to working with them to increase commercial research activity across the patch.

The CDRC gives patients access to pioneering clinical trials and treatments in record time and will support the rapid set-up of commercial studies, meaning patients can begin accessing treatments as part of clinical trials as early as possible. Studies show that research-active hospitals and organisations achieve better health outcomes for patients, due to better understanding of the effects of treatments, ongoing care and monitoring as part of a research study.

Patient Research Experience

The Participant in Research Experience Survey (PRES) is conducted annually by the National institute For Health Research (NIHR) Clinical Research Network (CRN). For the first time in 2025-26 the NIHR issued a requirement for the MWL to reach a target of 121 responses with a stretch target of 161.

The PRES is a priority for MWL as participant experience is at the heart of research delivery. We are pleased to report that we met the target and are placed in 6th position on the RRDN dashboard.



Please see below some quotes from some of the participants who took part in research during 2025-26 across the Trust:

"The research team were helpful and friendly and made it easier to understand"

"Everything was explained to me. They were very polite my whole experience of participating in research was perfect, I understood everything"

"Knowing I was helping research that may lead to new treatments"

2.2.4 Clinical goals agreed with commissioners

In 2025-26, the nationally mandated CQUIN scheme remained paused whilst a wider review of incentives for quality is undertaken.

2.2.5 Statements from the Care Quality Commission (CQC)

The CQC is the independent regulator for health and adult social care services in England. The CQC monitors the quality of services the NHS provides and takes action where they fall short of the fundamental standards required. The CQC uses a wide range of regularly updated sources of external information and assesses services against five key questions to determine the quality of care a Trust provides, asking if

services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

There have been three announced CQC inspections in 2025/26:

- Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) CQC Inspection on the Whiston Site on 30th April 2025.
- St Helens Urgent Care Treatment Centre (UTC) on 8th May 2025. This was one of our first comprehensive inspections undertaken using the CQC's single assessment framework the CQC rated all key questions as good and the service is rated good overall.
- Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) CQC Nuclear Medicine Inspection on the Whiston Site on 5th August 2025.

Following the transaction and the formation of Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) on 01 July 2023, the original ratings from the former St Helens and Knowsley Teaching Hospitals NHS Trust 2018 inspection remain in place; therefore, the overall Trust rating remains Outstanding.

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Good	Outstanding	Good	Outstanding	Outstanding

The Trust is required to register with the Care Quality Commission, and its current registration status is in place without conditions.

The Care Quality Commission has not taken enforcement action against MWL during 2025/26.

2.2.6 Information Governance Toolkit

Information Governance (IG) is the approach taken by MWL to manage its information, and ensure that all information, particularly personal and confidential data, is handled legally, securely, efficiently and effectively. It provides both a framework and a consistent way for employees to deal with the many different information handling requirements in line with Data Protection legislation.

MWL uses the Data Security and Protection Toolkit (DSPT) to benchmark its IG and IT security controls set out in legislation and national policy. The DSPT transitioned in September 2024 to align with the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF). This CAF-aligned DSPT aims to improve data security by emphasising informed decision-making and understanding of information risks

within healthcare organisations. This is the first major change to the DSPT since its introduction in 2018, changing the assessment significantly to focus on cyber security. Prior to this change it concentrated on data protection with a slight nod to cyber / IT security.

MWL's Information Security Team, who provide assurances that MWL's IT assets are protected from the ever-changing cyber threat landscape within the digital world are supported by MWL's Information Governance in providing and submitting evidence for the DSPT.

MWL submitted the DSPT assessment at the end of June 2025 for the 2024/25 submission and was able to submit evidence items for all but one of the 'outcomes.' MWL therefore submitted a "standards not met" rating. In order to achieve "standards met" all outcomes within the DSPT must be achieved. It must be noted that due to the significant change to the now CAF-aligned DPST, NHS England were expecting the majority of organisations to not achieve "standards met." Failure to provide sufficient evidence for just one principle even though evidence has been submitted for all the other areas means that an organisation cannot submit "standards met."

This 2024-25 DSPT was also audited by Mersey Internal Audit Agency, who check the quality and veracity of the evidence that has been provided. In line with the 'standards not met' submission, MWL has received the rating of 'Moderate Assurance' against its DSPT. Reflecting the one outcome that requires further evidence and assurance Multi-Factor Authentication (MFA).

During 2026 / 2027 MWL will work towards implementing Multi-Factor Authentication (MFA) on all remote user access to all systems and all privileged user access to externally-hosted systems.

As required when an organisation submits 'standards not met,' the Trust has provided an Improvement Plan to NHSE for this outcome, this plan has been accepted by NHSE which has moved the Trust to 'Approaching Standards' for this DSPT.

MWL has assigned specific roles to ensure the Cyber strategy and IG framework is adhered to and is fully embedded:

- Director of Informatics – Senior Information Risk Owner (SIRO)
- Assistant Medical Director - Caldicott Guardian
- Head of Risk Assurance and Data Protection Officer
- Cyber Security Manager

All four staff are appropriately trained.

2.2.7 Cyber Security

During 2025–26, the Trust has continued to strengthen its cyber security arrangements to protect patient data and ensure the resilience of critical digital

systems. Building on previous work, all Trust devices are now covered by nationally provided, 24/7 cyber monitoring services, enabling rapid identification and response to potential threats at any time.

Further improvements have been made to technical controls, incident response, and organisational awareness, reducing cyber risk and improving overall preparedness. Cyber security remains a key component of the Trust's approach to quality, safety, and operational resilience.

2.2.8 Clinical coding

Clinical coding is the translation of medical terminology that describes a patient's complaint, problem, diagnosis, treatment, or other reason for seeking medical attention into codes that can then be used to record morbidity data for operational, clinical, financial and research purposes. It is carried out using International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) for diagnosis capture and Office of Population, Census and Statistics Classification of Interventions and Procedures Version 4.10 (OPCS 4.10) for procedural capture.

MWL was not subject to the Payment by Results clinical coding audit during 2025-26 by the Audit Commission.

The Trust was subject to an audit of clinical coding, based on national standards undertaken by Clinical Classifications Service (CCS) approved clinical coding auditors in line with the Data Security and Protection Toolkit (DSPT) 2025-26.

It is widely known throughout the NHS that there is a local and national shortage of qualified and experienced Clinical Coders, which unfortunately creates recruitment challenges across the country. Despite vacancy challenges faced by the team, the Trust and wider community should be reassured that the data reported at MWL is accurate and reflects the activity that is taking place, demonstrated by the 2025-26 DSPT clinical coding audit submission achieving a high standard of accuracy.

These results demonstrate that the department continues to maintain the excellent quality of clinical coding.

Mersey and West Lancashire Teaching Hospitals NHS Trust			
	%	Audited	Errors
Primary Diagnosis	95.00	200	10
Secondary Diagnosis	95.17	891	43
Primary Procedure	92.09	139	1
Secondary Procedure	94.99	379	19

MWL will be taking the following actions to further improve data:

- Continuing to promote clinical engagement to ensure that clinical coding accurately reflects the patient journey

- Ensuring staff are working towards achieving the national clinical coding qualification (NCCQ)

- Ensuring staff attend regular refresher workshops to ensure coding skills are kept up to date

- Continuing to provide a robust audit service to highlight areas for improvement

2.2.9 NHS number and General Medical Practice Code Validity

During 2025-26 MWL submitted records to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and the patient's valid registered GP practice code contributes to the overall Data Quality Maturity Index (DQMI) scores. The DQMI score for the most recent 12 months is shown in the table below.

DQMI	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Trust Score	93.6	93.7	93.5	93.6	93.8	92.5	92.5	92.7	92.8	93.2	93.3	93.3	93.4
National Average	74.1	73.5	71.1	71.1	70.2	69.3	67.9	70.7	70.9	67.9	70.4	69.7	68.7

(Source: DQMI)

The Trust performed better than the national average, highlighting the importance the Trust places on data quality.

The Trust takes the following actions to improve data quality:

- The Data Quality team monitors the nationally mandated submissions via the NHS digital toolkit and a formal report is presented at the Information Steering Group meeting. Any elements requiring action are agreed at this meeting
- The Data Quality Team continues to monitor data quality throughout the Trust via a suite of reports
- Provision of data quality awareness sessions regarding the importance of good quality patient data and the impact of inaccurate data recording
- The Trust Data Quality Forum is well established and provides oversight to ensure the timely completion of data quality checks across departments in the Trust. The group reports directly into to the Information Steering Group (ISG).

2.2.10 Data quality

The Trust continues to be committed to ensuring accurate and up-to-date information is available to communicate effectively with GPs and others involved in delivering care to patients. Good quality information underpins effective delivery of patient care and supports better decision-making, which is essential for delivering improvements.

Data quality is fully embedded across the organisation, with robust governance arrangements in place to ensure the effective management of this process. Audit outcomes are monitored to ensure that the Trust continues to maintain performance in line with national standards. The data quality work plan is reviewed on an annual basis ensuring any new requirements are reflected in the plan.

There are a number of standard national data quality items, which are routinely monitored, including:

- Blank/invalid NHS numbers
- Unknown or dummy practice codes
- Blank or invalid registered GP practices
- Patient postcodes

The Trust implemented a new Patient Administration System (PAS), Careflow, in 2018 which has the functionality to allow for National Spine integration, giving users the ability to update patient details from national records using the NHS number as a unique identifier.

The Careflow configuration restricts the options available to users. Validation of this work is on-going and forms part of the annual data quality work plan.

2.2.11 Learning from Deaths (LFD)

MWL has well-established processes across all sites to review deaths occurring in hospital and identifying areas of learning where practice can be improved.
All deaths are scrutinised by Medical Examiners at both sites and support the LFD process by reporting learning through the Mortality Operational Group (MOG) meetings. Any concerns found where lapses in care could have contributed to a patient's death are reported through the Patient Safety Panel route, which also reports learning back to the MOG. Alongside this, deaths within scope of the National Quality Board (NQB) criteria for Subjective Judgement Review (SJR) are referred to the Mortality Group for allocation and SJR completion. Any concerns around lapses in care or learning is categorised in accordance with the national guidance and logged via the mortality incident reporting system.

SJRs are rated as Green, Green with learning, Green with positive learning, Amber (areas identified possibly contributing to patient harm) or Red (death more than likely due to problems with healthcare). Those graded Amber or Red are immediately referred to the Patient Safety Team for consideration of investigation through the PSIRF procedure and cases are presented and discussed at the Mortality Surveillance

Group (MSG) meetings, held monthly. Any learning is fed back to the Divisional team and shared throughout the organisation to ensure that all staff are given the opportunity to determine how this could impact on their practice, to make improvements for other patients.

During Quarters1-4 2025-26, 2185 of MWL's patients died in hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 566 in Q1
- 589 in Q2
- 610 in Q3
- 420 in Q4 – up to 18 February 2026

By the end of Quarter 4, 148 case record reviews have been carried out in relation to the 2185 deaths.

To date the LFD results have been presented for Quarter 1 and Quarter 2 of 2025-26 to the Trust Board:

	Quarter 1 (April-June)	Quarter 2 (July-Sept)
Total cases with Structured Judgement Review (SJR) Quarter 1	51	48
Total outstanding with a review Quarter	45	48

Current status of SJRs for MWL: 53 'open SJRs', 44 awaiting completion with 13 unallocated, 9 completed awaiting MSG review.

Summary of learning from deaths

- **Sepsis of uncertain origin**
  - When patients present 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. Infection control 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

prescribing.

- **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 patient's 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.

- **Mental Capacity Act (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 decisions complexity. For important decisions, 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.

Lessons identified from the Structured Judgement Reviews have been shared with the Trust Board, Quality Committee, Finance & Performance Committee, Clinical Effectiveness Council, Patient Safety Council, Patient Experience Council, Grand Rounds, Team Brief, intranet home page, global email, local governance and directorate meetings.

2.2.12 Freedom to Speak Up (FTSU)

The Trust has well-established systems and routes to encourage and support staff to raise concerns. Concerns can be raised through their own line management structure or via the Freedom to Speak Up (FTSU) Team. In addition, the Trust has a Non-Executive Director, who leads on and champions FTSU. The Chief Executive Officer also has a scheme “Ask Rob”, where staff can raise concerns directly with him. Staff are encouraged not only to speak up about anything that gets in the way of delivering great care and treatment but also about areas of good practice that could be replicated elsewhere. The Trust also has a contract with an online supplier “Work in Confidence”, this IT system provides a mechanism for staff to raise concerns and communicate with either a FTSU Guardian or a Human Resource representative anonymously, if they wish to.

The Trust has four registered FTSU Guardians, two of whom undertake a dedicated role to both support staff and the development of a speak up, listen up and follow up culture. The team is supported by a FTSU Specialist Administrator and a network of FTSU champions, who come from different professional groups and are working at various levels and roles within the Trust. Whilst champions primarily support the culture within the teams, in which they are embedded, they may also offer support and signposting to any staff member within the Trust. Guardians and champions come together once a month to share information and develop ideas for further developing the culture. A Champions away day is held annually, and further bespoke training is set up, as required. The away day, held in October 2025 had a theme of Equality, Diversity and Inclusion (EDI), and sessions included an introduction to EDI, Civility and Respect oversight and Active Bystander Training.

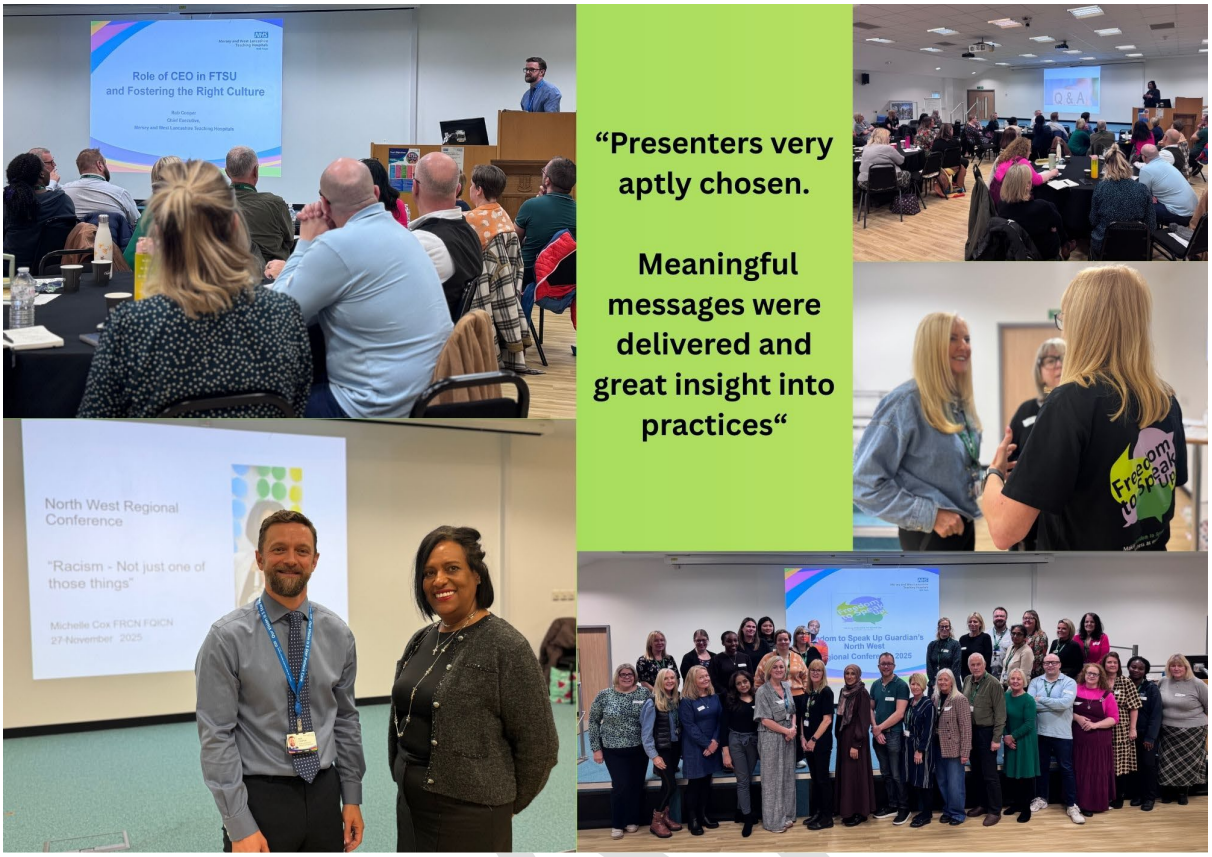
FTSU is discussed at the Trust Induction events and Guardians regularly undertake sessions with staff, including individual departments or as part of training programmes. The FTSU Guardians meet on a regular basis to discuss any emerging trends, whilst maintaining confidentiality regarding individual cases.

The Trust Board completed a review of the self-assessment of the FTSU arrangements within the Trust in January 2025, using the National Guardian’s Office and NHS England’s Reflection and Planning Tool. This will be undertaken every two years, going forward in line with National Guidance. The outcome of this has been used to develop an action plan for continuous improvement and an FTSU Strategy.

During October 2025, FTSU week was held and had a focus on engagement with night staff. A number of night walk arounds were undertaken by the FTSU Team, to raise awareness of how staff could raise concerns and provide information and materials. In addition, the Trust published a spotlight series on a number of Champions via the internal social media channels and in the weekly Trust News. A Team talks session dedicated to FTSU was undertaken with the Chief Executive and a number of staff at the St Helens Hospital site and one of the FTSU Guardians presented at the weekly Trust Wide Trust Team Brief.

The Trust also hosted the annual Northwest FTSU Guardian's conference in November 2025, with excellent evaluations from delegates. Sessions included:

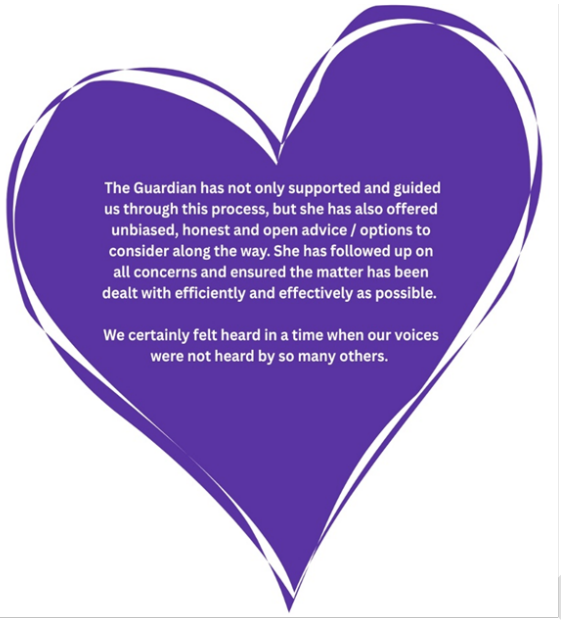
- Learning from the Countess of Chester Hospital NHS Foundation Trust following the Lucy Letby case and their journey in FTSU
- Learning from a successful Employment Tribunal Case against NHS England involving racism and personal experience of speaking up
- The role of FTSU from a Chief Executive Perspective and how Guardians can be supported.

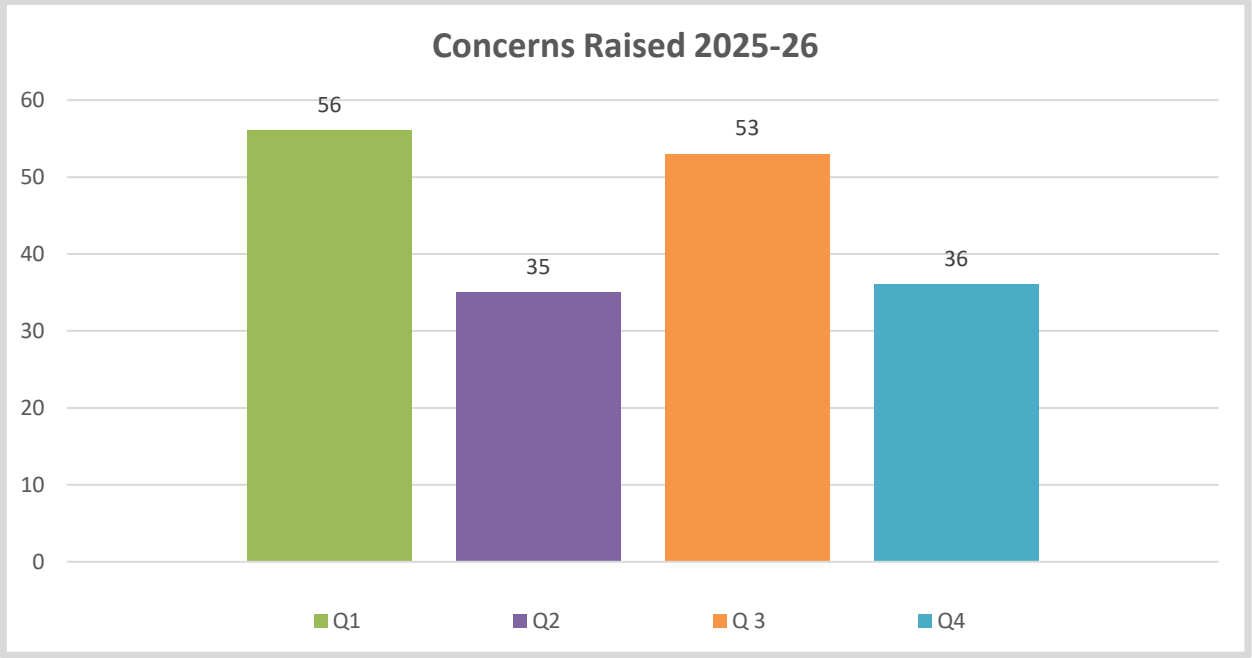


In 2025-26, in line with national trends and themes, the majority of concerns raised with the FTSU Team relate to how staff behave towards each other. Whilst staff rarely wish for such concerns of unwarranted and at times, unintentional behaviour to be raised formally through a Human Resource process, they wish to pursue a resolution through raising the concern and for such behaviour to stop. Whilst individual concern would be raised and responded to in a confidential way, the trend has been recognised and the FTSU Team working with the support of other colleagues has developed Active Bystander Training. This training has been piloted and is now being rolled out to all sites with monthly training being offered.

The FTSU Guardians meet quarterly with the Chief Executive, The Trust Chair, The Chief People's Officer and the Chief Nurse to discuss emerging or actual trends in terms of categories of concerns or areas where a number of concerns are being raised. Whilst individual cases are not discussed due to confidentiality, this meeting allows an open discussion of areas of concern and for actions to be agreed. This informal meeting is supported by formal reporting to the Quality Committee and its associated sub committees on a six-monthly basis. In any case where a staff member has reported possible detriment, as a result of speaking up, a report is made to the CEO and Chief Peoples Officer, and the concern is sent for review and investigation by the relevant FTSU Guardian. The Trust has a zero-tolerance approach to detriment in this regard.

Feedback to the FTSU Team from staff has been consistently positive through the year.





The Trust continues to work in partnership with the National Guardian's Office and Northwest Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns.

The range of other routes for staff to raise concerns and receive support are listed below:

Health, work and wellbeing hotline

Staff members have access to a dedicated helpline, to provide advice and support regarding health and wellbeing aspects relating to work or impacting on the individual. Bespoke support can be offered depending on the needs and circumstances. Concerns about the workplace can be raised through the hotline.

Hate crime reporting

A hate crime is when someone commits a crime against a person because of their disability, gender identity, race, sexual orientation, religion, or any other perceived difference. The Trust, in partnership with Merseyside Police, continues to support staff members with the first ever Hate Crime Reporting Scheme based at an NHS Trust. This is a confidential online reporting service that enables anyone from across our organisation and local communities to report, in complete confidence, any incidents or concerns around hate crime to Merseyside Police.

Policies and procedures

There are a number of Trust policies and procedures that facilitate the raising of staff concerns, including the Freedom to Speak Up policy, Grievance Policy and Procedure, Respect and Dignity at Work Policy and Being Open Policy. Staff are also encouraged to informally raise any concerns to their manager, nominated HR lead or their staff-side representative, as well as considering the routes listed above.

All concerns are taken seriously, and changes are made where appropriate, including making changes to the working environment, providing individual support and information to staff and reviewing staffing levels in key areas. The Trust has made available nationally recommended FTSU training to all staff members on its e-learning platform.

2.2.13 NHS Doctors in Training

This section is intended to illustrate the number of exception reports raised against the vacancy rate by the grade of doctor. Fill rates for ad hoc shifts are provided to illustrate how successfully vacant shifts are filled. This section also illustrates the actions taken to mitigate the risk of having unfilled shifts and any adverse impact on the training experience of Doctors in Training whilst on rotation to the Trust.

High level data

- Number of doctors and dentists in training (total): 293 hosted trainees and 192 locally employed foundation trainees.

- The medical vacancy rate is 0.7%.

