

Trust Board Meeting (Public)

To be held at 10.00 on Wednesday 30 September 2026

CMO Meeting Room, Corporate Management Offices, Southport Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	Employee of the Month (August and September 2026) <i>Purpose: To note the Employee of the Month presentations for August and September 2026</i>	Presentation	Chair (15 mins)
10.15	2.	Patient Story <i>Purpose: To note the Patient Story</i>	Presentation	Chair (15 mins)
10.30	3.	Chair’s Welcome and Note of Apologies <i>Purpose: To record apologies for absence and confirm the meeting is quorate</i>	Verbal	Chair (10 mins)
	4.	Declaration of Interests <i>Purpose: To record any Declarations of Interest relating to items on the agenda</i>	Verbal	
	5.	TB26/060 Minutes of the previous meeting and Written Resolution 01.26 <i>Purpose: To approve the minutes of the meeting held on 29 July 2026 and Written Resolution 01.26</i>	Report	
	6.	TB26/061 Matters Arising and Action Logs <i>Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and approve completed actions</i>	Report	
Performance Reports				
10.40	7.	TB26/062 Integrated Performance Report 7.1. Quality Indicators 7.2. Operational Indicators 7.3. Workforce Indicators 7.4. Financial Indicators	Report	S O’Brien / S Dowson L Neary J Waldron G Lawrence

		<i>Purpose: To note the Integrated Performance Report</i>		(30 mins)
Committee Assurance Reports				
11.10	8.	TB26/063 Committee Assurance Reports 8.1. Executive Committee 8.2. Audit Committee 8.3. Quality Committee 8.4. Strategic People Committee 8.5. Finance and Performance Committee <i>Purpose: To note the Committee Assurance Reports</i>	Report	R Cooper S Connor N Fletcher S Connor obo M Singh S Connor obo C Spencer (40 mins)
Other Board Reports				
11.50	9.	TB26/064 Learning from Deaths Quarterly Report (Q3 and Q4 2025/26) <i>Purpose: To note the Learning from Deaths Quarterly Report for Q3 and Q4</i>	Report	S Dowson (10 mins)
12.00	10.	TB26/065 Appraisals and Medical Revalidation Annual Report 2025/26 <i>Purpose: To approve the Appraisals and Medical Revalidation Annual Declaration</i>	Report	S Dowson (10 mins)
12.10	11.	TB26/066 Emergency Planning Response and Resilience (EPRR) 2026/27 Compliance with the National Core Standards. <i>Purpose: To approve the EPRR Statement of Compliance with National Core Standards for 2026/27</i>	Report	L Neary (10 mins)
12.20	12.	TB26/067 Statutory Pay Gap Annual Declaration 2025/26 <i>Purpose: To approve the Statutory Pay Gap Annual Declaration 2025/26</i>	Report	J Waldron (15 mins)
12.35	13.	TB26/068 MWL Health Inequalities Strategy Annual Progress Review <i>Purpose: To note the MWL Health Inequalities Strategy Annual Progress Review</i>	Report	W Longshaw (15 mins)

12.50	14.	TB26/069 Communications and Engagement Strategy <i>Purpose: To approve the Communications and Engagement Strategy</i>	Report	R Cooper obo AM Stretch (10 mins)
13.00	15.	TB26/070 Maternity and Neonatal Update following the National Reviews, including 10-Point Plan for Maternity & Neonatal Services Baseline Assessment <i>Purpose: To note the updates</i>	Report	S O'Brien (20 mins) (supported by Sue Orchard and Kevin Thomas)
Concluding Business				
13.20	16.	Effectiveness of Meeting	Verbal	Chair (5 mins)
13.25	17.	Any Other Business <i>Purpose: To note any urgent business not included on the agenda</i>	Verbal	Chair (5 mins)
		Date and time of next meeting: Wednesday 28 October 2026 at 09:30		13.30 close
15 minutes lunch break				

Chair: Steve Rumbelow

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

Title of Meeting	Trust Board			Date	30 September 2026
Agenda Item	TB26/000				
Report Title	Employee of the Month (August and September 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 winners for August and September 2026.					
Executive Summary					
<u>August 2026</u> The Employee of the Month winner for August 2026 was Kate Thompson, a Specialist Physiotherapist in the Medicine and Surgery Therapy Team at Southport Hospital. She was nominated following exceptional feedback from a colleague regarding the recent treatment of an Intensive Therapy Unit (ITU) step-down patient during a challenging admission. Kate plays an important role in helping patients regain strength, mobility and independence following illness or injury. Working closely with patients, families and colleagues across the multidisciplinary team, she is committed to supporting recovery and helping make meaningful progress. Throughout the patient’s journey, Kate consistently championed their needs, advocating with the medical team to ensure appropriate investigations were carried out while continuing to support their rehabilitation. Through her determination, clinical expertise and unwavering belief in the patient, she helped secure a positive outcome, resulting in significant progress to the patient’s mobility and function that far exceeded initial expectations. Her commitment demonstrated not only outstanding professional skill, but also a dedication to helping them achieve their full potential. This example reflects the qualities Kate brings to her role every day. She continually looks beyond traditional approaches and never loses sight of the individual behind the diagnosis. Her ability to work collaboratively with colleagues while maintaining a strong focus on what is best for the patient makes her an invaluable member of the Medicine and Surgery Therapy Team.					
<u>September 2026</u> Employee of the Month winner for September 2026 was Shoaib Seraz, Resident Doctor at Southport Hospital. He was nominated by Laura Watson, Sister on Ward 11B, following heartfelt feedback she received from the family of a patient in his care. Shoaib was recognised for the exceptional support he recently provided to a young patient with Rett syndrome, who is non-verbal and has profound learning disabilities. Throughout her time in hospital, Shoaib treated both the patient and her family with dignity and respect, taking the time to understand their individual needs and ensuring they felt listened to and reassured every step of the way. He was praised for his excellent communication and ability to build trust during an incredibly difficult time. By carefully considering the concerns raised by the patient’s family and acting upon them, Shoaib demonstrated a truly person-centred approach to care.					

The nomination highlighted how his empathy, professionalism and compassion stood out. The support he provided not only had a positive impact on the patient's experience but also gave her family confidence and reassurance when they needed it most.

This feedback reflects the qualities Shoaib brings to his role every single day. His commitment to treating every patient with understanding and respect, while recognising the importance of listening to those closest to them, embodies the Trust values of being Kind, Open and Inclusive.

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to note the Employee of the Month winners.

Strategic Objectives

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

Title of Meeting	Trust Board		Date	30 September 2026
Agenda Item	TB26/000			
Report Title	Patient Story			
Executive Lead	Sarah O'Brien, Chief Nursing Officer			
Presenting Officer	Michelle Kitson, Matron Patient Experience			
Action Required		To Approve	X	To Note
Purpose				
To inform the Trust Board of the impact of changing technology on the management of diabetes and the supportive care received from the Diabetic Specialist Nursing team				
Executive Summary				
John is 77 years old and tells his story from being diagnosed as an insulin dependent diabetic when he was 29 years old, and his care journey over the following years with specific reference to the changes in equipment and technology used to provide better management of his diabetes. When John was first diagnosed, he met patients who had experienced the adverse effects of diabetes such as sight loss and amputation, and he was determined that he was not going to have the same experience. His diabetes care over the years has moved from sterilising his own glass insulin syringes to John's current management using an insulin pump. John highlights the benefit of the specialist nurse roles that have supported him throughout this change which has resulted in improved management of his diabetes and the ability to relinquish the majority of his diabetic control to technology, resulting in a better quality of life. John's story acknowledges the ongoing positive impact of technology on improving healthcare, supporting the aims of the NHS 10-year health plan, and recognising the value of specialist nurse roles to deliver support, education and training to patients to assist them in managing their own long-term conditions.				
Financial Implications				
Not applicable				
Quality and/or Equality Impact				
Not applicable				
Recommendations				
The Board is asked to note the Patient Story.				

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

Minutes of the Trust Board Meeting
Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 29 July 2026

(Approved at Trust Board on Wednesday 30 September 2026)

Name	Initials	Title
Steve Rumbelow	SR	Chair
Gill Brown	GB	Non-Executive Director and Deputy Chair
Rob Cooper	RC	Chief Executive
Anne-Marie Stretch	AMS	Deputy Chief Executive
Khalid Anis	KA	Associate Non-Executive Director
Simon Dowson	SD	Chief Medical Officer
Neil Fletcher	NF	Associate Non-Executive Director
Malcolm Gandy	MG	Director of Informatics
Elsie Hayford	EH	Shadow Non-Executive Director (via MS Teams)
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Chief Finance Officer
Lesley Neary	LN	Chief Operating Officer
Mini Singh	MSi	Non-Executive Director
Sarah O'Brien	SO	Chief Nursing Officer
Carole Spencer	CS	Non-Executive Director
Malise Szpakowska	MS	Chief People Officer

In Attendance

Name	Initials	Title
Kim Hughes	KH	Assistant Director of Communications (Observer via MS Teams)
Christine Oakley	CO	Deputy Director of Finance and Information (Observer via MS Teams)
Yvonne Mahambrey	YM	Quality Matron, Patient Experience (Agenda Item 2 via MS Teams)
Alison Powell	AP	Matron General Surgery (Agenda Item 2 via MS Teams)
Sukitha Rupasinghe,	SRu	Consultant General, Bariatric and Upper GI surgeon (Agenda Item 2 via MS Teams)
Matt Shawcross	MSh	HBSUK (Observer via MS Teams)
Zoe Tidman	ZT	Senior Correspondent, Health Service Journal (HSJ) (Observer via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Steve Connor	SC	Non-Executive Director
Neil French	NFr	Non-Executive Director
Simon Regan	SRe	Director of Corporate Services

Agenda Item	Description
Preliminary Business	
1.	Chair's Welcome and Note of Apologies
	1.1. SR welcomed all to the meeting and made the following statement on behalf of the Trust Board: <i>Before we begin today's meeting, I would like to take a moment to acknowledge that today marks the second anniversary of the tragic events in Southport on 29 July 2024.</i> <i>Our thoughts are with the families of Alice, Bebe and Elsie, everyone who was injured, and all those whose lives were changed by that day.</i> <i>We also remember the many colleagues and emergency responders who provided care and support in the immediate aftermath and continue to feel the impact of those events.</i> <i>At 15:00 today, communities across Southport will observe a three-minute silence to remember everyone affected. The Trust is supporting this through opportunities for colleagues to come together at both Southport and Ormskirk Hospitals for reflection and remembrance, led by our Chaplaincy team.</i> <i>On behalf of the Board, I would like to recognise the compassion, professionalism and kindness shown by our staff then and in the years since. We continue to hold everyone affected in our thoughts.</i> 1.2. SR noted that this would be LK's last Board meeting as her term of office was ending in August 2026 and thanked her on behalf of the Board for her hard work, commitment and leadership during in her tenure. 1.3. SR acknowledged the following awards and recognition for Trust staff and services: • The Critical Care Team at Whiston Hospital has been shortlisted in the Critical and Emergency Care category at the Nursing Times Awards • Jayne Gore, Matron for Community Urgent Care, was invited to a reception at 10 Downing Street hosted by (now former) Prime Minister, Sir Keir Starmer, as part of celebrating 78 years of the NHS • Helen Hughes, Blood Transfusion Co-ordinator, has won the Lifetime Achievement Award at the NHS North West Healthcare Science Awards • Dr Ayo Olatoye, Acute Medical Consultant, Whiston Hospital, made the final in the Lifetime Achievement category at the Caribbean & African Health Network (CAHN) Black Healthcare Awards. 1.4. The Annual Staff Awards had taken place on Friday 26 June 2026 and SR thanked the Communications and Media Team for organising the event and congratulated all the award winners. SR also thanked the members of the Board who had attended and looked after the guests and sponsors.

	Apologies for absence were noted as detailed above.
2.	Employee of the Month
	2.1. The Employee of the Month for July 2026 was George Babu (GBa), Health Care Assistant (HCA), Southport Hospital. SR advised that, unfortunately, GB was unable to attend Board today as he was currently working nights and a member of the Communications and Media Team would arrange for SO to hand over his certificate and pin badge at a later date. 2.2. SR read out the citation for GBa. 2.3. GB reflected on her experience of breaking down on the M6 and noted how frightening this had been, even without responsibility for a patient or working in extreme heat and commented that GBa was an excellent example of the lengths that staff went to in providing care and support to patients. RESOLVED: The Board noted the Employee of the Month for July 2026 and congratulated the winner.
3.	Patient Story
	<i>(YM, SRu and AP joined the meeting)</i> 3.1. SR welcomed YM, SRu and AP to the meeting. 3.2. YM introduced the Patient Story video which highlighted the impact that patient centred care can have for a patient. Lisa, a 47-year-old single mother, had shared her experience and described her bariatric surgery at Whiston Hospital as lifesaving. Her motivation was not just weight loss, but to also reduce her risk of early death, especially as her father had a heart attack at 46, as well as to be able to keep up with her children. Lisa had chosen Whiston Hospital for its thoroughness and good reputation. The type of surgery was explained to her and the process included attending a bariatric school for education and expectation management, meeting the multidisciplinary team (MDT), and receiving repeated guidance from surgeons, nurses, and dietitians. Lisa commented that she had been reassured by daily visits from the surgical team and appreciated the personalised approach. Lisa had lost 94% of her excess weight which had exceeded her expectations. Post-surgery, Lisa had reported dramatic improvements: she avoided diabetes and high blood pressure, became active with her children, and described herself as healthier than in her 20s and 30s.

	3.3. SR thanked Lisa for sharing her story and noted that it had demonstrated the significant and lasting impact of bariatric surgery on her health and quality of life. 3.4. YM commented on the importance of listening to patients and continually learning from their feedback, which had helped the team to shape and improve the bariatric service. The Bariatric School played an integral part in preparing patients to be successful in their treatment post-operatively. Lisa's story was a reminder that behind every referral and clinic appointment there was a patient with aspirations for their own future. YM thanked the Communications Team for helping to articulate Lisa's feedback. 3.5. GB asked if the Bariatric School was standard across the NHS or whether it was something unique to Whiston Hospital. SRu responded that as part of any service there should be patient education and engagement including group teaching sessions and noted that MWL's bariatric school was more personalised than others in the region, with face-to-face multidisciplinary sessions. SRu advised that Lisa now contributed to a patient-led support group, helping others navigate surgery and recovery, extending the impact of the service and noted that the lived-experience of patients like Lisa was seen as crucial for service improvement and shaping educational programs. 3.6. GB noted the importance of lived-experience in supporting patient engagement and commended the work undertaken which had highlighted the contribution of the surgeons, specialist nurses and the wider team for their role in the success of the service. Additionally, GB noted that the presentation had been informative and impactful, and provided a valuable insight into bariatric surgery and the Trust's service. 3.7. SR thanked YM, SRu and AP for their presentation. RESOLVED: The Board noted the Patient Story. <i>(YM, SRu and AP left the meeting)</i>
4.	Declaration of Interests
	4.1. There were no new declarations of interests made in relation to the meeting agenda items.
5.	TB26/049 Minutes of the previous meeting
	5.1. The meeting reviewed the minutes of the meeting held on 24 June 2026 and approved them as a correct and accurate record of proceedings subject to the following amendments:

	5.1.1. 7.3.3. to be amended to read ‘GB reported that there had been two neonatal deaths relating to premature births and assured that the Committee had not identified any concerns with the care provided to the babies or their families’. 5.1.2. 7.3.4 to be amended to read ‘GB highlighted the Committee’s commitment to recognising quality and safety issues throughout the Trust’s services and implementing improvement actions, however, sustaining these remained a challenge. It was anticipated that the ongoing quality improvement work would provide stability, however, this would need to be an area of focus going forward.’” RESOLVED: The Board approved the minutes from the meeting held on 24 June 2026 subject to the amendments detailed above
6.	TB26/050 Matters Arising and Action Logs
	6.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 6.2. The following actions were closed: • Action Log number 31 (TB26/019 Committee Assurance Reports 8.1 Executive Committee) – the Digitising Documentation Paper was currently progressing through the appropriate governance approval processes. The paper would set out the strategic approach, implementation plan, and proposed timeline for reducing paper-based processes across the Trust. Subject to governance approval, the paper was scheduled to be presented to the Closed Board in September, and an action has been included on the Closed Board action log. Action closed. • Action Log number 33 (TB26/029 Corporate Risk Register) –the Corporate Risk Register (CRR) has been reviewed, and the relevant risks have been streamlined. Action closed. • Action Log number 3 (TB26/036 Aggregated Incidents, Complaints and Claims Report (Q4) – an update was included in agenda item 5 (TB26/055 Aggregated Incidents, Complaints and Claims Report (Q1). Action closed. • Action Log number 4 (TB26/044 Committee Assurance Reports / 7.3 Quality Committee) – the 2025/26 Safeguarding Annual Report (including case studies) that was presented at Quality Committee was circulated to Board members. Action closed. 6.3. There were no other outstanding actions. RESOLVED: The Board approved the action log
Performance Reports	