Period	Medicine	Surgery	Emergency Medicine	Orthopaedics	Ophthalmology	Urology	Obs & Gynae	Total
April - June 2025	19	8	0	0	0	2	0	29
July - September 2024	29	41	0	3	0	0	0	73
October - December 2024	32	26	3	2	0	2	0	65
January - March 2026	100	58	2	3	1	9	49	222
Total	180	133	5	8	1	13	49	389

The numbers represent a count of unique exception reports recorded by trainees. Grades range from Foundation Year (FY) 1, 2 through to Specialist Trainee (ST) 1,2,3,4,5,6,7 and 8.

Issues arising

There was a significant change made to the exception reporting process from 4th February 2026. There was a variation to the 2016 Resident Doctor Terms and Conditions of Service which removed the Educational Supervisor from the exception reporting process. The resident doctors now log exceptions, and for anything under 2 hours the Trust is required to approve the exception and process for payment. Anything beyond this must be investigated by the Guardian of Safeworking. This was implemented as many felt unable to exception report as they do not wish to be seen in a less favourable light by their supervisors. This change has seen a significant increase in reports, however it has given the opportunity to review some areas and work with the operational and clinical managers to make positive changes to aim to resolve issues, such as doctors being unable to take breaks or regularly being required to work beyond their finish times.

2.2.14 Reporting against core indicators

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, where the NHS is aiming to improve. All trusts are required to report against these indicators using a standard format. NHS Digital makes the following data available to NHS trusts. The Trust has more up-to-date information for some measures; however, in the main only data with specified national benchmarks from the central data sources is reported, therefore, some information included in this report is from the previous year or earlier and these timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Please note the information below is based on the latest nationally or locally reported data with specified benchmarks from the central data sources.

Summary Hospital-level Mortality Indicator (SHMI)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
SHMI	NHS Digital	Dec-24 to Nov-25	0.996	1.009	0.719	1.318
SHMI	NHS Digital	Nov-24 to Oct-25	0.992	1.010	0.718	1.396
SHMI	NHS Digital	Oct-24 to Sep-25	0.997	1.008	0.719	1.341
SHMI	NHS Digital	Sep-24 to Aug-25	0.991	1.008	0.713	1.358
SHMI	NHS Digital	Aug-24 to Jul-25	0.983	1.007	0.717	1.352
SHMI	NHS Digital	Jul-24 to Jun-25	0.992	1.006	0.717	1.311
SHMI	NHS Digital	Jun-24 to May-25	0.993	1.006	0.710	1.266
SHMI	NHS Digital	May-24 to Apr-25	0.997	1.005	0.712	1.276
SHMI	NHS Digital	Apr-24 to Mar-25	1.002	1.004	0.715	1.269
SHMI	NHS Digital	Mar-24 to Feb-25	1.015	1.003	0.715	1.256
SHMI	NHS Digital	Feb-24 to Jan-25	1.051	1.004	0.709	1.340
SHMI	NHS Digital	Jan-24 to Dec-24	1.018	1.004	0.699	1.332

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
SHMI Banding	NHS Digital	Dec-24 to Nov-25	2	2	1	3
SHMI Banding	NHS Digital	Nov-24 to Oct-25	2	2	1	3
SHMI Banding	NHS Digital	Oct-24 to Sep-25	2	2	1	3
SHMI Banding	NHS Digital	Sep-24 to Aug-25	2	2	1	3
SHMI Banding	NHS Digital	Aug-24 to Jul-25	2	2	1	3
SHMI Banding	NHS Digital	Jul-24 to Jun-25	2	2	1	3
SHMI Banding	NHS Digital	Jun-24 to May-25	2	2	1	3

SHMI Banding	NHS Digital	May-24 to Apr-25	2	2	1	3
SHMI Banding	NHS Digital	Apr-24 to Mar-25	2	2	1	3
SHMI Banding	NHS Digital	Mar-24 to Feb-25	2	2	1	3
SHMI Banding	NHS Digital	Feb-24 to Jan-25	2	2	1	3
SHMI Banding	NHS Digital	Jan-24 to Dec-24	2	2	1	3

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
% of patient deaths having palliative care coded	NHS Digital	Dec-24 to Nov-25	52.0%	44.5%	17.2%	69.2%
% of patient deaths having palliative care coded	NHS Digital	Nov-24 to Oct-25	52.2%	44.4%	17.8%	69.3%
% of patient deaths having palliative care coded	NHS Digital	Oct-24 to Sep-25	52.2%	44.3%	17.7%	71.1%
% of patient deaths having palliative care coded	NHS Digital	Sep-24 to Aug-25	52.0%	44.5%	17.8%	72.4%
% of patient deaths having palliative care coded	NHS Digital	Aug-24 to Jul-25	51.8%	44.5%	17.8%	70.8%
% of patient deaths having palliative care coded	NHS Digital	Jul-24 to Jun-25	51.3%	44.6%	17.4%	69.8%
% of patient deaths having palliative care coded	NHS Digital	Jun-24 to May-25	51.3%	44.6%	16.8%	68.8%
% of patient deaths having palliative care coded	NHS Digital	May-24 to Apr-25	52.0%	44.7%	16.7%	67.2%
% of patient deaths having palliative care coded	NHS Digital	Apr-24 to Mar-25	52.2%	44.8%	16.7%	68.0%
% of patient deaths having palliative care coded	NHS Digital	Mar-24 to Feb-25	52.6%	44.7%	16.4%	68.0%
% of patient deaths having palliative care coded	NHS Digital	Feb-24 to Jan-25	45.8%	44.3%	16.6%	65.0%
% of patient deaths having palliative care coded	NHS Digital	Jan-24 to Dec-24	51.0%	44.2%	17.0%	65.7%

MWL considers that this data is as described for the following reasons:
- Information relating to mortality is monitored monthly and used to drive improvements.
- The mortality data is provided by an external source (NHS Digital).

MWL has taken the following actions to improve the indicator and percentage, and so the quality of its services by:

- Monthly monitoring of available measures of mortality.
- Learning from Deaths Policy implemented with continued focus on reviewing deaths to identify required actions for improvement and effective dissemination of lessons learned.

Patient Reported Outcome Measures (PROMS)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-24 to Mar-25 (final)	0.394	0.451	0.268	0.544
EQ-5D adjusted health gain: Hip Replacement Primary	NHS Digital	Apr-23 to Mar-24 (final)	0.456	0.458	0.352	0.581
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-24 to Mar-25 (final)	0.299	0.320	0.231	0.497
EQ-5D adjusted health gain: Knee Replacement Primary	NHS Digital	Apr-23 to Mar-24 (final)	0.288	0.323	0.231	0.405

MWL considers that this data is as described for the following reason:
- The questionnaire used for PROMs is a validated tool and administered for the Trust by an independent organisation (IQVIA).

MWL has taken the following action to improve these outcome scores, and so the quality of its services, by:
- Reviewing the process for PROMs collection Trust-wide and agreeing a Trust-wide forum where results will be discussed.

FRIENDS & FAMILY TEST (FFT)

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Feb-26	82.56%	79.20%	60.16%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Jan-26	82.85%	77.53%	54.55%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Dec-25	83.32%	78.15%	53.05%	100.00%

Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Nov-25	83.64%	77.48%	56.66%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Oct-25	83.45%	77.30%	22.22%	95.65%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Sep-25	87.24%	78.78%	61.11%	98.28%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Aug-25	85.03%	80.85%	33.33%	98.57%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Jul-25	85.63%	79.65%	50.00%	98.37%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Jun-25	84.77%	79.54%	35.71%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	May-25	85.53%	79.97%	17.39%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Apr-25	85.26%	79.86%	62.21%	98.62%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Mar-25	81.56%	79.58%	34.78%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - A&E	NHS England	Feb-25	80.46%	78.62%	18.18%	100.00%

Indicator	**Source**	**Reporting Period**	**MWL**	**National Performance**		
				Average	**Lowest Trust**	**Highest Trust**
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Feb-26	94.33%	94.81%	70.73%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Jan-26	92.85%	94.67%	77.36%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Dec-25	94.88%	94.59%	75.60%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Nov-25	94.23%	94.55%	76.42%	99.72%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Oct-25	93.86%	94.47%	62.50%	100.00%

Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Sep-25	93.61%	94.67%	81.91%	99.57%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Aug-25	94.36%	94.66%	80.65%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Jul-25	94.35%	94.69%	82.37%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Jun-25	94.18%	94.60%	82.71%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	May-25	94.27%	94.48%	5.88%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Apr-25	93.65%	94.71%	70.87%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Mar-25	93.96%	94.60%	80.39%	100.00%
Friends and Family Test - % that rate the service as Very Good or Good - Inpatients	NHS England	Feb-25	94.80%	94.89%	80.56%	100.00%

MWL considers that this data is as described for the following reasons:
- The Trust actively promotes the FFT across all areas.
- The data was submitted monthly to NHS England.

MWL has taken the following actions to improve these percentages, and so the quality of its services by:
- Continuing to promote FFT using a variety of methods, including face-to-face and digital technology, supported by volunteers in key areas.
- Actively working with ward staff to improve levels of engagement with the system, to ensure the latest results are shared at local level and actions are delivered to respond to the feedback.

VTE

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 4 2025-26	87.4%	Data not released yet		
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2025-26	88.7%	91.5%	14.9%	99.0%

% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2025-26	86.1%	91.2%	15.4%	100%
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2025-26	81.8%	90.5%	14.5%	99.7%

MWL considers that this data is as described for the following reasons:
- Reviews are carried out for all patients who develop a hospital acquired thrombosis (HAT). A HAT venous thromboembolism (VTE) covers all VTEs that occur in hospital and within 90 days after a hospital admission. Treatment in relation to VTE prevention.
- Patient Safety Investigations undertaken on VTEs are recorded on Datix to ensure best practice is followed.

MWL is taking the following actions to improve this percentage, and so the quality of its services, by:
- Utilising IT systems and pathways to facilitate VTE risk assessment and prescribing of thromboprophylaxis.
- Undertaking audits on the administration of appropriate medications to prevent blood clots.
- Completing investigations on all patients who develop a hospital acquired venous thrombosis to ensure that best practice has been followed.
- Sharing any learning from these reviews and providing ongoing training for clinical staff.

C. DIFFICILE

Indicator	Source	Reporting Period	MWL	National Performance		
				Average	Lowest Trust	Highest Trust
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-25 to Mar-26	Data not released yet			
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-24 to Mar-25	47.1	53.0	2.7	125.3
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-23 to Mar-24	51	46.8	0	131.2
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-22 to Mar-23	46.6	43.9	0	133.6
	GOV.UK	Apr-21 to	46.5	44.3	0	138.4

C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)		Mar-22				
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Total cases)	GOV.UK	Apr-20 to Mar-21	41.6	46.2	0	140.5

MWL considers that this data is as described for the following reasons:
- All new cases of C. difficile infection are identified by the laboratory and reported to the Infection Prevention Team, who co-ordinate mandatory external reporting.
- The Trust is maintaining compliance with the national guidance on testing stool specimens in patients with diarrhoea.
- Cases are thoroughly investigated, which is reported back to a multidisciplinary panel to ensure appropriate care was provided and lessons learned are disseminated across the Trust. The Trust has implemented improvement plans in place for E. coli, indwelling devices and C. difficile. This has resulted in the Trust being below the threshold set for rates of E. coli and C. difficile.

MWL has taken the following actions to improve this rate, and so the quality of its services, by:
- Focusing on ensuring staff compliance with mandatory training for infection prevention.
- Ensuring compliance with IPC practice including isolation of patients with suspected / confirmed symptoms.
- Actively promoting the use of hand washing and hand gels to those visiting the hospital.
- Providing a proactive and responsive infection prevention service to increase levels of compliance.
- Ensuring comprehensive guidance is in place on antibiotic prescribing.

Infection prevention remains an ongoing priority for the Trust.

INCIDENTS

Incidents per 1,000 bed days	Internal	Apr-24 to Mar-25	53.263
Incidents per 1,000 bed days	Internal	Apr-25 to Mar-26	53.114
Number of incidents	Internal	Apr-24 to Mar-25	23705
Number of incidents	Internal	Apr-25 to Mar-26	24909
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-24 to Mar-25	0.124
Incidents resulting in severe harm or death per 1,000 bed days	Internal	Apr-25 to Mar-26	0.102
Number of incidents resulting in severe harm or death	Internal	Apr-24 to Mar-25	55

Number of incidents resulting in severe harm or death	Internal	Apr-25 to Mar-26	45
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-24 to Mar-25	0.23%
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-25 to Mar-26	0.19%

MWL has taken the following actions to improve this number and rate, and so the quality of its services by:
- Undertaking comprehensive investigations of incidents resulting in moderate or severe harm.
- Delivering simulation training to enhance team working in clinical areas.
- Providing staff training in incident reporting and risk management.
- Monitoring key performance indicators at the Patient Safety Council, Quality Committee and the Trust Board.
- Continuing to promote an open and honest reporting culture to ensure incidents are consistently reported.

2.2.15 Performance against national targets and regulatory requirements Awaiting Update

The Trust aims to meet all national targets. Performance against the key indicators for 2025-26 is shown in the table below:

Performance Indicator	2024-2025	2025-2026	
Cancelled operations (% of patients treated within 28 days following cancellation)	88.67%	90.12%	
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	64.58%	66.53%	
Cancer: 31-day wait from diagnosis to first treatment	90.25%	93.63%	(Apr-Feb)
Cancer: 62-day wait for first treatment from urgent GP referral	79.71%	78.59%	(Apr-Feb)
Cancer: 28 day wait from GP referral to Diagnosis informed	73.97%	70.30%	(Apr-Feb)
Emergency Department waiting times within 4 hours – all types (mapped performance)	78.08%	78.18%	
Clostridium Difficile	114	109	
MRSA bacteraemia	6	4	
18 weeks: % of Diagnostic Waits who waited <6 weeks	93.13%	86.65%	

Part 3 – Other Information

This section of the Quality Report provides information on our quality performance during 2025-26. Performance against the priorities identified in our previous quality report and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

3.1 Summary of how we did against our 2025-26 Quality Account objectives

Every year the Trust identifies its priorities for delivering high quality of care to patients, which are set out in the Quality Account. The section below provides a review of how well the Trust did in achieving the targets set last year.

	Fully achieved		Partially achieved		Not achieved

4. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				
1.1	Improve measurable success in areas where our patients told us we didn't get it right first time including inpatient areas, ED, maternity with a focus on antenatal.	CNO	Improvement against previous year's national survey results in relation to: • Management of pain. • Kindness and compassion whilst in hospital. • Experience of waiting time information.	
			As a minimum, conduct quarterly local surveys based on national survey indicators.	
			Maintain and embed the patient experience score from 5* Ward Accreditation Programme.	
1.2	Ensure improvement and sustainability of nutritional standards for patients.	CNO	Achieve 95% of adult inpatients screened for malnutrition on admission using the MUST tool. Achieve 95% of patients with a score of 2 or more who receive an appropriate care plan. Improve the processes to ensure 95% of high-risk patients are referred to a dietician.	
			Achieve and maintain 90% for nutrition score consistently across all wards for the 5* Ward Accreditation Programme.	
1.3	Improve measurable success for people that birth have told us we didn't get it right first time who access antenatal services.	CNO	Improvement against previous year's national survey results via quarterly surveys.	
5. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1	Continue to ensure the timely and	COO / CNO	Achieve 95% of appropriate patients triaged in the emergency departments in line with the national standard of triage within 15 mins.	

	effective assessment and care of patients in the Emergency Department.		NEWS – 80% of observations completed on time or within tolerance.	
			All patients with a working diagnosis of sepsis receive antibiotics in line with the NICE guidance.	
2.2	Improve the Trust's compliance with IPC standards.	CNO	Eliminate methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia infections as a result of lapses of care.	
			Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for Level 2 across MWL (practical).	
			90% compliance with visual infusion phlebitis (VIP) monitoring.	
			Achieve 90% for the IPC and indwelling devices standard for the 5* Ward Accreditation programme.	
6. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**				
3.1	Continue to improve the effectiveness of the discharge process for patients and carers.	COO	Achievement of 20% target for patients discharged before noon by March 2026.	
			10% improvement in discharges by 6pm and 8pm during the week against 2024/25 position.	
			Improve average discharge prescription dispensing turnaround time by 10 mins (from 92 to 82 mins) by March 2026 to below the national average.	
			Reduce average take home prescription arrival time to pharmacy by 60 minutes.	

3.2 Patient experience and Inclusion

The Trust acknowledges that patient experience is fundamental to quality of healthcare and that a positive experience leads to better outcomes for patients, as well

as improved morale for staff. Patient experience is at the heart of the Trust's vision to provide 5 star patient care.

The first MWL Patient Experience Strategy 2025-28 was approved in 2025. The strategy is also informed by initiatives such as the Equality Diversity System 2022, Veteran Accreditation and Equality Impact Assessments maintaining our commitment to inclusivity.

There is a total of 13 objectives, 26 actions and 44 measures that sit under the commitments. As we approach our 12 month milestone of the strategy, the Patient Inclusion and experience team can demonstrate many improvements that are now in place as a result, these include:

- Friends and Family Test merged into a single platform so that all MWL data can be centralised.
- Staff monthly kindness and compassion award in place.
- Central database of patient surveys across the Trust has been developed.
- The harmonisation of patient experience audits as one organisation.
- Process mapping, template documents and guidance documents have been developed for the Trust accessibility assessments.

The strategy is reinforced with a detailed implementation plan which is monitored by the Trust Patient Experience Council.

At MWL, we know that patient experience is more than just meeting our patient's physical needs, but also about treating each patient as an individual with dignity, compassion, and respect. We do not want to just meet expectations; we want to exceed them. This means we are committed to working in partnership with our patients to improve the quality of care that we provide, and actively seeking, listening and acting on feedback received from our patients.

Patient stories have continued to be shared in multiple formats such as handwritten, digital and filmed. Stories have been collected from a wide variety of areas and have included

- Emergency Care.
- Empowering patients through values-based procurement during Cancer treatment.
- Digital communication in Dementia care.
- Welcoming Louby Lou the clown to our children's ward/departments to provide activity and reassure patients and their families/carers.
- The support of the children of those affected by cancer.
- The importance of acknowledging both the physical and spiritual and/or religious needs of our patients in order to deliver holistic care.
- Utilising the activities co-ordinator in the achievement of holistic care to patients with a focus on improving wellbeing, increasing social interaction and cognitive stimulation.

Patient stories are shared at the Patient Experience Council and bi-monthly at Trust Board. Stories presented demonstrate both positive experiences and those where learning and improvements are required. Digital stories are uploaded to the staff intranet to allow viewing at anytime and provide resources for teaching and education Some of the improvements implemented as a result of the patient stories include:

- Secured Ruth Strauss Foundation training for 40 Clinical Nurse specialists/Advanced nurse practitioners titled 'No Conversation Too tough' which will better equip those having difficult conversations.
- Strengthening the awareness of spiritual care and chaplaincy within ward accreditation.
- Improved multidisciplinary documentation of treatment plans for deteriorating patients to support on call teams when asked to review.
- Extending the activity co-ordinator role other wards (Duffy Suite at St Helens hospital) to increase the number of patients positively impacted by the activity co-ordinator role.
- Environmental improvements to the bereavement room within the Emergency Department at Southport Hospital.
- Additional member recruited to the Patient Participation group.

Equality Delivery System (EDS)

The patient element in the new EDS 2022 system is Domain 1, which involves a deep dive into three services each year to see how inclusive and accessible they are, and to identify any gaps and opportunities for improvement.

For Domain 1 – 'commissioned and provided services' – each Trust must select three services to focus the assessment on. Following a self-assessment of the evidence provided, a presentation is given to a panel consisting of senior staff, relevant stakeholders and the Governance Lead from Cheshire and Merseyside Integrated Care Board who also score the evidence presented and agree a final domain score

for the Trust.

The 2025-2026 EDS assessment was held on 19th February 2026, and our agreed scores for each service and the overall Domain 1 score are shown below.

During 2025-26 the services studied were:

- Diabetes and endocrinology service = scored excelling
- Radiology service = scored excelling
- Interpreting service = scored achieving

Domain 1: Commissioned and provided services Approved scores 2025-26	
1A: patients (service users) have required levels of access to the service	**ACHIEVING**
1B: Individual patients (service users) health needs are met	**EXCELLING**
1C: When patients (service users) use the service, they are free from harm	**EXCELLING**
1D: Patients (service users) report positive experiences of the service	**EXCELLING**

Veterans Aware

In March 2025 MWL was pleased to announce that the Veterans Aware Accreditation had been awarded to the Trust.

Since then, we have continued working to support the armed forces community by networking across different sectors and identifying partnership opportunities, to further embed and enhance the support that MWL offers to members of the armed forces community.

The eight manifesto requirements assessed to be accredited Veteran Aware and MWL must continue to meet until our next reaccreditation are:

Manifesto Requirements Met	
1. The Organisation understands and is compliant with the Armed Forces Covenant	Yes
2. The Organisation has clearly designated Veterans and armed forces Champions	Yes
3. The Organisation identifies Veterans and armed forces community status patients to ensure they receive appropriate care	Yes
4. Staff at the Organisation are trained and educated in the needs of veterans and the armed forces community	Yes
5. The Organisation has established links to appropriate nearby veteran and armed forces community services	Yes
6. The Organisation will refer veterans and armed forces community to other services as appropriate	Yes
7. The Organisation raises awareness of veterans and armed forces community	Yes
8. The Organisation supports the UK Armed Forces as an employer	Yes

3.3 Friends and Family Test (FFT)

The FFT allows patients to rate their overall experience of care. It is an important feedback tool that supports the fundamental principle that people who use NHS services are able to offer real-time feedback at any point in their care.

Feedback that is gathered is used to identify trends and themes to direct local improvements to patients, families and carers. Positive feedback is often shared with staff to ensure that they feel their work is recognised and valued.

The opportunity to give feedback is provided via multiple methods such as postcards, online surveys, automated SMS text messaging and interactive voice messaging.

Wards and departments across the Trust monitor the patient feedback and display ‘you said, we did’ improvements to highlight the actions being taken to continuously improve the care we provide, as well as providing staff recognition and influencing change. The table below highlights some examples of feedback received and actions taken:

You Said	We Did
When having a plastics procedure at Southport Hospital, it is too far and expensive to travel to Whiston Hospital for a follow up appointment.	The plastics service added a further an all-day clinic which started in October-25 at Southport Hospital to create further follow up appointments.
It is too far to walk from the main car park at Ormskirk Hospital to the Ruffwood Therapy Centre Ormskirk.	Information further reviewed - patients are advised within appointment letters of where their appointment will be, either the main dept or Ruff lane. All patients are provided with a map and location as produced by the Trust with departments is clearly marked. The post code to Ruff lane is also included so that if people have an appointment in this building they can be dropped off/ park in this area.
Food items were cold/lukewarm when reaching patients on inpatient wards at Southport Hospital.	New heated kitchen trollies launched across Southport and Ormskirk hospital sites.
Chairs not suitable in Emergency Department waiting room at Southport Hospital.	All chairs renewed with cushioned seats and of differing sizes (inc. bariatric and chairs with arm rests.)
There was a lack of information when attending for Deep Vein Thrombosis (DVT). I was sent by my GP for a scan however, the assessment process did not include a scan.	A DVT patient information leaflet has been devised and is readily available as required. The leaflet outlines what a DVT is, the assessment process and the Urgent Treatment Centre management of DVT.
More is required to support of the children of those parents/guardians affected by cancer. (St Helens Hospital)	Through work in the McMillan Centre at St Helens Hospital using monies from charitable funds, a video has been commissioned that will use a patient's story to support patients with children to include them in their cancer journey.
Robust documentation was required in ED pertaining to the management of patients property in traumatic situations or where the patient Dies in the department (ED Whiston Hospital)	A care of the deceased to include their property has been implemented to explicitly document who cared for the patient and dealt with the patient's property
There was disparity between visiting times at differing hospital sites. (Trust wide)	A trust wide consultation including patients was undertaken to explore an open visiting model. Patients told us that they did not want/require an open visiting model. Pm visiting times were extended by 1 hour at Whiston, Newton and St Helens in line with Southport and Ormskirk sites.
The Patient information leaflet about admission to a hospital ward was very outdated. (Trust Wide)	A new information leaflet "Your admission to hospital" was created so that patients know what to expect when admitted to an in-patient ward.

You Said	We Did
Migrant patients are experiencing barriers to healthcare. (St Helens Urgent Treatment Centre)	Recognising that migrant patients often face unique barriers, such as language differences, limited knowledge of the healthcare system, or cultural considerations, and traumatic life experiences, St Helens UTC has proactively sought support and insight from community groups, voluntary organisations, and professional partners. We have developed clearer, multilingual patient information to help people understand when and how to access the UTC. We collaborate with local volunteer groups to support patients who may need help navigating their visit. We have also enhanced cultural awareness training for UTC staff to ensure care remains compassionate and inclusive and practiced under the trust values an developed a new QR code to help people register with a GP.
Our patients want to know that the positive feedback that they provide about a member of staff is disseminated. (Trust wide)	“kindness and compassion” awards developed to recognise those staff nominated by patients who have gone above and beyond.
Patients are disturbed by unnecessary noise and lighting in in-patient wards. (Trust wide)	A trust wide “Silent Night “ campaign was undertaken to raise awareness of noise at night and provide resources to staff and fellow patients to reduce disturbance and promote rest.

Patient Experience Conference

In September 2025, 160 nurses, midwives and allied health professionals (AHPs) came together at Edge Hill University for the 5 Star Patient Experience Conference.

Chief Executive, Rob Cooper, opened the event, explaining how important it is to make sure every patient has the best experience possible during their time with us. His words set the tone for the day, inspiring everyone to remember the huge difference we make to the lives of our patients and their families.

Each Division, alongside several teams such as Patient Advice and Liaison Service (PALS), Spiritual Care, Dementia and Delirium, the Patient Experience Team and Learning Disabilities practitioners showcased some of the fantastic initiatives we have in place across MWL which helps us to achieve our vision of 5 Star Patient Care.

3.4 Complaints

MWL takes patient and carer complaints and feedback extremely seriously. Staff work hard to ensure that any concerns are acted on as soon as they are identified and that there is a timely response to resolve issues at the earliest opportunity. Concerns, complaints, comments and feedback are raised either at a local level, via the Trust's two PALS Teams, or through the Chief Executive's 'AskRob' process.

Matrons, Ward and Departmental Managers are available for patients and their carers or representatives to discuss any concerns and to provide timely resolution to ensure patients receive the highest standards of care. In every area across the Trust there is a Patient Experience noticeboard to highlight how patients and carers can raise a concern.

Regrettably, sometimes patients or their carers may wish to raise a formal complaint. These are thoroughly investigated and afterwards complainants are provided with a comprehensive written response. Complaints leaflets are available across the Trust and information on how to make a complaint is also available on the Trust website. MWL has a current target to respond to formal complaints within 60 working days, where appropriate. During the reporting period there have been an increased number of resolution meetings held with senior staff and complainants which has led to complaints being resolved as early as possible.

	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4
MWL First stage complaint	109	122	144	142	115	161	146	157
Second Response Trust Target Less than 12 per Q	14	13	12	27	16	16	19	20
Response Compliance Trust Target 80%	74.76%	57.44%	62.9%	64.6%	50.7%	71.6%	60.7%	64.8%
MWL number of complaints breached 60 working timeframe	28	52	54	50	57	34	77	63

Complaint Themes

Themes of Closed Complaints (Top 5)	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4
Clinical Treatment	69	63	61	54	66	73
Patient Care (Nursing)	18	20	19	17	21	27
Values & Behaviours	14	6	2	5	6	13
Communication	21	14	14	21	22	20
Admission & Discharge	0	1	9	4	9	25

**Figures correct at time of reporting from InPhase*

In 2025-26 the Trust received 579 new complaints. This is an increase to the previous year during which the Trust received 517 new complaints.

During 2025-26 the Trust has received 71 complaints back for Stage 2 further investigation. This is an increase in comparison to the previous year when the Trust received 48 complaints.

MWL has achieved total compliance of 60% against the timescale of 60 working days during 2025-26. Significant work has been undertaken by key staff at the Trust who are committed to reducing the time taken to respond to complaints, to play a pivotal role in the drive to improve patient experience. Early resolution has increased significantly and Divisional Leads and the Head of Complaints meet with complainants regularly to address issues head on and offer apologies, resolution and inform service improvement.

Figures are reported monthly and subsequently summarised in quarterly reports and complaints cases may be subject to change as per complainants wishes. Because of this, figures may be subject to change and therefore minor variances can occur between reporting periods.

3.5 Our volunteers

The contribution made by our Volunteers cannot solely be quantified by data but also by the rich experience made to patients and carers, relatives, visitors, and staff through their service to the Trust. MWL recognises the impact our volunteers make for people who use our services.

Providing opportunities to volunteer at MWL also benefits individuals who choose to

give up their time to help others. Volunteers complement our workforce and provide a valuable contribution to providing a better experience for our people.

During 2025-26 the Volunteer Service has delivered:

Our roles

Butterfly Volunteers

Launched in June 2024 in partnership with the Anne Robson Trust, the team have provided over 1100 hours of bedside support to 1773 people (488 patients and 1285 visitors) since the service began. Further funding has been secured to enable the project to continue beyond the initial 2-year pilot, with the aim of providing companionship to patients identified as being in the last days and hours of life.

Feedback continues to be positive, and a family member commented that the butterfly volunteers “are like angels who put their wings around my husband and I”.

Families have welcomed the opportunity to be offered respite from bedside, giving them the chance to go home, update family members or just have a bite to eat. Clinical staff are appreciative of the service, an Emergency Department nurse said “ I just wanted you to know about a patient who died in ED Resus and had no next of kin. We were thankful that someone could sit with him while we dealt with other emergencies. The volunteer sat and played music and read to him and it was such a weight off our shoulders that he wasn’t alone”.

Discharge Support

The Volunteer discharge support service at Southport Hospital continues to provide targeted support to patients that are 48 hours post-discharge via telephone. This can often result in engaging with community-based services to provide additional support to the patient.

AGE UK referral feedback

'Just a quick email to say thank you again for your referral for this lovely lady earlier in January. Over the last few weeks, I have been out to visit three times and kept in touch on the phone in-between.

Support given to signpost to the Alzheimer's society for her husband and made referrals to community OT / Physio for support with moving and handling assessments etc to look at providing support /aids etc. I have also helped with completion of a Blue Badge application.

Both OT and Physio teams have been in touch and due to go out to see them next week and the Alzheimer's Society have also arranged a visit to see the family next week.'

Dining Companions

We currently have 11 active volunteer dining companions across Whiston and Southport hospitals. Our dining companions play a crucial role in the hospital; encouraging and enabling patients to eat and drink, therefore helping to reduce the risk of malnutrition and dehydration. Staff welcome the addition of this assistance, and their feedback is very positive.

Voice of the Volunteer

The Annual Volunteer Survey produced many positive areas, when asked what they found most rewarding about volunteering with MWL, responses included:

Helping visitors to the hospital, be they outpatients or family/friends visiting inpatients. Meeting with NHS staff who our role brings us into contact with.

Knowing that being there with a patient or other's is helping. Knowing that the support is there if needed.

An opportunity to interact with a range of diverse individuals. Dealing with situations that demand I analyse situations and attempt to identify solutions.

During 2025-26 quarterly forums have been introduced to provide additional opportunities for our volunteers to provide feedback. The volunteers are encouraged to come along, meet their fellow volunteers and share experiences. These forums allow for any concerns or suggestions to improve the service to be shared in a relaxed environment.

Training our Volunteers

Mandatory Training

During Q3 & Q4 of 2025-26 we have added our volunteers' details onto the NHS Electronic Staff Record (ESR) with a mandatory training profile. The training profile consists of 14 modules including Oliver McGowan training. This has resulted in the departure from using paper-based training methods to completion of on-line training modules. Movement to the use of ESR and the associated reporting tools, allow the Volunteer Service Managers to quickly identify those Volunteers who require support to complete their training and keep our patients and service safe and compliant.

Regular reminders will then be sent directly to the Volunteers to advise when any of their mandatory modules are due to expire. This results in a more effective use of the Volunteer Service Managers time and will improve compliance for training.

Supplementary Training has been arranged by our Volunteer Service managers with subject matter experts throughout the Trust. The delivery of this training is a direct result of patient or volunteer feedback.

Deaf Awareness Training

Training is delivered by Merseyside Society for Deaf People. The training explores the different types of deafness and the technology that is available. The session provides practical tips when lip reading and teaches basic signs. Volunteers assist patients and visitors every day and delivery of this training has raised awareness and confidence levels within the volunteer team.

Sight Loss Training

This is delivered by the MWL Liaison Officer at the Rennie Eye Clinic. The sessions are offered to all volunteers; however, attendance is not compulsory. The training is face to face for 90 minutes and feedback received is very positive. The training explores the practical and emotional impact of sight loss and the principles of Sighted guiding and use of canes.

Comments from the Volunteers include:
'I would be happy to put this in practice' and *'Very well understood, the speaker was interesting and engaging'*

Wheelchair Training

This is arranged and delivered by the Moving & Handling Lead and takes 30 minutes. The training consists of a wheelchair presentation, with direction on the correct procedures when assisting wheelchair users. The H&S aspects of using a wheelchair and how to report a broken wheelchair are all covered in the session.

3.6 Patient safety

MWL continues to promote a safety improvement culture and to learn from safety incidents to reduce the risk of harm, improves safety outcomes and thus improve the experience of our patients across MWL

The Trust introduced one incident management system in March 2025 which has enabled us to measure consistently across all MWL sites for incidents as well as risk. The incident management system has been developing throughout 2025-26 to ensure staff members are supported in its use and reporting numbers have improved the year.

We have expanded on the number of multi-disciplinary meetings to review incidents, identify learning and agreed on actions which has resulted in more variety of reviews and a reduction in Patient Safety Incident Investigations which have been focussed on our priorities as laid out in our Patient Safety Incident Response Framework Plan (PSIRP) for 2024-26.

We have introduced divisional safety meetings across all divisions in the year 2025-26 as part of our tiered approach to safety which also includes daily triage of events with divisional colleagues.

We have taken the opportunity to share the learning from our Never Events at Cheshire and Mersey level to spread knowledge as well as cooperate with other providers with similar incidents as part of system learning.

3.6.1 Falls

The falls team continues to develop strategies to minimise the occurrence of inpatient falls. The Trust has continued with falls reduction improvement actions and has achieved 6.34 falls per 1000 bed days for 2025/26. Compared with 2024/25, Trust achieved a 32 percentage reduction in falls resulting in harm, with falls with harm of 0.118 per 1000 bed days for 2025/26.

A Trust Falls Prevention Framework for 2026/27 has been developed by the Falls Improvement Group. The Framework has a focus on 5 key areas for improvement:

- Ensure all care measures are in place for every patient.
- Ensure supplementary care is in place at the time of a fall.

- Ensure post fall manual handling of patients is appropriate.
- Demonstrate a culture of Improvement and learning.
- Ensure adequate and appropriate education and development is in place for all staff who care for patients.

The Falls team has continuously provided staff with support, education and guidance to ensure the improvement action plan is completed. Furthermore, the Falls team undertake proactive reviews of falls care standards in areas with reported higher falls numbers and to those areas where support is requested. Real time audits and training are in place to help with culture and learning on wards and areas.

The Trust implemented a decaffeinated hot beverages pilot for patients on six inpatient wards across the Trust. Decaffeinated drinks were offered as the first line option for patients, to reduce bladder irritability and urgency. Positive feedback was received from patients. The Trust plans to roll out availability of decaffeinated drinks preferred option for patients at high risk of falls, across all of our sites in 2026.

Falls prevention training continues to be provided to newly qualified nursing staff, junior doctors and healthcare assistants, as part of the induction programmes. This includes updating and training staff on various medical equipment and manual handling devices.

Trust falls team is an active member of the Northwest Regional Falls Nurse Forum. The forum provides an opportunity for all members to share best practice and news on national and local initiatives in falls prevention roles across the region.

3.6.2 Pressure Ulcers

The Trust has continued to focus on reducing the risk of patients developing hospital acquired pressure ulcers.

Key highlights the main activities implemented in year to improve performance and improvements

- Weekly pressure ulcer prevention training
- Continued support to preceptorship training
- Specialist training to high-risk areas including Emergency Department
- Equipment training
- End of life care training for prevention of skin breakdown
- Moisture lesion training
- TVN team support with Pressure Ulcer prevention intervention
- Harmonisation of dressings
- Harmonisation of bed and mattresses

Tissue Viability Team also hosted awareness sessions on International Stop the Pressure Day in November 2025.

The Trust also provides specialist Tissue Viability Nursing Service for St Helens Community Service. The team supports and provides skill enrichment to residential and nursing care homes and domiciliary care service teams in the Borough.

3.6.3 Venous thromboembolism (VTE)

VTE covers both deep vein thrombosis (DVT) and the possible consequence, pulmonary embolism (PE). A DVT is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the blood stream it can travel to the lungs and cause a blockage (PE) that could lead to death.

The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action. This might include prescribing and administration of appropriate medication to prevent blood clots and application of specialised stockings.

National reporting for VTE risk assessment compliance was recommenced in 2024/25 after a pause following the Covid-19 outbreak. For the year 2025/26 VTE risk assessment cumulative compliance for the year was 85.98%.

The Trust continues to support timely completion of VTE risk assessment and VTE prevention intervention:

- Significant progress has been achieved in the transition of VTE risk assessments from Careflow to the Electronic Prescribing and Medicines Administration (EPMA) system. Completion of a VTE risk assessment is now a mandatory requirement before any prescribing activity can take place on EPMA-enabled wards/locations.

- Clinicians have been advised to complete these assessments proactively for all admitted patients, either in advance or during the working day, to avoid delays during prescribing or ward rounds.

- The VTE Team will continue to review compliance data, identify areas where further improvement is required, and work with services to develop targeted action plans to strengthen performance Trust-wide.

- Ongoing VTE training including Moodle-based online learning for all clinical staff.

- Face to face training for new starters to the Trust.

3.6.4 Sepsis

Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Improving early identification and timely administration of antibiotics of patients with sepsis is a key patient safety and quality objective.
To improve antibiotic compliance, we have implemented a Trustwide quality improvement project and there is a Trustwide sepsis group along with a ratified MWL sepsis policy. Our sepsis clinical leads are also working with the clinical audit team to create an MWL inhouse data collection tool using AMaT that will enable timely review of sepsis patients across the Trust.

3.6.5 Medicine safety

Alongside members of the MDT, the Pharmacy Department has continued to lead on the safe provision of our medicines to our patients, with a number of actions taken as outlined below.

Electronic Prescribing and Medicines Administration (ePMA)

The ePMA system is being developed and expanded, with plans to unify systems across sites by 2026-2027 to improve medicines management processes. Since October 2025 ePMA has been live in all patients on the Intensive Care Unit at Whiston whilst the potential to utilise ePMA in maternity and paediatrics has been raised as a future project.

A pilot of transcribing discharge prescriptions directly from ePMA and subsequently into ICE has been ongoing since November 2025 on floor 5 at Whiston, with further roll out planned from April 2026 giving a much more efficient discharge process.

Pharmacy digital transformation (at Whiston, St Helens and Newton sites, and Southport Spinal Unit)

Ward Dashboards continue to integrate data from multiple systems to prioritise clinical pharmacy tasks, reduce missed doses, and optimise medicines management. Artificial Intelligence (AI) driven notifications and robotic process automation have enhanced workflow efficiency and patient safety at our Whiston and St Helens sites.

Power BI which is an interactive data visualisation programme provides dashboards that are real-time highlighting operational insights, and the Drug Finder electronic resource was updated in 2025 to aid medication location across sites, improving staff efficiency and reducing delays.

Homecare and Artificial intelligence (AI)

Our Digital HSJ awards nominated AI-enabled robotic process automation was introduced to transform the hospital homecare prescription workflow, replacing a slow, manual, paper-based system that caused delays, duplication, and governance risks. The solution automatically uploads prescriptions into the patient record in real time. It has processed over 5,000 prescriptions with 98% accuracy, reduced handling time dramatically, and released 7.5 staff hours per week.

Medicines Safety

The Medicines Safety team continue to provide an exemplary service to the Trust with highlights such as:

- Quarterly safe and secure handling audits of wards, with plans to align to Trust's 5 Star accreditation process.
- Cross site medicines safety bulletins
- Started 'tip of the month' cascade of medicines safety messages across prescribers/pharmacy/nursing safety huddles/link nurse meetings/global news
- Critical medicines guidance cards updated for use across MWL.
- Development of paediatric and neonatal drug error reduction system (drug library) for rollout at Ormskirk, with plan to extend to StHK sites after pilot.
- Contribution to Patient Safety Incident Review (PSIR) and Investigations (PSIIs), pharmacy representation at weekly patient safety panel, divisional patient safety meetings and the monthly patient safety council
- Thematic reviews of serious incident medicines priorities, insulin
- Missed doses audits presented at medicines safety group.
- Ongoing work to review NHS England's (NHSE) enduring standards to benchmark and align processes across MWL.
- Artificial Intelligence (AI) supported oversight of MHRA medicines recalls and assurance these are dealt with in a timely manner.
- Work with risk department regarding timely management of national patient safety alerts.
- Contribution to IV access group including review of extravasation policy
- Re-introduced link nurse group, extended to Southport and Ormskirk hospital sites, so now an MWL group.
- Medicines Safety Week: 3-9 November Focus on "five rights" of medicine safety, and reporting medicines reactions and device defects, and drug library. Trust team takeover and educational materials/stalls.
- InPhase dashboard set up and functioning well. Reviewed at monthly Medicines safety group meetings
- Top third contributor to regional yellow card reporting scheme, with highest variability in region on professions reporting (i.e.outside of pharmacy team).

Clinical Pharmacy

Work has been ongoing to harmonise clinical practice across our sites with the extensive review of clinical standard operating procedures, guidelines and policies to enable staff to work to one consistent standard within clinical services. This will be further realised when ePMA is rolled out to the Southport and Ormskirk sites. Specialist pharmacists frequently collaborate to facilitate common clinical pathways across all sites.

Developments in 2025-2026 include:

- Discharge medicines service to prompt follow-up of patients by community pharmacists continues to perform well.
- Combined weekly clinical education sessions
- Combined pharmacy audit meeting
- Constant review of clinical pharmacist staffing resource to re-allocate staff to priority areas (increased pharmacist presence on the ED at Southport site, increased pharmacist establishment at the Ormskirk site, increased support to women's and children's services at Whiston site)
- Falls and AKI reviews of patients by clinical pharmacists.
- Specialist inpatient diabetes and pain reviews (Southport only) are embedded in practice.
- Specialist pharmacists managing own caseload for gastroenterology outpatients.
- Consultant pharmacist and other pharmacist colleagues providing input to frailty and virtual wards.
- Active pharmacist involvement in antimicrobial stewardship programme on both acute sites.
- Introduction of one neonatal drug chart across MWL sites.
- Improved external profile through regular attendance and presentation at national conferences

Antimicrobials

In support of the antimicrobial resistance (AMR) agenda,

- Antibiotic guidelines (adult, paediatric, and neonatal) continue to be delivered via the EOLAS medical device platform.
- The IVOST clinical decision support tool has been tested and successfully launched within the EOLAS platform to support IV-to-oral antibiotic switch decisions. There are several important benefits to IVOST, including decreased risk of bloodstream and catheter-related infections, reduced equipment costs, carbon footprint and hospital length-of-stay, increased patient mobility and comfort, and released nursing time to care for patients.
- Pharmacists remain actively involved in the antimicrobial stewardship programme across both acute sites, undertaking ward rounds in medicine, surgery, and virtual wards, including OPAT services as well as weekly attendance at Infection Prevention and Control (IPC) Panel to support with the learning reviews, system improvements and dissemination of learning.
- The paediatric antimicrobial policy was reviewed and relaunched in 2025.

- A Trust-wide point prevalence audit is conducted annually 6-monthly, with learning, ward-level feedback and any systems improvements and root cause analysis provided bi-monthly through the Hospital Infection Prevention Group (HIPG).
- MWL Trust MRSA and related infection control policies were aligned in 2025.
- The Trust continues to deliver education events across all sites, including initiatives such as World Antimicrobial Resistance Awareness Week (WAAW).
- OPAT business cases are in development to support expansion of the MWL service across all our geography.

Pharmacy

In addition to the above there have been a number of significant improvements specifically to the pharmacy team and pharmacy environments:

- The Medicines Information service is now merged and based at Ormskirk site.
- The new pharmacy robot at our Southport site is due to come on line by Easter 2026.
- MWL Pharmacy SOP alignment continues to progress alongside Policy harmonisation.
- Monies have been awarded from NHSE to introduce a Consultant Microbiology Pharmacist to support the AMR agenda within MWL and across our Places.

3.6.6 Infection prevention and Control (IPC)

The Health and Social Care Act 2008 requires Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infections (HCAI). The Trust's Director of Infection Prevention and Control (DIPC) reports to the Chief Nursing Officer and Board level responsibility for infection control. The position of a designated Director of Infection Prevention and Control (DIPC) was formally appointed to in January 2025.

The Trust's infection prevention priorities are to:

- Reduce the incidence of healthcare associated infections.
- Adopt and promote evidence-based infection prevention and control practice across the Trust.
- Identify, monitor and prevent the spread of pathogenic organisms, including multidrug-resistant organisms throughout the Trust.
- Reduce the incidence of HCAI by working collaboratively across the whole health economy.

The Infection Prevention and Control Team provides expert advice to the organisation regarding all aspects of IPC, including national policy initiatives and the development and implementation of the HCAI Annual Plan with key stakeholders.

The NHS Standard Contract for 2025/2026 outlines the reportable healthcare associated infections, and the combined threshold for the Trust is as follows.

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

Trust performance against NHSE objectives

MWL YTD	HOHA	COHA	Total	
MRSA	3	1	4	Above threshold (x 4 cases)
MSSA	57	21	78	No threshold set (12 cases less than previous year)
CDT	70	39	109	Above threshold (x 12 cases)
E coli	84	77	161	Above threshold (x 10 cases)
Klebsiella	27	20	47	Above threshold (x 2 cases)
Pseudomonas	10	5	15	Above threshold (x 1 cases)

MRSA bacteraemia

A zero-tolerance approach is still in place to support no MRSA bacteraemia. Reducing MRSA bacteraemia remains a Trust Quality Objective as laid out in the Quality Account 2025-26.

Disappointingly, there have been 4 healthcare-associated MRSA cases during the period April 25 to March 26. This is a reduction of 3 cases compared to last financial year.

Hospital associated MRSA bacteraemia 2025/26

Case	Date	Attribution	Dept	Site	Source	Avoidable
1	22/04/25	Hospital (HOHA)	7B	Southport	Shoulder joint	No
2	04/09/25	Hospital (HOHA)	3B	Whiston	Prosthetic hip	Yes
3	08/02/2026	Community (COHA)	ED	Whiston	Contaminant	No
4	17/03/2026	Hospital (HOHA)	1D	Whiston	Cannula	Awaiting outcome

MSSAb.

There is no NHSE threshold for MSSAb however, the Trust set a 10 % reduction on the previous year's number of cases. MWL had 79 cases (57 and 22 COHA) which is a reduction of 11 cases from the 90 cases in 2024-25. (12.1% reduction).

The Bloodstream Infection Improvement Plan was implemented in 2025/26 is in progress. Prompt identification and management of sepsis is a key action, with measures of NEWS and Sepsis 6 monitored to provide assurance. VIP monitoring compliance is a key measure within the Bloodstream Infection Improvement Plan and the Trust Quality Objective for MRSA reduction. The VIP score is a validated tool used to assess and manage early signs of phlebitis in patients with peripheral intravenous catheters.

Tendable compliance data for each quarter is in the table below:

Quarter	**VIP % Compliance**
Quarter 1	84.81%
Quarter 2	80.22%
Quarter 3	84.75%
Quarter 4	83.34%
Average annual compliance	83.28%

This is below the Trust's target of minimum 90% compliance, however cannula-related bloodstream infections have reduced compared to previous financial years, with 1 potential MRSA-attributable cases to be confirmed.

Prompt identification and management of sepsis is a key action within the Bloodstream Infection Improvement Plan, as one of the most common themes within IPLR reviews. The most recent data available is Q3 compliance and indicates a slight reduction in compliance with timely blood cultures and antibiotic treatment compared to Q2. Microbiology tests within 1 hour for severe diagnosis and 3 hours for moderate diagnosis was 74.4%, and antimicrobials given within 1 hour of severe diagnosis and 3 hours for moderate diagnosis was 60.3%.

Aseptic Non-Touch Technique (ANTT) is a standardised clinical practice framework designed to ensure safe and effective aseptic technique during invasive health care procedures. ANTT compliance for Levels 1 and 2 training has reduced slightly at the end of Q3. Level 1 e-learning is below the Trust target at 88.5% while Level 2 (practical) meets the target at 83.6%. ANTT compliance is monitored within the divisional IPC meetings and any need for improvement in compliance is discussed at the weekly IPLR meetings, as individual cases are discussed. .

IPC Level 1 e-learning compliance was 89.2% in February 2026 which is above the Trust target of 85% minimum. Level 2 e-learning compliance for clinical staff was 85.3% therefore achieved the Trust target in February This will remain an area of focus for divisional teams with assurance to HIPG.

The IPC Team continues to raise the need for improvement with ANTT and IPC

mandatory training at IPLR reviews and at Divisional IPC Governance meetings.