7.	TB26/051 Integrated Performance Report
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for June 2026 was presented.
7.1.	Quality Indicators
	7.1.1. SO, and SD presented the Quality Indicators. SO highlighted the following: • Performance against the National Early Warning Score (NEWS) observation compliance in the Emergency Department (ED) at Southport and Whiston Hospitals remained below the 80% target overall. However, Southport ED had improved from 79.53% in May 2026 to 82.65% in June 2026, and Whiston ED had increased from 61.13% to 62.93% over the same period. Targeted work was taking place in both EDs and there was an expectation of incremental improvements that would result in sustained new ways of working. It was noted that this had been discussed at Quality Committee. • Complaints response within 60 days performance had improved from 59.2% in May 2026 to 73% in June 2026 (target 80%). SO assured the Board that work was ongoing with the Clinical Divisions to ensure timely responses. • The Nurse fill rate was 94.6% against a target of 90% and SO advised that performance had remained consistent. • There had been zero Never Events reported in June 2026, and this reflected ongoing work in theatres. SO noted that Health Innovation Northwest were undertaking an external review. • Four neonatal deaths had been reported. Three related to babies born at less than 28 weeks' gestation, and one related to a baby born later in pregnancy with a severe genetic disorder associated with a high rate of early mortality. SO noted that these cases had been reviewed at the Quality Committee. • There had been a continued focus on nutrition and hydration across all sites and the challenges with accurate reporting had been resolved. The Trust-wide Nutrition and Hydration Group was working with clinical areas to improve the use of the Malnutrition Universal Screening Tool (MUST) score as well as fluid balance monitoring. Additionally, this formed part of the Nursing Strategy and had been addressed in Senior Nurse meetings. • Infection, Prevention and Control (IPC) rates, especially <i>Clostridioides difficile</i> (C.Diff) remained an area of focus and the 'Gloves Off' campaign had been launched across the Trust. This was supported by the Advancing Quality Alliance (AQaA) and the Service Improvement Team who were working with the frontline staff to introduce improvement methodology with a focus on quality improvements rather than reactive fixes. 7.1.2. SD highlighted that the Hospital Standardised Mortality Ratio (HSMR) had increased to 116.2 in March 2026 and a clinical review was underway to understand the drivers for this. SD noted that as no specific clinical issues

	had been found to date, the quality of the data was being examined and meetings were on going. An update would be provided at a future Board meeting.
7.2.	Operational Indicators
	7.2.1. LN presented the operational indicators and reported that June performance had been mixed, with continued pressures reported across urgent and emergency care, elective care and diagnostics. It was noted that the strategic transformation programmes were moving from recovery into transformation, with clear milestones established and early improvements being seen. 7.2.2. LN highlighted the following: <u>Urgent and Emergency Activity</u> 7.2.3. The Trust 4-hour mapped waiting time performance for June 2026 was 76.7% which was a slight decrease from 77.3% in May 2026 (target 82%). This compared to 75% nationally and 73.2% for Cheshire and Merseyside (C&M). During June 2026 there had been a 2.7% increase in attendance. 7.2.4. 12hour waits had decreased to 19.1% in June 2026 (target 15.6%). 7.2.5. Bed occupancy had improved to 103.4% in June 2026 from 105.2% in May 2026 and the non-criteria to reside (NCTR) had improved to 20.6% compared to 22.2% in May 2026. 7.2.6. Ambulance handovers within 45 minutes had improved to 84% in June 2026 compared to 74.8% in May 2026. 7.2.7. Corridor care had reduced from an average 100 patients per day being cared for in a corridor during January and February 2026 to an average of between 40 to 50 patients in June 2026. 7.2.8. The transformation programmes had continued with a focus on delivery over the next 90 days. The involvement of senior clinicians at the front door had supported improved performance where this approach had been consistently embedded, and recruitment of several consultants at Southport Hospital would further strengthen the position at that site. Progress was being made in relation to the expansion of the Same Day Emergency Care (SDEC) which had improved patient flow. Additionally, the work undertaken with wards through the Perfect Ward programme had started to demonstrate improvements. There had also been a focus on the expected date of discharge accuracy, plus seven-day length of stay (LOS), plus 21-day LOS, and discharges before midday. 7.2.9. Work was ongoing with system partners around admission avoidance, implementation of a single point of access, as well as discharges, and LN highlighted the variation in services across the different PLACEs served by

	the Trust. The Trust had gone live with the Transfer of Care Hub (TOCH) at Southport and Ormskirk Hospitals. <u>Elective Care</u> 7.2.10. The Trust remained one of the strongest performing organisations in C&M for elective performance. However, waiting list growth had been reported and increasing demand continued to place pressure on elective services. Referral to Treatment (RTT) performance for June 2026 was 66.8%, which was above both the national average and the Trust's planned trajectory. 7.2.11. There were 11 patients waiting over 65 weeks at the end of June 2026, an increase of six patients compared to May 2026. LN noted that these related mainly to complex patients within the dermatology pathway who required plastics support. 7.2.12. Elective activity was well managed, although some challenges remained. LN reported that opportunities had been identified to improve theatre productivity, and the need to balance elective demand with non-elective and front door pressures as part of the transformation programme was noted. Work had been undertaken to protect elective capacity, particularly at Southport Hospital, where opportunities had been identified to deliver care differently. Progress had also been made to standardise 'to come in' (TCI) processes and associated operational arrangements. In addition, a booking team had been established to support patients attending for procedures. <u>Cancer Performance</u> 7.2.13. Performance against the 28-day cancer target had improved to 76.8% in May 2026 (target 80%) compared to 76% in April 2026. This compared to 79% nationally and 78.9% for C&M 7.2.14. Performance against the 62-day performance had also improved to 81.7% in May 2026 (target 80%) compared to 80.4% in April 2026. This compared to 74.4% for C&M and 69.6% nationally. 7.2.15. LN highlighted that lower gastrointestinal (GI) colorectal cancer was highlighted as the tumour site of greatest concern. This was linked to the wider diagnostic challenges, and a range of recovery programmes were underway to support improvements and improvements were anticipated in quarters three and four. 7.2.16. Performance for the 28-day skin cancer pathways was 87.1% which was a significant improvement over the preceding six months. <u>Diagnostics</u> 7.2.17. A detailed discussion had taken place at the Finance and Performance Committee regarding diagnostic performance.
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	7.2.18. Diagnostics performance had remained unchanged from May 2026 at 80.6% (target 95%), and this compared to 87.6% for C&M and 76% nationally. There were plans in place to sustain the current position. 7.2.19. There were two main underperforming specialities: Non-Obstetric Ultrasound (NOUS) and endoscopy. NOUS demand had increased by 38% over recent years, and a business case was being developed to expand sonographer training. It was noted that workforce was a national challenge for this speciality. 7.2.20. In endoscopy, increased demand and capacity challenges had been identified. Early improvements were expected in July 2026, with further progress anticipated following the actions planned for September and October 2026. 7.2.21. MSi welcomed the improved cancer performance and asked what had been done differently to achieve the results, including whether any learning could be applied to non-cancer pathways. LN reported that whilst skin cancer pathway demand had increased significantly, this had not resulted in a corresponding increase in conversion to cancer pathways. The Trust had implemented skin analytics, an artificial intelligence (AI) technology, to support the initial review and triage of patients and this had reduced demand at the first stage of the pathway and reduced the number of patients requiring clinical appointments. MSi noted that, nationally, dermatology as a specialty was leading in the application of AI and asked whether the same approach could be applied more widely across other specialties. LN responded that AI was being considered across a number of specialties, both clinically and administratively, and emphasised that whilst this work needed to be undertaken safely, it had a clear role in supporting new ways of working rather than applying more of the same capacity to existing pressures. 7.2.22. MG commented that several AI initiatives were being considered across the Trust and an AI Steering Group had been established, with clinical representation, to ensure that proposed solutions were reviewed appropriately and implemented safely. Robust checks and balances were applied to each proposed solution, particularly from a clinical safety perspective, and noted that skin analytics was a positive example and that further opportunities, including theatre productivity and ambient voice technology (AVT), were also being evaluated. 7.2.23. SD commented that progress in the adoption of AI in dermatology was supported by clear diagnostic pathways, and that further opportunities were also emerging in gastroenterology, including virtual endoscopy. AI was expected to develop significantly across medicine over the coming years and that the Trust's role would be to identify the right opportunities and implement them safely. MSi asked if there was any learning from the implementation of AI that could be shared with clinicians as part of future
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	education and training requirements. SD noted that the trainees entering the workforce were increasingly familiar with technology and that their future roles would be different as AI and digital tools became more embedded in clinical practice. 7.2.24. RC commented that this was beginning to form part of recruitment discussions for new consultants, with a focus on achieving the right balance between clinical expertise, AI and technology. Technology should support clinicians by enabling secondary care specialists to focus their time on the most complex patients and by improving triage so that patients were directed to the right service at the first opportunity. RC referenced the work that was taking place around the C&M integrated referral model which focussed on supporting patients to access primary care, community and tier two services where appropriate, so that those requiring secondary care could be seen sooner, however, these developments needed to be implemented safely, with careful consideration of processes and pathways and appropriate testing before wider adoption. 7.2.25. SR noted that, while improvements across pathways should not be overlooked, the greatest and quickest benefits were often achieved by improving access at the front end of pathways. MSi agreed with SR's comment and added that this was particularly relevant to urgent and emergency care, where patients could present to services that were not best placed to meet their needs, however, the early intervention by directing patients appropriately was important regardless of the service or clinical pathway. 7.2.26. AMS reflected on the recent consultant interviews that she and CS had attended and commented that these had demonstrated that newly trained consultants were engaged with the NHS 10-Year Plan and the move from analogue to digital ways of working, with candidates bringing forward constructive ideas for future service development.
7.3.	Workforce Indicators
	7.3.1. MS presented the Workforce Indicators and highlighted the following: • The compliance rate for appraisals was 70.5% (target 85%). MS advised that performance was expected to decline initially following the opening of the 2026/27 appraisal window. • The compliance rate for mandatory training was 89.9% (target 85%), however, some areas remained below the compliance threshold. The Executive Committee would be considering an enhanced escalation framework to ensure that compliance was achieved across all areas. Additionally, a 12-week recovery plan would also be reviewed, and further actions would be overseen by the Quality Committee. • Sickness absence has increased to 6.7% in June 2026 compared to 6.4% in May 2026 (target 5%). The main reasons for sickness absence were stress/anxiety/depression, musculoskeletal (MSK) issues, and

	gastrointestinal issues. It was noted that sickness absence was a regional challenge and remained an area of focus for the HR directorate and recent actions included a deep dive into long-term sickness, outputs from the Absence Task Force, and an absence summit for HR teams which had focussed on providing advice on sickness absence management. Feedback on the lessons learnt would be presented to Executive Committee. The CEOs at the Cheshire and Merseyside Provider Collaborative (CMPC) Board had requested further prioritisation of sickness absence and had previously established a project supported by the Efficiency at Scale programme. Achievements included a C&M-wide policy, which was out to local Trusts for consultation, additional advice and guidance documents, as well as consistent reporting approach to ensure accurate benchmarking. Additionally, the group was also looking at other types of absence, such as special leave. The average time to hire was 50 days in June 2026 against a target of 40 days. Benchmarking showed that the Trust was above the national target but only slightly behind regional peers, and improvement work would continue to be monitored by the Strategic People Committee.
7.4.	Financial Indicators
	7.4.1. GL presented the financial performance indicators and reminded the Board that a deficit plan of £16.7m had been submitted for 2026/27, however this excluded deficit support funding. The plan had met the control total issued by NHS England (NHSE) and this would allow the Trust to access deficit funding to achieve a breakeven plan. The plan had assumed the delivery of a recurrent internal Cost Improvement Programme (CIP) of £49.7m (circa 5%). 7.4.2. At the end of the first quarter, the Trust was reporting an adjusted position of £6.8m deficit and, if deficit support funding was excluded, the adjusted position was a £11m deficit, which was in line with the plan. 7.4.3. GL highlighted the following: - Agency spend was 1.2% of total pay spend, however, bank spend required further work. - The Trust had successfully delivered £9.9m of CIP year to date (YTD) against a full year plan of £49.7m. - The run rate continued to improve and the forecast for the financial year was to deliver to plan, however, this would be dependent on CIP schemes in the latter part of the year. - The Trust was marginally below plan for elective activity, with opportunities to improve in Q2. - Cash remained tight but was being managed within Trust limits and deficit support funding for Q2 has been received. RESOLVED:

	The Board noted the Integrated Performance Report.
Committee Assurance Reports	
8.	TB26/035 Committee Assurance Reports
8.1.	Executive Committee
	8.1.1. RC presented the Executive Committee Assurance report for the meetings held in June 2026. 8.1.2. Agency staff requests that breached the NHSE cost thresholds were reviewed at each meeting, and the Chief Executive's authorisation recorded. Reports from the weekly vacancy control panel were also presented at every meeting. 8.1.3. RC alerted to the Board that the current provider of the Laboratory Information Management System (LIMS) was unable to continue providing the existing software on a longer-term basis. Additionally, the C&M contract for a single LIMS across the system had progressed; however, a nine-month delay had been identified. Updates on the C&M LIMS rollout to determine whether the nine-month delay could be mitigated were awaited. RC advised that, as the Trust needed to manage its internal laboratory management system during this period, several options had been reviewed by the Executive Committee, which had approved option three (upgrade the current system and extend the system support until May 2028). However, there was an associated financial requirement, and further work was underway to assess the resulting cost pressure and whether this could be addressed through the Sustainability and Improvement Team or from another area within the division. 8.1.4. The Committee had received the regular monthly reports for: • Appraisal and Mandatory Training Assurance Reports • Nurse Safer Staffing • Vacancy Control Panel (VCP) activity • Financial Improvement Group (FIG) update • Risk Management Council Assurance Report 8.1.5. RC highlighted the following items from the report: • The Committee had received the Corridor Care Update which highlighted the continued focus on eradicating corridor care and the use of other escalation areas, including areas where additional beds or spaces were used. It was noted that, whilst the formal reporting position had not yet shown a significant shift, performance had reduced by around half when compared with earlier levels and continued to improve. Further work was required and this would be supported through the Trust's wider transformation programme. • The Committee had received the Community Diagnostic Centre (CDC) Development Case for Southport Hospital, which supported the Trust's

	ambition to shift more care into the community and closer to patients' homes. • The Committee had received the Strategic Transformation and Programme Management Office (PMO) update which provided an overview of the transformation programmes that had been developed to support continuous improvement in the delivery of 5 Star Patient Care across six workstreams. An update on the PMO function which was being mobilised to support focused delivery of the programmes was also presented, which included the consolidation of the project management capacity across the Trust. • The Committee had received the Maternity & Neonatal Report which included a review of the MWL reported metrics for Maternity and Neonatal Services, against external reporting requirements. The report had provided assurance on the MWL reported metrics and distinguished between external reporting requirements and internal reporting requirements. It was noted that the Local Maternity and Neonatal System (LMNS) had viewed the MWL reporting methodology as an exemplar for wider use across maternity services. The Committee had discussed several options to improve the internal report which included the development of a dashboard which used the red, amber, green (RAG) methodology to support the Quality Committee and Board in understanding areas that may require more focus. • The Committee had received the quarterly Cyber Report which provided assurance that the Trust continued to maintain robust data security, the cyber risk profile continued to improve and that key controls operated effectively. • The Committee had reviewed the business case which proposed recruitment of an ED Consultant at Whiston with a special interest in Frailty, which was aligned with the Trust's acute frailty work and supported decision-making at the right time and in the most appropriate setting, ensuring that patients were seen by the right clinician. It was anticipated that the post would be cost neutral and would support training and enhance the interface with community services with an implementation date in Q2. The Committee had agreed that, once the additional benefits information had been received, the proposal could be approved outside the meeting. Additionally, a benefits realisation report would be reviewed in 12 months. • The Committee had received the proposal for the Management of Community Services and the creation of a Community Division that was separate to other clinical divisions as this would enable the Trust to develop a strategy for community services that would be aligned to the 10-year plan as well. • The Committee had approved the commissioning of a Developmental Well Led Review which would provide external insights on the Trust's processes and pathways now that the Trust had been formed for three years as MWL. 8.1.6. The Committee had approved the following investments during June 2026:
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	• Specialist Palliative Care – short-term locum recruitment had been approved to provide medical cover while substantive posts were progressed. • LIMS extension - £278k funding for the extension of the support contract for the existing LIMS system was approved.
8.1.7.	GB asked whether there was also a frailty consultant based in the ED at Southport Hospital. RC advised that the proposed post related to an ED consultant with a specialist interest in frailty and noted that this expertise was not currently available within the Southport Hospital ED team. The appointment would provide an opportunity to develop frailty expertise within emergency care and to use the Trust's revised medical structure to support training, pathway development and the delivery of a consistent service provision across sites.
8.1.8.	SD commented that this development would present a positive opportunity, given that this skill set was not currently available within the ED team at Southport Hospital. MSi agreed and noted that the proposed role was distinctive, as emergency medicine and frailty training pathways were separate specialties. MSi suggested that the Trust should engage with the deanery to support future workforce planning and regional training opportunities. RC commented that, in his view, the role would not be unique in relation to an individual's interests, but rather in the job description, which would be distinctive in combining emergency medicine with a specialist interest in frailty. RC noted that there were opportunities to strengthen the connection between frailty, older people's services and emergency care, reflecting the shift towards an acute frailty and frailty front door model. Consideration would therefore need to be given to the future delivery of acute frailty care, with a focus on directing patients to the most appropriate setting rather than encouraging attendance at ED for a specialist frailty opinion.
8.1.9.	SR commented that the focus should not be on appointing an individual with these combined specialist interests to the ED, however, this was currently the right course of action. RC agreed and noted that the appointment would provide an opportunity to further develop the service.
8.1.10.	SO commented that, whilst she agreed that the frailty care pathways should be mainly delivered within the community, staff would require appropriate training and experience to respond effectively to patients' needs as the population lived longer with multiple comorbidities and increasing complexity.
8.1.11.	SO reflected on a discussion that had been taking place internally about the advantages of having nurses who had some mental health training as well as general nursing training. There was an opportunity for the system to work with higher education providers who offered combined training routes; however, it would be important for the Trust to develop the roles to make

	the best use of staff skills and multidisciplinary training. RC commented that similar observations had been made in relation to midwifery training. 8.1.12. RC commented that previously an 18-month foundation course had provided a broad shared grounding across midwifery, mental health nursing, registered general nursing and paediatric nursing, however, more recent training routes did not always provide the same general professional base. The remainder of the report was noted. <i>(ZT left the meeting)</i>
8.2.	Audit Committee
	8.2.1. GB, on behalf of SC, presented the Audit Committee Assurance Report for the meeting held on 23 June 2026 and noted that a verbal update had been provided at the Board meeting on 26 June 2026. The report was noted
8.3.	Charitable Funds Committee
	8.3.1. NF, on behalf of NFr, presented the Charitable Funds Committee Assurance Report for the meeting held on 29 June 2026. 8.3.2. NF highlighted the following: • The Committee received the Head of Charity Report which provided an overview of the activity between March and June 2026. • The Committee received a summary of the applications received since March 2026 and eight projects with a combined valued of £22,600 had been granted. These included the provision of cold cap comforters to support patients during their chemotherapy treatment and Neonatal patient milestones signage. • The Committee had received an update on the Butterfly Project which provided an overview of the support that trained volunteers provided to patients who were approaching end of life and their families. • The Committee received the Finance Report (including Treasury Matters) and NF clarified that the fund balance was £1.4m and not £1.5b as noted in the report. 8.3.3. NF advised that the Whiston Hospital Abseil event that took place on 17 July 2026 raised circa £21,000 to date and thanked the Head of Charity and her team for their hard work as well as everyone who took part in the event, including RC and SO. It was noted that the next planned Charity event was the Southport 10k on 02 August 2026. 8.3.4. GB commented on the current balance of charitable funds, which stood at circa £1.4m, and noted that around £22,600 had been approved since March 2026. GB highlighted the importance of ensuring that charitable

	funds were used appropriately for the benefit of patients and staff, and that staff were made aware of the opportunity to apply for funding. SR agreed with GB's comment and noted that, whilst the funds were intended to be used, there were restrictions on how they could be spent. The remainder of the report was noted
8.4.	Quality Committee
	8.4.1. MSi presented the Quality Committee Assurance Report for the meeting held on 21 July 2026, noting the key quality performance indicators had already been discussed earlier in the meeting. 8.4.2. MSi highlighted the following points from the report: <u>Patient Safety Report</u> 8.4.3. There had been an increase in overall incident reporting levels which was a reflection of a positive reporting culture. 8.4.4. One new Patient Safety Incident Review (PSIR) had been reviewed by the Patient Safety Panel (PSP). 8.4.5. 2,841 incidents had been reported on InPhase, and it was noted that most of these had been incidents of low harm. The Committee had noted that incidents resulting in moderate harm or above represented 0.91% of reported incidents and it had been agreed that further information would be provided on historic trends to enable the Committee to understand whether this position was increasing, decreasing or remaining stable, rather than considering the figure at a single point in time. 8.4.6. The Patient Safety Council Assurance Report for July 2026 was received. 8.4.7. The Committee had received an update on the implementation of Martha's Rule, and a further update was requested. <u>Infection, Prevention and Control Annual Report 2025/26</u> 8.4.8. It was highlighted that during 2025/26 the Trust had exceeded the thresholds as set out in the NHS Standard Contract for Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, Escherichia coli (E. Coli), Pseudomonas bacteraemia, and Clostridioides difficile (C.Diff). 8.4.9. Further work was being undertaken to understand the Trust's position in relation to C.Diff cases, which had remained above expected levels, and to identify learning and improvement actions. 8.4.10. 129 outbreaks had been managed during the reporting period, affecting 1,149 patients, with just under 2,000 lost bed days and an estimated operational impact of £827k. The Committee requested further information on any associated impact on staff, including sickness absence linked to outbreaks, to support a fuller understanding of the overall economic impact. 8.4.11. Following MIAA's review of the Trust's management of the norovirus outbreak, significant assurance had been received, and it was noted that the Trust was performing well against the required standards. 8.4.12. There was an increase in hip and knee surgical site infections and improvement plans had been developed to address this.