Clostridioides difficile (CDI)

The C. difficile NHSE threshold for MWL is for no more than 97 cases in year. There were 108 healthcare-associated cases which related to 70 HOHA and 38 COHA cases, and the Trust is above NHSE threshold by 11 cases. This represents a decrease of six cases compared to the previous year (114).

The regional UKHSA benchmarking data indicates that MWL is the only large acute Trust in C&M below the C&M rate from Q1-Q3.

The IPC Team continues to support wards and departments with improving diarrhoea management (timely testing and isolation) across the Trust.

The Consultant Nurse IPC continues to represent the Trust at the Cheshire and Mersey IPC Provider Collaborative (CMAST), which developed a C. difficile Toolkit, which includes standardisation of the approach to diarrhoea management and testing, cleaning and Antimicrobial Stewardship (AMS).

All cases of hospital-associated C. difficile undergo infection prevention learning review (IPLR). Themes in these cases are largely unchanged, with the most common lessons identified in the timely isolation and stool testing of patients, and antimicrobial stewardship in some cases.

The Infection Prevention Team undertakes a programme of clinical practice and environmental audits, to provide assurance on compliance with key standards and to identify areas where improvements can be made.

E. coli

The NHS Standard Contract for 2025-26 outlines the E. coli threshold for MWL for no more than 151 cases in year. The trust reports there has been 161 healthcare-associated cases (84 HOHA and 77 COHA) which is 10 cases above NHSE threshold, and 3 cases above the same period last year (158).

In the most recent comparative data available, in Q3 the MWL rate of 35.2 per 100,000 bed days is below the C&M rate of 40.3. MWL has been below the C&M rate for the last four quarters, and the E. coli bloodstream infection (BSI) improvement plan was closed.

Klebsiella

The NHS Standard Contract for 2025 -26 outlines the Klebsiella threshold for MWL for no more than 49 cases in year. The trust has reported 46 cases (27 HOHA and 19 COHA) healthcare-associated cases which is 3 cases below NHSE threshold and 7 cases above the same period 2024-25 (47).

Following an increased incidence of cases over the summer months the Trust is now identified as a low outlier in Cheshire and Merseyside.

A revised IPLR process is also being trialled in collaboration with divisional leads, using an after-action review (PSIRF) template. The aim of this to identify learning in a timelier manner and to engage with clinicians and clarify decision making regarding patient management while they remain inpatients.

Pseudomonas

The NHS Standard Contract for 2025 -26 outlines the Pseudomonas threshold for MWL for no more than 14 cases in year. The trust has reported 15 (10 HOHA and 5 COHA) healthcare-associated cases which is 1 case above NHSE threshold, but equal to the same period of 2024/25.

There was a period of increased incidence of infection in Q1, and water safety and related clinical practices were reviewed in the clinical areas, who have not had any further cases since then.

Outbreak management

There were 127 outbreaks during April 2025 to March 2026 at MWL, with the majority relating to respiratory infections, and Norovirus.

This increase in outbreaks corresponded with widespread community transmission of Influenza A and Norovirus and impacted significantly on both operational and staffing pressures. The IPC team work in collaboration with operational managers and clinical teams to ensure prompt isolation of patients and specimen collection were possible to reduce transmission of infections). The IPC team provided comprehensive support throughout each incident, implementing enhanced cleaning procedures and ensuring that all affected wards received the appropriate level of decontamination. Norovirus-related outbreaks resulted in bed closures, creating pressure on patient flow. To help mitigate this impact, the IPC team has continued to support operational flow through regular coordination meetings.

Covid and influenza

There were 19 Covid and 10 Influenza and 5 influenza and Covid outbreaks across MWL during 2025-26.

Hospital Onset COVID infection (HOCI) includes three categories for determining Hospital Onset covid infections:

- Hospital-Onset Indeterminate Healthcare-Associated (HO-iHA) – First positive specimen date 3-7 days after admission to trust.
- Hospital-Onset Probable Healthcare-Associated (HO-pHA) – First positive specimen date 8-14 days after admission to trust.

- Hospital-Onset Definite Healthcare-Associated (HO-dHA) – First positive specimen date 15 or more days after admission to trust

There were 87 definite and 51 probable health care associated Covid infections at Whiston, St Helens and Newton sites during 2025-26 with the peak in September and October months , this was significantly lower than Southport and Ormskirk (predominately Southport) who had 179 definite and 84 probable health care associated Covid infections with peak months between June to December, lack of side rooms will have contributed to ability to isolate the patients.

Cases of influenza A have continued to rise across MWL from October, with legacy Whiston, St Helens and Newton experiencing a notable increase from 294 cases in November to 418 cases in December There was a total of 883 cases confirmed in Q3, of which 4.5% of cases sites were healthcare-associated.

In Q3 there were 352 cases confirmed at the Southport and Ormskirk sites, with healthcare-associated cases representing 15% of cases.

This upward trend was also highlighted during the NHSE IPC Regional Network meeting, where it was acknowledged that case numbers during December exceeded the national average.

To support winter respiratory viruses the following is in place;

- Increased laboratory testing at the Southport & Ormskirk sites
- The Viral Respiratory Infections Policy
- IPC Team working closely with operational and Patient Flow teams
- Staff vaccination arrangements
- Staff Filtering Face Piece (FFP) fit testing. Fit testing is a practical examination to ensure face masks can properly seal around a wearer's face and is therefore suitable for the individual.

At the Winter Debrief summit it was identified that IPC would be a key objective in planning for next winter.

To support winter respiratory viruses the following is in place;

- Increased laboratory testing at the Southport & Ormskirk sites
- The Viral Respiratory Infections Policy
- IPC Team working closely with operational and Patient Flow teams
- Staff vaccination arrangements (led by HWWB)
- Staff FFP fit testing

IPC Audit

IPC practices and the clinical environments continued to be audited by the IPC Team in Q3. Feedback is given directly to clinical teams and reported within divisions. The

IPC Team has worked collaboratively across the legacy IPC teams, to align the MWL IPC Audit programme, to address key priorities and lessons from infection and outbreak reviews.

Clinical areas are required to submit hand hygiene, PPE, and cannula audits monthly via the Tendable app. Audit findings are presented within the legacy Trusts IPC reports. The IPC Team is working on the harmonisation of these reports across the Trust to support divisional governance processes.

Improvements in the IPC Practice and Environment audits are required as the majority of areas are scoring less than 90% (see audit report). The IPC Team is supporting individual areas with IPC improvements, delivering training, engaging the wider MDT and support teams (e.g. Estates and Facilities), and considering human factors and ergonomics in driving improvement in clinical IPC.

These audits are reported within the divisional IPC meetings and action plans monitored.

Further achievements for 2025-26 included:

The Infection Prevention Team works collaboratively across the MWL Trust, with a focus on harmonising policies and guidance to ensure standardised and reliable IPC practice.

The revised Infection Prevention Learning Review (IPLR) process has been embedded across all sites for hospital-associated CDT cases, and MSSA, E coli, Klebsiella and Pseudomonas HOHA bloodstream infections. The aim is to support the PSIRF principles and to assist with thematic review across MWL, to identify further areas for improvement regarding healthcare-associated infections.

As part of the MWL Mandatory Training project, ANTT has now been harmonised with alignment of the delivery model, frequency and staff groups who require training.

Proactively responded to the endemic and emerging infections e.g. mpox, tuberculosis and measles, ensuring appropriate surveillance and management of the patients presenting to the Trust.

The IPC Team plays a key supportive role in the Trust's clinical accreditation programme.

The IPC Team supports a network of IPC link practitioners and delivers regular education sessions and study days to develop their knowledge and skills.

Improved engagement with ward leaders to optimise the clinical environment for patients, with a programme of 'estates walkarounds', with the Estates Team and the IPC Team Matron.

Support from the IPC Team on the extensive capital estates projects, to improve the built environment for patients and staff across MWL.

The IPC Team continues to work closely with Trust sustainability leads and Procurement to seek further efficiencies, both financially and in terms of driving the sustainability agenda e.g. improving waste streaming and standardising hand hygiene and cleaning products.

3.6.7 Being Open – Duty of Candour

The Trust is committed to ensuring that we tell our patients and their families/carers if there has been an error or omission resulting in harm. This duty of candour is a legal duty for Trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust promotes a culture of openness, honesty and transparency. Our statutory duty of candour is delivered under the Trust's Being Open - A Duty of Candour Policy, which sets out our commitment to being open when communicating with patients, their relatives and carers about any failure in care or treatment. This includes an apology and a full explanation of what happened with all the available facts. The Trust operates a learning culture, within which all staff feel confident to raise concerns when risks are identified and then to contribute fully to the investigation process in the knowledge that learning from harm and the prevention of future harm are the organisation's key priorities.

The Trust's incident reporting system has a mandatory section to record duty of candour. Weekly incident review meetings are held, where duty of candour requirements are reviewed on a case-by-case basis allowing timely action and monitoring. This ensures the Trust meets its legal obligations.

The Trust has continued to raise the profile of duty of candour through the lessons learned processes and incident review meetings. In addition, duty of candour training is included as part of mandatory training and investigation training for staff.

3.6.8 Never events

Never events are described as serious incidents that are wholly preventable by NHS England in the 2018 framework. Each never event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a never event.

The Trust remains committed to understanding the cause of these incidents through comprehensive investigation. This approach is underpinned by the Trust's commitment to ensuring an open and honest culture in which staff are encouraged to

report any errors or incidents and to feed back in the knowledge that the issues will be fairly investigated, and that any learning and improvement opportunities will be implemented.

The Trust reported four never events in 2025-26, which met the criteria.

Incident	Date of Incident	Harm Level
Insulin Never Event	June 2025	Low
Wrong site nerve block	September 2025	None
Wrong site nerve block	January 2026	Low
Wrong implant	February 2026	None

The Trust has also extended its focus on learning from never events to a targeted approach on improving processes in theatres and other clinical environments where invasive procedures are performed. This has led to the formation of the Invasive Procedures Working Group which endeavours to improve safety by reviewing current best practice whilst taking into account the principles of NatSSIPS2. The group has senior clinical leadership representative and is underpinned by Quality Improvement (QI) methodology. The key drivers for this area of improvement are the recent never events and the learning identified following investigation.

Learning from these incidents was identified using Systems Engineering Initiative in Patient Safety (SEIPS) methodology to minimise chances of a such an incident happening again in the future. This methodology is part of the national PSIRF toolkit and is a well-recognised and endorsed system-based model.

A number of actions were identified and implemented. These include reviewing and updating the policy for the Local Safety Standards for Invasive Procedures (LocSSIP) and local safety checklists and enhancing the pause/stop moment for local anaesthetic procedures. In March 2026, the Medical Director for the Surgical Division oversaw an extraordinary theatre audit event, opened by the Chief Medical Officer, which focused on improving safety in theatres with interdisciplinary presentations on civility, check lists, themes from reviews and human factors in theatres.

3.6.9 Theatre safety

The Trust Operating Theatre Department continues to develop and refine patient safety initiatives in keeping with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs), to reduce the number of patient safety incidents related to invasive procedures.

The department has reported 3 incidents meeting Never Event criteria in 2025-26, which relate to wrong implant insertion and 2 incidents of wrong site nerve block. There has not been any identified long-term harm to the patients affected as a result of these incidents.

All incidents have been subject to an in-depth Patient Safety Incident Investigation (PSII) in accordance with the Patient Safety Incident Response Framework (PSIRF). Careful evaluation of systems and pathways using Systems Engineering Initiative in Patient Safety (SEIPS) has been undertaken and learning shared across all theatre teams.

As an outcome of the trends with the Never Events an extraordinary theatre audit event was held on 11 March 2026 and was led by the Chief Medical Officer and the Divisional Medical Director for Surgery.

The session focused on shared learning from Never Events and included:

- Adherence to Theatre Safety Checklists across the patient pathway
- Scenario-based demonstrations
- Introduction to Human Factors and application within theatre environments
- Civility, respectful relationships, and the associated impact on patient outcomes

The event adopted an interdisciplinary approach, with contributions from Deputy Divisional Directors and the Central Patient Safety Team. Feedback was gathered from staff across Whiston and Southport sites to inform further improvement work across all MWL theatre locations.

3.6.10 Safeguarding

The Trust is committed to ensuring safeguarding responsibilities are carried out in line with legislation and national and local policy. There are dedicated Safeguarding Teams situated on different Trust sites. Within these teams there are Named Nurses and Named Midwifes for both children and adults supported by specialist safeguarding practitioners. Assistant Directors support the Chief Nursing Officer to ensure that the Trust is fulfilling its statutory safeguarding responsibilities.

The Trust has a suite of safeguarding policies, along with associated robust processes to protect unborn infants, children and young people and adults at risk (including those with a diagnosis of a learning disability and/or autism) from harm or abuse. In addition, there is a specific harmonised MWL Safeguarding Training Needs Analysis which identifies the level of training every staff member within the organisation must complete, including safeguarding adult and children training, mental capacity, deprivation of liberty, Prevent, and learning disability awareness. The Safeguarding Teams ensures there are processes in place to support patients who are unable to consent to care and treatment and require a formal capacity assessment and

authorisation of an urgent Deprivation of Liberty Safeguard (DoLS). This process has been digitalised across all sites, and all urgent authorisations and applications for a standard DoLS are quality assured and processed by the Safeguarding Teams.

The Safeguarding Teams maintain a visible presence across Trust sites and are available to offer advice, support and supervision to all staff. The Trust safeguarding key performance indicators (KPIs) are submitted on a quarterly basis and quality assured by the Integrated Care Board (ICB) Designated Nursing Team (St Helens and Sefton Places). During 2025-26, a red/amber/green (RAG) rating of green was given in all areas except safeguarding training compliance where at the end of Q4 there were 2 levels below the required 90%, with adult's level 3 at 87.1% and mental capacity that only fell below 90% in the last quarter to 88.3%,

The compliance for the Children in Care key performance indicator has been between 83% and 98% throughout 2025 -2026 which is an improvement from the previous year; The expectation in relation to initial health assessments for Children in Care is that 100% of children will receive their assessment within 20 days of entering the care system.
The Developmental Paediatric Team has taken steps to ensure that there is capacity to support appointments, however breaches are still an issue due to a number of children not being brought or having to re arrange appointments, as well as some late notifications from the Local Authority.

The ICB continue to support assurance in relation to safeguarding activity which has risen consistently across all areas demonstrating appropriate referrals and extensive multi-agency working. Quarterly safeguarding reports and an annual report are presented to the Quality Committee, and a safeguarding report is presented quarterly to the Clinical and Quality meeting for each Division.

The Trust provides representation at five local safeguarding partnership boards for adults and children, and to their associated subgroups. When required there is additional representation and contribution to adult and children multi-agency reviews, domestic abuse-related death reviews (previously known as Domestic Homicide Reviews) and theme specific multi-agency audits.

3.7 National Staff Survey

The National Staff Survey provides a key measure of the experiences of Trust staff, with the findings used to reinforce good practice and to identify any areas for improvement. For the 2025 survey, reported in 2026, the Trust conducted a full census staff survey. 3835 completed questionnaires were returned giving a 35% response rate.

Eligibility to participate in the NHS Staff Survey continues to include Bank workers in NHS organisations, using a tailored version of an online questionnaire. Eligibility was based on Bank workers who had worked in the six months between 1 March 2025 and 1 September 2025 and who did not have a substantive or fixed term contract. Out of

the 1344 people the survey was sent to, 150 people responded providing a response rate of 11%.

We are able to make comparisons with the Trust's benchmarking group, which comprises the data for 'like' organisations, weighted to account for variations in individual organisational structure. The Trust's benchmarking group comprises 122 organisations under the heading 'Acute and Acute & Community Trusts' although this does include a couple of specialist children's hospitals such as Alder Hey.

The survey questions remain related to the themes and sub-themes of the NHS People Promise with additional themes of staff engagement and morale retained from earlier surveys. The results give a wide picture of satisfaction across the whole organisation.

Results are reported both as individual question responses and as themes, aligned to the NHS People Promise which are:

- We are a team
- We are always learning
- We are compassionate and inclusive
- We are recognised and rewarded
- We are safe and healthy
- We each have a voice that counts
- We work flexibly

In addition, there are the two recurring themes:
- Staff engagement
- Morale

The results for MWL against the best/worst/average for our comparator group are shown in the chart below: *Scores are out of a scale of 10 with 10 being the best.*

Theme	MWL	Best Result	Average	Worst Result	
We are compassionate and inclusive	7.32	7.71	7.28	6.71	Above Average
We are recognised and rewarded	5.82	6.34	5.87	5.27	Below Average
We each have a voice that counts	6.60	7.12	6.60	5.93	Average
We are safe and healthy	6.17	6.58	6.07	5.51	Above Average
We are always learning	5.48	6.21	5.57	4.98	Below Average
We work flexibly	5.86	6.74	6.22	5.69	Below Average
We are a team	6.61	7.14	6.75	6.29	Below Average
Staff engagement	6.75	7.36	6.74	5.92	Above Average
Morale	5.90	6.42	5.84	5.06	Above Average

Results from the NHS Staff Survey have been disseminated to service leads, managers, and subject matter experts. Plans have been developed to implement improvements based on the feedback received.

Additionally, Staff Survey engagement is being scheduled at each site to engage with

staff and discuss the implications of the survey results.

3.8 Equality, Diversity and Inclusion (EDI)

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally underserved groups are not disadvantaged when accessing the services that the Trust provides.

The Trust's EDI Steering Group meets regularly to ensure compliance with all external standards, including those statutory requirements conferred on the Trust by the Equality Act 2010. The membership of the group is drawn from a wide range of staff from all disciplines, clinical, non-clinical, trade union representatives, Healthwatch representatives and members of the Trust staff networks.

The Trust is a member of the following external charter marks, accreditations and commitments, which are used to further our equality strategy:

- Armed Forces Covenant (re-signed 2023)
- Defence Employer Recognition Scheme (Armed Forces, gold accreditation 2024)
- Disability Confident Scheme, Leader (Level 3, reaccredited 2023)
- Dying to Work Charter (member, 2023)
- North West Anti-Racism Framework (Bronze, accredited 2025)
- NHS Rainbow Badge Accreditation (LGBT) (Bronze, accredited 2022)
- NHS Sexual Safety Charter (member, 2023)
- Veterans Aware (Armed Forces, reaccredited 2023)
- North West region Stroke Voices

3.9 Summary of national patient surveys reported in 2025-26

The national patient survey programme is run by the Care Quality Commission to gather data on patient feedback on patient experiences in healthcare settings. It aims to identify areas for improvement in care and treatment across the NHS. The surveys cover various aspects of the patient journey including access to services and treatment experiences.

National Inpatient Survey 2024	Published September 2025
National Maternity Survey 2025	Published December 2025
National Children and Young Peoples Survey 2024	Published May 2025
National Urgent and Emergency Care Survey 2024	Awaiting publication of report: November 2026
National Cancer patient experience survey 2024	Published June 2025
National General Practice GP patient survey 2025	Published June 2025

The full results for all the latest Care Quality Commission's national patient surveys

can be found on their website at www.cqc.org.uk.

National Inpatient Survey 2024

The 2024 National Inpatient Survey was undertaken between January and April 2024. 1186 patients aged 16 or over who had spent a minimum of one night in hospital in November 2024 were invited to give their views and feedback on the care they received throughout their admission.

352 invited participants completed the survey, which was a response rate of 30%. This was lower than the national average of 41%.

Of the 45 questions asked, MWL, about the same as other Trusts in 42 questions, 1 question somewhat worse than expected and 2 questions worse than expected.

The table below details the overall section scores:

Section	Trust Score 2023	Trust Score 2024	Trust Ratings
Admission to hospital	6.4/10	5.6/10	Worse than expected
The hospital and ward	7.5/10	7.510	About the same
Basic needs		7.9/10	About the same
Doctors	8.5/10	8.9/10	About the same
Nurses	8.2/10	8.4/10	About the same
Care and Treatment	7.8/10	8.3/10	About the same
Leaving Hospital	6.8/10	7.1/10	About the same
Kindness and Compassion	8.6/10	8.8/10	About the same
Respect and Dignity	8.8/10	8.9/10	About the same
Overall Experience	7.9/10	8.1/10	About the same

Question where MWL were somewhat worse than expected:

Question	Trust Score 2023	Trust Score 2024	National Average 2024
How long did you wait, in total, before you were admitted onto a ward?	No score new question in 2024.	4.5	5.6

Questions where MWL were worse than expected:

Question	Trust Score 2023	Trust Score 2024	National Average

			2024
How did you feel about the length of time you were on the waiting list before your admission to hospital?	6.6	5.5	6.9
How would you rate the quality of information you were given, while you were on the waiting list to be admitted to hospital? This includes verbal, written or online information	7.2	6.6	7.6

The following actions are being taken to improve results from the National Inpatient Survey:

- Improve the patient experience whilst being on a waiting list.
- Support patients to sleep well at night.
- Improve information and the experience of receiving care on a virtual ward.
- Improve information regarding medicines that patients take home from hospital.

National Maternity Survey 2025

The 2025 National Maternity Survey was undertaken between April and Aug 2024. 463 women aged 16 or over at the time of delivery who had given birth to a live baby between 1st and 28th February 2025 at Whiston Hospital, Ormskirk Hospital or at home, were invited to give their views and feedback on the care they received throughout their pregnancy journey.

141 invited participants completed the survey, which was a response rate of 35.79%. This was lower than the national average of 39%.

Of the 58 questions asked, MWL scored better than most Trusts for 3 questions, somewhat better for 1 question, about the same as other Trusts in 51 questions and 3 questions somewhat worse.

The table below details the overall section scores:

Section	Theme	Trust Score 2024	Trust Score 2025	Trust Ratings
Antenatal Care	Start of care during pregnancy	6.8	7.4	About the same
	Antenatal check-ups	7.8	8.2	About the same
	During your pregnancy	8.0	8.4	About the same
Labour and Birth	Your labour and birth	8.0	8.6	About the same
	Staff caring for you	8.1	8.7	About the same
Postnatal Care	Care in the ward after birth	6.6	6.8	About the same
	Feeding your baby	7.8	8.3	About the same

	Care at home after birth	7.7	7.9	About the same
Triage	Assessment and evaluation	New question in 2025	7.8	About the same
Complaints	Complaints	6.4	6.6	About the same

Questions where MWL performed better than expected:

Question	Trust Score 2024	Trust Score 2025	National Average 2025
If you raised a concern during labour and birth, did you feel that it was taken seriously?	7.9	9.1	8.2
Thinking about your care during labour and birth, were you treated with respect and dignity?	8.8	9.7	9.2
Thinking about the last time you attended triage in person, how did you feel about the length of time before you waited to be seen by a midwife?	New Question	7.7	6.4

Questions which scored somewhat better than expected:

Question	Trust Score 2024	Trust Score 2025	National Average 2025
If, during evenings, nights or weekends you needed support or advice about feeding your baby, were you able to get this?	6.0	7.4	6.3

Questions which scored somewhat worse than expected were:

Question	Trust Score 2024	Trust Score 2025	National Average 2025
During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	8.1	8.4	9.0
Thinking about your stay in hospital, if your partner was involved in your care, were they able to stay with you as much as you wanted	4.9	4.7	7.4
Thinking about the last time you contacted the telephone triage line, did you feel that you got the advice that you needed?		7.5	8.3

The following actions are being taken to improve results from the National Maternity Survey:

- Increase timely feedback from service users.

- Expanding the maternity education offer to support informed decision making.
- Improve the communication during contact via the triage line.
- Continue to improve pain management with a specific focus on the post-natal period.
- Continue to progress the ability to support partners to stay overnight.

National Children and Young People Survey 2024

The 2024 National Children and Young People Survey was undertaken between January and April 2024. 1250 children/parents/carers between the age of 0-15 years who were admitted to hospital during March, April and May 2024 were invited to give their views and feedback on the care they received throughout their admission:

- Parent and carers of children aged 0 to 7 answered a questionnaire to feedback on their child's experiences.
- Children and young people aged 8 to 11 and 12 to 15 each answered their own questionnaire, which also included questions for their parent or carer.

150 invited participants completed the survey, which was a response rate of 12%. This was lower than the national average of 20%.

Of the 78 questions asked, MWL scored better than expected than most Trusts for 7 questions, somewhat better than most Trusts for 4 questions, 65 questions were about the same as other Trusts, 1 question somewhat worse than expected and 1 question worse than expected.

*This was the first survey as MWL NHS Trust and therefore cannot be compared to previous survey results.