	8.4.13. Limited side room capacity at Southport Hospital remained an ongoing challenge and this reflected the wider constraints associated with the estate and existing infrastructure. 8.4.14. The Committee had been assured that the governance structures that were in place were robust and met requirements. 8.4.15. The Committee discussed the application of improvement methodology, including the distinction between achieving immediate change and securing sustained improvement. It was noted that further work was required to understand how sustained change could be embedded in practice, including how education could be incorporated into improvement cycles to support meaningful behaviour change within clinical practice. <u>Never Events</u> 8.4.16. The Committee had received the Never Events deep dive which provided an objective evaluation of current theatre practice within the Surgical Division. The review had been undertaken in collaboration with Health Innovation North West Coast, which had provided external expertise in process improvement methodology. 8.4.17. Following observations by the Corporate Safety Team, learning and recommendations from the two surgical Never Events reported in January and February 2026 had been identified. 8.4.18. The Committee had discussed the impact of observation on behaviour change, including the distinction between observed practice and routine practice, with reference to the Hawthorne effect. 8.4.19. The external advice and experience provided by Health Innovation North West Coast would support further consideration of human factors and how any resulting learning could be implemented across other areas. <u>Lost to Follow Up Report</u> 8.4.20. The Committee had received an update on the lost to follow-up work which related to a historical cohort of ophthalmology patients. It was noted that 91% of patients had been reviewed with no additional harms identified. 8.4.21. The work was nearing completion, and a final report would be presented to Quality Committee in due course. <u>Maternity Update</u> 8.4.22. The Committee had discussed the recently published maternity reports, including the Ockenden and Amos reports, in detail and noted that national guidance was awaited before any gap analysis or action plans were developed. It was noted that national reviews included a requirement to confirm that accountability for the quality of maternity and neonatal services, and oversight of action plans, was shared between the Chief Nursing Officer (SO for MWL) and the Chief Medical Officer (SD for MWL) at Executive level. 8.4.23. It was noted that reviewing the actions arising from the national maternity work would represent a significant additional work programme for the maternity team. The Committee had commended the maternity team for their continued dedication.
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	8.4.24. The Board would be kept informed as further information became available. <u>Clinical Effectiveness Council</u> 8.4.25. The Committee received the report and noted that the Executive Committee would be undertaking a review of the Council's operational arrangements, membership and integration within the Trust's governance structure and recommendations would be presented at a future Quality Committee. <u>Care Quality Commission (CQC) Quarterly and Accreditation Report</u> 8.4.26. The Committee had received the report, and the positive engagement visit to St Helen's Hospital on 08 June 2026 was noted. 8.4.27. It was noted that the Trust had not received any information about potential inspections. 8.4.28. SR reflected on maternity services and reiterated that whilst work would continue to identify further actions that could be taken, the Trust was awaiting additional information and guidance from NHSE following the publication of the recent reports. The remainder of the report was noted.
8.5.	Strategic People Committee
	8.5.1. LK presented the Strategic People Committee (SPC) Assurance report for the meeting held on 22 July 2026 and noted that some of the points noted had already been discussed in earlier reports to the Board and would not be repeated. 8.5.2. LK highlighted the following: • The Committee had received the Time to Hire recovery plan which included a breakdown of the delays across the stages of the recruitment pathway. The recovery plan had outlined the actions to be taken to address some of the delays. The Committee had been assured that the work underway was expected to have an impact and it was anticipated that recruitment activity was expected to return to more normal levels by the end of August or early September 2026, which had affected the Trust's ability to meet the target. • The Committee had received the Guardian of Safe Working (GOSW) Annual Report for the Trust and it was noted that since revising the reporting process (in response to trainee feedback), there had been a significant increase in reports, with two months' worth of activity now matching what previously took twelve months. Additionally, the GOSW Annual Report for the Lead Employer (LE) had highlighted that there had been an increase in the number of LE issues being managed locally. • The Committee had received the Lord Mann Review gap analysis and Action Plan.

	8.5.3. MS reported that the Trust's Resident Doctor Leads had attended the meeting and had contributed to the development of the Board Assurance Framework (BAF) self-assessment relating to resident doctors. It was noted that MS and SD, as the Senior Resident Doctor Leads, with support from the wider Resident Doctor Lead group, had undertaken significant work to develop the document and although the Resident Doctor Leads had not provided detailed comments during the meeting, they had been integral to the development process and had indicated that they were supportive of the Trust's self-assessment. 8.5.4. AMS commented that the involvement of the Resident Doctor Leads had provided valuable assurance, as it enabled the Committee to hear directly from those with lived experience, in a similar way to the value gained from patient stories. It had been acknowledged that, whilst there remained areas for further improvement, the Resident Doctor Leads had been positive about the level of engagement and the opportunity to contribute to the process. MS noted that the Trust was in a positive position, as all four Resident Doctor Leads were expected to remain with the organisation for at least the next 12 months. This continuity was considered beneficial, as it would support the retention of knowledge, strengthen organisational understanding, and enable the Resident Doctor Leads to continue contributing to the delivery of the plan, and to further improvements in this area. MS commented that whilst the 10-point plan emphasised the importance of ensuring that the basics were completed consistently and to a high standard, the Trust should continue to identify areas where further challenge and improvement could be pursued, as this would support a high-quality experience for resident doctors in the future. The remainder of the report was noted.
8.6.	Finance and Performance Committee
	8.6.1. CS presented the Finance and Performance Committee (F&P) Assurance report for the meeting held on 23 July 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. 8.6.2. Other points to highlight from the report were: • The Committee had received the Chief Financial Officer's (CFO) update, and it was noted that the Trust had achieved productivity growth of 6.3% by March 2026, and this was recognised as evidence of strong delivery against the CIP. • The Committee had received the NHSE Regulatory Update, which included the updated performance measures and regulatory frameworks, including the NHS Oversight Framework for 2026/27. It was noted that these were being reviewed to ensure that the changes were accurately reflected in reporting and incorporated into the operational performance report.

	8.6.3. CS reported that the Trust had made a positive start to the year and remained on plan. The run rate was being actively reviewed, and mitigation plans were being developed, if required, to reduce the risk of material changes during the year. It was noted that, following extensive discussions and correspondence, the contract for 2026/27 appeared to be progressing towards conclusion, although formal confirmation had not been received at the time of the Finance and Performance Committee. Additionally, the Committee had noted that variability in both demand and capacity had contributed to challenges in some areas, and assurance was provided that there was a focused approach to improving performance and ensuring that the solutions implemented were resilient and sustainable. 8.6.4. The Committee had received assurance reports from the CIP, Capital Planning, IM&T and Estates and Facilities Management Councils, with no issues escalated. 8.6.5. SR reported that a signed joint letter, which reflected an agreed position, had been submitted in relation to the proposed resolution of the contract dispute and the Trust awaited confirmation from NHSE. 8.6.6. RC reflected on CIP in the context of the Trust's wider work on financial stability and transformation and noted that, if the Trust moved towards breakeven or generated a surplus over the coming years, this could reduce the required CIP percentage and support a more reasonable and deliverable programme. SO asked whether any future surplus would be available for reinvestment within the organisation or whether it would be required to support the wider system. RC responded that national discussions suggested a move towards organisations being able to retain and reinvest surpluses locally, alongside a shift towards organisational control totals rather than a system-level approach. SR noted that this would provide an incentive for organisations to deliver their plans. CS commented that a strong track record of CIP and financial plan delivery would support confidence in the Trust's ability to plan effectively and make best use of available resources. GL highlighted the importance of recurrent CIP delivery and noted that future planning assumptions would remain dependent on cost pressures and local constraints, including the Trust's Private Finance Initiative (PFI) contracts for Whiston and St Helens sites and associated Retail Price Index (RPI)-linked costs. It was noted that the Trust's projected performance placed it in a stronger position and could provide greater flexibility in future planning. The remainder of the report was noted RESOLVED: The Board noted the Committee Assurance Reports
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Other Board Reports	
9.	TB26/053 Corporate Risk Register
	<i>(SR left the meeting briefly and GB took over as Chair)</i> 9.1. SO, on behalf of SRe, presented the Corporate Risk Register (CRR) and noted that there was a robust process for risk management in place. 9.2. SO highlighted the following: • There were 216 risks overdue for review, and SRe had introduced strengthened oversight and challenge through the divisions and Divisional Performance Reviews (DPR) to ensure these were reviewed and addressed. • There were currently 22 risks on the CRR, all scored at 15 or above, each with an Executive Director owner and an up-to-date review. • The total number of risks on the CRR was 979 compared to 1,015 in April 2026. • Three new risks had been escalated in July compared to seven in April 2026. • Four risks had been closed or de-escalated from the CRR since April 2026. 9.3. CS referred to the risk profiles for each of the Trust's divisions and the collective Corporate Services bar chart and requested clarification regarding the high volume of risks shown for Community and Clinical Support Services. SO explained that the higher volume reflected the scale of activity, staff numbers and administrative support functions within those areas, including booking services, and acknowledged the ongoing challenges within patient booking and administration. Additionally, CS asked whether the colour coding (green, yellow and red) corresponded to risk scores. SO confirmed that this was correct and agreed that it would be beneficial to include a key in the table for clarity. 9.4. NF referred to the same bar chart and asked whether the number of newly created risks within surgery reflected new staff identifying risks or wider challenges within the service. SO responded that, at the time the report was prepared, 24 new risks had been added, of which 16 related to surgery and had not yet been graded. SO advised that this appeared to reflect the recent addition of those risks, rather than indicating a specific issue. 9.5. AMS referred to the risks that had been closed or de-escalated and suggested that it would be helpful to record the rationale for these changes, for example, the closure of the interventional radiology service risk (MWL Risk ID 319). AMS proposed that this be discussed with SRe at the Executive Committee. SO agreed with AMS' suggestion and RC noted that this detail had been included previously. 9.6. GL highlighted a typographical error with risks 12 and 13 noting that the year should be 2026/27 and not 2025/26 and requested that the report was updated to reflect this.

	9.7. SO advised that, as there had been several questions in SRe's absence, she would provide feedback regarding the points raised. Action: SO to provide feedback to SRe regarding the points raised. By: September 2026. RESOLVED: The Board noted the Corporate Risk Register
10.	TB26/054 Board Assurance Framework
	10.1. RC, on behalf of SRe, presented the Board Assurance Framework and noted that each BAF risk had been reviewed by the lead Executive and updates provided in relation to closed and new actions. 10.2. RC reported that the overdue actions relating to BAF 5 (Failure to work in partnership with stakeholders) were proposed for closure. This reflected the progress made by the Alliance Group in setting objectives and outcomes, which had been incorporated into the sources of assurance. RESOLVED: The Board approved the Board Assurance Framework
11.	TB26/055 Aggregated Incidents, Complaints and Claims Report (Q1)
	11.1. SO presented the Aggregated Incidents, Complaints and Claims Report (Q1) and noted that the figures and trends remained consistent with previous reports, with no significant rise in incidents or complaints, and no major changes in themes. SO reported that pressure ulcers had been identified as the top theme for incidents, with most cases being community-acquired and monitored upon admission. 11.2. SO provided an update on Martha's Rule, which was being embedded across all hospital sites. There had been 18 Calls for Concern raised during the quarter, which was a relatively low number but consistent with the national position. It was noted that initial concerns that the Trust might have been overwhelmed by the volume of calls had not materialised. 11.3. SO reported that 69.2% of complaints had been responded to within 60 days, which remained below the 80% target. Sustained improvement had been reported within the Medicine and Urgent Care Division, which managed the highest volume of complaints. SO noted that delays in receiving responses from medical colleagues remained an area for further focus. 11.4. SO noted that, as requested, the report had been updated to include additional information in relation to Public Health Service Ombudsman (PHSO) activity at the Trust. It was noted that no complaints had been upheld

	by the PHSO during the quarter, although some cases remained under review from earlier reporting periods. 11.5. SO reported that, in respect of claims and inquests, there were no specific matters that required escalation to the Board. Additionally, no Prevention of Future Deaths reports had been received during the quarter. 11.6. SO highlighted the update on the Public Office (Accountability) Bill (“the Hillsborough Law”), which had recently passed its final reading in the House of Commons. It was expected to have implications for public sector bodies, including NHS organisations, and an update about the potential implications had been presented at Executive Committee. SO advised that focused Board learning would be required to support members’ understanding of the legislation, including its relationship with the duty of candour and the rights of service users to challenge public bodies and suggested either a Board development session or as a focused item at a future Strategy Board. Action: A focused Board learning session on the implications of the Hillsborough Law, including its relationship with the duty of candour and the rights of service users to challenge public bodies, either through a Board development session or as a focused item at a future Strategy Board. BY: September 2026 11.7. SD agreed with SO’s comments about the delayed response from medical colleagues and advised that it was anticipated that the new Clinical Director (CD) structure as well as the professional standards for clinicians that was being drafted would address the response times as well as improve escalation. MSi asked whether complaint responses were incorporated into appraisals. SD responded that whilst this was expected he was unable to provide more detail. Additionally, MSi asked whether the complexity of medical responses contributed to delays. SD responded that medical complaints were often more complex but did not wish to use this as an excuse for untimely responses. There was a duty of care to address complaints appropriately and SD acknowledged that some cases required more time and the Trust remained an outlier in turnaround times. 11.8. RC suggested that clinical expertise should enable timely responses, and that the complexity was more about managing the complaint across the various individuals and departments involved. Additionally, RC commented that he expected a clinical expert to respond in a timely manner, however, there should be allowances for cases requiring more time. 11.9. GB reflected on how Martha’s Rule would be rolled out in the Neonatal areas considering the recent national reviews. 11.10. GB referred to a birth injury claim dating from 1998 and asked whether an update should be provided to the Quality Committee on why this remained active. RC advised that this was not unusual, as assessment of a child’s
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	development could require extended timescales. SD confirmed that this was considered standard practice, and SO advised that the matter had been reviewed with the Head of Legal Services. GB was assured by the explanation provided, and no further action was required. RESOLVED: The Board noted the Aggregated Incidents, Complaints and Claims Report (Q1)
12.	TB26/057 Informatics Reports
12.1.	Data Security and Protection Toolkit (DSPT)
	<i>(SR rejoined the meeting)</i> 12.1.1. MG presented the Data Security and Protection Toolkit (DSPT) 2025/26 which provided assurance that MWL operated within the parameters defined in the DSPT and maintained strong arrangements for protecting patient and organisational data, as well as digital services. The Trust had completed the annual submission demonstrating this compliance. 12.1.2. An independent audit by MIAA had assessed the submission to provide assurance on its accuracy, and rated the Trust as 'Low Risk', equivalent to the former rating known as 'Substantial Assurance'. It was noted that, despite the 'Low Risk' rating, MIAA had made several recommendations to further strengthen data security, and work was ongoing to implement these. 12.1.3. MG highlighted the following: • This year's submission had been significant due to alignment with the National Cyber Security Centre Cyber Assessment Framework (CAF), which required additional evidence and a shift towards cyber resilience. • The Trust had submitted its assessment before the national deadline and achieved "standards met" across all requirements.
12.2.	Information Governance Annual Report 2025/26
	12.2.1. MG presented the Information Governance Annual Report 2025/26 which provided assurance that the Trust has an effective Information Governance Framework in place. The report detailed the progress made against the Information Governance (IG) work programme for 2025/26. 12.2.2. MG reported that the Information Governance Steering Group (IGSG) provided effective oversight and was supported by the Senior Information Risk Owner (SIRO), the Caldicott Guardian, as well as Data Protection Officers. During 2025/26, the Trust had reviewed and strengthened policies, privacy notices, Data Protection Impact Assessment (DPIA) processes, and governance controls to reflect legislative changes and emerging technologies.