The table below details the overall section scores:

Section	Trust Score 2024	Trust Ratings
The waiting area – Parents and carers' reports (0-7years)	7.6/10	About the same
The waiting area – Children's and young people reports (8-15years)	6.2/10	About the same
Hospital ward - Parents and carers' reports (0-7years)	9.7/10	About the same
Hospital ward - Children's and young people reports (8-15 years)	6.6/10	About the same

Talking to hospital staff - Parents and carers' reports (0-7 years)	9.0/10	About the same
Talking to hospital staff - Parents and carers' reports (0-15 years)	8.3/10	About the same
Talking to hospital staff - Children's and young people reports (8-15 years)	8.8/10	About the same
Being looked after in hospital - Parents and carers' reports (0-7years)	7.4/10	About the same
Being looked after in hospital - Parents and carers' reports (0-15 years)	8.6/10	About the same
Being looked after in hospital - Children's and young people reports (8-15 years)	7.8/10	About the same
Hospital food- Parents and carers' reports (0-11 years)	6.1/10	About the same
Facilities – Parents and carers' reports (0-15 years)	7.3/10	About the same
Facilities – Children and young people's reports (8-15 years)	6.6/10	About the same
Pain – Parents and carers' reports (0-15 years)	8.6/10	About the same
Pain – Children and young people's reports (8-15 years)	8.4/10	About the same
Operations and Procedures- Parents and carers' reports (0-15 years)	9.1/10	About the same
Operations and Procedures- Children and young people's reports (8-15 years)	8.3/10	About the same
Leaving hospital - Parents and carers' reports (0-15 years)	8.3/10	About the same
Leaving hospital - Children and young people's reports (8-15 years)	8.1/10	About the same
Overall experience - Parents and carers' reports (0-15 years)	8.8/10	About the same
Overall experience - Children and young people's reports (8-15 years)	8.8/10	About the same

Questions where MWL performed better than expected:

Question	Trust Score 2024	National Average 2024

Being able to stay as much as needed (parents and carers).	9.9	8.0
Not being stopped from sleeping by lighting (8-15 years).	9.4	8.4
Staff introductions (parents and carers).	9.5	9.0
Able to ask staff questions (8-15 years).	9.2	8.0
Accommodating individual needs (parents and carers).	8.9	8.7
Staff explanation before operation and procedure (parents and carers).	9.4	9.0
Explaining how well an operation or procedure went (parents and carers).	8.9	8.2

Questions where MWL performed somewhat better than expected:

Question	Trust Score 2024	National Average 2024
Understandable communication (8-15 years).	9.1	8.8
Privacy during care (parents and carers).	9.5	8.6
Confidence and trust in staff (parents and carers).	8.8	8.4
Hospital food choice (12-15 years).	7.5	7.0

Questions where MWL performed somewhat worse than expected:

Question	Trust Score 2024	National Average 2024
Activities during hospital stay (parents and carers).	4.2	5.0

Questions where MWL performed worse than expected:

Question	Trust Score 2024	National Average 2024
Being around others of own age on the ward (8-15 years).	4.7	6.5

The following actions are being taken to improve results from the Children and Young People Survey:

- Where appropriate, placing children receiving care with those of a similar age.
- Review of play specialist resource.
- Parents to be provided with the relevant discharge information leaflets to so they know who to contact with any concerns after discharge.
- Alignment of care plans to incorporate the signature of the Child or Young Person (where age appropriate) onto the care plan to ensure Voice of the Child is captured.

National Cancer Patient Experience Survey 2024

The sample for the survey included all adult (aged 16 and over) NHS patients, with a confirmed primary diagnosis of cancer, discharged from an NHS trust after an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2024. The fieldwork for the survey was undertaken between November 2024 and February 2025.

The MWL 2024 response rate was 47% (423 patients). This compares to a national response rate of 50%.

Of the 59 questions asked, MWL scored above the expected range for 6 questions which related to the availability and quality of information. There were 0 questions where scores were below the expected range with all other questions within the expected range.

Cancer services have identified three priorities from the 2024 results – improving information about support services, enhancing shared decision making and clarifying patients' understanding of the side effects of cancer treatment.

Further information can be found at www.ncpes.co.uk

National General Practice (GP) Patient Survey Updated

Marshalls Cross Medical Centre participates in the National GP Patient Survey each year. In 2025, 122 surveys were returned providing a response rate of 27%.

Question	Marshalls Cross	National Results	Inhouse Survey
-find it easy to get through to this GP practice by phone	39%	53%	79%
-find it easy to contact this GP practice using their website	28%	51%	70%
-find it easy to contact this GP practice using the NHS App	32%	49%	78%
-find the reception and administrative team at this GP practice helpful	26%	83%	96%
-usually get to see or speak to their preferred healthcare professional when they would like to	14%	40%	87%
-were offered a choice of time or day when they last tried to make a general practice appointment	21%	54%	44%
-were offered a choice of location when they last tried to make a general practice appointment	7%	14%	24%

-felt they waited about the right amount of time for their last general practice appointment	48%	67%	92%
-say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment	77%	87%	94%
-say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment	73%	86%	87%

As part of our improvement plan, we have recently reignited our patient participation group and have 2 groups with one being digital and the other face to face. We have also undertaken and inhouse survey in January 2026 which replicates the national survey to measure our improvement journey more frequently.

3.10 5 Star Accreditation Programme

NHS England recommends that locally driven ward/unit accreditation approaches bring together key measures into a single overarching framework. These programmes incorporate a set of standards so that areas for improvement can be identified as well as areas of excellence celebrated. These programmes can drive continuous improvement in patient outcomes, satisfaction and staff experience.

In the last 12 months, we have successfully completed phase 1 of the 5 Star Accreditation, which has included 48 adult inpatient areas. Phase 2 was commenced late 2025 for speciality areas such as Accident and Emergency, Paediatrics and Critical Care Units. The 5 Star Accreditation Programme is now a continuous schedule of quality assessments completing within the trust, which provides a benchmark of quality and improvement performance.

Each of the 16 standards focuses on a key theme covering key quality elements of care: Documentation, Environmental Observations, Patient Questions/Experience, Staff Questions / Knowledge and Ward Manager Questions / Leadership. The standards are reviewed on an annual basis.

The ward/department accreditation framework provides Ward to Board assurance of quality and safety standards, highlighting performance across the five CQC key standards and the Trust's 5 Star Vision which not only focuses on continuous improvement strategies but also highlights excellence in practice.

The accreditation framework has the following benefits:

- Targets setting consistent expectations of patient care delivery across the Trust
- Provides strong focus to the leadership team

- Strengthens leadership
- Improves quality
- Reduces avoidable harm
- Improves patient experience
- Provides evidence compliance against regulatory standards thus improving CQC ratings
- Improves clinical efficiency and effectiveness
- Shares good practice
- Team building

Since the Accreditation launch in 2024, there has been significant improvements within the Trust, supported by the Quality Team and subject matter experts. Data analysis shows there has been a reduction in aspiring areas and an overall increase in 3 star, 4 star and 5 star outcomes.

Following assessments, clinical areas are provided with action trackers to develop and monitor their own improvement plans, which are monitored within the divisions and supported by the quality team. An accreditation dashboard has been developed which emphasises areas of good practice and areas requiring improvement across all standards (also aligned to the CQC domains of safe, effective, caring, well-led and responsive).

Appendix 1

National Clinical Audits

NHS England Quality Accounts List 2025-26. The table below lists the National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2025-26.

Number	Project Name	MWL Status
1	BAUS British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	Participating
2	BAUS Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Participating
3	Breast and Cosmetic Implant Registry	Participating
4	British Spine Registry	Not applicable –
5	Case Mix Programme (CMP) - Intensive Care National Audit & Research Centre (ICNARC)	Participating
6	Child Health Clinical Outcome Review Programme	Participating
7	Cleft Registry and Audit NEtwork (CRANE) Database	Not applicable
8	RCEM - Adolescent Mental Health	Participating
9	RCEM - Mental Health Self Harm	Participating
10	RCEM - Care of Older People	Participating
11	RCEM - Time Critical Medications	Participating
12	Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Participating
13	Fracture Liaison Service Database (FLS-DB	No service, not applicable
14	National Audit of Inpatient Falls (NAIF)	Participating
15	National Hip Fracture Database (NHFD)	Participating
16	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Participating
17	Maternal, Newborn and Infant Clinical Outcome Review Programme1	Participating
18	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Participating
19	Mental Health Clinical Outcome Review Programme	Not Applicable
20	National Diabetes Core Audit	Participating
21	Diabetes Prevention Programme (DPP) Audit	Not applicable
22	National Diabetes Footcare Audit (NDFA)	Participating
23	National Diabetes Inpatient Safety Audit (NDISA)	Participating
24	National Pregnancy in Diabetes Audit (NPID)	Participating
25	Transition (Adolescents and Young Adults) and Young Type 2 Audit	Participating
26	Gestational Diabetes Audit	Participating
27	National Audit of Cardiac Rehabilitation	Participating

28	National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	Not applicable
29	National Audit of Care at the End of Life (NACEL)	Participating
30	National Audit of Dementia (NAD)	Participating
31	National Audit of Eating Disorders (NAED)	Not applicable
32	National Bariatric Surgery Registry	Participating
33	National Audit of Metastatic Breast Cancer (NAoMe)	Participating
34	National Audit of Primary Breast Cancer (NAoPri)	Participating
35	National Bowel Cancer Audit (NBOCA)	Participating
36	National Kidney Cancer Audit (NKCA)	Participating
37	National Lung Cancer Audit (NLCA)	Participating
38	National Non-Hodgkin Lymphoma Audit (NNHLA)	Participating
39	National Oesophago-Gastric Cancer Audit (NOGCA)	Participating
40	National Ovarian Cancer Audit (NOCA)1	Participating
41	National Pancreatic Cancer Audit (NPaCA)	Participating
42	National Prostate Cancer Audit (NPCA)	Participating
43	National Cardiac Arrest Audit (NCAA)	Participating
44	National Adult Cardiac Surgery Audit (NACSA)	Not applicable
45	National Congenital Heart Disease Audit (NCHDA)	Not applicable
46	National Heart Failure Audit (NHFA)	Participating S&O sites behind with data collection
47	National Audit of Cardiac Rhythm Management (CRM)	Not applicable
48	Myocardial Ischaemia National Audit Project (MINAP)	Participating S&O sites behind with data collection
49	National Audit of Percutaneous Coronary Intervention (NAPCI)	Not applicable
50	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Not applicable
51	Left Atrial Appendage Occlusion (LAAO) Registry	Not applicable
52	Patent Foramen Ovale Closure (PFOC) Registry	Not applicable
53	Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Not applicable
54	National Child Mortality Database (NCMD)	Participating
55	National Clinical Audit of Psychosis (NCAP)	Not applicable
56	National Comparative Audit of Bedside Transfusion Practice - 2025 Major Haemorrhage Audit	Participating
57	National Early Inflammatory Arthritis Audit (NEIAA)	Participating
58	National Emergency Laparotomy Audit (NELA) Laparotomy	Participating
59	National Emergency Laparotomy Audit (NELA) No-Lap	Participating
60	National Joint Registry	Participating
61	National Major Trauma Registry	Participating
62	National Maternity and Perinatal Audit (NMPA)	Participating
63	National Neonatal Audit Programme (NNAP)	Participating

64	National Obesity Audit (NOA)	Participating
65	Age-related Macular Degeneration Audit - National Ophthalmology Database (NOD):	Participating
66	Cataract Audit - National Ophthalmology Database (NOD):	Participating
67	National Paediatric Diabetes Audit (NPDA)	Participating
68	National Perinatal Mortality Review Tool	Participating
69	National Pulmonary Hypertension Audit	Not Applicable
70	COPD Secondary Care	Participating
71	Pulmonary Rehabilitation	Participating
72	Adult Asthma Secondary Care	Participating
73	Children and Young People's Asthma Secondary Care	Participating
74	National Vascular Registry (NVR)	Participating
75	Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	Not applicable
76	Paediatric Intensive Care Audit Network (PICANet)	Not applicable
77	Perioperative Quality Improvement Programme	Not participating
78	Improving the quality of valproate prescribing in adult mental health services	Not applicable
79	Use of clozapine	Not applicable
80	Use of medicines with anticholinergic properties in older people's mental health services	Not applicable
81	Sentinel Stroke National Audit Programme (SSNAP)	Participating
82	Serious Hazards of Transfusion (SHOT)	Participating
83	UK Cystic Fibrosis Registry Adults	Participating
84	UK Cystic Fibrosis Registry Children	Partcipating
85	UK Interstitial Lung Disease (ILD) Registry	Not applicable
86	UK Parkinsons Disease Audit	Participating
87	UK Renal Registry Chronic Kidney Disease Audit	Not applicable
88	UK Renal Registry National Acute Kidney Injury Audit	Not applicable

Annex A
Statement of directors' responsibilities in respect of the Quality Account

The Trust Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered for 2025-26.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board.

Steve Rumbelow
Steve Rumbelow, Chairman

Rob Cooper
Rob Cooper, Chief Executive

Annex B
Written statements by other bodies

Annex C

Amendments made to the Quality Account following feedback and written statements from other bodies

The following amendments were made following feedback from other bodies:

Annex D
Abbreviations

ADR	Adverse drug reaction
AHPs	Allied Health Professionals
AI	Artificial intelligence
AIS	Accessible Information Standard
AKI	Acute kidney injury
AMU	Acute Medical Unit
ANC	Ante-natal Clinic
ANTT	Aseptic non-touch technique
App	Application
AQ	Advancing Quality
AMaT	Audit Management and Tracking (computer package)
ARC NWC	Applied Research Collaboration North West Coast
BADGERNET	Maternity electronic notes programme
BAME	Black, Asian and minority ethnic
BAUS	British Association of Urological Surgeons
BJP	Bence Jones Protein
BP	Blood pressure
BRAIN	Benefits, Risks, Alternatives, Intuition and Nothing – tool used during pregnancy to help parents get the information they need to make decisions about their care providers during pregnancy, birth and postpartum.
BSI	Blood stream infection
BSL	British Sign Language
BSPED	British Society for Paediatric Endocrinology and Diabetes
BTS	British Thoracic Society
C&M	Cheshire and Merseyside
Careflow	Electronic Patient Record System
CCS	Clinical Classifications Service
CD	Controlled drugs
C. difficile	Clostridioides difficile infection
CDT	Clostridioides difficile infection
CGM	Continuous glucose monitoring
CHPPD	Care hours per patient per day

CNO	Chief Nursing Officer
CMAST	Cheshire and Merseyside Acute and Specialist Trust provider collaborative
CMP	Case mix programme
COHA	Community Onset Health Care Associated
COO	Chief Operating Officer
COPD	Chronic obstructive airways disease
CPD	Continuing professional development
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQuIN	Commissioning for quality and innovation
CRAB	Copeland risk adjusted barometer
CRB	Cervical ripening balloon
CRN NWC	Clinical Research Network, North West Coast
CSP	Cervical Screening Programme
CT	Computerised tomography
CTG	Cardiotocography
CYP	Children and young people
Datix	Integrated risk management, incident reporting, complaints management system
DIEP	Deep inferior epigastric perforators
DIPC	Director of Infection Prevention and Control
DLQI	Dermatology Life Quality Index
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation
DQMI	Data quality maturity index
DRC	Deafness Resource Centre
DrEaM	Drink, eat and mobilise
DSPT	Data Security and Protection Toolkit
DVT	Deep vein thrombosis
EASI	Eczema Area and Severity Index
ED	Emergency Department
EDI	Equality, diversity and inclusion
EDS or EDS2	Equality Delivery System
EMIS	Egton Medical Information System
ENT	Ear, nose and throat
ePMA	Electronic prescribing and medicines administration
EPR	Electronic patient record
ESR	Electronic staff record
eVTE	Electronic venous thromboembolism (recording)
FBC	Full blood count
FDA	Food and Drug Administration
FDS	Faster diagnosis standard
FFT	Friends & Family Test
FGR	Fetal Growth Restriction
FRAX	Fracture Risk Assessment Tool
FTSU	Freedom to speak up

GAP	Growth assessment protocol
GAP SCORE	Growth assessment protocol standardised case outcome review and evaluation
GI	Gastrointestinal
GIRFT	Get it right first time
GP	General Practitioner
HASU	Hyper-Acute Stroke Unit
HAT	Hospital-acquired or hospital-associated thrombosis
HbA1c	Haemoglobin A1c - average blood glucose (sugar) levels for the last two to three months
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HCSW	Healthcare Support Worker
HES	Hospital Episode Statistics
HHS	Hyperosmolar Hyperglycaemic State
HOHA	Hospital Onset Health Care Associated
HPMA	Healthcare People Management Association
HR	Human Resources
HS	Hidradenitis Suppuritiva
HWWB	Health, Work and Well-being
IBD	Inflammatory bowel disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICB	Integrated Care Board
ICCR	Individual care and communication record
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
ICS	Integrated Care System
IG	Information governance
IMCA	Independent mental capacity advocate
IPC	Infection prevention and control
IT	Information technology
IV	Intravenous
JAK	Janus Kinase
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
LAC	Looked after children
LeDeR	Learning disability mortality review
LFPSE	Learn from Patient Safety Events
LGA	Large for gestational age
LGBT	Lesbian, gay, bisexual, transgender
LGBTQIA+	Lesbian, gay, bisexual, transgender, questioning, intersex, asexual
LocSSIPs	Local safety standards for invasive procedures
MBRRACE-UK	Mothers and babies - reducing risk through audits and confidential enquiries across the UK
MDT	Multi-disciplinary team

MHRA	Medicines and Healthcare products regulatory agency – primary role is to regulate medicines, medical devices and blood components for transfusion ensuring they meet safety, quality and efficacy standards to protect public health.
MINAP	Myocardial infarction national audit programme
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant staphylococcus aureus
MRSAb	Methicillin-resistant staphylococcus aureus bacteraemia
MSSA	Methicillin-sensitive staphylococcus aureus
MWL	Mersey and West Lancashire Teaching Hospitals NHS Trust
NACAP	National asthma and COPD audit programme
NACEL	National audit of care at the end of life
NAOGC	National audit oesophago-gastric cancer
NatSSIPs	National safety standards for invasive procedures
NBOCA	National bowel cancer audit
NCAA	National cardiac arrest audit
NCAP	National cardiac arrest programme
NCCQ	National clinical coding qualification
NCEPOD	National confidential enquiry into patient outcome and death
NCPES	National cancer patient experience survey
NDA	National diabetes audit
NELA	National emergency laparotomy audit
NEWS	National early warning score
NG	Nasogastric
NHS	National Health Service
NHSE	National Health Service England
NHSP	NHS Professionals
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National joint registry
NLCA	National lung cancer audit
NMPA	National maternity and perinatal audit
NMTR	National Major Trauma Registry (formerly TARN)
NNAP	National neonatal audit programme
NOD	National ophthalmology audit
NPCA	National prostate cancer audit
NPDA	National paediatric diabetes audit
NRLS	National Reporting & Learning System
NVR	National Vascular Registry
OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OH	Occupational Health
OPAT	Outpatient Antibiotic Therapy
OPCS	Office of Population, Census and Statistics Classification of Interventions and Procedures
OSCE	Objective structured clinical examination
OT	Occupational Therapist/Therapy

P2, P3, P4	Priority 2, 3, 4
PALS	Patient Advice and Liaison Service
PACS	Picture archiving and communication system
PAS	Patient administration system
PCC	Prothrombin complex concentrate
PCI	Percutaneous coronary intervention
PE	Pulmonary embolus
PIR	Post infection review
PLACE	Patient-led assessments of the care environment
PMRT	Perinatal mortality review tool
PPE	Personal Protective Equipment
PRES	Participant in research experience survey
PROMs	Patient reported outcome measures
PSII	Patient safety incident investigation
PSIRF	Patient Safety Incident Response Framework
QI	Quality improvement
QICA	Quality Improvement and Clinical Audit
RAG	Red, amber, green
RCEM	Royal College of Emergency Medicine
RDI	Research, development and innovation
RDIG	Research, Development and Innovation Group
RCOG	Royal College of Obstetricians and Gynaecologists
RLC	Rugby League Cares
RN	Registered Nurse
RNDA	Registered Nurse Degree Apprenticeship
RTT	Recruiting to time and target
RSV	Respiratory syncytial virus
SAG	Safeguarding Assurance Group
SAMBA	Society for Acute Medicine (SAM) benchmarking audit
SAU	Surgical Assessment Unit
SBAR	Situation, background, assessment, recommendation
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SFLC	Serum free light chains
SHMI	Summary hospital-level mortality indicator
SHOT	Serious hazards of transfusion
SIRO	Senior Information Risk Owner
SJR	Structured judgement review
S&O	Southport and Ormskirk Hospital NHS Trust
SOP	Standard operating procedure
SSI	Surgical site infection
SSNAP	Sentinel stroke national audit programme
STHK	St Helens and Knowsley Teaching Hospitals NHS Trust
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TAR	Transfusion authorisation record
TAT	Thrombin-Antithrobin Complex

TIA	Transient ischaemic attack
TILIA	Tozorakimab in Patients Hospitalised for Viral Lung Infection Requiring Supplemental Oxygen
TNA	Trainee nursing associate
TTO	To take out
TURBT	Transurethral resection of bladder tumour
TURP	Transurethral resection of prostate
uDNACPR	Unified do not attempt cardiopulmonary resuscitation
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
UK	United Kingdom
VBAC	Vaginal birth after caesarean
VIP	Visual infusion phlebitis
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WHO	World Health Organisation
WRES	Workforce Race Equality Standard

Annex E

Contact details

Additional information about the Trust is available on the website: www.merseywestlancs.nhs.uk

If you have any queries relating to this Quality Account please direct them to the following email: sarah.o'brien2@merseywestlancs.nhs.uk

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 May 2026
Agenda Item	**TB26/039**			
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 review at MWL providing assurance that deaths occurring at MWL have undergone robust review and learning has been identified.

Executive Summary

MWL has processes for reviewing deaths to provide assurance and identify learning.

This report considers Q2 2025/26 consistent with standardised case review (Structured Judgement Reviews) reporting to the National Quality Board. Additional ongoing assurance is provided by the Medical Examiner Service, Patient Safety Incident Investigations and mortality statistics.

Significant progress has been made catching up with the backlog of Structure Judgement Reviews with an objective to clear the backlog and complete all these in the quarter following identification.

There are no concerns to escalate.

Financial Implications

None

Quality and/or Equality Impact

No change in impact

Recommendations

The Board is asked to note the Learning from Deaths 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

Introduction

Mortality assurance and learning is sought from a number of indicators at MWL:

1. Structured Judgement Review (SJR's)
2. Medical Examiner review
3. Patient Safety Incident Investigations (PSII's)
4. Mortality Statistics

Deaths and associated information are considered in individual case review meetings, Mortality Oversight Group (MOG), Clinical Effectiveness Council (CEC) and Quality Committee.

1. Structured Judgement Review (SJR's)

Structured Judgement Review (SJR's) a standardised medical case-note review process developed by the Royal College of Physicians to evaluate the care a patient received before their death in a hospital. It is recognised methodology for the return to the National Quality Board (NQB). The primary goal of the review is not to place blame, but rather to identify strengths, share best practices, and uncover any gaps or areas where system improvements can be made.

At MWL the outcome of the SJR is recoded as green, amber or red depending on the level of concern.

Triggers for SJR review are listed in Appendix 1.

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 14 *(3 o/s)*	11	0	0	0	0
May 2025 12 *(1 o/s)*	12	0	0	0	0
June 2025 21 *(4 o/s)*	15	0	2	0	0

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 13 *(7 o/s)*	3	0	3	0	0
August 2025	12	6	1	0	0

20 *(1 o/s)*					
September 2025 *11* *(9 o/s)*	1	1	0	0	0

Number of SJR requests Q3 October 2025 – December 2025

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
October 2025 *3* *(3 o/s)*					
November 2025 *0* *(0 o/s)*					
December 2025 *0* *(0 o/s)*					

Number of SJR requests Q4 January 2026 – March 2026

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
Jan 2026 *1* *(1 o/s)*					
February 2026 *1* *(1 o/s)*					
March 2026 *4* *(4 o/s)*					

Notes:

- Total open SJRs: 52
  Allocated: 39
  Unallocated 13

- Historically there has been a significant backlog of SJR's but 201 have been completed in Q4 2025/26 and Q1 2026/27 with a view to complete outstanding reviews in Q2 2026/27. The intention going forward is to complete SJR in the quarter after the request is made.

- No amber or red cases were identified for Q2 25/26.

Action plan to maintain performance of SJR completion

No.	Action	Lead	Due by	comments
1	Recruitment of new reviewers	AMD for Mortality	Ongoing	Limited by lack of remuneration available for reviewers. Options to be considered as part of job planning
2	Review of outstanding SJRs to see if any can be eliminated	AMD for Mortality	End of Q4 2025/2026	See SJR triggers
3	Collaborative working with medical examiners	AMD for Mortality	End of Q4 2025/26	Process agreed across both sites and will form part of updated Learning from Deaths Policy. Continued NQB criteria triggering for SJRs across both sites with shared learning from ME offices at MOG meetings (quarterly)
4	Targeted reviews to specific staff members	TBC	Ongoing	Under consideration with SJR reviewers available

Learning into Action

- Following each quarterly SJR 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

2. Medical Examiner Service

- All deaths are scrutinised by a Medical Examiner (The Medical Examiners (England) Regulations 2024) as a statutory function. Medical Examiners are senior, independent NHS doctors who review the causes of deaths not investigated by a coroner. This process acts as a time sensitive review triggering patient safety investigation or SJR where appropriate.