	12.2.3. MG highlighted the increased use of AI across the organisation and assured that all AI deployments underwent robust review processes, including clinical governance and oversight by clinical safety officers, to ensure safety and compliance. 12.2.4. MG highlighted the following: • Information governance training compliance remained above the national threshold. Additionally, the subject access request (SAR) processes had been further strengthened. • There had been four incidents in 2025/26 that had met the threshold for notification to the Information Commissioner's Office (ICO) and MG advised that each incident had been investigated promptly and there had been no enforcement actions or financial penalties issued to the Trust. • The focus for the coming year was to continue maturing and maintaining the Trust's information governance position 12.2.5. GB commented on the positive report and commended the team for their hard work in a rapidly changing environment. GB reflected on the SAR compliance, which had reduced due to a significant increase in demand, mainly driven by the national maternity investigations and the infected blood inquiry and requested additional information. MG responded that SARs required significant work and noted that the increase was driven by these two headline issues. The complexity and volume had increased, especially with the involvement of solicitors. 12.2.6. KA commented that, from his experience, AI-driven SAR requests were becoming more common, resulting in lengthy, complex requests that required significant review time. MS commented that some of the increase in the SAR requests could be attributed to the increased number of workforce requests being received and agreed with KA's comment about the increase in the complexity of the requests which increased the overall time needed to review the documentation.
12.3.	Freedom of Information Act Annual Report 2025/26
	12.3.1. MG presented the Freedom of Information (FOI) Act Annual Report 2025/26 which provided assurance that MWL was compliant with the Freedom of Information Act. 12.3.2. MG highlighted the following: • There had been 838 FOI requests received in 2025/26, containing over 7,000 individual questions. It was noted that whilst the number of requests remained similar to previous years, the complexity had significantly increased, with over 1,500 additional individual questions compared to the previous period. • The Trust had completed over 99% of all FOI requests, demonstrating continued compliance with its statutory obligations. The compliance rate had improved from 63.6% to 67.9%. Across all requests received, only

	three internal reviews and one ICO appeal had been received, which was considered a low level of challenge and provided assurance regarding the robustness of responses. An improvement plan to support achievement of the ICO's 90% compliance target had been developed and would be presented at the Executive Committee. It was noted that FOI requests often required input from multiple teams, which increased both workload and complexity. 12.3.3. SR commented that the action plan should take account of information already available in the public domain, noting that some requests, particularly those from journalists, could be addressed by signposting to published data. 12.3.4. KA commented that the increasing complexity of FOI requests was likely to be a national issue and queried whether this was being discussed at a national level. RC commented that the position was likely to become more challenging, particularly with the introduction of the Hillsborough Law, which was expected to increase information requests. RC suggested that the Trust should consider a more proactive approach to publishing information in order to reduce the FOI workload. 12.3.5. Board members discussed the impact of AI, noting that it offered opportunities to support innovation but could also increase the workload and complexity associated with FOI and subject access requests. The need to balance innovation with the management of potential unintended consequences was noted. RESOLVED: The Board noted the Informatics Reports
13.	TB26/058 Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26
	13.1. LN presented the Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2025/26 and noted that the Trust has legal obligations as a Category 1 responder under the Civil Contingencies Act 2004 (CCA 2004) to ensure it has robust Emergency Preparedness arrangements in place. It was noted that the report had also been reviewed by the Risk Management Council and Executive Committee. 13.2. The report outlined how the Trust's EPRR risks, both local and national, were managed. LN advised that all risks were recorded and discussed through the EPRR Group and Risk Management Council. The report also provided an overview of the Trust's framework for responding to incidents, the importance of business continuity, communication arrangements with patients, and multi-agency cooperation.

	13.3. LN reported that the annual self-assessment against the EPRR core standards had been completed, with compliance reported at 97%. This represented an improvement from 44% in 2023/24 and 81% in 2024/25. It was noted that compliance was reset annually, requiring all plans to be reviewed from a zero baseline. MIAA also undertook an audit of Trust EPRR arrangements, which provided further assurance and provided a rating of 'Substantial Assurance'. 13.4. LN highlighted the training requirements for on-call staff, as set out in the report. The report also included a summary of the incidents and exercises undertaken during the year, including industrial action and full capacity events. It was noted that all exercises included debriefs and action plans, which were reported to the EPRR Group. Examples included "Bedlock" in relation to internal escalation, "Black Sky" in relation to a power outage, and "May Day" in relation to a regional no-notice communications exercise. 13.5. GB commented on the improvement in compliance, noting the system-wide progress and congratulating LN and the EPRR team for achieving near-top compliance rates in the region. RESOLVED: The Board approved the Emergency Planning Response and Resilience (EPRR) Annual Report 2025/26
14.	TB26/059 Infection Prevention and Control Annual Report 2025/26
	14.1. SO presented the Infection Prevention and Control Annual Report 2025/26 which provided assurance that the Trust was taking the necessary action to monitor, manage and prevent hospital acquired infections. The report had been reviewed by the Quality Committee which also received quarterly IPC reports as part of the annual workplan. 14.2. SO reported that there was a need to shift from reactive responses to infections to more proactive and sustainable improvement, especially regarding embedding solutions and changing staff culture. SO noted that whilst there were many actions and learning reviews in place, sustained improvement was not always achieved, and further work was needed to enhance education and improvement methodology. 14.3. SO noted that the report included detailed information on infection rates, thresholds and targets, and advised that the national targets for the current year had not yet been confirmed. It was noted that Trusts such as MWL, which had historically performed well, were likely to receive increasingly challenging stretch targets each year. 14.4. SO advised that there remained several areas of concern, particularly C.Diff rates in Q1. However, assurance was provided that the IPC team were

	committed to maintaining standards and good at providing an expert view on the IPC risks to operational decisions. LN added that the IPC and operational teams had worked collaboratively, particularly during the recent winter period, and commended the effective teamwork between both groups. It was noted that the IPC team had been willing to discuss risks and challenges and had demonstrated a pragmatic and flexible approach when compared with other organisations. 14.5. RC reflected on the development of modern service frameworks, including those relating to sepsis, and asked whether these frameworks should be reflected in national metrics. Additionally, RC asked whether national discussions were moving towards expected levels rather than performance-based targets. SO responded that, whilst she was not aware of any direct discussions, the national approach appeared to be moving in that direction and could have contributed to delays in the confirmation of targets, with expected levels based on population health rather than previous performance. 14.6. SR commented that the report provided assurance and acknowledged that more work was needed. 14.7. NF asked whether there were any contractual challenges with infection thresholds. SO responded that historically there had been financial penalties for exceeding targets and GL confirmed that such penalties used to exist but were not currently in place. SO commented that current monitoring focused on triangulating multiple key performance indicators (KPIs) rather than isolated infection rates. 14.8. SR referred to one of the comparative tables included in the report which described the Trust as “MWL combined” and queried whether, where possible, future reporting could avoid reinforcing legacy distinctions between sites unless separate reporting was required. SO responded that some external reporting continued to be received in legacy formats, however, work was underway to move towards a more unified reporting approach. RESOLVED: The Board approved the Infection Prevention and Control Annual Report 2025/26
15.	TB26/060 Amended Trust Board Meeting Arrangements 2026/27
	15.1. AMS presented the amended Trust Board Meeting Arrangements for 2026/27, which proposed rotating Trust Board meetings across MWL sites where operationally feasible. It was noted that the proposal aimed to strengthen staff engagement, increase Board visibility and support greater organisational cohesion across the Trust. Whilst Whiston Hospital remained the Trust’s headquarters, Southport Hospital had suitable space and IT facilities to host meetings. The suitability of Ormskirk Hospital was still being assessed, particularly in relation to IT capability, while Newton and St Helens

	Hospitals did not have sufficient space to accommodate Board meetings. The revised arrangements would be reviewed after several months to assess their effectiveness. 15.2. AMS confirmed that additional ways to improve Board visibility at locations unable to host Board meetings would be discussed. 15.3. SR commented that the proposal was positive in principle; however, it would be important to ensure that it could be implemented effectively in practice and supported the view that the arrangements were reviewed in March 2027 to assess their effectiveness. 15.4. MSi asked whether the NEDs pre-Board meetings would also be held at the alternate sites and SR confirmed that the NEDs pre-Board meetings would take place at the same site as the main Board meeting. Additionally, MSi raised a concern about travel and car parking logistics at the alternate sites. AMS acknowledged these concerns, noting that car parking could present challenges and would need to be considered. RESOLVED: The Board approved the amended Trust Board Meeting Arrangements 2026/27
Concluding Business	
16.	Effectiveness of Meeting
	16.1. Board members agreed that meeting had been effective.
17.	Any Other Business
	17.1. GB reflected on the success of the Annual Staff Awards evening. The evening had been delivered to a high professional standard and provided an important opportunity to celebrate the achievements and contributions of staff. SR, on behalf of the Board, expressed thanks to the Communications Team and wider team involved in organising the event. 17.2. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.26. The next Board meeting would be held on Wednesday 30 September 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	✓	✓	✓	A								
Rob Cooper	✓	✓	✓	✓								
Simon Dowson	✓	✓	✓	✓								
Neil Fletcher	✓	✓	✓	✓								
Neil French	✓	✓	✓	A								
Malcolm Gandy	✓	A	✓	✓								
Lisa Knight	A	✓	✓	✓								
Gareth Lawrence	✓	✓	✓	✓								
Lesley Neary	A	A	✓	✓								
Sarah O'Brien	✓	✓	✓	✓								
Simon Regan			✓	A								
Mini Singh	✓	✓	✓	✓								
Carole Spencer	✓	✓	✓	✓								
Malise Szpakowska	✓	✓	✓	✓								
In Attendance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Elsie Hayford	✓	A	✓	✓								
Richard Weeks	✓	✓	✓	✓								
Marie Wright	✓											
✓ = In attendance A = Apologies												

Item ref: Written Resolution (WR) 01.26

Meeting: Board of Directors



**Mersey and West Lancashire
Teaching Hospitals**
NHS Trust

Written Resolution Request to Board Members

Subject: Maternity and Neonatal 10 Point Plan Baseline Assessment - Assurance Submission

Pursuant to the Board of Directors' Standing Orders, the following resolution is submitted for consideration.

BUSINESS TO BE CONSIDERED:

NHS England has requested submission of a Maternity and Neonatal 10 Point Plan Baseline Assessment from all NHS Trusts.

The attached submission has been reviewed by the Quality Committee and is now presented to the voting members of the Board of Directors for approval. The assessment provides the Trust's baseline assessment against the Maternity and Neonatal 10 Point Plan, and identifies areas of compliance, development and planned improvement.

The deadline for submission set by NHS England falls before the next scheduled meeting of the Board of Directors. It has therefore not been possible to seek approval through the normal Board meeting cycle.

Approval is therefore sought by written resolution to enable submission of the Trust's response within the required timeframe.

RESOLUTION

The Board of Directors RESOLVE to approve the attached Maternity and Neonatal 10 Point Plan Baseline Assessment, and authorise its submission to NHS England on behalf of the Trust.

Resolution Issued	22 September 2026
Long stop date for approval	24 September 2026 (5pm)
Number required for assent	Majority vote in line with Standing Orders
Date resolution effective	24 September 2026

Simon Regan

Director of Corporate Services

OUTCOME OF VOTE

Voting Member	Email approval/dissent received	Date
Steve Rumbelow, Chair	Approved	23.09.26
Gill Brown, Non-Executive Director and Deputy Chair	Approved	23.09.26
Steve Connor, Non-Executive Director	Approved	22.09.26
Neil French, Non-Executive Director	Approved	23.09.26
Mini Singh, Non-Executive Director	N/A: Absent	
Neil Fletcher, Non-Executive Director	Approved	23.09.26
Carole Spencer, Non-Executive Director	Approved	23.09.26
Rob Cooper, Chief Executive	N/A: Annual Leave	
Anne-Marie Stretch, Deputy Chief Executive	N/A: Absent	
Gareth Lawrence, Chief Finance Officer	Approved	22.09.26
Sarah O'Brien, Chief Nursing Officer	Approved (in Quality Committee)	22.09.26
Simon Dowson, Chief Medical Officer	Approved (in Quality Committee)	22.09.26

Trust Board (Public)
Matters Arising Action Log (updated 23 September 2026)

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

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion (for overdue actions)	Status
29	26/11/2025	TB25/093 Research and Development Annual Report and Capability Statement	SD to develop a new MWL Research Strategy. <u>Update</u> (19/06/2026) The new MWL Research Strategy to be developed in line with the Clinical Strategy following Clinical Director (CD) development.	SD	Jun-2026 Oct 2026		
2	26/04/2026	TB26/031 MWL Health Inequalities Strategy Annual Progress Review	WL to update the revised action plan for 2026/27 to include digital exclusion and the creation of a map reflecting digital poverty across the MWL footprint.	WL	Sep-26		
5	29/07/2026	TB26/053 Corporate Risk Register	SO to provide feedback to SRe regarding the points raised in the meeting. <u>Update</u> (23/09/2026) SO has provided feedback to SRe. Action completed	SO	Sep-26		Completed
6	29/07/2026	TB26/055 Aggregated Incidents, Complaints and Claims Report (Q1)	A focused Board learning session on the implications of the Hillsborough Law, including its relationship with the duty of candour and the rights of service users to challenge public bodies, either through a Board development session or as a focused item at a future Strategy Board. <u>Updated</u> (23/09/2026) This has been included on the agenda for the Board Away Day on 06 November 2026. Action completed.	SO	Sep-26		Completed

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	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 Jul-26 Sep-26	24/07/2026 - The Digitising Documentation Paper is currently progressing through the appropriate governance approval processes. The paper will set out the strategic approach, implementation plan, and proposed timeline for reducing paper-based processes across the Trust. Subject to governance approval, the paper is scheduled to be presented to the Closed Board in September.	Action Closed. Delegated to Closed Board in September 2026
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.	SO	Jul-26	24/07/2026 - CRR reviewed and updated. Risk Register reviewed and relevant risks streamlined. Action completed. 22/05/2026 - Risk on corridor care on CRR, but three on RR. Risks being reviewed and consolidated.	Action closed
3	27/05/2026	TB26/036 Aggregated Incidents, Complaints and Claims Report (Q4)	Future Aggregated Incidents, Complaints and Claims reports to include additional information regarding the number of Parliamentary and Health Service Ombudsman (PHSO) cases that had been upheld.	SO	Jul-26	24/07/2026 - An update has would be included under Agenda Item 11 TB26/055 Aggregated Incidents, Complaints and Claims Report (Q1)	Action closed
4	24/06/2026	TB26/044 Committee Assurance Reports 7.3 Quality Committee	The Safeguarding cases studies included in the 2025/26 Safeguarding Annual Report to be circulated to Board members. <u>Update (14/07/2026)</u> The 2025/26 Safeguarding Annual Report (including case studies) that was presented at Quality Committee was circulated to Board members. Action completed.	SO	Immediate	24/07/2026 - The 2025/26 Safeguarding Annual Report (including case studies) that was presented at Quality Committee was circulated to Board members.	Action closed

Title of Meeting	Trust Board		Date	30 September 2026
Agenda Item	TB26/062			
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 51 key metrics. Quality has 20 metrics, Operations 15 metrics, Workforce 6 metrics and Finance 10 metrics.				
Financial Implications				
The forecast for 2026/27 financial outturn will have implications for the finances of the Trust.				
Quality and/or Equality Impact				
The 18 metrics for Quality provide an overview for summary across MWL.				
Recommendations				
The Trust Board is asked to note performance for assurance.				
Strategic Objectives				
X	SO1 5 Star Patient Care – Care			
X	SO2 5 Star Patient Care – Safety			
X	SO3 5 Star Patient Care – Pathways			
X	SO4 5 Star Patient Care – Communication			
X	SO5 5 Star Patient Care – Systems			
X	SO6 Developing Organisation Culture and Supporting our Workforce			
X	SO7 Operational Performance			
X	SO8 Financial Performance, Efficiency and Productivity			
X	SO9 Strategic Plans			

Board Summary

Overview

Mersey and West Lancashire Teaching Hospitals (“The Trust”) has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.

The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Never Events	Aug-26	0	0	0	
Falls ≥ moderate harm per 1000 bed days	Aug-26	0.19	0.00	0.19	
Nurse Fill Rates	Aug-26	92.0%	90.0%	93.9%	
NEWS Obs on Time or Within Tolerance (A&E)	Aug-26	70.3%	80.0%	69.2%	
% Screened using the MUST tool	Aug-26	83.1%	95.0%	80.4%	
Fluid balance chart in place and accurately completed	Jul-26	59.5%	90.0%	58.0%	
MRSA	Jul-26	0	0	0	
C.difficile	Jul-26	6	97	36	
MSSA	Jul-26	4	0	27	
E.coli	Jul-26	25	145	78	
Complaints Responded In 60 Days	Aug-26	79.6%	80.0%	72.9%	
FFT - Inpatients % Recommended	Aug-26	91.1%	94.0%	93.2%	Worst 40%
Mortality - HSMR	Mar-26	116.2	100	97.4	Best 50%
Mortality - SHMI	Apr-26	1.02	1.00		
Mortality - SMR - Sepsis	Mar-26	83.6	100	83.2	
Neonatal Deaths	Aug-26	0	0	7	
Stillbirths (intrapartum)	Aug-26	1	0	1	
Sepsis: Admin of Antibiotics within agreed timescale	Jul-26	78.7%	80.0%	76.0%	
Average instances of Corridor Care (ED)	Aug-26	40.7	0.0	54.0	
Average instances of Corridor Care in (G&A) (IP)	Aug-26	0.7	0.0	0.8	

Operations	Period	Score	Target	YTD	Benchmark
A&E Triage: % < 15 mins	Aug-26	74.8%	95.0%	72.7%	
A&E Standard (Mapped)	Aug-26	77.7%	82.0%	77.4%	Best 40%
% of patients spending more than 12 hours in A&E	Aug-26	19.3%	15.6%	19.1%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Aug-26	79.1%	100.0%	78.0%	
RTT % less than 18 weeks	Aug-26	65.0%	70.6%	65.0%	Best 40%
18 weeks: % 52+ RTT waits	Aug-26	2.1%	1.0%	2.1%	Worst 30%
Diagnostic Waits: % <6 weeks	Aug-26	80.9%	95.0%	80.9%	
G&A Bed Occupancy	Aug-26	97.3%	92.0%	97.1%	Worst 20%
Discharges Before Noon	Aug-26	17.9%	25.0%	19.3%	
% of Patients With No Criteria to Reside	Aug-26	18.9%	15.0%	21.6%	
Cancer Faster Diagnosis Standard	Jul-26	72.4%	80.0%	74.4%	Worst 30%
Cancer 31 Days	Jul-26	95.5%	94.0%	95.5%	
Cancer 62 Days	Jul-26	78.0%	80.0%	78.8%	Best 20%
Elective Actual Utilisation: Capped Orm & St.H	Aug-26	74.8%	78.7%	74.3%	
Elective Actual Utilisation: Capped S'port & Whist	Aug-26	79.6%	84.5%	80.3%	

Board Summary

Overview

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The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.

The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Workforce	Period	Score	Target	YTD	Benchmark
Mandatory Training	Aug-26	89.7%	85.0%	89.7%	
Appraisals	Aug-26	67.7%	85.0%	67.7%	
Sickness: All Staff Sickness Rate	Aug-26	7.2%	5.0%	6.8%	
Sickness Rate - All Staff (Rolling 12 months)	Aug-26	7.0%	5.0%		
Average time to recruit (days) - All Staff	Aug-26	53	40	54	
Staffing: Turnover rate	Aug-26	1.6%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Reported Surplus/Deficit (000's)	Aug-26		-6,665	-6,665	
Forecast outturn surplus/(deficit) (£000)	Aug-26		16	16	
Delivery of CIP savings (000's)	Aug-26		18,222	18,222	
Cash Balances - Days to Cover Operating Expenses	Aug-26	1.5	2		
Capital Spend £ 000's	Aug-26		13,137	10,323	
Value of aged debt >90days overdue £000's	Aug-26			17,078	
Outpatients Activity v Plan	Aug-26		0.0%	-4.5%	
Elective Activity & DC v Plan	Aug-26		0.0%	6.4%	
Non Elective Activity v Plan	Aug-26		0.0%	-1.6%	
A&E Activity v Plan	Aug-26		0.0%	1.5%	

Board Summary - Quality

Quality

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

Falls: There were 10 Falls with Harm (moderate and above) in July 2026 (6 moderate and 4 severe). August data is yet to be validated for harm and learning reviews are currently underway for all falls with harm. Falls is an integral part of accreditation and Nursing Care Indicators (NCI) with targeted support in areas requiring improvement.