- Medical Examiner Services are in place at both Whiston and Southport Hospitals with learning shared at the Mortality Oversight Group.

3. Patient Safety Incident Investigations (PSII's)

- 3 PSII's into concerns where the patient subsequently died were closed in Q2 2025/26 with completed action plans and no outstanding concerns.

4. Mortality Statistics

- At the end of Q2 2025/26 (Sept 2025):

Trust crude mortality =	2.2%
Hospital Standardised Mortality Rate (HSMR) =	93.1 (expected 100)
Standardised Hospital Mortality Index (SHMI) =	1.00 (expected is 1)

- No diagnostic subgroups were of significant concern

ENDS

Appendix 1: Categories of death for SJR

- **Cardiac arrest** – Resuscitation team members review every cardiac arrest, if concerns are identified referral is made for an SJR.

- **Post operative** – All elective surgical deaths are referred. Emergency surgical deaths are referred for SJR if the cause of death is considered a specific complication during/from surgery and not underlying indication for the surgery. Deaths triggering Patient Safety Incident Investigation are excluded.

- **Learning disability and Autism** – All Learning Disability and LeDeR deaths are referred.

- **Concern** – Significant concerns thought to have contributed to death need alerting to the Patient Safety team in a timely manner. SJR to follow if expected to contribute to investigation.

- **CQC Alert** – SJR if alerted, these are unusual.

- **Diagnosis group** – HSMR and SHMI alerts may be referred.

- **External request** – An external SJR or concern would be managed by the Patient Safety team. Repeat MWL SJR if indicated.

- **Internal request** – MWL staff or Medical Examiner Concern, details considered by the Patient Safety team. SJR to follow if expected to contribute to investigation.

Title of Meeting	**Trust Board**			**Date**	**27 May 2026**
Agenda Item	**TB26/040**				
Report Title	2025/26 Board and Committee Effectiveness Reviews				
Executive Lead	Rob Cooper, Chief Executive				
Presenting Officer	Anne-Marie Stretch, Deputy Chief Executive				
Action Required	X	**To Approve**		**To Note**	

Purpose

To provide the Board with a pack of revised Board and Committee Terms of Reference (ToR) and Board Work Plan that reflect the outcomes of the 2025/26 meeting effectiveness review process and Board.

Executive Summary

1. The annual effectiveness review of the Board and its Committees has been undertaken, reflecting the meetings that took place in 2025/26.
2. The detailed review of each committee has been shared with the committee chair and has reported in the meeting.
3. A summary of the findings of each review will be reported to the Audit Committee.
4. The conclusion of the reviews is that the purpose, remit and organisation of the Trust Board and its Committees remain fit for purpose and provides the assurance that the Trust is effectively and appropriately managed. This evidence supports the development of the Annual Governance Statement.
5. The final part of this review is the issuing of revised ToR incorporating any agreed changes from the reviews (in red text).
6. Following the presentation of the Draft Work Plan in November 2025, the final Board Work Plan is included in the report.

The changes ensure that, as a whole, the Board governance structure remains comprehensive and there are clear lines of accountability.

Financial Implications

None directly because of this report

Quality and/or Equality Impact

Not applicable

Recommendations

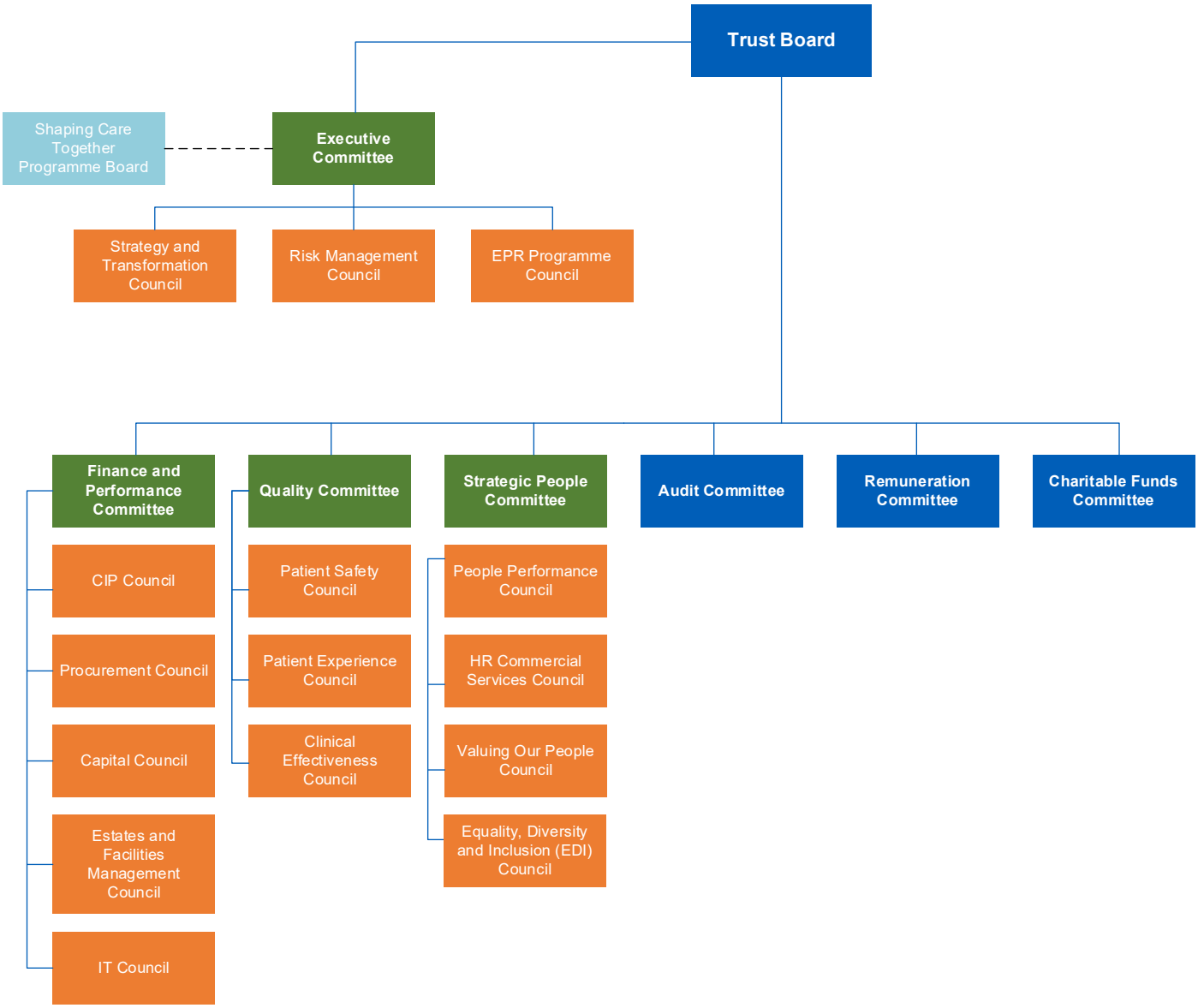
The Board is requested to approve the updated Terms of Reference and Board Work Plan.

Strategic Objectives

	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways

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

GOVERNANCE STRUCTURE 2026/27



COMMITTEE TERMS OF REFERENCE 2026/27

TRUST BOARD – Terms of Reference (2026/27) – Proposed	
Authority	Mersey and West Lancashire Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the St Helens and Knowsley Hospital Services National Health Service Trust (Establishment) Order 1990 (SI 1990/2446) (the Establishment Order) amended by SI 1999/632 and SI 2023/711. The principal place of business of the Trust is the address as per the Establishment Order. The terms under which the Trust Board operates are described in the Standing Orders section of the Corporate Governance Manual (section 7.3).
Delegated Authority	The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board and appended within the Corporate Governance Manual. The Board has delegated authority to the following Committees of the Board i) Audit Committee ii) Remuneration Committee iii) Quality Committee iv) Finance & Performance Committee v) Strategic People Committee vi) Charitable Funds Committee vii) Executive Committee
Agendas	The Board will have a forward work programme for the ensuing year that provides an outline plan for reporting throughout the year. This will include items on quality, performance, and statutory compliance as well as reports from the Trust's Committees where more in-depth scrutiny of items has occurred in the presence of both Non-Executive and Executive Directors. This does not prevent agenda items being added as required and may result in items being deferred to another month if the agenda becomes too congested. A Board member desiring a matter to be included on an agenda shall make their request to the Chairman a minimum of ten days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should

	include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairman. Where a petition has been received by the Trust the Chairman of the Board shall include the petition as an item for the agenda of the next Board meeting.
Accountability and reporting	All ordinary meetings of the Board are open meetings which members of the public can attend to observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate, however, contributions from the public at such meetings can be considered at the discretion of the Chairman. Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers. Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that: i) relate to a member of staff, ii) relate to a patient, iii) would commercially disadvantage the Trust if discussed in public, iv) would be detrimental to the operation of the Trust.
Review	Each year the Board will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Terms of Reference.
Membership	**Core Members (voting)** Non-Executive Chairman (chair) Six Non-Executive Directors (one of which will be appointed Vice Chair) Chief Executive Four Executive Directors (to include Chief Finance Officer, Chief Medical Officer, Chief Nursing Officer, plus one other, which is the Deputy Chief Executive) Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors; both share responsibility

	for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as quality assurance, health and safety and financial oversight that Board members need to meet. Each Board member has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public. **In attendance** The Board shall be able to require the attendance of any other Director or member of staff.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year.
Quorum	50% of the core membership must be present including at least one Executive Director and one Non-Executive Director.
Meeting Frequency	The Trust Board will meet monthly (with the exception of August and December). All meetings will have public and private elements.
Agenda Setting and papers	Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Trust Board should be in line with the corporate standard.

AUDIT COMMITTEE – Terms of Reference (2026/27) – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Audit Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Board may request the Committee to review specific issues where the Board requires additional scrutiny and assurance.
Role	The Committee shall review the establishment and maintenance of an effective system of integrated governance internal control and risk management across the whole of the organisations clinical and non-clinical activities that support the achievement of the Trust's objectives.
Duties	The Committee will undertake the following duties: <u>Internal Control and Risk Management</u> 1. In particular the Committee will review the adequacy of: • All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board. • The structures, processes and responsibilities for identifying and managing key risks facing the organisation. • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any other reporting and self-certification requirements. • The operational effectiveness of policies and procedures via internal audit reviews. • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Agency (NHSCFA) 2. The Committee will: • Consider the findings of other significant assurance functions (e.g. regulators, professional bodies, external reviews); • Ensure there is a clear policy for the engagement of internal and external auditors to supply non-audit services, to ensure auditor independence and objectivity. • Review the work of other Trust Committees whose work will provide relevant assurance to the Audit Committee's own areas of responsibility. • Request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

	• Request assurance of the delivery of the annual trust objectives aligned to the Committee. <u>Internal Audit</u> 3. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 4. To review the internal audit programme, consider the major findings of internal audit investigations (and management's response), and ensure coordination between the Internal and External Auditors. 5. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. <u>External Audit</u> 6. Make recommendations to the Trust Board about the appointment and independence of the External Auditor. 7. Consider the audit fee, as far as the rules governing the appointment permit, and make recommendation to the Board when appropriate. 8. Discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health community. 9. Review External Audit reports, including value for money reports and annual audit letters, together with the management response. 10. Review the adequacy and effectiveness of statements within the quality account in line with DHSC guidance. 11. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-statutory audit work including the pre-approval by the Audit Committee's Auditor Panel for this work. <u>Financial Reporting and Governance</u> 12. Approve the Annual Report and Accounts on behalf of the Trust Board, when the audit timetable does not allow for the Annual Report and Accounts to be approved at a scheduled Trust Board meeting. When approving the Annual Report and Accounts the Audit Committee should focus particularly on: • The Annual Governance Statement; • Changes in, and compliance with, accounting policies and practices; • Unadjusted mis-statements in the Financial Statements; • Letters of representation; • Major judgemental areas, and; • Significant adjustments resulting from the audit. 13. Consider any proposed changes to Standing Orders and Standing Financial Instructions and to the Scheme of Reservation and Delegation of Powers including delegated limits and make recommendations to the Trust Board. (NB. All of these are incorporated within the Trust's Corporate Governance Manual.) 14. Consider any proposed changes to the Trust's Standards of Business Conduct Policy and Anti-Fraud, Bribery and Corruption Policy and make recommendations to the Trust Board.

	15. Review responsibilities in respect of the appropriate processes and compliance with Standing Orders for the use of the seal (delegated from the Board), tender waivers, losses and special payments, and aged debt, gifts and declarations of interests.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.
Membership	**Core Members** The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members, one of whom will be the committee chair (who will be a qualified accountant or have a finance background). **In attendance** The Chief Finance Officer, the Director of Corporate Services, the Head of Internal Audit, and a representative of the External Auditors shall normally attend meetings. However at least once a year the Committee may wish to meet with the External and Internal Auditors without any Executive Board Director present. The Committee shall be able to require the attendance of any other Director or member of staff. Specifically, the Committee should consider inviting the Chief Executive to attend the Audit Committee to discuss the Annual Governance Statement and Internal Audit Plan.
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: • Ensure that they read papers prior to meetings, • Attend as many meetings as possible, • Contribute fully to discussion and decision-making, • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	A quorum shall be two members.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Audit Committee Chair.
Meeting Frequency	Meetings shall be held not less than three, but usually four to five times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Director of Corporate Services. Documents submitted to the Committee should be in line with the corporate standard.

REMUNERATION COMMITTEE – Terms of Reference (2026/27) – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Remuneration Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee is authorised to make recommendations to the Trust Board on the appropriate remuneration and terms of service for the Chief Executive and Executive Directors and Associate Directors with due regard to market rates, NHS guidance, affordability, and equal value.
Duties	The Committee will undertake the following duties: 1. To receive and consider information and advice from the Chief Executive on the levels of remuneration for individual Directors taking into account internal relativities, the particular contribution and value of individual Directors and affordability. 2. To consider the level of remuneration for the Chief Executive taking into account the above factors. 3. To receive and consider external information on the wider pay scene including: - Guidance on Executive remuneration from the Department of Health or NHS England. - The levels of Executive remuneration offered by similar NHS organisations. - Consideration of the environment in which the organisation is operating. 4. To advise and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate including the approval process for: - Redundancy payments made to Chief Executives and Directors. - Redundancy payments in excess of £50,000 made to all other staff. - Special payments, i.e. any severance payments exceeding contractual obligations (or exceeding 3-months pay in lieu of notice). 5. Ratify the appointment of new Directors and approve the remuneration and terms of service if outside the parameters agreed for previous appointments to the role. 6. Approve novel or potentially contentious changes to the pay or terms and conditions of other staff working for the Trust
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Membership will comprise the Chairman and all Non-Executive Directors. **In attendance** The Chief Executive (except during discussions about his /her remuneration or terms of service) shall normally attend meetings. The Chairman may co-opt other members, such as the Director of Finance, as appropriate, in order to assist the Committee in meeting its objectives.

Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible, - Contribute fully to discussion and decision-making, - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress.
Quorum	The Remuneration Committee would be considered quorate when the Trust Chair or Deputy Chair plus 3 Non-Executive Directors are in attendance.
Accountability & Reporting	The Remuneration Committee is a Non-Executive function and its decisions must be agreed by a majority of the Non-Executive Directors and reported in accordance with the Trust's publication scheme, via the annual report and accounts.
Meeting Frequency	The Committee will meet at least once a year. Meetings may be convened with the agreement of all members at any time.
Agenda Setting and papers	The Director of Corporate Services (Company Secretary) will be responsible for all administrative arrangements.

QUALITY COMMITTEE – Terms of Reference (2026/27) – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Quality Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to quality of services and subsequent risk to patients. In establishing the Committee, the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is considered of Board level significance it is to be reported to the Board for approval before action. The Board may request the committee to review specific aspects of quality performance where the Board requires additional scrutiny and assurance. The Committee is authorised by the Board to commission independent professional or legal advice within the delegated authority of the Chief Nursing Officer or the Chief Medical Officer.
Role	The Committee shall review all aspects of clinical quality, including patient experience, patient safety and clinical effectiveness and provide assurance to the Trust Board that the Trust is delivering high quality safe care to patients. To assist it in its role, the Committee has constituted the following Councils: Patient Safety Council, Patient Experience Council, and Clinical Effectiveness Council.
Duties	The Committee's role is to: 1. Provide assurance on clinical quality, including triangulating relevant information and ensuring an effective framework in place for learning lessons and acting on feedback from incidents, complaints, claims, patient, and staff feedback. 2. Provide assurance that appropriate quality governance structures, processes and controls are in place through reviewing relevant internal and external reports (including CQC recommendations and compliance, national patient surveys) and assessing the Trust's performance against each. 3. Provide assurance to the Board on the delivery of the Trust's Clinical Strategy, based on the Trust's vision for 5-star patient care. 4. Provide assurance to the Board of compliance with regulatory standards and guidelines, including compliance with NICE. 5. Monitor the Trust's performance against other internal and external quality targets via the IPR and to advise the Board of relevant actions if performance varies from agreed tolerances. 6. To recommend measures of success /targets in relation to new quality improvement initiatives so that the Board can monitor outcomes.

	7. Identify areas for action to address any under-performance, initiating and monitoring quality improvement programmes, and where necessary escalating issues to the Board. 8. Request assurance of the delivery of the annual trust objectives aligned to the Committee. 9. Review the final draft Annual Quality Account prior to submission to the Board for approval. 10. Gain assurance that the reporting councils are approving the policies and procedures for which they are responsible, in line with the Trust Procedural Documents development and Management Policy. 11. Approve any policies and procedures that are aligned to the Quality Committee and if necessary, make recommendation to the Board, in line with the Trust Procedural Document Development and Management Policy. 12. Agree the ToR and the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of quality is delegated appropriately. ~~13.~~ Receive assurance reports from the Council chairs following each meeting of the Councils and to request in-depth reviews where performance is below the expected levels. 14. Receive assurance that effective safeguarding arrangements are in place. 15. Receive assurance that high quality maternity services are delivered, for example confirmation and approval of the CNST MIS submission to the Board. 16. Receive annual reports on behalf of the Board, e.g., complaints, infection prevention control, safeguarding, medicines management, patient engagement strategy, the clinical audit and clinical research programmes. 17. Receive assurance that the appropriate quality and equality impact assessments of proposed service developments or service changes are being undertaken. 18. Undertake any reasonable quality related reviews as directed by the Board or initiated from work of the Committee or its Councils. 19. Escalate any issues or concern or newly identified risks relating to quality to the Board.
Review	Terms of reference and effectiveness of the Committee will be reviewed annually and included in the report to the Board.
Membership	**Core Members** • Non-Executive Director (Chair) • Non-Executive Directors x 2 • ~~Chief Executive~~ • Deputy Chief Executive • Chief Nursing Officer • Chief Medical Officer • Chief People Officer • Chief Finance Officer • Chief Operating Officer • Director of Corporate Services

	The Chief Executive can attend any meeting of the committee, but it is recognised that the responsibilities in relation to the Cheshire and Merseyside ICS and external engagements do not allow regular attendance. Core members should ensure that if they are unable to attend a meeting, a fully briefed deputy is appointed and attends in their place. **In attendance** In addition to core members the committee shall be able to require the attendance of any other member of staff, to present reports, including the Chief Pharmacist, Divisional Directors of Nursing/Midwifery, Head of Safeguarding, Infection Prevention Control lead, Deputy Director of Nursing and member of the Corporate Nursing Team including Council Chairs (where this is not the Chief Nursing Officer of Chief Medical Officer). ~~A log of all members and supporting staff names and titles (and where external members, email addresses) are to be recorded on the Group's membership and circulation list. This list is to be reviewed and/or updated every financial year in accordance with the terms of reference review.~~
Attendance	Core Members are expected to attend a minimum of 70% of meetings per year. Members are expected to: • Ensure that they read papers prior to meetings, • Attend as many meetings as possible, • Contribute fully to discussion and decision-making, • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress. A record of attendance will be maintained throughout each financial year
Quorum	A quorum shall be 50% of core members including at least two Non-Executive Members (including the Chair).
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meeting is presented to the next Board meeting by the Quality Committee Chair. The Committee should undertake regular effectiveness reviews, including reviews of the terms of reference and annual workplan. Meeting effectiveness will be a standing agenda item.
Meeting Frequency	The Committee will meet monthly each year, except August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the office of the Chief Nursing Officer. Documents submitted to the Committee should be in line with the corporate standard.

FINANCE & PERFORMANCE COMMITTEE – Terms of Reference (2026/27) – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as the Finance & Performance Committee which will formally be constituted as a Committee of the Board. The Committee shall provide assurance to the Board on all matters pertaining to financial and operational performance and subsequent risk of the Trust. In establishing the Committee, the Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Board meeting. Where the issue is of Board level significance it is to be reported for approval before action. The Board may request the Committee to review specific aspects of financial or operational performance where the Board requires additional scrutiny and assurance.
Role	To enable the Board to obtain assurance that the Trust has robust activity and financial plans in place to meet both short and long-term sustainability objectives and maintain the Trust as a going concern. To contribute to the overall governance framework and support the development and maintenance of effective financial and performance governance arrangements throughout the Trust to promote the efficient and effective use of resources and identify, prioritise and manage risk from Trust activities.
Duties	The Committee will undertake the following duties: - 1. To review and make recommendations to the Board on the annual financial and business/activity plan and the assumptions which underpin it and review the Trust's longer-term financial and operational strategies to be able to make recommendations to the Board. 2. To monitor the performance of the Trust against all elements of the Trust finance and activity objectives via the monthly Committee Performance Report (CPR) including against national and contractual waiting time and access standards. To make recommendations to the Board on key risks, and actions and recovery plans to ensure the Trust performs to the optimum level and operates within the resources available. 3. To oversee the Trust's commercial services activity and the decision-making underpinning service developments and market strategy, including for the Informatics shared services, Payroll, Lead Employer. 4. To monitor the effectiveness and delivery of the Trust Information and digital strategy annual work programme. 5. To review proposed Cost Improvement Programme (CIP) and to monitor implementation and report, to the Board, proposals for corrective actions if required. 6. To monitor the financial and non-financial benefits realisation from approved business cases to provide assurance of a return on investment.

	7. To approve policies and procedures in respect of finance and performance and if necessary, make recommendations to the Board. 8. To receive reports on the impact and efficacy of finance policies and controls to deliver the agreed financial plans and provide assurance to the Board. 9. Based on forecast resources available, to plan the five-year rolling capital programme and in year delivery of the agreed capital programme 10. To review and monitor progress with annual contract negotiations and the impact on Trust sustainability, escalating any concerns to the Board. 11. To consider relevant central guidance, benchmarking reports, reference costs or consultations and where appropriate make recommendations to the Board 12. To review the ToR including the annual work programme for the reporting Councils, ensuring that the governance of all relevant aspects of finance and performance is delegated appropriately. 13. To receive assurance reports from the reporting Council chairs following each meeting of the Procurement, CIP, Capital Planning, Estates and Facilities Management and IT councils and to request in-depth internal reviews, commission independent reports where necessary or make recommendations to the audit committee. 14. To undertake any reasonable finance and performance related reviews as directed by the Board or initiated from work of the Committee or its Councils. 15. To provide assurance that appropriate governance structures, processes and controls are in place through reviewing relevant internal and external benchmarking reports (including Model Hospital, GIRFT, ERIC, Corporate services benchmarking and report recommendations) and seek assurance on the action being taken where the Trust is an outlier. 16. Monitor delivery of the Trusts annual objectives where the assurance route is via the committee.
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. Part of this process will include a review of the Committee ToR.
Membership	**Core Members** Non-Executive Director (chair) Non-Executive Director x 2 ~~Chief Executive~~ Chief Financial Officer Deputy Chief Executive Chief People Officer Chief Medical Officer Chief Operating Officer Director of Corporate Services

	Director of Informatics The Chief Executive can attend any meeting of the committee, but it is recognised that the responsibilities in relation to the Cheshire and Merseyside ICS and external engagements do not allow regular attendance. The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. **In attendance** In addition to core members the Deputy Director of Finance, Assistant Director(s) of Finance, Deputy Director of Estates and Facilities and nominated Divisional Directors of Operations may be in attendance. The Committee shall be able to require the attendance of any other Director or member of staff. Members are selected for their specific role or because they are representative of a professional group or Department. As a result, members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet monthly each year with the exception of August and December.
Agenda Setting and papers	Agendas agreed by the Chair will be in accordance with the annual work plan and reporting schedule of the Committee. Meeting administration, minute production and distribution are via the office of the Chief Finance Officer. Documents submitted to the Committee should be in line with the corporate standard.