Safe Staffing: Registered Nurse/Midwife Overall fill rates (combined day and night) - STHK : 93.63%, S&O: 89.05%

NEWS:

Whiston ED: In August, a total of 27,163 sets of observations were recorded compared to 25,772 in July, representing an increase of 1,391 observations (5.4%). Compliance with observation completion also improved during this period, increasing from 62.04% in July to 64.5% in August. This represents a 2.46 % improvement. These results demonstrate both an increase in the volume of observations undertaken and an improvement in overall compliance during August.

Southport ED

Southport ED remains above 80% in our compliance, and we are continuing our focus on highest risk areas for overdue observations due to frequent patient movement and highest nurse to patient ratio across the department.

MUST: The timely completion of MUST assessments within 24 hours of ward admission and the completion of subsequent reassessments in line with policy requirements is reviewed routinely within ward performance meetings, matrons' reviews, and divisional governance forums, with expectations communicated through safety huddles, ward briefings, and team meetings.

Fluid Balance: There has been a 30% improvement in compliance with fluid balance indicating that education and training is improving performance. Performance is an agenda item on the new MWL AKI meeting which commenced in September 2026.

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

Clostridium difficile infection: There were 6 healthcare-associated CDT cases at MWL in July, and the Trust is 4 cases above threshold, which is an improved position compared to previous months.

MSSA: There were 12 healthcare-associated MSSA bacteraemia in month. The Bloodstream Infection Improvement Plan remains in progress, and timely blood culture collection within the sepsis pathway continues to improve.

Gram-negative bloodstream infections, E coli: There were 25 healthcare-associated E coli bacteraemia in July and the Trust is 30 cases above threshold, which is a 16% increase compared to 2025/26. Cases of E coli can increase during summer months secondary to dehydration and UTI.

Complaints: In August there were 57 new first stage complaints received and in July there were 58. This illustrates a minor decrease on last month (1). 8 second stage complaints were received in August compared to 10 in July 2026.

54 first stage complaints were closed in August, 43 within the agreed Trust 60 working day target resulting in a sustained improvement in compliance of 79.6% for August 2026.

FFT:

August positive score 91.09%, 2.91% below internal target of 94% (Most recent national average score June 2026 - 95%). Local surveys are ongoing and reported through Patient Experience Council.

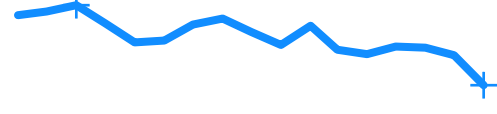
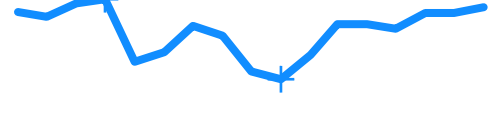
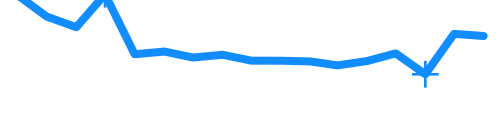
HSMR: The final HSMR for financial year 2025-26 was 97.4 for MWL (93.8 for STHK and 107.0 for S&O). Mortality HSMR has risen with ongoing detailed case review, no immediate concerns have been identified.

SHMI: The latest SHMI data for 12 months ending Mar-26 is 1.02 (1.04 for STHK and 1.0 for S&O).

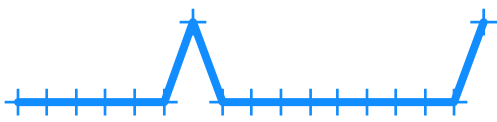
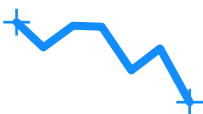
Neonatal Deaths:

Stillbirths (intrapartum) Intrapartum Stillbirth at Whiston Site. Fetal Death in Utero diagnosed on arrival to Maternity Triage. Case has been reported to MNSI/ STEIS/PMRT.

Board Summary - Quality

Quality	Period	Score	Target	YTD	Bench...	Trend
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Mortality - SHMI	Apr-26	1.02	1.00			
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Board Summary - Quality

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Board Summary - Operations

Operations

Urgent Care Pressures A&E

4-Hour performance increased in August, achieving 73.7% (all types). Trust performance is below National (75.0%) and equal to C&M (73.7%). The Trusts mapped 4-Hour performance achieved 77.7%.

Patient Flow

Bed occupancy across MWL averaged 104.3% in August equating to 80 patients - an ongoing trend of high occupancy. There was a peak of 124 patients (52 at S&O, 72 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Admissions were 10% higher than last August, with a 15% increase in 0 day LOS activity and 3% increase in 1+ day LOS activity. St Helens had a 2.4% increase in 0 day LOS activity and 4.6% increase in 1+ day LOS activity from August 25 to August 26, however Southport had a 37.8% increase in 0 day and a 0.9% increase in 1+ day LOS activity. Average length of stay for emergency admissions remains high, at 9.1 at S&O and 7.5 at StHK, with an overall average of 7.9 days, the impact of non CTR patients being 18.9% at Organisation level, however, this is 3.4% lower than July 26 and 1.6% lower than August 25 (24.1% S&O and 16.3% StHK for August 26).

Elective Activity

The Trust had 1,752 52-week waiters at the end of August, (185 S&O and 1,567 StHK), 30 65-week waiters and 1 78-week waiter.

The 52-week position is a increase of 57 from July and the 65-week waiters have increased by 12 from July to August. There is 1 new 78-week waiter. 18-Week performance in August for MWL was 65.0%, S&O 66.8% and StHK 64.4%. This was below national performance (latest month July) of 65.3% and C&M regional performance of 65.7%.

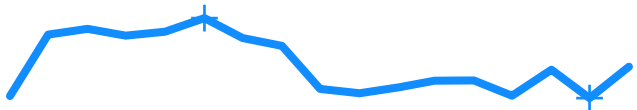
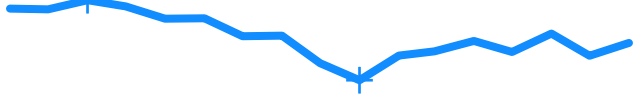
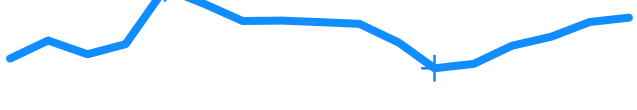
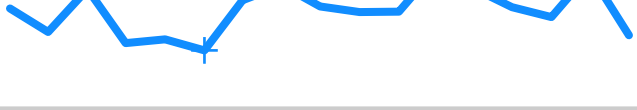
Cancer

Cancer performance for MWL in July deteriorated to 72.4% for the 28 day standard (target 80%), with Southport achieving 73.2% and St Helens performance being 71.8%. Latest published data (July) shows national performance of 79.3% and C&M regional performance of 77.2%. Performance for 62-day improved, achieving 78.0% (target 80%), with Southport achieving 72.6% and St Helens 80.0%. C&M performance was 76.2% and National 71.2%. Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2026/27.

Diagnostics

Diagnostic performance in August improved to 80.9% for MWL, however, failed to achieve the 95% target, with S&O achieving 72.1% and StHK 86.1%. MWL performance is ahead of national performance (latest month July) of 76.9% and below C&M regional performance of 86.8%.

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
A&E Triage: % < 15 mins	Aug-26	74.8%	95.0%	72.7%		
A&E Standard (Mapped)	Aug-26	77.7%	82.0%	77.4%	Best 40%	
% of patients spending more than 12 hours in A&E	Aug-26	19.3%	15.6%	19.1%		
Ambulance Arrival to Vehicle Handover: % <45 mins	Aug-26	79.1%	100.0%	78.0%		
RTT % less than 18 weeks	Aug-26	65.0%	70.6%	65.0%	Best 40%	
18 weeks: % 52+ RTT waits	Aug-26	2.1%	1.0%	2.1%	Worst 30%	
Diagnostic Waits: % <6 weeks	Aug-26	80.9%	95.0%	80.9%		
G&A Bed Occupancy	Aug-26	97.3%	92.0%	97.1%	Worst 20%	
Discharges Before Noon	Aug-26	17.9%	25.0%	19.3%		
% of Patients With No Criteria to Reside	Aug-26	18.9%	15.0%	21.6%		
Cancer Faster Diagnosis Standard	Jul-26	72.4%	80.0%	74.4%	Worst 30%	
Cancer 31 Days	Jul-26	95.5%	94.0%	95.5%		
Cancer 62 Days	Jul-26	78.0%	80.0%	78.8%	Best 20%	
Elective Actual Utilisation: Capped Orm & St.H	Aug-26	74.8%	78.7%	74.3%		
Elective Actual Utilisation: Capped S'port & Whist	Aug-26	79.6%	84.5%	80.3%		

Board Summary - Workforce

Workforce

Mandatory Training

The Trust continues to exceed its mandatory training target, achieving 89.7% compliance in August 2026, above the 85% target. The Learning and Organisational Development team continues to work with areas below the required compliance level, particularly within Corporate Services (Estates and Facilities) and Medical and Dental staff groups. Targeted support remains in place to ensure staff can access training and sustain compliance across all staff groups.

Appraisals

Appraisal compliance reduced further to 67.7% in August 2026, against the Trust target of 85%. This figure is anticipated following as we are currently in 2026/27 appraisal window on however we are currently behind our planned trajectory for meeting the Target by the end of September. Updated appraisal documentation, incorporating the Trust Behavioural Framework, is available and managers are being supported through training, targeted communications and one-to-one assistance to improve completion rates. All divisions have targeted plans in place to support the completion of appraisals by the end of September 2026.

Sickness Absence

Sickness absence increased by 0.3% to 7.1% in August 2026, above the Trust target of 5%, with the rolling 12-month absence rate remaining static at 7%.

Increases in sickness absence has significantly increased across Nursing and Midwifery which has increased by 0.7% to 8.9% in August. Sickness absence across Admin and Clerical has also increased by 1% to 6.6% in month.

Decreases in sickness absence have however been seen across our Additional Clinical Services, Medical and Dental and Estates and Ancillary staff groups.

The Absence Support and HR Team continue to provide focused support to high-risk areas, alongside targeted initiatives for areas with consistently high levels of absence, manager coaching and attendance management training. Sickness absence remains a key workforce priority for the Trust.

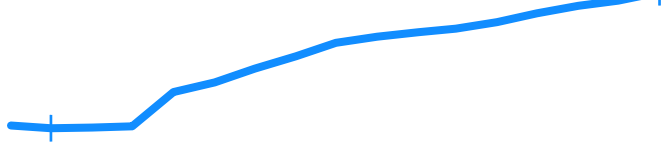
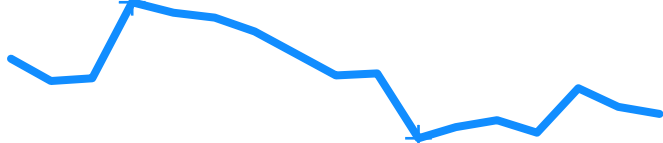
Turnover

In-month turnover for August 2026 increased to 1.6%, which is above the Trust target of 1.1%. This is anticipated increase for this time of year due to the rotation within medical staffing

Time to Hire

The average time to recruit in August was 52.9 days, compared to the Trust target of 40 days. This has decreased from 53.9 days in July 2026. Recruitment activity is continuing to operate at significantly higher levels than the same period last year and increased demand associated with substantive recruitment continues. Increases have also been impacted by increased activity within the Health, Work and Wellbeing Department associated with Resident Doctor onboarding. Onboarding Recovery actions remain in place and the current trajectory assumes activity will begin to reduce and it is anticipated we will achieve the 40 day target by December 2026

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Mandatory Training	Aug-26	89.7%	85.0%	89.7%		
Appraisals	Aug-26	67.7%	85.0%	67.7%		
Sickness: All Staff Sickness Rate	Aug-26	7.2%	5.0%	6.8%		
Sickness Rate - All Staff (Rolling 12 months)	Aug-26	7.0%	5.0%			
Average time to recruit (days) - All Staff	Aug-26	53	40	54		
Staffing: Turnover rate	Aug-26	1.6%	1.1%	1.0%		

Board Summary - Finance

Finance

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

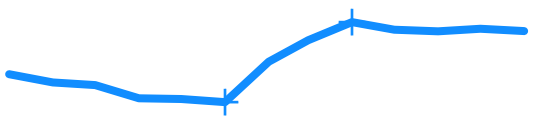
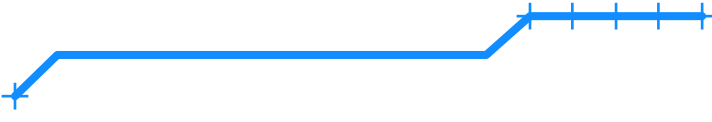
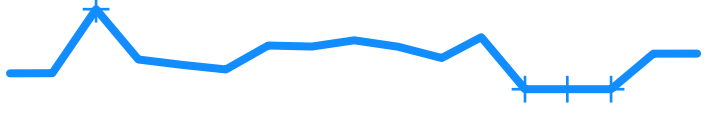
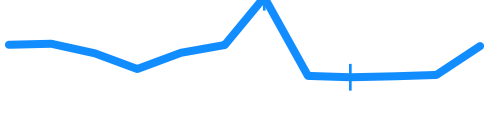
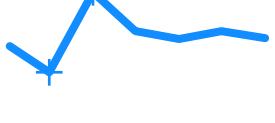
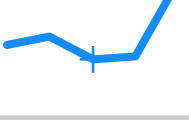
Surplus/Deficit – At the end of Month 5, the Trust is reporting an adjusted position of £6.7m deficit. Excluding deficit support funding, the adjusted position is £13.7m deficit, in line with plan. This includes the impact of the 2026/27 pay awards and industrial action costs which are mitigated within the overall position.

CIP - The Trust's CIP target for financial year 2026/27 is £49.7m, all of which is to be delivered recurrently. As at Month 5, the Trust has successfully transacted CIP of £18.2m year to date, in line with plan. The year to date efficiencies include £12.1m recurrent and £6.1m non recurrent.

Cash - At the end of M5, the Trust's cash balance was £3.8m. 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 £38.4m capital PDC funding 2026/27.

Capital - The Trust's original capital plan for 2026/27 was £42.2m (including PFI lifecycle and lease remeasurements). Since submitting the plan, the Trust has been informed that it will receive an additional £3.5m for Shaping Care Together, £3.2m PDC in relation to the Estates Safety Fund (now £4.6m) and an additional £1.9m capital. The total revised plan (including revised PFI lifecycle of £0.6m and lease remeasurements) is c. £51.2m. Capital expenditure for the year-to-date [including PFI lifecycle maintenance and lease remeasurements] totals £10.3m, which is £2.8m below plan.

Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Reported Surplus/Deficit (000's)	Aug-26	-6,665	-6,665	-6,665		
Forecast outturn surplus/(deficit) (£000)	Aug-26	16	16	16		
Delivery of CIP savings (000's)	Aug-26	18,222	18,222	18,222		
Cash Balances - Days to Cover Operating Expenses	Aug-26	1.5	2			
Capital Spend £ 000's	Aug-26		13,137	10,323		
Value of aged debt >90days overdue £000's	Aug-26			17,078		
Outpatients Activity v Plan	Aug-26		0.0%	-4.5%		
Elective Activity & DC v Plan	Aug-26		0.0%	6.4%		
Non Elective Activity v Plan	Aug-26		0.0%	-1.6%		
A&E Activity v Plan	Aug-26		0.0%	1.5%		

Committee Assurance Report			
Title of Meeting	Trust Board	Date	30 September 2026
Agenda Item	TB26/063 (8.1)		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the nine Executive Committee meetings held in July and August 2026		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		
Agenda items			
Title	Description	Purpose	
The Executive Committee met on five occasions during July 2026 and four occasions in August 2026.			
At each meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive’s authorisation recorded. The weekly vacancy control panel decisions were also reported at each Committee meeting.			
02 July 2026			
Emergency Department (ED) Consultant Southport Business Case	- The Chief Operating Officer introduced the report which sought approval to recruit additional ED Consultants for Southport Hospital, in addition to the two posts previously approved by the Committee. - The Committee considered the proposal to recruit an additional 2.0 whole time equivalent (WTE) ED Consultants at Southport Hospital to strengthen service resilience and support clinical quality. - Subject to confirmation from the Chief Executive and Chief Finance Officer, the proposal was approved and a benefits realisation review requested after 12 months.	Approval	
BadgerNet Update	- The Director of Informatics provided an update on some technical issues identified during user acceptance testing of the BadgerNet system and noted that a further report would be presented setting out options and next steps. - The Committee noted the update.	Assurance	
Health Records Update	- The Director of Informatics presented the report, which provided an update on the health records scanning backlog, the impact on clinical coding and the actions taken to recover performance. - The national reintroduction of Payment by Results had significantly changed the timetable for coding	Assurance	

	of activity and the Committee noted that delays in scanning had contributed to the April coding submission deadline being missed. • A further report was requested to progress resolving the immediate scanning/coding risks. • The Committee noted the report.	
Benchmarking Update	• The Deputy Director of Finance and Information presented the Corporate Benchmarking report for approval, which was due for submission to NHS England on 08 July 2026. • The Committee reviewed and approved the Corporate Benchmarking submission to NHS England, noting positive performance against national requirements and awaiting publication of comparative data. It was noted that the averages may change once data from other organisations had been published.	Approval
Lost to Follow Up (LTFU) Update	• The Chief Operating Officer introduced the report to provide the Lost to Follow Up update. • As of 02 July 2026, there remained 160 (10%) patients that required a review. • The Committee noted continued progress in reducing the Lost to Follow Up backlog and would continue monitoring this until all reviews had concluded.	Assurance
Emergency Planning Response and Resilience (EPRR) Annual Report 2025/26	• The Chief Operating Officer presented the report which demonstrated the Trust's compliance against core standards April 2025-March 2026. • The Trust was noted to be one of the top performing acute Trust's in the Cheshire and Mersey region for emergency preparedness. • An Internal Audit was evaluated as providing substantial assurance. • The Committee approved the report, which was also due to be presented to the Board of Directors in July 2026.	Approval
Specialist Nurse Activity	• The Chief Nursing Officer presented the report which outlined the variation across the Trust in relation to Specialist Nurse roles. This largely related to evolving roles and arrangements that originated in legacy organisations prior to the formation of MWL. • A small advisory group had been established to review the arrangements for specialist nursing roles. • The Committee approved the review to develop a more consistent approach but noted that a more	Approval

	detailed plan and proposals would be required at a later date.	
Matron Staffing Rota	- The Chief Nursing Officer presented the report which outlined the variation across the Trust in terms of on call arrangements for Matron's, largely relating to arrangements that originated in legacy organisations, prior to the formation of MWL and suggested next steps to review the arrangements. - The Committee supported work to review and standardise matron on-call arrangements and requested further consideration of future operating models, once these had been developed.	Approval
Communications and Media Quarterly Activity Report	- The Deputy Chief Executive introduced the report which covered communications and media activity during Q4 2025/26 and scheduled activities for Q1 2026/27. - The Committee discussed the proposal for a Newsround of completed and upcoming activity. - The Committee noted the report.	Assurance
9 July 2026		
Lord Mann Letter and Actions	- The Chief People Officer introduced the report which provided a summary of the NHS England (NHSE) recommendations to address racism and antisemitism within the NHS. - There were 36 recommendations; a gap analysis had been undertaken to review current activity, and improvement actions were included in the report. - The Committee approved the report and action plan, noting that this would be presented to the Strategic People Committee.	Approval
BadgerNet Implementation Update	- The Director of Informatics introduced the report which provided options for implementation of the BadgerNet Maternity system. - Technical limitations associated with multiple patient administration and electronic patient record systems created challenges to implementing a single integrated solution. - Members requested additional information regarding technical assumptions and operational impact. - No decision was made and a supplementary report was requested.	Approval
Board Visibility	The Director of Corporate Services presented the report which sought endorsement to amend the	Approval

	Trust Board arrangements to increase Board visibility and engagement across Trust sites. • The proposed approach included rotating Board locations and increasing direct engagement with clinical teams and departments. • The proposal was endorsed, subject to Chair and Board approval.	
Financial Improvement Group (FIG) Update	• The Director of Strategic Resourcing presented the report which gave an update on meetings of the groups since the last update. • Two meetings had been held during the reporting period, focusing on financial improvement actions and delivery. • The Committee noted the report.	Assurance
PMO Options Appraisal	• The Chief Executive introduced the report which provided an options appraisal for the future Programme Management Office (PMO) function. • The Committee approved an integrated hub and spoke model to provide PMO support across the organisation. • The Committee also approved that the PMO function once established would sit within the Chief Executive's portfolio to support the Trust's strategic transformation plans.	Approval
Freedom of Information (FOI) Report	• The Director of Informatics presented the report which detailed the compliance rate against the 20-working day response time for FOIs within each director's portfolio. • Overall, Trust compliance remained below the 90% target for responding within 20 days and the Committee requested a review of the approach and any mitigations to support the improvements needed.	Assurance
16 July 2026		
NHS Service Change Guidance Assessment	• The Chief Finance Officer introduced the report which provided an update on the revised NHS England guidance relating to service changes. • A standardised service change risk assessment had been developed to support future decision making. • The Committee noted the report and approved the adoption and use of the Service Change Risk Assessment Template for future service change proposals, subject to the minor updates requested.	Approval

BadgerNet Supplementary Report	• The Director of Informatics introduced the report which provided an update on the proposed implementation of the BadgerNet maternity system. • Following further technical review, the implementation of one instance of BadgerNet was not considered possible until the Trust has one patient administration system (PAS) and one electronic patient record (EPR) system in place. • It was noted that, whilst a fully unified maternity solution remained the preferred long-term position, implementation of BadgerNet under the proposed arrangements would provide an improvement on existing processes and support national expectations for digital maternity records. • Risks, operational impacts and testing requirements were reviewed. • Following discussion, the Committee approved progression towards implementation in November 2026, subject to successful testing and readiness activities.	Approval
Workforce Plan – Month 3	• The Chief People Officer introduced the report which considered workforce performance against the 2026/27 plan for Month 3. • Workforce levels remained broadly on trajectory, although sickness absence continued to create pressure on temporary staffing expenditure. • The Committee noted the report.	Assurance
Healthcare Records Update	• The Director of Informatics presented the report which included progress against recovery plans for health records scanning and coding performance. • Performance had improved significantly, supported by additional oversight and productivity measures. • Assurance was provided that coding submission deadlines were being achieved and performance continued to improve towards target. • The Committee noted the update.	Assurance
Resident Doctors 10 Point Plan (10PP) Board Assurance Framework (BAF)	• The Chief People Officer introduced the report which provided assurance that MWL is meeting the requirements of NHS England's 10 Point Plan to Improve Resident Doctors' Working Lives. • Most standards were assessed as compliant, with a small number requiring further improvement. • Areas of partial compliance related primarily to rota transparency, annual leave and payroll.	Assurance

	The Committee noted the report.	
MWL Mental Health Act Legal Administration	- The Chief Nursing Officer presented the report which provided options to ensure continued compliance with the statutory regulations of the Mental Health Act when a patient is detained to any of the Trust sites. - Two options were presented. However, an additional option had been introduced since the report had been drafted required further evaluation. - The Committee did not approve any options and noted that an update would be provided in due course.	Approval
Unlawful Access – Patient Records	- The Director of Informatics presented a report following recent national concerns regarding inappropriate access to patient records. - The Trust continued to report high compliance with information governance training and had reinforced national awareness activity through internal communications. - The Committee received assurance regarding the controls, monitoring arrangements and investigation processes in place and noted the report. - An overview of audits undertaken was requested.	Assurance
Board Assurance Framework (BAF)	- The Director of Corporate Services presented the BAF update for Quarter 1 2026/27, to be recommended to the Trust Board. - The Committee noted the report.	Assurance
Risk Management Council Assurance Report and CRR – July 2026	- The Director of Corporate Services presented the report which provided an update on risk management activity and performance. - An increase in overdue risk reviews was noted, and actions were underway to improve compliance. 22 risks were included on the Corporate Risk Register (CRR). - The Committee noted the report.	Assurance
Nurse Safe Staffing Report – May 2026	- The Chief Nursing Officer presented the report. - Registered Nurse (RN) fill rates had been 94.68% and Healthcare Assistant (HCA) fill rates were 104.59%. - It was noted that fill rates on the Southport site were lower than Whiston, reflecting difficulties in identifying staff during times of escalation or in times where staff needed to be moved.	Assurance

	• The Enhanced Therapeutic Observations of Care (ETOC) pilot outcomes were under review, and updates would be included in future reports. • The Committee received assurance that mitigations were in place to maintain safe staffing levels.	
Month 3 Finance Update	• The Chief Finance Officer introduced the report which summarised the Month 3 financial position and the actions to deliver the planned outturn position by the end of the financial year. • The Committee noted the report.	Assurance
Information Governance (IG) Annual Report	• The Director of Informatics presented the draft IG annual report ahead of reporting to the Trust Board. • The report demonstrated that the Trust remains compliant with the legal requirements. • There had been four reportable incidents to the Information Commissioners Office, and no fines had been imposed at the time of the report. • The Committee noted the report.	Assurance
Integrated Performance Report (IPR) – June 2026	• The Chief Finance Officer presented the IPR metrics, and the Committee discussed the commentary that needed to be completed for the Committee Performance Reports to be issued. • The Committee noted the increased Hospital Standardised Mortality Ratio (HSMR) which had increased to 116.2 at the latest refresh (March 2026), further reviews were requested to identify the specific areas that that had increased. • The Committee noted the report.	Assurance
23 July 2026		
Band 5 Job Description Review Delivery Plan	• The Chief Nursing Officer introduced the report, which provided an overview of the Trust's delivery plan for the national review of Band 5 registered nursing roles. • The programme had commenced and was being progressed through partnership arrangements, with Executive oversight from the Chief People Officer and Chief Nursing Officer. • The delivery plan would be delivered over a phased programme from October 2026 to October 2028. • The Committee approved submission of the delivery plan subject to there being no material changes required, as part of discussions with staff side.	Approval

Data Security & Protection Toolkit (DSPT) – Final Submission Report 2025/26 for MWL	- The Director of Informatics introduced the report which provided an overview of the Trust's 2025/26 DSPT submission. - The submission and evidence confirmed that the Trust has achieved a 'Standards Met' rating and that this had been reviewed by MIAA who had categorised the Trust's arrangements as Low Risk, which is seen as positive. - The Committee noted the report.	Assurance
PMO Operating Model	- The Chief Finance Officer introduced the report which presented a business case proposing the creation of a Programme Management Office (PMO) with a hub and spoke mode to support significant transformation schemes in the Trust. - The Committee approved the proposal, and the associated staffing model.	Approval
Board Engagement Visits Arrangement	- The Committee considered the proposal for Board engagement visits during the Trust Board meeting in July 2026. - The Committee deferred implementation until September 2026 to allow further planning and development.	Approval
Revised Trust Board Meeting Arrangements	- The Chief Executive presented the report which proposed amendments to the location of Trust Board meetings to alternative sites for 2026/27 on a rotational basis. - The proposal was intended to improve visibility and engagement across the organisation. - The Committee approved the report.	Approval
Ledger System	- The Chief Finance Officer introduced the report which provided a business case related to the procurement of the financial ledger as the contract for the current system is due to end at the end of March 2027. - It was noted that any replacement would follow a procurement process. - The Committee approved the process continuing to next stage of procurement.	Approval
30 July 2026		
Consolidation of Oral & Maxillofacial Unit (OMFU) Services at Ormskirk	- The Chief Operating Officer introduced the report which considered proposals to consolidate Oral and Maxillofacial services onto the Ormskirk site. - The proposal would improve service resilience and support delivery of referral to treatment (RTT) and cancer performance standards.	Approval

	• A service change risk assessment had identified the proposal as low risk. • The Committee approved Option 2 as the preferred way forward. Approval was given to progress the enabling work required to support implementation. • The Committee noted that final implementation would be subject to completion of readiness requirements and formal approval to progress. Regular progress updates were requested.	
Southport & Ormskirk Anaesthetics Business Case	• The Chief Executive introduced the report which provided a business case to meet increased anaesthetic activity and separate the anaesthetic and intensive care unit (ICU) Consultant rotas. • The business case was not considered in the meeting and instead, a discussion took place about an alternative approach to this overall business case. • The Committee did not endorse the proposal at this stage.	Approval
Children's Observations (ChObs) Development Plan	• The Chief Operating Officer introduced the report which included proposals to address environmental and capacity pressures within the Children's Observations service. • A phased approach was proposed, including immediate service reconfiguration and longer-term development options. • The Committee approved Phase 1 of the ChObs Development Plan and requested regular updates in advance of the Business Case in April 2027 to ensure the likely proposals would be supported by the Committee.	Approval
Sickness Absence Taskforce Action Plan Update	• The Chief People Officer presented the report which provided an update on actions and progress made by the Absence Task Force. • The Task Force was set up to provide targeted interventions for areas of high, persistent sickness absence and initially focussed on 6 areas. • Improvements had been achieved across most of the identified focus areas, although some challenges remained. • Learning from the programme would inform future workforce improvement activity. • The Committee noted the report.	Assurance
Mandatory Training Performance Report	• The Chief People Officer presented the report which provided an update on mandatory training performance and identified that a targeted 12-	Assurance

and Escalation Framework	week recovery plan had been developed, alongside a structured escalation framework for persistent non-compliance. • Overall, the Trust reported good compliance with mandatory training, however, there were some staff groups that remained below compliance. • The proposed escalation arrangements were intended to support sustained improvements in compliance. • The Committee noted the report	
Financial Improvement Group (FIG) Update	• The Chief Finance Officer presented the report which reported on meetings of the groups since the last update. • Two meetings had been undertaken since the last update. Discussions had focussed on workforce productivity and service improvement opportunities. • The Committee noted the report.	Assurance
Sterile Services (Cheshire & Merseyside Decontamination Collaborative (CMDC) Recommendation Report	• The Chief Finance Officer presented the report advising there had been no change to the costings of the business case the Committee had previously approved, however, this had now been extended to include Cheshire & Merseyside. • The Committee approved the proposal.	Approval
Health Records Incident Review Report	• The Director of Informatics presented an overview of the review into delays in health records scanning, and the impact on coding submissions. • The review found that the potential impact of delays in scanning was not fully recognised or escalated within the team. • Recovery actions had delivered a significant reduction in the backlog from 57 days to nine days at the time of the report, with performance approaching the required service standard of six days, which was expected to be achieved by the end of August 2026. • Further actions were underway to improve escalation and performance monitoring processes. • The Committee received assurance that recovery was on track and that sustainable arrangements were being established to maintain performance.	Assurance
Freedom of Information (FOI) Triage Proposal	• The Director of Informatics introduced the report which proposed changes to processes to address issues relating to FOI compliance.	Assurance

	- Options to strengthen triage and oversight arrangements were discussed. - The Committee supported further development of the proposals. - The Committee noted the report.	
Audit Policy and List of Audits	- The Director of Informatics presented the report which provided assurance regarding audits of access to patient records between January 2025 and July 2026. - An overview of the audits in the period was provided demonstrating robust controls and effective management arrangements were in place. - A further discussion was planned about options for proactive checks of access to records, to consider how the controls could be enhanced.	Assurance
Management of Intellectual Property Policy	- The Chief Medical Officer presented the report which included an updated Intellectual Property Policy that had been updated to reflect guidance for the NHS in England, published in November 2025. - The Committee noted the report and the revised policy.	Assurance
6 August 2026		
Procedural Documents Quarterly Report	- The Chief Nursing Officer introduced the report which provided the Procedural Document position as of 03 August 2026. - Progress was being made to reduce overdue documents, although challenges remained across some areas. - Potential options were being explored to identify if there were digital solutions or additional administrative support that could support teams and improve the compliance. - The Committee noted the report.	Assurance
Community Division Update	- The Director of Strategy introduced the report, providing an update on the establishment of the Community Division and the successful transfer of community services from West Lancashire on 1 July 2026. - Initial operational challenges had been resolved, and positive feedback had been received regarding the visibility and support provided by leaders and corporate services throughout the transition process. - Progress was noted against implementation of the Community Division structure. Recruitment to key	Assurance

	leadership posts was progressing alongside planning for the next phase of service transformation. • The Committee noted the report.	
Delivering 5 Star Patient Care Through MWL's Divisional Model	• The Deputy Chief Executive presented the report which provided an update on work to support development of the Trust's divisional operating model. • External support had been commissioned to undertake a diagnostic review and identify opportunities for further improvement. It is anticipated this will conclude by the end of January 2027. • The Committee noted the report.	Assurance
Nurse Safe Staffing Report – June 2026	• The Chief Nursing Officer presented the report. • Registered Nurse (RN) fill rates had been 94.60%, and Healthcare Assistant (HCA) fill rates were 104.72%, which were similar to May 2026. • It was noted that one of the key factors in improving corridor care is effective discharge, however, Nurse-led discharge had been challenging as Ward Managers and Matrons have had reduced management time. • The Committee noted that the Nursing Establishment Review would be presented at a future meeting.	Assurance
Maternity Patient Survey Quarterly Report	• The Chief Nursing Officer presented the report, summarising feedback from the 2025 NHS Maternity Patient Experience Survey and progress against the associated action plan. • The completion rate of 36% was slightly below the national average. However, the results showed a positive year-on-year trajectory, with improvements in kindness and respect, involvement in decision-making, and timeliness of postnatal discharge. Benchmarking indicates MWL performed better than expected in several areas, though continued improvement is required in postnatal communication and partner involvement on the postnatal ward. • Actions to improve were reported as either completed or progressing to plan, with improvements expected in future survey results. • The Committee noted the report.	Assurance
Neighbourhood Health (NH) Pioneer Programme Update	• The Director of Integration presented the report, providing an update on the developments in	Assurance

	neighbourhood health across the two Pioneer Places, and in Halton. • National Pioneers have been asked to pursue some high-impact transformation opportunities, with local programmes progressing - Scaling Integrated Neighbourhood Teams (St Helens), Outpatient Transformation (Sefton) and Frailty initiatives (Halton). • Progress was reported across St Helens, Sefton and Halton, including governance development, leadership engagement and integrated multidisciplinary team working. • Further opportunities to strengthen delivery were being made through bids for funding. • The Committee noted the report.	
Freedom of Information (FOI) Report	• The Director of Informatics presented the report which detailed the compliance rate against the 20-working day response time for FOIs within each director's portfolio. • Overall, Trust compliance remained below the 90% target for responding within 20 days and the Committee discussed the impact of the actions taken to date to improve compliance, acknowledging the increasing complexity and number of questions asked in each individual FOI, that required coordination across multiple services to provide the requested information. • Work had commenced to redesign the FOI triage operating model and benchmarking against other organisations. • The Committee noted the report.	Assurance
EPR Joint Programme Board Report	• The Director of Informatics presented the report which provided an update on progress across the Electronic Patient Record (EPR) programme. • The programme continued to make progress against a number workstreams. Discussions are ongoing with regional teams regarding long-term funding to support the EPR programme. • The Committee noted the report.	Assurance
EPR Executive Steering Group Assurance Report	• The Director of Informatics presented the EPR Executive Steering Group assurance report, providing an update on delivery of the Electronic Patient Record (EPR) programme. • The report noted continued progress across key programme workstreams, including Electronic Prescribing and Medicines Administration (EPMA) implementation, work to digitise and standardise	Assurance

	clinical documentation, and preparations for BadgerNet deployment. • Ambient Voice Technology (AVT) deployment was being progressed to support productivity and there were ongoing discussions regarding interoperability and integration opportunities. • The Committee noted the report.	
13 August 2026		
Lost to Follow Up (LTFU) Update	• The Chief Operating Officer introduced the report to provide the Lost to Follow Up update. • As at the time of the report 94% of patients had been reviewed. • There was one case of potential harm identified since the last update and a formal harm review process had commenced. The outcome of this would be reported through normal patient safety processes. • The Committee noted the report.	Assurance
90 Day S&O Staff Survey Action Plan	• The Chief People Officer introduced the report to present an update on the 90-day staff survey improvement plan developed in response to lower staff engagement scores at Southport and Ormskirk sites. • Priority themes for improvement included strengthening leadership, creating opportunities to listen and learn, improving everyday behaviours and supporting each other. • Engagement with staff and subject matter experts had been undertaken to understand specific drivers underlying survey results. • An overview of the actions taken to support improvements were recorded. The group established to oversee the 90-day plan had now concluded their work, with a plan to continue the necessary actions as part of ongoing improvement and transformation workstreams. • The Committee noted the report.	Assurance
Financial Improvement Group (FIG) Update	• The Director of Strategic Resourcing presented the report which reported on meetings of the groups since the last update. • Two meetings had been undertaken since the last update. • The Committee requested amendments to the reporting format to show a clearer overview of data, targets and outcomes. • The Committee noted the report.	Assurance