STRATEGIC PEOPLE COMMITTEE – Terms of Reference 2026/27 – Proposed	
Delegated Authority	The Trust shall establish a Committee to be known as Strategic People Committee which will formally be constituted as a Committee of the Trust Board. The Committee shall provide assurance to the Trust Board on all matters pertaining to the quality, delivery and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, education and training, employee health and wellbeing, learning and development, employee engagement, organisational development, leadership, workforce development, workforce planning and culture, diversity, and inclusion. In establishing the Committee, the Trust Board agrees the delegated power for it to take appropriate action regarding issues within the remit of the Committee and for this to be reported at the next Trust Board level significance it is to be reported to the Trust Board for approval before action. The Trust Board may request the Committee to review specific aspects of workforce performance where the Board requires additional scrutiny and assurance.
Role	The Committee will provide assurance to the Trust Board of the achievement of the Trust's strategic and operational objectives and specifically the Trust's People Strategy. To enable the Board to obtain assurance that high standards of workforce and people practices and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: 1. Provide assurance to the Board on all workforce issues. 2. Identify, prioritise, and monitor risk arising from workforce and people policies and practice. 3. Ensure the effective and efficient use of resources through benchmarking and evidence-based practice. 4. Protect the health and safety and wellbeing of Trust employees. 5. Ensure compliance with legal, regulatory, and other obligations. The Committee has established a Valuing our People Council, People Performance Council, the HR Commercial Services Council, and Equality, Diversity and Inclusion Council and may recommend additional Councils aligned to key areas of its activity as it deems appropriate. Triangulation with other committees of the Board to ensure themes are identified and actions are progressed to support the development of the people agenda and delivery of high-quality services.

Duties	The Committee will undertake the following duties: - 1. Consider and recommend to the Board, the Trust's overarching People Strategy and associated action/implementation plans. 2. Obtain assurance of the delivery of the People Strategy through the associated action/implementation plans. 3. Consider and recommend to the Board the key people and workforce performance metrics and improvement targets for the Trust. 4. Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case. 5. Review the people and workforce risks on the corporate risk register and the risks relating to HR/Workforce as detailed on the Board Assurance Framework (BAF). 6. Receive reports in relation to internal and external quality and performance targets relating to people and workforce and associated activity/implementation plans. 7. Conduct reviews and analysis of strategic people and workforce issues and to recommend the Board level response. 8. Review and make recommendations to the Board in respect of regulatory and statutory workforce publications and returns, such as: • Annual Gender/BAME/Disability Pay Gap • Freedom to Speak Out declarations • The annual staff survey • WDES/WRES//MWRES/Bank WRES/PSED • Workforce planning 9. Approve the ToR and annual workplan for any reporting Councils, ensuring that the governance is delegated appropriately. 10. Receive assurance reports from the Council chairs following each meeting of the Councils.
Review	The Committee will undertake an annual meeting effectiveness review. Part of this process will include a review of the Committee Terms of Reference.
Membership	**Core Members** • Non-Executive Director (chair) • Non-Executive Directors x 2 • ~~Chief Executive~~ • Deputy CEO • Chief People Officer • Chief Nursing Officer • Chief Operating Officer • Chief Finance Officer

	• Director of Corporate Services The Chief Executive can attend any meeting of the committee, but it is recognised that the responsibilities in relation to the Cheshire and Merseyside ICS and external engagements do not allow regular attendance. **Other Members** Deputy Director of HR x 2 (by invitation as per agenda) The attendance of fully briefed deputies, with delegated authority to act on behalf of core members is permitted. **In attendance** In addition to core members, other officers of the Trust may be co-opted or requested to attend as considered appropriate may be asked to attend all or part of the meetings to present on specific issues. Members are selected for their specific role or because they are representative of a function of service. As a result, members are expected to: - Ensure that they read papers prior to meetings, - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress, - Contribute fully to discussion and decision-making, - Represent their professional group or their department as appropriate in discussions and decision making and provide feedback to colleagues.
Attendance	Core Members are expected to attend a minimum of 70% of meetings.
Quorum	50% of the core membership (or appropriate deputies) must be present including at least one Executive and two Non-Executive Directors.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	The Committee will meet 10 times per annum
Agenda Setting and papers	Agendas agreed by the Chair and Chief People Officer, will be in accordance with the annual reporting schedule of the Committee. Administration, minute production and distribution are via the PA to the Deputy Director of HR & Governance. Items for the agenda must be sent to the Chair a minimum of 5 working days prior to the meeting. Urgent items may be raised under any other business.

	The agenda will be sent out to the Committee members at least 3 working days prior to the meeting date together with the updated action list and other associated papers. Formal minutes shall be taken of all Committee meetings. Once approved by the Committee the Chair will produce an assurance report for the following Trust Board. Assurance reports from the People Councils reporting to the Strategic people Committee (and associated groups) will be received by the Committee along with the reports as agreed.

CHARITABLE FUNDS COMMITTEE – Terms of Reference 2026/27 – Proposed	
Delegated authority	The Trust shall establish a Committee to be known as the Charitable Funds Committee which will formally be constituted as a Committee of the Trust Board (Board). The Committee has no executive powers other than those specifically delegated in these Terms of Reference (ToR).
Purposes	The Charitable Funds Committee ('the Committee') is established to ensure that the Trust's duties as Corporate Trustee of its subsidiary charity ('the Charity') have been discharged. The formal purposes of the Charitable Funds Committee can be summarised as follows: • To agree the purpose, strategy, policies, and controls of the Charity. • To oversee the Charity's financial and treasury management processes. • To control expenditure from the funds. • To control and support fundraising and income initiatives. • To recommend an Annual Report and Accounts to the Corporate Trustee, outlining the Charity's key achievements. The Board of Directors of the Corporate Trustee maintains overall responsibility and legal obligations for these areas. However, the Charitable Funds Committee has delegated authority/responsibility, from the Corporate Trustee, within the limits set out in this ToR.
Authority	The Committee will oversee the administration of the Charity in line with statute and with Charity Commission (and other regulatory) requirements. The Committee has duties and delegated authority from the Board as follows. i) Approve the purpose, strategy, policies, and controls of the Charity, having due regard for propriety, compliance, risk, effectiveness, and efficiency. ii) Approve any significant changes in the Charity's governing document and registration with the Charity Commission, for recommendation to the Board of Directors of the Corporate Trustee. iii) Review those aspects of Standing Orders and Standing Financial Instructions that relate to the Charity and its operation, advising the Audit Committee on any such matters which need further attention. iv) Control all charitable expenditure in accordance with the Charity's Objects, Charities Act 2011/2016, *patient benefit criteria*, and best practice, through review and approval of the Charity's *Expenditure Policy.* v) Control income generation / handling mechanisms, including official fundraising, in accordance Charities Act 2016 and best practice, through review and approval of the Charity's *Fundraising*

	and Incomes Policy. vi) Approve detailed proposals for: appeals, the accumulation of funds for major purchases, delegated fundholder-ship and financial limits, fund structure, closing funds, and/or the establishment of new funds. vii) Oversee the use of investments in line with the Trustee Act 2000 and best practice, restricted to the explicit conditions or purpose of each donation, bequest, or grant, through review and approval of *the Charity's Treasury Management Policy* and the *Reserves Policy.* viii) Oversee the appointment of investment advisors when required and monitor the performance of any resultant portfolio. ix) Receive and consider reports addressing the Charity's risks and risk management arrangements. x) Receive regular reports on the performance of the Charity, and steer activity with a view to maintaining acceptable levels of risk and maximising compliance and effectiveness. xi) Appoint the external auditor for the Charity and approve any change from audit to independent examination if the Charity qualifies as below-threshold. xii) Receive the Annual Report and Accounts, consistent with *Charities SoRP* and relevant legislation and accounting standards, for review and recommendation for final approval to the Board of Directors of the Corporate Trustee. The Charitable Funds Committee's duties may be discharged by any sub-committees or working groups that it seeks to establish. It would approve the Terms of Reference, workplans and duration of any such groups. The Committee must respond to any action plans referred to it by the Audit Committee. The Committee is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources. **All decisions on behalf of the Charity must be distinct from Trust decisions, must be in the best interests of the Charity, and must be in accordance with the *duty of prudence*.**
Associated documents	This ToR is to be read in conjunction with the following. • ***The essential trustee: what you need to know, what you need to do*** – *Charity Commission* (to be interpreted for an NHS Charity context, and a Corporate Trustee context). • **The Trust's Standing Financial Instructions -** Additionally, the following governance documents – taken as a set - describe the separate Charity entity**.**

	• **The Charity's 5-year Vision and Income Strategy**, as approved by this Committee. • **The Charity's Annual Report and Accounts,** which outlines the Charity's history, constitution, governance, and management arrangements, as recommended to the Trust Board for approval. • **The Charity's policies**, as approved by this Committee, including the following. o Treasury Management Policy; o Reserves Policy; o Fundraising and Incomes Policy; and o Expenditure Policy, including Mission Statement. The above documents make direct reference to the following legislation. • Charities Acts 2011 and 2016 • Trustee Act 2000 • General Data Protection Regulation (GDPR) 2018
Review	Each year the Committee will undertake an annual Meeting Effectiveness Review. This process includes review of this ToR, and the setting of the Committee's annual workplan.
Membership	**Core membership** • Nominated Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Finance Officer • Chief Operating Officer • Chief Nursing Officer In attendance • Head of Charity • Charitable Funds Financial Accountant • Charitable Funds Officer • Assistant Director of Communications • Fundraising Team representatives • Assistant Director of Finance, Financial Services • Corporate Governance Manager All members should aim to attend all scheduled meetings. Other officers of the Trust may be invited to attend on an ad-hoc basis to present papers or to advise the Committee. Professional advisors and/or auditors may be invited to attend, when deemed necessary. Other members of the Board of the Corporate Trustee may attend meetings of the Committee if they wish. The Committee may establish appropriate time-limited working groups to consider specific issues on a project basis. Representation from such groups may be required at Committee meetings.

Attendance	Core Members are expected to attend a minimum of 60% (2 of the 3 meetings) of meetings per year. Members are expected to engage as follows. • Ensure that papers are read prior to meetings. • Attend as many meetings as possible. • Contribute fully to discussion and decision-making. • If not in attendance, seek a briefing from another member who was present, to ensure that they are informed about progress. Core members, and officers who engage in Charity business, are also expected, from time to time and with appropriate notice, to contribute to Charity events and promotional activities, as requested by the Head of Charity. If a decision is needed between meetings, it can be made via an ad hoc virtual meeting, or a shared email trail, with quoracy as below. It must be ratified at the next full meeting of the Committee.
Quorum	The Committee would be considered quorate with 50% attendance, to include both of the following. • At least one Non-Executive Director. • At least one Executive Director.
Accountability & reporting	The Committee will report to the Board of Directors following each meeting via a Chair's report, covering key decisions, developments and risks, and the basis of any recommendations made to the Board.
Frequency	The Committee will meet at least three times per year. Meetings may also be convened with the agreement of all core members at any time.
Administration	The office of the Chief Finance Officer will be responsible for all administrative arrangements, including the following. • Timely notice of meetings. • Agendas based on the Committee's annual workplan. • Distribution of electronic papers at least 4 working days prior to the Committee, unless there are exceptional circumstances agreed with the Chair. • Minutes and Action Log updates for each meeting.

EXECUTIVE COMMITTEE – Terms of Reference (2026/27) – Proposed	
Delegated Authority	The Trust shall establish a committee to be known as the Executive Committee which will formally be constituted as a committee of the Board.
Role	The Executive Committee meeting is established as the most senior executive forum within the Trust. This forum will be the final arbiter on all operational issues. The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.
Duties	Duties of the Committee will include: 1. To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts 2. To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within the year. 3. To monitor the delivery and benefits realisation of approved business cases and service developments 4. To review and approve significant tender/bid documents submitted by the Trust for new services 5. The management of issues with reputational and relationship management significance 6. The monitoring of Trust performance against all objectives, standards and targets including the development of any remedial actions 7. Receiving and considering the Chair's report from the Risk Management Council, the Premium Payment Scrutiny Council, the Transition and Transformation Council and other appropriate supporting governance or project groups 8. Governance matters including preparation and arrangements for regulatory review 9. Brief the Trust's senior managers on the business and decisions made at the Executive Committee
Review	Each year the Committee will undertake an Annual Meeting Effectiveness Review. Part of this process will include a review of the Committee Terms of Reference.

Membership	Core membership of the meeting will comprise: • Chief Executive (chair) • Deputy CEO (vice chair) • Chief People Officer • Chief Medical Officer • Chief Nursing Officer • Chief Financial Officer • Director of Corporate Services • Chief Operating Officer • Director of Informatics • Director of Integration • Director of Strategy The attendance of deputies will not routinely be permitted, however attendance by Trust staff and stakeholders is allowable for specific agenda items.
Attendance	Members are expected to attend a minimum of 70% of meetings. Members are expected to: - Ensure that they read papers prior to meetings - Attend as many meetings as possible and if not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress - Contribute fully to discussion and decision-making.
Quorum	A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.
Accountability & Reporting	The Committee reports to the Trust Board and a written summary of the latest meetings are provided to each meeting of the Board.
Meeting Frequency	Meetings will be scheduled weekly on a Thursday.
Agenda Setting and papers	Agendas agreed by the Chair will be in the accordance with the annual reporting schedule of the Committee. Minute production and distribution is via the Trust office secretariat under the direction of the EA to the Chief Executive. Documents submitted to the Committee should be in line with the corporate standard.

BOARD WORK PLAN 2026/27

ANNUAL TRUST BOARD WORKPLAN 2026/27 (PROPOSED)																
Month			**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**Report**	**Presenter**
Scheduled agenda items	General	Employee of the month	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Dep CEO	Chair
		Patient story		✓		✓		✓		✓		✓		✓	CNO	Various
		Apologies	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Declaration of interests	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Minutes of the previous meeting	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Action list / matters arising	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Meeting Effectiveness Review	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
		Any other business	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	Chair	
	Committee Reports	Audit (inc. approval of Corp Governance Manual and Standing Financial Instructions)	✓		✓			✓		✓			✓		CFO	NED
		Executive	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	DoCS	CEO
		Finance and Performance	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CFO	NED
		Quality (inc. Safer Staffing, Maternity and Infection Control)	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CNO	NED
		Strategic People Committee	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CPO	NED
		Charitable Funds			✓					✓				✓	CFO	NED
	Operational performance reports	Integrated performance report	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	CFO	
		Corporate Risk Register	✓			✓			✓			✓			DoCS	
		Board Assurance Framework	✓			✓			✓			✓			DoCS	
		Aggregated Incidents, Complaints and Claims report		✓		✓			✓			✓			CNO	
		Informatics Report and Strategy update								✓					Dof Inf	
		Learning from Deaths Quarterly Report and Annual Report (July)	✓			✓			✓			✓			Chief Medical Officer	
		Maternity and Neonatal Services Assurance Report		✓						✓					CNO	
	Annual reports	Approval of Quality Account		✓											CFO	
		NHS Licence Conditions Board declarations			✓										DoCS	
		Board and Committee Effectiveness Review		✓											DoCS	

Cyber Assessment Framework (CAF) Toolkit Results and Information Governance Annual Report				✓									Dof Inf	
Trust objectives approval, mid-year and year end reviews		✓						✓				✓	DoCS	CEO
Medical revalidation annual declaration						✓							Chief Medical Officer	
Research & Development Annual Report								✓					Chief Medical Officer	
Research & Development Annual Capability Statement								✓					Chief Medical Officer	
Biennial Review of NHS Constitution (next scheduled for 2026)								✓					DoCS	
Trust Board meeting arrangements								✓					DoCS	
EPRR Annual Report				✓									COO	
EPRR Compliance statement						✓							COO	
WRES & WDES Reports and Action Plans							✓						CPO	
Clinical Strategy annual update							✓						Chief Medical Officer	
Safeguarding Annual Report (Adult & Children)			✓										CNO	
Operational Plan - Budget and activity approval										✓		✓	CFO/COO	
National Quality Board - nursing workforce plan/staffing review								✓				✓	CNO	
Infection Control Annual Report				✓									CNO	
CQC registration												✓	CNO	
Mixed sex annual declaration												✓	CNO	
Fit and Proper Persons Chair's Annual Declaration			✓										DoCS	Chair
Freedom to Speak Up - Board Self-Assessment (*to be presented bi-annually – next due Feb 2027)*											✓		Dep CEO	
Freedom to Speak Up – Annual Report			✓											
CNST MIS Self Declaration & Approval *(allocate 30 minutes on 2027 agenda)*										✓			CNO	
Pay Gap Annual Declaration						✓							CPO	
Staff survey report and action plan												✓	CPO	

	Health Inequalities Strategy Annual Review		✓											DoInt	CEO
	NHS Oversight Framework – Provider Capability Self-Assessment			✓										DoCS	CEO
	NHSE New Experience of Care Framework Annual Update/Self-Assessment	✓												CNO	
Closed Session	Chair and NED meeting (or as required)	✓		✓				✓				✓		Chair	
	Chief Executives report		✓		✓		✓		✓		✓		✓	CEO	
	Patient Safety Incident Investigation Report		✓		✓		✓		✓		✓		✓	CNO	
	Staff Suspensions and Exclusions Report		✓		✓		✓		✓		✓		✓	CPO	
	Cyber Security Assurance Report		✓				✓		✓				✓	Dof Inf	
	NHS Oversight Framework – Provider Capability Self-Assessment		✓											DoCS	CEO
	Feedback from external meetings and events		✓		✓		✓		✓		✓		✓	All	
	Review of meeting effectiveness		✓		✓		✓		✓		✓		✓	Chair	

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	27 May 2026
Agenda Item	**TB26/040**			
Report Title	Trust Objectives 2025-26 – Year End Review			
Executive Lead	Rob Cooper, Chief Executive			
Presenting Officer	Rob Cooper, Chief Executive			
Action Required		**To Approve**	X	**To Note**

Purpose

To note the assessment of delivery of the 2025/26 Trust Objectives.

Executive Summary

In March 2025 the Board approved the Trust Objectives for 2025/26.

The Trust Objectives are aligned to the Trust vision to deliver Five Star Patient Care: with 5 supporting the Five Star Patient Care criteria of Care, Safety, Pathways, Communications and Systems. A further 4 categories cover; financial performance, efficiency, productivity, and strategic planning.

In November the Executive Leads reviewed the progress with delivery at the end of quarter 2 and this was reported to the Board. At that stage of the year the performance against the 27* live objectives was –

Objective fully delivered at end of Q2 or with high confidence of full delivery by 31 March 2026	7
Objective progressing as planned and on track to be fully delivered by 31 March 2026	19
Objective behind plan and at risk of not being delivered by 31 March 2026	1

**Objective 4.3 was superseded and was therefore not included in the Mid-Year Review assessment*

For the Year End assessment, the colour coding reflects the position on 31 March 2026.

Objective fully delivered by 31 March 2026	9
Objective partially delivered by 31 March 2026	14
Objective not delivered by 31 March 2026	0

Several of the objectives that were not fully delivered in 2025/26 have been rolled forward into the 2026/27 Trust objectives that were approved by the Board in March 2026.

Financial Implications

Included in 2026/27 budgets

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board are asked to note the Year End assessment of delivery of the 2025/26 Trust objectives	
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

Mersey and West Lancashire Teaching Hospitals NHS Trust

2025/26 Trust Objectives – Year End Review

	Objective fully delivered		**Objective partially delivered**		**Objective not delivered in 2025/26**

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**					
1.1	Improve measurable success in areas where our patients told us we didn't get it right first time including inpatient areas, ED, maternity with a focus on antenatal.	CNO	• Improvement against previous year's national survey results in relation to: ○ Management of pain ○ Kindness and compassion whilst in hospital ○ Experience of waiting time information	Quality Committee	<table><tr><th></th><th>2023 NIP* Survey</th><th>2024 NIP Survey</th></tr><tr><td>Management of pain</td><td>8.3</td><td>8.6</td></tr><tr><td>Kindness and compassion whilst in hospital</td><td>8.6</td><td>8.8</td></tr><tr><td>Experience of waiting time information</td><td>7.2</td><td>6.5</td></tr></table>*National inpatients survey (NIP) • Action plan in place in response to 2024 survey results including specific focus on the question 'How would you rate the quality of information you were while you were on the waiting list to be admitted to hospital?' • Plan includes waiting list validation, further promotion of the My Planned Care website and divisional pilot projects to improve communication to patients whilst on a waiting list. • A survey of waiting times has been completed across all relevant hospital sites and results analysed to identify a focus for improvement while waiting recommendations from NHSE.
			• As a minimum, conduct quarterly local surveys based on national survey indicators		• Monthly local surveys are now in place for Adult Inpatient and Maternity. Survey results are monitored at Patient Experience Council. <table><tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr></table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year End Review and RAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>Were you kept informed about how long you had to wait for a web on the ward?</td><td>80%</td><td>81%</td><td>84%</td><td>81%</td></tr>
<tr><td>Do you think the hospital staff do everything they can to help ease your pain?</td><td>95%</td><td>89%</td><td>98%</td><td>99%</td></tr>
<tr><td>Do you feel you are treated with kindness and compassion?</td><td>99%</td><td>99%</td><td>98%</td><td>99%</td></tr>
</table>
</td></tr>
<tr><td></td><td></td><td></td><td>• Maintain and embed the patient experience score from 5* Ward Accreditation Programme</td><td></td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>90.0%</td><td>92.2%</td><td>94.6%</td><td>94.2%</td></tr>
</table>
• Achieved over 90% patient experience score throughout 2025/26
</td></tr>
<tr><td>1.2</td><td>Ensure improvement and sustainability of nutritional standards for patients.</td><td>CNO</td><td>• Achieve 95% of adult inpatients screened for malnutrition on admission using the MUST tool</td><td>Quality Committee</td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>76.6%</td><td>73.3%</td><td>70.9%</td><td>72.0%</td></tr>
</table>
• Improvement work is ongoing with the dietetic team promoting nutrition and hydration week in March 2026 with stands at each site providing information and resources to staff and patients.
• Data reflects the new collection method which includes all adult patients admitted to hospital rather than a small sample from each ward as previously done
• Further work includes assessments via the 5 Star Ward Accreditation with required improvements identified and actioned with ward managers and heads of nursing and quality
</td></tr>
<tr><td></td><td></td><td></td><td>• Achieve 95% of patients with a score of 2 or more who receive an appropriate care plan</td><td></td><td>
<table>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>MUST 2+ Care Plan in place</td><td>92%</td><td>89%</td><td>86%</td><td>91%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year End Review and RAG</th></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td>• Improve the processes to ensure 95% of high-risk patients are referred to a dietician</td><td rowspan="2"></td><td>
<table>
<tr><td>Referral to dietician</td><td>92%</td><td>89%</td><td>92%</td><td>90%</td></tr>
</table>
• Southport and Ormskirk sites achieved care plan target in Q3 and Q4
• Southport and Ormskirk sites achieved referral to dietician in Q1, Q2 and Q3
• The essential nursing care plan has been updated to include more detail in the section for MUST. Education and training is ongoing and nutrition and hydration documentation is reviewed monthly at ward and divisional performance meetings. Sharing of best practice from areas achieving over 90% compliance is encouraged</td></tr>
<tr><td>• Achieve and maintain 90% for nutrition score consistently across all wards for the 5* Ward Accreditation Programme</td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>87%</td><td>94%</td><td>90%</td><td>86%</td></tr>
</table>
• Performance decreased in Q4 as no accreditations were carried out in January 2026 due to operational pressures reducing the total accreditations in the quarter. Only one of 11 areas did not achieve the standard which has received targeted support from the quality matrons and heads of quality and nursing for the divisions</td></tr>
<tr><td>1.3</td><td>Improve measurable success for people that birth have told us we didn’t get it right first time who access antenatal services</td><td>CNO</td><td>• Improvement against previous year’s national survey results via quarterly surveys</td><td>Quality Committee</td><td>• Local antenatal surveys, based on the National Maternity Survey questions have reported satisfaction levels >90% throughout the year or achieved by Q4 which is an improvement on the last survey data.
• New questions have been implemented from Q4 aligned to areas for improvement within the 2025 action plan.</td></tr>
<tr><td colspan="6">2. 5 STAR PATIENT CARE – Safety
We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care</td></tr>
<tr><td>2.1</td><td>Continue to ensure the timely and effective assessment and care of patients in the Emergency Department.</td><td>CNO</td><td>• Achieve 95% of appropriate patients triaged in the emergency departments in line with the national standard of triage within 15 mins</td><td>Quality Committee</td><td>
<table>
<tr><td></td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>15 min Triage</td><td>66.2%</td><td>80.8%</td><td>76.1%</td><td>75.2%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year End Review and RAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Average time to triage in Quarter 3 was 12 minutes on the Whiston site and 13 minutes on Southport Site, both below the national 15 minute target
and the Cheshire and Mersey position of 14.7 minutes.