Finance Month 4 Update	- The Deputy Chief Finance Officer introduced the report which summarised the Month 4 financial position and the actions to deliver the planned outturn position by the end of the financial year. - The Committee noted the report.	Assurance
Community Deconstructing the Block	- The Deputy Chief Finance Officer presented an update on NHS England's programme to move community services away from block contract funding arrangements. - Trusts had been asked to submit activity information to support development of future payment mechanisms from 2027/28 onwards. - The Committee noted the report.	Assurance
Workforce Plan Month 4	- The Chief People Officer introduced the report for MWL in relation to the Workforce Plan for Month 4, 2026/27. - The report showed Workforce remained broadly on trajectory although planned reductions and variable pay expenditure continued to require oversight. - The Committee noted the report.	Assurance
Information Steering Group Assurance Report	- The Chief Operating Officer introduced the report noting that several changes and recommendations have been approved since the previous report in relation to patient-initiated follow-up (PIFU). - It was noted that the Trust has achieved a green rating across all areas of the Data Quality Maturity Index. - The Committee noted the report.	Assurance
20 August 2026		
Zero Hours Reforms – MWL Impact	- The Chief People Officer introduced the report which outlined the proposed national reforms relating to zero-hours arrangements, and the potential implications for the Trust. - A public consultation on the proposals was due to end on 25 August 2026. NHS Employers were collating feedback from NHS Trusts to support the overall response. - MWL has developed a response to be sent to NHS Employers, and further analysis would be completed once consultation outcomes were known. - The Committee noted the report.	Assurance
Temporary Workforce Utilisation Update	The Chief People Officer introduced the report which outlined that there had been an increase in	Assurance

	the use of Agenda for Change (AfC) temporary workforce during the reporting period. • Vacancies, supplementary care and increased capacity were the main drivers for this increase; however, use of bank was below the vacancy gap. • The spend on medical workforce had reduced in month 4; there had been a specific focus to move from agency to bank. Next steps will be to focus on conversion from bank to substantive. • The Committee noted the report.	
Palliative Care Proposal	• The Chief Medical Officer introduced the report which provided a proposal to improve medical oversight for the Specialist Palliative Care service, which had presented a risk due to staff absence. • Recruitment of a substantive consultant was identified as the preferred option to address service risks. • The Committee approved the recruitment of 1.0 WTE substantive Consultant to the Specialist Palliative Care Service. Further work was requested in relation to the long-term MWL service model.	Approval
Triumvirate & Leading Operational Programme Update	• The Chief People Officer introduced the report which provided evaluation, outputs and feedback following the Triumvirate Leadership Programme. • Overall feedback from the programme had been positive with strong themes related to improved trust, relationship building and strengthening cross-Triumvirate support. • The programme had delivered the expected outcomes; however, consideration about longer-term provision was required, noting this would also need to be considered alongside the NHS Leadership and Management Framework, which had recently been published. • The Committee noted the report.	Assurance
Appraisal Compliance Report	• The Chief People Officer presented the Trust compliance report as of 31 July 2026. • Compliance was below target for this time in the appraisals window. • Actions were being taken to improve the position, and further updates would be provided ahead of the end of the window on 30 September 2026.	Assurance
Trust Board Agendas (September 2026) incl. Employee of the Month (EOTM)	• The Director of Corporate Services presented the draft Trust Board agenda for September 2026 for review.	Approval

	The Committee reviewed the EOTM nominations and selected the EOTM for August 2026.	
27 August 2026		
Financial Improvement Group (FIG) Update	- The Director of Strategic Resourcing presented the report which reported on meetings of the groups since the last update. - Feedback was provided on the reporting format with a request for clearer dashboards to show progress. - The Committee noted the report.	Assurance
Winter Planning 2026/27	- The Chief Operating Officer presented the report which sought approval of the draft 2026/27 Winter Planning Self-Assessment for regional submission by midday on 26th August 2026. - A Quality Impact Assessment had been completed as part of the process. - A regional Winter Exercise was planned for 18th September 2026. - A small number of areas required further refinement before final submission. The draft submission was subsequently approved for submission by the Chief Executive, noting that a final version would be considered by the Board on 30 September 2026.	Approval
Rheumatology Workforce Sustainability & Substantive Consultant Recruitment	- The Chief Operating Officer introduced the report which sought approval to expand the current recruitment authorisation from 1 WTE Consultant previously approved by the Committee, to 3 WTE Consultants. - The case required some additional financial information, and consideration of the workforce capacity and demand in the longer term once initial performance targets had been met. - The proposal was not approved at this stage.	Approval
Hillsborough Law	- The Chief Nursing Officer introduced the report which provided an update and potential implications for NHS Organisations following the Hillsborough Law final reading in the House of Commons in July 2026, and the expectation that the legislation will come into force imminently. - The Committee noted the report.	Assurance
Leadership & Management Framework	The Acting Chief People Officer presented the report which provided an update on the Leadership & Management Framework (LMF), and the proposed implementation plan.	Approval

	• The LMF was launched by NHSE in July 2026 to provide a consistent approach to leadership standards and enhance staff experience. • MWL is required to implement the framework for all line managers, and a phased implementation plan was included for approval, which included the actions required before the end of March 2027. • The Committee approved the proposed implementation approach.	
Quality Strategy for NHSE Funded Care in England	• The Chief Nursing Officer introduced the report which summarised the new national Quality Strategy and its implications for the Trust. • The strategy provides a 10-year framework for delivering care, centred around health inequalities and outcomes and reducing unwarranted variation, with it being seen as a call to action for the NHS to ensure the focus on high-quality care is maintained. • The strategy did not introduce new priorities but intended to bring together existing commitments and focus on areas where the greatest improvements could be made. • The Chief Nursing Officer agreed to develop a high-level plan and identify leads for each of the key areas, which would be progressed through existing arrangements and overseen through Quality Committee. • The Committee noted the report.	Assurance
Developmental Well-Led Review Update	• The Director of Corporate Services presented the report which gave an update on the Developmental Well-Led Review, which was progressing in line with the expected timetable. • Survey and focus group proposals were endorsed. • The Committee noted the report.	Assurance

Alerts:

Potential impacts arising from delayed health records scanning and coding submission performance. Recovery actions were implemented, submission performance has returned to expected levels, and enhanced oversight arrangements are now in place. The issue was reported to Audit Committee for oversight.

Decisions and Recommendations:

New investment decisions taken by the Committee during July and August 2026 were:

- The Committee approved the recruitment of 2.0 WTE substantive Consultant to the Emergency Department at Southport.
- The Committee approved the creation of a Programme Management Office (PMO) and the associated staffing model.

- The Committee approved the recruitment of 1.0 WTE substantive Consultant to the Specialist Palliative Care Service.

Committee Assurance Report			
Title of Meeting	Trust Board	Date	30 September 2026
Agenda Item	TB26/063 (8.2)		
Committee being reported	Audit Committee		
Date of Meeting	09 September 2026		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		
Agenda items			
Title	Description	Purpose	
External Audit Progress Report	GT provided an update on their approach to the external audit exercise for 2026/27, including progress on audit planning and sector updates.	Assurance	
Internal Audit Reports	MIAA summarised key messages from the internal audit progress report, confirming two reports had been issued, and six reports were at various stages of progress. MIAA also summarised the external assessments (EQA) results and action plan, confirming MIAA had achieved the highest classification possible following Chartered Institute of Public Finance and Accountancy (CIPFA's) assessment.	Assurance	
MWL Audit Log	Committee received the audit log report which highlighted key movements on the audit log, both in relation to internal and external audit recommendations.	Assurance	
Anti-Fraud Progress Report	MIAA summarised key messages from the anti-fraud progress update report.	Assurance	
Revised Audit Committee Workplan for 2026/27	The Corporate Governance Manager summarised the annual workplan update.	Assurance	
MWL Standard Operating Procedure for Service Level Agreements (SLA)/ Contracts	The Deputy Director of Finance (Governance) summarised the MWL Standard Operating Procedure for Trust SLA's/contracts.	Approval	

Financial Reports	The losses and special payments report was presented. Total losses identified as at 31 August 2026 was approximately £133k. £372k in total was recorded in 2024/25. Losses included potential challenges with uncoded income which will be reviewed as part of the internal audit programme. The aged debt report was presented. Specific attention was paid towards the age and value of aged debt in the >90 day category, and what actions would be needed to help reduce these values down going forward. The tenders and quotation waivers report was presented and its contents noted.	Assurance
Alerts:		
Not applicable		
Decisions and Recommendation(s):		
Not applicable		

Committee Assurance Report

Title of Meeting	Trust Board	Date	30 September 2026
Agenda Item	TB26/063 (8.3)		
Committee being reported	Quality Committee		
Date of Meeting	22 September 2026		
Committee Chair	Neil Fletcher, 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 July 2026 were approved and the actions due for update through to September were all reviewed and updated. - Matters arising noted and updated.	Assurance	
Quality Committee Corporate Performance Report (CPR).	- Zero Never Events reported in August. - Increase in Falls during July - close oversight continues through Harm Free Care panel. - Pressure Ulcers – eight year to date (YTD) and 12 with continued scrutiny. - Safer staffing fill rates remained above 90% with slight drop-in fill rate reflective of current sickness – close monitoring continues. - Improving position against Nutrition metrics – slight improvement against the Malnutrition Universal Screening Tool (MUST). Fluid balance remains an area of focus. - Infection Prevention and Control (IPC) - Clostridioides difficile (C.Diff) rates stabilised and gloves off campaign continues. - Zero Methicillin-Resistant Staphylococcus Aureus (MRSA) YTD. - Complaints just under 80% target (79.6%) - significant improvement sustained with ongoing focus. - Increased number of admissions to neonatal unit from delivery suite – assurance given on monitoring of all admissions and trends. Noted pathway changes and slight increase in prematurity. - Corridor Care - improving position with ongoing vigilance and supportive detailed plan monitored through Finance and Performance	Assurance	

	(F&P) Committee. Corridor care numbers were over 100 in January 2026 with average of 37.1 in September (34.1 Whiston site). • Mortality-Data in March 2026 - Hospital Standardised Mortality Ratio (HSMR) raised - assurance review completed identified no trends or concerns following deep dive. Full report being prepared for Executive Committee and for future report to Quality Committee. Awaiting next data set. • Action request for report on decreasing trend in percentage of outpatient prescriptions dispensed within 30 minutes and updated dataset.	
Monitoring of Trust Annual Objectives aligned to the Quality Committee	• Positively, transitional care is now live across all maternity units with positive qualitative feedback. • Improving position against Nutrition and Hydration. Malnutrition Universal Screening Tool (MUST) compliance slight improvement in Q1 from Q4 with ongoing focus. Chief Nursing Officer (CNO) asked to bring improvement plan and trajectories back to Executive Committee. • Fluid Balance – Improvements across Q1 with further ongoing focus particularly Whiston site. • Corridor Care – Healthwatch Visits across Emergency Department (ED) with improvements in performance noted in Q1 into Q2. • Observations in ED - Southport site significant improvements in Q1. Ongoing focus on slight improvements for the Whiston site. • Work with Theatres ongoing with assessment completed by Heath Innovation Northwest supporting future improvement sessions. • National Inpatient survey report noted improvements with future reporting to Executive Committee and Patient Experience Council. • Improvement in Sepsis performance. • Trajectory for improvements against Trust Objectives to be shared via Executive Committee. • Assured on data captured for Transitional Care. • Further assurance requested on administration of antibiotics within 3 hours against data for June.	Assurance

Patient Experience Report (including Assurance Report)	• Bi-monthly report received covering June and August with the Patient Experience Council Assurance reports for July and September 2026 - no alerts to Committee. • Detailed overview of the Trust's implementation of NHS England's (NHSE) Experience of Care improvement Framework. • Tenable reporting remains positive for inpatient experience with scores above 93% • Areas of focus include awareness of discharge booklet and involvement in treatment decisions. • Decreased response rates in August on Friends and Family Test (FFT) was attributable to introduction of new FFT system. Mitigation in place and continued monitoring. • Healthwatch visits to ED in March - reviewed corridor care and recognised dedicated, kind, caring and professional staff whilst acknowledging actions being taken to reduce reliance on corridor spaces for care delivery. Noted improved position since March visit with ongoing monitoring of response to recommendations through Patient Experience Council (PEC). • Introduction of National Quality Strategy elevating the focus of Patient Experience - Action for summary of Strategy and action plan to committee. • National Inpatient Survey 2025 reports continuous improvement across 9/10 domains, no questions reporting worse than expected against peers. Areas of significant improvement noted with discharge planning as area of improvement. • Assurance provided on actions being taken to align prayer facilities for Muslim colleagues. • Assurance provided on contacts via maternity Triage line due to reported numbers and drop in reporting for July. • NHSE medium term planning elective admissions- action to identify rollout plan inclusive of timelines prior to declaration and reporting to Board year end 2026/27.	Assurance
Quarterly Safeguarding Report	• Q1 report received • Key Performance Indicators (KPI) feedback from Q4 provides ongoing significant assurance except for Safeguarding training - two elements	Assurance

	just under 90% compliance (Adult and Mental Capacity Act (MCA) Level 3 training). • No concerns regarding DoLS referral rates – recent High Court decision for recording Deprivation of Liberty Safeguards (DoLS) noted. • Slight increase in number of Mental Health detentions. • Two Child deaths in Q1 – outside of hospital and relevant reviews taken place. • Allegations against staff – reviewing resource for Lead Employer aspects of the contract. • Training – compliant except MCA training due to reviews. • Fuller report recommendations actioned and reflected in Trust policies • Reviewing recommendations following Thirlwell enquiry – Trust in receipt of letter with assurance immediate asks regarding Sudden unexpected death in childhood (SUDIC) process under review. • Assurance on Safeguarding activity across the Trust noting numbers of initial contacts. Request for future divisional level of reporting of contacts for further assurance on areas.	
Infection Prevention and Control Quarterly Report	• Q1 above NHSE targets for C.Diff and Gram-Negative Blood Stream Infections (BSI) (below Cheshire and Mersey rate for C Diff). • 53 healthcare associated Escherichia coli (E-Coli) in Q1 (16 cases above NHSE threshold & increase on same period 2025/26. Deep dive of cases and themes to be shared. • Methicillin-sensitive Staphylococcus Aureus bacteraemia (MSSA) – no external target but increased by five cases compared to 2025/26 and above Cheshire & Mersey rate. Themes noted and blood stream infections action plan remains in place. • Zero Methicillin-Resistant Staphylococcus aureus (MRSA). • C.Diff- 30 cases (25 Whiston site) in Q1. Assured on actions taken including increased focus on cleanliness of clinical environments and focus on high use equipment. • Gloves off campaign implemented July (120-day improvement collaborative).	Assurance

	• Surgical Site Infection outlier for Hip and Knee 2025/26. Workstreams ongoing to support improvement work. • Visual Infusion Phlebitis score (VIP) monitoring -compliance below 90% in Q1. Improvement focused through divisional IPC oversight groups with support from audit and training from suppliers. • Aseptic Non-Touch Technique (ANTT) – Achieved above 90% for Level 2 -eLearning reduced during Q1 reporting at 82.6%. • 11 outbreaks in Q1 - Majority Norovirus. Assurance outbreak management is part of the Trusts winter planning. • Positive work on IPC policy review and development. • Further assurance requested on actions to improve and sustain standards on cleaning of patient equipment.	
Maternity and Neonatal Services Quarterly Report (Including letter and response re Antenatal and Newborn screening QA visit). 10- point plan submission to NHSE	• New Perinatal Oversight report -Q1 • Q1 three moderate harms (two Ormskirk, one Whiston). • There was one Level 1 Maternity Outcomes Signal System (MOSS) alert during the period. This was reviewed in accordance with the MOSS process and no underlying safety concerns were identified. • Two Patient Safety Incident Response (PSIR) - actions and learning noted. • Two Maternity and Newborn Safety Investigation (MNSI) returned Q1 – themes and learning noted. • Zero perinatal deaths - three babies transferred to Level 3 unit and three women required transfer to Level 3 unit. • One maternity claim in Q1 - reviewed within Trust process. • 12 complaints in Q1 with actions detailed. • Daily cross site multidisciplinary team (MDT) huddle commenced. • Neonatal services received four formal complaints Q1- themes noted. • Maternity and Neonatal Voice Partnership (MNVP) leads engaged with 94 families in Q1 noting consistent positive feedback regarding compassionate care and communication. • Two delays to induction due to extreme activity and acuity. No adverse outcomes.	Assurance

	• Two delays in elective caesarean sections >24hrs no adverse outcomes. • 24 attendances at homebirths of which 18 achieved. • Baseline assessment for submission 25 September 2026 of NHSE publication of National Maternity Triage Specification. Gap analysis to follow. • Perinatal culture improvement plan noted. • Baseline assessment against the Maternal Care Bundle standards for MWL completed and action plan submitted to Local Maternity and Neonatal System (LMNS) - awaiting feedback. • NHS Resolution Maternity Incentive Scheme (MIS) Year 8 – no concerns to escalate against compliance. • Bi-annual staffing reports received noting low vacancy rates in maternity and neonates. • Maternity and Neonatal 10-point plan -baseline assessment completed. Committee scrutinised the planned submission and supported plan for submission to Board for approval.	
Patient Safety Council assurance report-June and July.	• 13 new Patient Safety Incident Reviews (PSIR) discussed through Patient Safety Panel. • One MNSI, two Patient Safety Incident Investigations (PSIIs) commissioned in July. Significant learning noted. • Committee assured on 10% increase in reporting in July is not isolated area and reflective of the previous year. • Committee assured all reported patient safety incidents reflect the majority in low or no harm. Moderate harms slight increase in July relating to falls (falls improvement plan in place). Severe harm or fatal incidents decreased. • Increase in medication safety incidents in July – Task and Finish group established to support improvement work. • Pressure Ulcer increased reporting – no identifiable themes. • Learn from Patient Safety Events (LFPSE) Q4 reports received. • Assurance reports from Council meeting were received and no alerts to Committee. • Assurance received on review and compliance against related policies. • Committee requested data aligned to Martha's rule for future reporting including trends.	Assurance

Clinical Effectiveness Council (CEC) assurance report	• Committee received September assurance report. • Noted policies approved. • Substantial assurance noted regarding resuscitation. Do Not attempt Cardiopulmonary Resuscitation (DNACPR) documentation performance remains strong. • Divisional AAA received into CEC review for clarity on reporting ongoing. • Assurance against National Institute for Health and Care Excellence (NICE) compliance. • Pharmacy Aseptic unit - QA visits identified issues and actions in place. • Research and Development annual report received noting strong performance. • Intensive Care National Audit and Research Centre (ICNARC) - good assurance. • Non-Medical Prescribers (NMP) - successful recruitment to substantive lead. • Pathology Hub – UK Accreditation Service (UKAS) accredited.	Assurance
Any Other Business: Learning from Deaths	• Noted Paper to be presented to Board.	Assurance
Thirlwall enquiry	• Committee noted Trust in receipt of letter. • Committee provided with verbal summary and cited on the report and its recommendations. • Executive team taking all required immediate actions. Oversight of the key headline messages shared. • Immediate action - paper to next Committee and Board in October.	Assurance
Alerts:		
• No alerts		
Decisions and Recommendation(s):		
The Trust Board is asked to note the report.		