Quarter 4 data
13 minutes / 76.2% for Whiston
7 minutes / 90.3% Ormskirk
15 minutes / 64.7% Southport
12 minutes / 75.2% MWL total

Quality Improvement initiatives have commenced on the Southport site following completion of current Emergency Department (ED) capital scheme to expand the waiting room/create a new entrance.

The Whiston site have implemented a new triage process which has a streamer available during the day, to assist with a primary and secondary triage system.</td></tr>
<tr><td></td><td></td><td></td><td>• NEWS – 80% of observations completed on time or within tolerance</td><td></td><td><table><tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>NEWS Observations</td><td>65.4 %</td><td>65.5%</td><td>66.3%</td><td>65.2%</td></tr></table></td></tr>
<tr><td></td><td></td><td></td><td>• All patients with a working diagnosis of sepsis receive antibiotics in line with the NICE guidance</td><td></td><td><table><tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4*</th></tr><tr><td>70.5%</td><td>68.7%</td><td>60.3%</td><td>48.8%</td></tr></table>*Q4 only Jan & Feb 26 data available

Southport site
Themes:
• Moderate risk of sepsis - delay in senior review & delay in antibiotics
• Severe risk of sepsis - delays in antibiotic (unclear if time to prescription or time to administration), issues also identified with prescribing and administration times being documented
Actions:</td></tr>
</table>

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
					• New Sepsis lead appointed, initial meeting held to discuss data collection and issues • For severe risk of sepsis it appears that patients are being reviewed in a timely manner but issues with administration, training for the Emergency Department • AMAT (clinical audit IT system) audit tool updated to be more specific to Southport to improve data quality. • Discussions ongoing with Pharmacy Leads in relation to prescription issues. Southport will be moving to EPMA which should support improvement. **Whiston site** Themes: • Delay in antibiotic prescription and administration • Issues with patients being held on ambulances so delay in triage, assessment, when assessed prompt administration of antibiotic. Actions: • Issues with accuracy of scanning, discussions ongoing with records team. • Current digital/paper hybrid model of triage not able to be updated to add sepsis screening added to the risk register. • Departmental surveys and actions - sepsis team send out monthly bulletin with education themes, "sepsis star of the month" award, new ED sepsis link nurses, increase ad hoc teaching, survey results to be shared in ED governance and Sepsis Steering Group

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year End Review and RAG</th></tr>
<tr><td rowspan="4">2.2</td><td rowspan="4">Improve the Trust's compliance with IPC standards.</td><td rowspan="4">CNO</td><td>• Eliminate methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia infections as a result of lapses of care</td><td rowspan="4">Quality Committee</td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>1 case – No lapses or gaps in care that contribute to the infection</td><td>1 case – Lapse in care which contribute to the infection</td><td>No cases</td><td>2 cases
Case 1 – Blood culture contaminant
Case 2 – Under review</td></tr>
</table>
• Disappointingly there were four healthcare-associated MRSA cases during 2025/26, a reduction of 2 compared to 2024/25 but in breach of zero-tolerance compliance
</td></tr>
<tr><td>• Implement action to reduce avoidable hospital onset MSSA bacteraemia</td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>18</td><td>20</td><td>22</td><td>19</td></tr>
</table>
• 78 cases (57 HOHA and 22 COHA) which is a reduction of 12 cases from the 90 cases in 2024/25.
</td></tr>
<tr><td>• Achieve minimum aseptic non-touch technique (ANTT) compliance of 85% for Level 2 across MWL (practical)</td><td>
<table>
<tr><th></th><th></th><th>April</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td rowspan="2">ANTT Training</td><td>Level 1</td><td>92.8%</td><td>67%</td><td>78.7%</td><td>82.7%</td><td>84.6%</td><td>86.2%</td><td>87.2%</td><td>83.2%</td><td>82.9%</td><td>88.9%</td><td>89.2%</td><td>89.3%</td></tr>
<tr><td>Level 2</td><td>68.8%</td><td>68.5%</td><td>73.6%</td><td>77.5%</td><td>79.8%</td><td>80.9%</td><td>82.8%</td><td>87.6%</td><td>85%</td><td>84%</td><td>85.3%</td><td>82.6%</td></tr>
<tr><td colspan="14">85%</td></tr>
</table>
• Compliance for Levels 1 and 2 has continued to improve with a targeted approach.
• Level 1 (e-learning) has averaged 89.1% in Q4
• Level 2 (practical) met the target in Nov, Dec and Feb but was below target in Jan and Mar
</td></tr>
<tr><td>• 90% compliance with visual infusion phlebitis (VIP) monitoring</td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>84.81%</td><td>87.50%</td><td>83.50%</td><td>83.34%</td></tr>
</table>
• End of year compliance 84.9%, although cannula-related bloodstream infections have reduced compared
</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year End Review and RAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>to previous financial years and there were no MRSA attributable cases linked to cannula care.</td></tr>
<tr><td></td><td></td><td></td><td>• Achieve 90% for the IPC and indwelling devices standard for the 5* Ward Accreditation programme</td><td></td><td><table><tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>87.2%</td><td>91.3%</td><td>90.0%</td><td>81.2%</td></tr></table>• The Quality matrons review the key themes for improvement for the IPC and Indwelling devices ward accreditation standards; the IPC team and practice educattors provide theoretical and practiclar training to clinical teams to support improvement, with progress monitored and tracked throught he ward action trackers.</td></tr>
<tr><td colspan="6">3. 5 STAR PATIENT CARE – Pathways

As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient</td></tr>
<tr><td>3.1</td><td>Continue to improve the effectiveness of the discharge process for patients and carers.</td><td>COO</td><td>• Achievement of 20% target for patients discharged before noon by March 2026

• 10% improvement in discharges by 6pm and 8pm during the week against 2024/25 position

• 10% reduction in the number of patient bed moves after 9pm (core wards) against 2024/25 position

• 10% improved utilisation of the discharge/transfer lounges against the 2024/25 position.

• Improve average discharge prescription dispensing turnaround time by 10 mins (from 92 to 82 mins) by March 2026 to below the national average

• Reduce average take home prescription arrival time to pharmacy by 60 minutes.</td><td>Finance & Performance Committee</td><td>• Discharged before noon target achieved<table><tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>Discharge before noon</td><td>20.1%</td><td>18.4%</td><td>20.8%</td><td>20.4%</td></tr></table>• Reduction in discharges by 6pm and 8pm not achieved<table><tr><th></th><th>2024/2025 Q4</th><th>2025/26 Q4</th></tr><tr><td>Discharged by 6pm</td><td>65.2%</td><td>64.6%
-0.6%</td></tr><tr><td>Discharged by 8pm</td><td>79.9%</td><td>80.2%
+0.5%</td></tr></table>The ward and board round standardisation programme, that sits within the wider UEC improvement programme, remains on going. As of Quarter 3, nine wards across Whiston have been involved, with a positive impact in length of stay being seen across all participating wards. The programme will continue throughout 2026/27, with inclusion of the Southport and Ormskirk sites.</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year End Review and RAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Regarding timeliness of discharge;

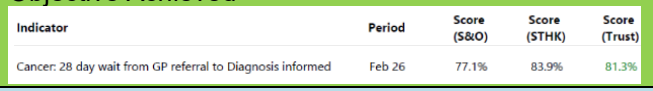
Discharges before 6pm
Comparing 2024/25 Quarter 4 to 2025/26 Quarter 4 there has been a decrease in the % of patients discharged by 6pm.

Discharges before 8pm
Comparing 2024/25 Quarter 4 to 2025/26 Quarter 4 there has been an increase in the % of patients discharged by 8pm.

To note, the above includes discharges from Same Day Emergency Care (SDEC) areas, which continue to accept referrals past 6pm. Maintaining the principles of SDEC, discharges will continue later into the evening, to avoid an overnight stay where possible.

Metric currently being reviewed to agree appropriate exclusions for wards across all sites.

• 3.5% more patients were discharged through the Discharge lounge in 2025/26. Q3 was a challenged period owing to IPC restrictions on wards, particularly on our Southport site, which meant fewer patients were able to go, due to isolation restriction.
<table>
<tr><th colspan="4">% Diff Quarter v Quarter</th><th rowspan="2">% Diff 2024/25 v 2025/26</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>-0.9%</td><td>11.7%</td><td>-1.2%</td><td>6.0%</td><td>3.5%</td></tr>
</table>
</td></tr>
<tr><td>3.2</td><td>Implement standardised clinical pathways across MWL.</td><td>CMO</td><td>• Implement a unified clinical leadership structure for all specialties</td><td>Quality Committee</td><td>• Divisional Medical Director, Deputy Divisional Medical Director and Associate Medical Directors in post. MWL Speciality Clinical Director recruitment underway, planned completion in June 2026 with additional departmental roles to follow.</td></tr>
</table>

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
			• Implement single clinical pathways for key conditions including sepsis and #NOF • Reduction in unwarranted variation of clinical outcomes across sites • Implement Trust professional standards for inter speciality referral in the ED and audit performance against the agreed standards.		• The expectation is that new clinical leadership will direct single pathway development and reduce unwanted variation measured by outcomes and performance. • Professional Standards now included in GIRFT Clinical Operational Standards and will be implemented in 26/27 as part of the Strategic 'Urgent and Emergency Care Transformation' workstream
3.3	Improve cancer pathways to deliver the national cancer performance cancer standards	COO	• 80% of patients to receive diagnosis or ruling out of cancer within 28 days of referral by March 2026.	Finance and Performance Committee	• Objective Achieved  Indicator / Period / Score (S&O) / Score (STHK) / Score (Trust) Cancer: 28 day wait from GP referral to Diagnosis informed / Feb 26 / 77.1% / 83.9% / 81.3%
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**					
4.1	Enhance internal communication efficiency.	DoI	• Enable Switchboard to work as a single team via harmonisation of the telephone operating system. • Reduce administration burden on clinicians by piloting and evaluating an AI tool in patient consultations to support real-time documentation, automate order placement within the EPR (Electronic Patient Record), and reduce administrative burden on clinicians.	Finance & Performance Committee	• A consistent telephony platform (NetCall) is now live across all MWL sites. This provides the technical foundation required for a single-team Switchboard operating model • An Ambient Voice Technology (AVT) pilot to commence in Q1 26/27with a small number of specialities. Different products being evaluated and a business case and options appraisal will be produced to determine adoption at scale.
4.2	Improve patient communication and engagement.	DoI	• Improve patient support and reduce missed appointments by expanding digital waiting list management solutions across all sites. • Pilot and evaluate an AI-driven Did Not Attend (DNA) or Was Not Brought (WNB) prediction tool.	Finance & Performance Committee	• Digital Waiting List validation is embedded at the Southport & Ormskirk sites, with 1,753 patients' self-removed during 24/25. System was implemented for the St Helens and Whiston Inpatient waiting lists in November 2025. • The Netcall solution has been reviewed in detail; GIRFT and Transformation leads reviewed an alternative solution and the Service Lead (Assistant Director of

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
			• Enable patients to view their outpatient letters on the NHS App through implementation of Phase 1 of the Patient Engagement Portal (PEP).		Operations) is currently producing a funding case to support the purchase of the Netcall module. • The Patient Engagement Portal is now live at Southport & Ormskirk, enabling outpatient letters to be viewed via the NHS App and directly via the PEP for non-NHS App users. Options to implement reduced elements of the Patient Engagement Portal at STHK are being explored with the supplier
~~4.3~~	~~Implement a new speech recognition system to improve the turnaround times for clinic letters.~~	~~DoI/ CMO~~	~~• Implement the new system and train staff in its use to consistently achieve a 48-hour (working week) turnaround for urgent letters and 7 days for routine letters~~	~~Finance & Performance Committee~~	• This objective has been superseded by the Ambient Voice Technology programme referenced under Objective 4.1.
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**					
5.1	Drive Digital System Convergence and Integration to ensure collaborative working across MWL.	DoI	• Launch the single EPR re-procurement process, ensuring alignment of clinical and operational processes across legacy systems. • Deploy a single maternity information system (BadgerNet) across MWL • Deploy Electronic Prescribing and Medicines Administration (EPMA) system at the Southport & Ormskirk Hospitals sites	Finance & Performance Committee	• The collaborative EPR procurement continues with North Cheshire & Mersey NHSFT; the pre-market engagement exercise was completed at the end of March, and the Outline business case is being reviewed, with a view to launch the formal procurement (ITT) in July 2026 • The Badgernet programme is working towards a go live date of November 2026 • EPMA deployment at Southport and Ormskirk sites is scheduled to commence in May 2026 with the go live currently scheduled to complete in early in early July
5.2	Continue to embed service improvement techniques and the culture of improvement across MWL	DoS	• Complete the cascade of training of staff in the MWL service improvement methodology • Embed the consistent approach to service improvement and transformation.	Executive Committee	**Improvement Model & Strategy** • Clear, maturing improvement model grounded in the IMPACT methodology • Strong governance aligned to Five Star Patient Care priorities • Board-approved Continuous Improvement Strategy embedded in wider Trust Strategy

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
					• Unified improvement language and collaborative cross-functional working driving improvement culture across the organisation **Capability Building & Training** • Structured capability offers that blends e-learning, leadership development, and specialist improvement training • Aqua Champions and Leaders programmes completed; celebration held March 2026 • Improvement learning integrated into the Leading Operational Excellence Programme • 26/27 training programme planning underway • Workforce capability building ongoing, with plans for a dosing-model approach to wider spread **Improvement Tools & Infrastructure** • Standardised improvement toolkits, mandates, documentation and dashboards • Enhances consistency, process reliability and real-time visibility **Governance & Transformation Structures** • Oversight via Trust Improvement Group and Strategic Transformation Council • Clear process for assessing, prioritising and allocating improvement resource
6. DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.					
6.1	Develop and embed a culture that empowers individuals to lead healthy lives and thrive at work by providing holistic wellbeing support.	CPO	• Develop a communications and engagement strategy to support and champion a cultural shift around flexible working and improve performance against the national average for 'We work flexibly' in the national staff survey.	Strategic People Committee	• Culture and engagement calendar of events agreed at Strategic People Committee in May 2025, and a digital calendar on the staff intranet (in the top 5 most visited intranet pages). • Summer Wellbeing Week 28th July- 1st August took place with a presence at 4 sites (Southport, St Helens, Ormskirk and Whiston) – flexible working was the

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
					focus. A series of virtual sessions also delivered with an average attendance of 20 staff. • MWL People Week focused on promoting flexible working opportunities, health and wellbeing and staff benefits. • Divisional engagement plans developed in response to Staff Survey feedback – included flexible working action plans, engagement and trial options for flexible working requests. • Roll out of unlimited roster requests in Delivery Suite and 2E – positively received and plans in place to roll out across Women's and Children's with a view to scaling up across Divisions as proof of concept and evaluation is concluded in Women's and Children's.
6.2	Create an environment where all staff feel supported, valued, and able to perform at their best.	CPO	• Complete the harmonisation of all workforce policies across MWL	Strategic People Committee	• A total of 19 policies have been ratified year to date and 6 are outstanding which require additional consultation with Trade Unions. Namely Medical Study Leave Policy, Annual Leave Policy (Non-medical), Alcohol, Drug and Substance Misuse Policy, Special Leave, Disciplinary Policy, Recruitment and Selection Policy and SOP (national policy adoption)
			• Ensure that all divisions are demonstrating adherence to the attendance management policy by proactively reviewing and managing absences in compliance with policy.		• Divisional People Meetings each month to monitor sickness absence trends and drive compliance with the attendance management policy. • Completion of welcome back conversations is a divisional performance metric. • Workforce FIG, PPC and SPC all focus on sickness absence. • Campaign launched to promote the Reasonable Adjustment Passport. • Establishment of Task Force Group. Deep dive on the data to identify key areas of need to look at the application of policy, wider cultural changes needed to embed a culture of wellbeing– linked to values and behaviours work. Work continues; however some progress has already been made resulting in reduced absence rates across all 6 identified areas.

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
6.3	Foster a workplace that champions equity, diversity, and inclusion to create a culture of belonging, respect, and opportunity for all.	CPO	• Improvement in the national staff survey theme "We are compassionate and inclusive" • Improvement in the national staff survey theme "We each have a voice that counts"	Strategic People Committee	• EDI Training programme 2025-2026 launched • Civility, Respect and Trust values embedded into all Leadership and Management Training. • Mapping of MWL Leadership and Management Development offer against the draft NHSE Leadership and Management Framework completed. • Launch of new 'Warm Welcome' induction programme • Launch of additional Induction for People Managers, focussed on expected behaviours. • Anti-Racism statement approved. • Anti-Racism Launch events August – October. • Bronze anti-racism accreditation achieved. • Staff Networks and Behavioural Standards agreed as one of the high Impact Actions from the Star Conference in April 25 and were launched in April 26. • Agreed launch of EDI Council from April 26, alongside supporting sub groups for disability, race and sexual orientation. Staff Networks will report in and expressions of interest will be sent for Chairs of the Network launched at Star Conference in April 26. • New FTSU champions recruited • Focus on Staff Survey 'You Said, We Did' communications
6.4	Strengthen core management and leadership skills within our workforce to ensure our leaders are equipped with the required skills and techniques.	COO	• Create a common set of tools and techniques for all operational managers in year 1	Strategic People Committee	• 'Operational excellence' development programmes established and commenced, for operational roles B6 to 8a and 8b to 8d. All
7. OPERATIONAL PERFORMANCE We will meet and sustain national and local performance standards					
7.1	Deliver 2025/26 elective/outpatient recovery targets	COO	• Deliver 5% improvement from 2024/25 position in referral to treatment (elective/day case and outpatients) targets for consultant led services • 1% reduction in 52 weeks + waiters	Finance & Performance Committee	<table><tr><th>Performance Indicator</th><th>2024-2025</th><th>2025-2026</th></tr><tr><td>Referral to treatment targets (% within 18 weeks and 95th</td><td>64.58 %</td><td>66.53 %</td></tr></table>

<table>
<tr><th>No</th><th>Objective</th><th>Lead Director</th><th>Measurement</th><th>Governance Route</th><th>Year End Review and RAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>
<table>
<tr><td>percentile targets) – Incomplete pathways</td><td></td><td></td></tr>
</table>
<table>
<tr><th>Site</th><th>01/03/2025</th><th>01/03/2026</th><th>Diff</th></tr>
<tr><td>S&O</td><td>1.4%</td><td>0.9%</td><td>-0.5%</td></tr>
<tr><td>STHK</td><td>3.0%</td><td>1.5%</td><td>-1.5%</td></tr>
<tr><td>MWL</td><td>2.5%</td><td>1.3%</td><td>-1.2%</td></tr>
</table>
</td></tr>
<tr><td>7.2</td><td>Deliver the NHS urgent and emergency care performance standards/targets</td><td>COO</td><td>• Improve A&E waiting times so that no less than 78% of patient are seen within 4 hours by March 2026

• Achieve 30 minute average ambulance handover target</td><td>Finance & Performance Committee</td><td>• In March 2026, 79.5% of patients were seen and discharged/admitted within 4-hours as per the national standard. This was the highest performance within C&M and third highest in NW.
<table>
<tr><td colspan="4">Average Vehicle Handover Time (hh:mm)</td></tr>
<tr><td>Whiston</td><td>Southport</td><td>Ormskirk</td><td>MWL</td></tr>
<tr><td>00:44</td><td>00:26</td><td>00:23</td><td>00:38</td></tr>
</table>
• 63.1% of patients handed over within 30 minutes.
• National standard changed to 0% over 45 minutes, 25/26 performance of 81.1% against new target</td></tr>
<tr><td>7.3</td><td>Deliver cancer improvement targets</td><td>COO</td><td>• 82% of patients treated within 62 days</td><td>Finance & Performance Committee</td><td>• 86.4% of patients waited less than 62 days for their first treatment, following an urgent GP referral, as report March 2026.</td></tr>
<tr><td colspan="6">8. FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY
We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money</td></tr>
</table>

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
8.1	Deliver the agreed financial plan including outturn, cash balances and capital resourcing limits.	CFO	• Achieve the approved financial plan for 2025/26 • Deliver the agreed Cost Improvement Programme • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme, to progress the strategic estates delivery plan, equipment replacement and IT investments	Finance & Performance Committee	• 2025/26 financial plan delivered • 2025/26 CIP Programme delivered £48.2m • Cash balance of £22.8m at year end • Capital programme delivered £55m of assets in line with plan
8.2	Work with partner organisations across the ICS to develop and deliver opportunities for collaboration at scale and increased efficiency.	CFO	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration with system partners e.g., payroll and Eastern Pathology Hub	Executive Committee	• East Pathology Hub Delivered in 2025/26
8.3	Deliver the agreed capital schemes to deliver the capacity needed to meet service demand and a safe, high-quality environment for patients and staff.	DoCS	• Deliver the planned estates capital developments for 2025/26 to optimise capacity/space utilisation and improve patient experience • Deliver year three of the backlog maintenance reduction programme at Southport and Ormskirk Hospitals, including options for decant spaces where required • Deliver the planned PFI lifecycle programme for St Helens and Whiston Hospitals to maintain the quality of the environment	Finance & Performance Committee	• Estates capital programme delivered in 2025/26 with significant improvements to critical infrastructure at the Southport and Ormskirk Hospital sites, schemes that have improved the experience and environment for patients, and increased sustainability. • Schemes to reduce high risk backlog maintenance were completed • The PFI lifecycle programme was delivered

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
9. STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**					
9.1	Deliver the key milestones of the Shaping Care Together Programme for 2025/26 in collaboration with ICB partners and NHS England.	CEO	• Achieve the 2025/26 milestones for the Shaping Care Together Programme – including approval of the Pre-Consultation Business Case and completing public consultation	Executive Committee	• 2025/26 milestones achieved with Decision-Making Business Case approved by Joint Committee March 2026
9.2	Work with the ICS and each of the Place Based Partnerships within the MWL footprint to improve patient flow and increase timely discharge from hospital to appropriate community /social care settings or home-based support.	DoInt	• Urgent Care Recovery Programme – work with Places to improve the discharge from hospital process, principal measures include: - ○ Reducing patients who are non-criteria to reside to < 15% ○ Reducing the patients ready for discharge days in line with best practice	Executive Committee	• The non criteria to reside performance is not consistent. Whiston hospital was 14% in February 2026 and are amongst the strongest performers in C&M. Southport is around 24% of patients. There have been delays in the EDIS implementation and the co-location of the TOCH as well as ongoing ward closures IPC
9.3	Working with NHSE and the ICB to develop a long-term plan for financial and clinical sustainability for MWL	CEO	• Agree a three-year financial recovery plan • Develop strategic service reconfiguration options and delivery plans to support long term clinical sustainability	Executive Committee	• The Trust has submitted a 3-year recovery plan to ICB/NHSE, which now requires agreement to move into delivery phase. • Once agreed in principle, further development of detailed plans and commitment from the ICB, aligned to strategic commissioning intentions, will be required to ensure delivery over the specified time frame. ICB and MWL CEO led meetings now diarised to ensure progress.
9.4	Develop a Community Services strategy to support the improved effectiveness and outcomes for patients and staff.	DoS	• Implementation of a Community Services strategy including service outcome measures, leadership structure, digital solutions, reporting and estates requirements	Executive Committee	• West Lancashire Community Services tender delayed with successful bid for contract. Transfer of services planned for 1st July 2026. • Draft Community services strategy being developed through community transformation programme
9.5	Co-ordinate the implementation of the Trust Health Inequalities Strategy and delivery plan	DoInt	• Develop the Health Inequalities dashboard to meet the requirements of the strategy and delivery plans	Executive Committee	• The BI Health Inequalities dashboard is completed and has been launched in November 2025. This has developed from a MWL only tool to a universal application for all C&M Acute Trusts and Places to use.

No	Objective	Lead Director	Measurement	Governance Route	Year End Review and RAG
			• Work with system partners to create a shared Health Inequalities dashboard for the ICB which is shared on the CIPHA platform • Demonstrable Trust contribution and improvements in the delivery of Core20plus5 for Adults and Children and Young People • Continue to maximise the potential of the Trust as an anchor institution in our communities to improve health, education and employment.		• The Trust is playing a lead role in both Neighbourhood Health Wave 1 “Pioneer” Places (Sefton & St Helens) and will be supporting the delivery using case finding tools that address Core 20plus5 concept. • The Trust has led the refurbishment of a Health and Skills Careers Hub as part of a £1.7m capital redevelopment scheme • The Trust has led the development of a Health and Care Career Hub in St Helens, The Chief Executive has taken a place on the Liverpool CEO forum, and the Trust is represented on the Knowsley Chief Officer Group, all examples of our wider commitment to the growth of places and communities