Committee Assurance Report			
Title of Meeting	Trust Board	Date	30 September 2026
Agenda Item	TB26/063 (8.4)		
Committee being reported	Strategic People Committee		
Date of Meeting	23 September 2026		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		
Agenda items			
Title		Description	Purpose
Committee Performance Report (CPR)		Mandatory Training - compliance remains strong at 89.7%, exceeding the Trust target of 85%. Targeted support continues for areas below target particularly within Estates and Facilities and Medical and Dental staff groups. Appraisal Compliance - compliance reduced to 67.7%, below the 85% target and currently behind the planned trajectory for the appraisal window. Local plans in place across all division and confident that target would be met by the end of the window Sickness Absence - sickness absence increased to 7.2%, remaining above the Trust target of 5%, with the rolling 12-month rate static at 7.0%. Increases are primarily driven by Nursing and Midwifery and Administrative and Clerical staff groups. Enhanced support continues. The Committee noted the extensive support in place via the Absence Support Team and ongoing plans to in relations to this key priority for the Trust with digital automation plans to support managers through the process. Vacancy Rate - vacancy levels increased marginally to 8.3% against the target of 8.0%. Workforce pressures remain most significant within Administrative and Clerical and Senior Healthcare Assistant (HCA) roles. Focused recruitment activity continues across identified priority areas. Time to Hire - average time to hire improved from 53.9 to 52.9 days but remains above the 40-day target. The Committee noted that a full paper was tabled today in relation to Time to Hire.	Assurance

	Turnover - turnover increased to 1.6%, above the target of 1.1%. Expected in august due to medical staff rotations Health, Work and Wellbeing - pre-employment screening performance remains within target. Did not Attends (DNA) rates increased slightly to 10.5%, marginally above the 10% target. The Committee noted the report	
Workforce Operation Plan M5	The Committee received the Month 5 workforce operational plan update. The report noted that the workforce position remains broadly aligned to plan, with workforce growth driven primarily by bank staffing used to cover sickness absence and vacancies. Agency usage remains controlled. The Committee noted the need for a clear year-end workforce bridge to demonstrate delivery of planned workforce reductions and alignment with financial reporting. Assurance was provided in response to a query from the Committee that work is underway to strengthen local recruitment pipelines through apprenticeships, widening participation initiatives and partnerships with schools, colleges and community organisations. Opportunities to expand apprenticeship provision and maximise apprenticeship levy funding are being explored to support recruitment particularly within Band 2/3 roles and Operating Department Practitioner pathways. It was noted that there remains a challenge around service capacity to support apprentices during periods of high vacancy and sickness absence; however, a cohort-based apprenticeship model was discussed as a potential solution to improve recruitment, retention and workforce sustainability.	Assurance
Staff Survey Action Plan	The Committee received an overview of the mobilisation plan for the 2026 NHS Staff Survey noting the focus on strengthening local accountability, increasing participation and ensuring visible action is taken in response to staff feedback. The Committee noted the update regarding the four Trust priorities following the 2025 survey and the	Assurance

		processes undertaken locally within divisions to develop localised improvement plans Assurance was provided that targeted engagement would be undertaken to support completion rates on the 2026 survey. It was noted that the Bank Workforce Survey would also run concurrently The Committee noted that the survey will run from 28 September to 27 November 2026 with first iteration of the results expected in December	
Time to Hire Update		The Committee received the Trust's Time-to-Hire recovery plan update. It was noted that the plan remains on trajectory, with performance improving to 52.9 days in August, ahead of the planned recovery milestone of 53 days and progressing towards the Trust target of 40 days by December 2026. The Committee noted that delays continue to be driven primarily by the timely return of interview documentation by recruiting managers and extended reference-checking times. Targeted engagement is being undertaken with services to address recurring delays, while benchmarking work is underway to identify opportunities to improve reference turnaround times. Assurance was provided that a range of mitigating actions are in place. The continued development of automation solutions to streamline recruitment processes would further support performance. While recruitment demand remains high, particularly during large-scale recruitment campaigns, current performance remains aligned with the agreed recovery trajectory.	Assurance
Operational Programme Update	Excellence	The Committee received an update on the continued investment in leadership development across the Trust. The Committee noted positive feedback from participants of both the Triumvirate Development and Leading Operational Excellence programmes, with reported improvements in leadership confidence, cross-organisational collaboration and peer learning.	Assurance

	The Committee further noted that participants identified benefits in collective leadership, strategic thinking and partnership working, with ongoing peer networks and future development activity planned to sustain and embed learning across the organisation. Members highlighted the importance of evidencing organisational impact beyond participant experience. Assurance was provided that future cohorts will strengthen the application of learning through alignment with Trust priorities, supported by the emerging NHS Leadership and Management Framework and appraisal processes to demonstrate improvements in leadership practice and organisational outcomes. The Committee further noted the planned development of a multidisciplinary clinical leadership programme to support clinical staff transitioning into leadership roles and strengthen leadership capability across the organisation.	
Equality Delivery Service (Workforce Domains)	The Committee received and noted the update on the annual Equality Delivery System (EDS) assessment, which achieved an overall 'Achieving' rating across the workforce wellbeing and inclusive leadership domains. The Committee noted that a comprehensive improvement plan is in place to enhance EDI performance, including strengthening workforce data, reporting, staff networks, leadership capability and governance arrangements. Progress against these actions will continue to be monitored through established EDI governance structures, with opportunities identified to further improve performance and achieve higher ratings in future assessments.	Assurance
Assurance Reports from Sub-groups	The following assurance reports were received and noted: • Valuing Our People Council • People Performance Council • HR Commercial Services Council • Employee Relations Oversight Group	Assurance

	It was noted that a retrospective internal audit review will be undertaken to provide assurance that actions implemented in response to the Bankers' Automated Clearing System (BACS) control issue remain effective	
Alerts:		
None		
Decisions and Recommendation(s):		
The Board is asked to note the report.		

Committee Assurance Report			
Title of Meeting	Trust Board	Date	30 September 2026
Agenda Item	TB26/063 (8.5)		
Committee being reported	Finance and Performance Committee		
Date of Meeting	24 September 2026		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		
Agenda items			
Title	Description	Purpose	
Chief Financial Officer (CFO) narrative Update on emerging news.	- Update received on System financial position; deterioration remained a risk. - Community block deconstruction underway, will remain an important piece of work to ensure services appropriately resourced.	Assurance	
Committee Performance Report Month 5 2026/27	- Four-hour urgent care performance was 77.7% in August, below plan. Corridor care continues to reduce and averaged at 41.1 incidents in August. 18 Week performance in August was 65.0%, the Trust had 1,752 52-week waiters, 30 65-week waiters and one 78- week waiter. Long waiters are in complex pathways which continue to be reviewed. - Diagnostic six-week performance improved to 80.9% in August and continues to improve but remains below the 93.4% trajectory. Non-obstetric ultrasound (NOUS) and endoscopy remain the principal pressures linked to workforce availability. - The 28-day Faster Diagnosis Standard deteriorated to 72.4%, and “Challenge 7” is being used to strengthen early pathway booking. - The 62-day Standard improved to 78% ahead of both system and region at 76.2% and 71.2% respectively. - General and Acute (G&A) bed occupancy averaged 97.3% in August	Assurance	
Finance Report Month 5 2026/27	- The Trust reported a £13.7m year-to-date deficit excluding deficit support, reducing to £6.7m after support and in line with plan. - The Trust continues to forecast delivery of plan, including £16.7m deficit support.	Assurance	

	• Agency spend remained controlled at 1.3% of pay. Bank costs, income run rate, coding depth and the full-year recurrent effect of Cost Improvement Programme (CIP) require continued management. • Capital spend was £10.3m, £2.8m behind plan, plans are in place to deliver the programme for the year. • Cash was £3.8m and further improvement to the cash forecast is expected as receipts and aged debt actions progress.	
Cost Improvement Programme (CIP) and Surgery CIP Update	• The £49.7m annual CIP target remains supported by over-identification of schemes, with £68.7m currently identified. • Approximately £7m of additional schemes have been transacted over recent months. • The key focus is conversion of identified schemes into delivered, recurrent savings and clear divisional ownership, rather than identification alone. • Surgery Division reported their progress on CIP delivery in 2026/27 schemes including work to further develop ideas.	Assurance
Contract Update	• Greater Manchester arrangements are agreed and cash has been received. Relationships and routine meetings with Lancashire and South Cumbria are in place, although a formal response on outstanding pricing matters is awaited. • Continued work with Cheshire and Merseyside (C&M) around timing issues regarding U-code reporting and month-end processes. • Work ongoing to further develop contracts for the current and future years.	Assurance
Forecast	• Committee received an update on the M5 forecast outturn position including the forecast run rate and associated actions to improve which are needed to meet the financial plan. • Executive ownership is assigned and the actions are reviewed through Executive Committee and Senior Leadership Group. • The underlying position is being refreshed to reflect acute and potential community block deconstruction.	Assurance
Planning Update	• The Committee received updates on the Trust's rolling integrated planning cycle across activity, workforce, quality and safety, finance, estates and digital.	Assurance

	• Divisions and specialties are completing capacity and demand modelling and strategic plans during Q2, feeding into detailed integrated plans in Q3. • Current indications are that the three-year national submission will be required in December, subject to formal guidance.	
Q1 NHS Oversight Framework	• MWL is ranked 51st nationally and is the highest-performing Acute Trust in C&M in the Q1 assessment. • The Trust remains in segment 3 because receipt of deficit support triggers a financial override. • The Committee noted that relative rankings can move independently of the Trust's own score and that several metrics have limitations.	Assurance
Urgent Care Performance Delivery Review	• The review linked governance for the strategic transformation programme and the corridor-care improvement plan. • Four-hour performance compares favourably with peers, but 19.6% of patients spent over 12 hours in ED compared with a national average of 9.7%, demonstrating continuing safety and flow risk. • Corridor-care instances reduced from 63.2 to 41.1 per day and to 37 in September to date. Whiston ambulance handover remained the principal concern, although September performance showed improvement. • Ambulance attendances were reported as 13% higher than the same period in the prior year. The Committee noted that future updates should demonstrate continued evidence that actions deliver sustained reductions in long waits and corridor care.	Assurance
Assurance Reports from Subgroups	• Procurement Council Update • CIP Council Update • Capital Planning Council Update • IM&T Council Update • Estates & Facilities Management Council Update	Assurance
Alerts:		
• Urgent Care Performance Delivery Review: Improvements to performance have been made and action plan in place to further improve. However significant elements remain to be delivered.		

Decisions and Recommendation(s):
The Board is asked to note the report.

Title of Meeting	Trust Board			Date	30 September 2026
Agenda Item	TB26/064				
Report Title	Learning from Deaths Q3 and Q4 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 that learning has been identified.					
Executive Summary					
This report provides assurance to the Board that mortality review processes at MWL are established, multi-sourced and subject to oversight through the Mortality Operational Group (MOG), Clinical Effectiveness Council and Quality Committee. The report draws together mortality statistics, Emergency Department (ED) reviews, Structured Judgement Reviews, Medical Examiner and coronial scrutiny, PSIRF (Patient Safety Incident Response Framework) reviews, and reviews of deaths in vulnerable groups. The data on ED reviews and Medical Examiner activity is presented for the first time in the Learning from Deaths Report. Overall Q3 and Q4 mortality performance is within the expected range; however, Hospital Standardised Mortality Rate (HSMR) has risen and has been subject to extended review, with no clinical concerns identified. The reduction in outstanding Structured Judgement Reviews (SJRs) is positive and reflects increased reviewer capacity and targeted improvement work; however, the remaining backlog and unallocated cases should continue to be monitored. No major systemic patient safety concerns have been identified during the reporting period. Local learning themes are consistent across the sources (Emergency Department, SJRs, coronial learning, PSIRF reviews and vulnerable group reviews) and indicate opportunities to strengthen documentation, communication, escalation and timely decision-making. There were seven neonatal deaths, one child death and no maternal deaths during Q3 and Q4, and no trends or concerns were noted in the reported neonatal deaths.					
Financial Implications					
None					

Quality and/or Equality Impact	
No change in impact	
Recommendations	
The Board is asked to note the Learning from Deaths Q3 and Q4 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
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

Mortality assurance and learning is sought from several indicators at MWL:

1. Mortality Statistics
2. Deaths in the Emergency Department
3. Structured Judgement Reviews (SJRs)
4. Medical Examiner Service and Coronial Review
5. Patient Safety Incident Response Framework (PSIRF) reviews
6. Review of all deaths in vulnerable groups

Deaths and associated information are considered in individual case review meetings, Mortality Operational Group (MOG), Clinical Effectiveness Council (CEC) and Quality Committee.

Learning from Deaths is shared at team brief, at Trust Councils, and appears on the intranet, with specific key learning priorities [shared on the intranet](#) (link only accessible to staff internally).

This report covers Quarter 3 and Quarter 4 of 2025/26.

2. Mortality Statistics

Overall performance for Q3 and Q4:

- The crude mortality rate was within the expected range throughout Q3 and Q4 2025/26.
- Hospital Standardised Mortality Rate (HSMR) was noted in July to be raised at 116 for MWL (December 2025 to March 2026), having been 97.4 on a rolling year-to-date basis; this is an outlier. The increase was noted at both sites; the change was more marked at Southport, with pneumonia a specific outlier. An audit of the Medical Examiner reviews of all 68 pneumonia deaths at Southport in the relevant period was completed in July and did not find any lapses in care.

A further deep dive, including a second review by the Associate Medical Director (AMD) for Mortality of 10 deaths coded with pneumonia, had raised no clinical concerns. It was noted that patients had high levels of frailty and palliative care needs, which were not always coded, as well as less detailed coding; all of these factors can influence the HSMR by changing the estimated risk of death and therefore, the number of expected deaths. Notwithstanding this, a report in relation to the review and conclusions is being finalised for presentation to the Quality Committee. Further HSMR data is expected to be available in October.

- The SHMI (Summary Hospital-level Mortality Indicator) was consistent within the expected range throughout Q3 and Q4, at 0.99 at the start of Q3.

2.1 Deaths in the Emergency Department (ED)

Reviewing all deaths in ED is best practice. The ED has a Mortality Review Team who perform Royal College of Emergency Medicine approved mortality reviews of deaths. These are presented each week at ED Patient Safety Meetings. Any concerns are escalated to patient safety investigation processes to consider harm, and learning is shared through ED governance and weekly consultant meetings.

Q3 and Q4 2025/26 deaths in ED

Month	Deaths in ED (Whiston)	Deaths in ED (Southport)
October 2025	27	11
November 2025	30	20
December 2025	35	25
Total Q3	92 (all Green or Green with Learning following ED PSM scrutiny)	56 (No concerns identified from peer review of cases)
January 2026	25	13
February 2026	23	20
March 2026	19	21
Total Q4	67 (all Green or Green with Learning following ED PSM scrutiny)	54 (No concerns identified from peer review of cases)

Outcomes are recorded differently in the two departments. No deaths were considered avoidable. Individual cases are shared for local learning; concerns are recorded as incidents and triangulated with other sources, with further action taken as appropriate.

3. Structured Judgement Reviews (SJRs)

A Structured Judgement Review (SJR) is 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 hospital. It is a recognised methodology for reporting to the National Quality Board (NQB). The primary goal of the review is not to place blame, but rather to identify strengths, share best practice, and identify any gaps or areas where system improvements can be made.

At MWL the outcome of the SJR is recorded as green, green with learning, green with positive feedback, amber or red depending on the level of concern. All amber or red cases are escalated to the Patient Safety Team for consideration of investigation.

Current SJR position

Total open SJRs	57
Total open and allocated	28
Total completed awaiting MOG review	2
Total open and unallocated	29
Total pending input into Mortality InPhase	44 (to July 2026)
Current oldest open SJR	July 2025 (Q2)

Number of SJR requests Q3 October 2025 – December 2025

No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
<i>October 2025</i> 13 (0 o/s)	8	3	2		
<i>November 2025</i> 7 (1 o/s)	4	1		1 (escalated to PSP)	
<i>December 2025</i> 13 (4 o/s)	5	3	1		

Number of SJR requests Q4 January 2026 – March 2026

No. of reviews (outstanding)	Green	Green with Learning	Green with positive feedback	Amber	Red
<i>Jan 2026</i> 21 (15 o/s)	5	1			
<i>February 2026</i> 21 (13 o/s)	8				
<i>March 2026</i> 23 (17 o/s)	3	2	1		

The number of outstanding SJRs has significantly reduced over the last year. The waiting time for SJRs has also reduced. This reflects increased mortality reviewer capacity and a significant push from individual reviewers.

4. Medical Examiner Service and Coronial Review

All deaths not investigated by a coroner are scrutinised by a Medical Examiner (The Medical Examiners (England) Regulations 2024) as a statutory function. Medical Examiners are senior, independent NHS doctors.

Medical Examiner Services are in place at both Whiston and Southport Hospitals, with learning shared at the Mortality Oversight Group. Concerns are logged as incidents and triangulated with other sources. This process acts as a time-sensitive review, triggering a patient safety investigation or SJR, where appropriate.

The number of deaths referred by MWL ME offices for clinical governance review or patient safety investigation during Q3 and Q4 2025/26 was 42.

STHK site	OCT	NOV	DEC	TOTAL FOR Q3
ME reviews	163	147	185	494
Coronial referrals	21	25	21	67
S&O site				
ME reviews	48	65	87	200
Coronial referrals	2	8	9	19

STHK site	JAN	FEB	MAR	TOTAL FOR Q4
ME reviews	189	154	161	503
Coronial referrals	4	8	5	17
S&O site				
ME reviews	78	90	82	250
Coronial referrals	6	3	8	17

4.1 Learning from Coronial Review and Inquests

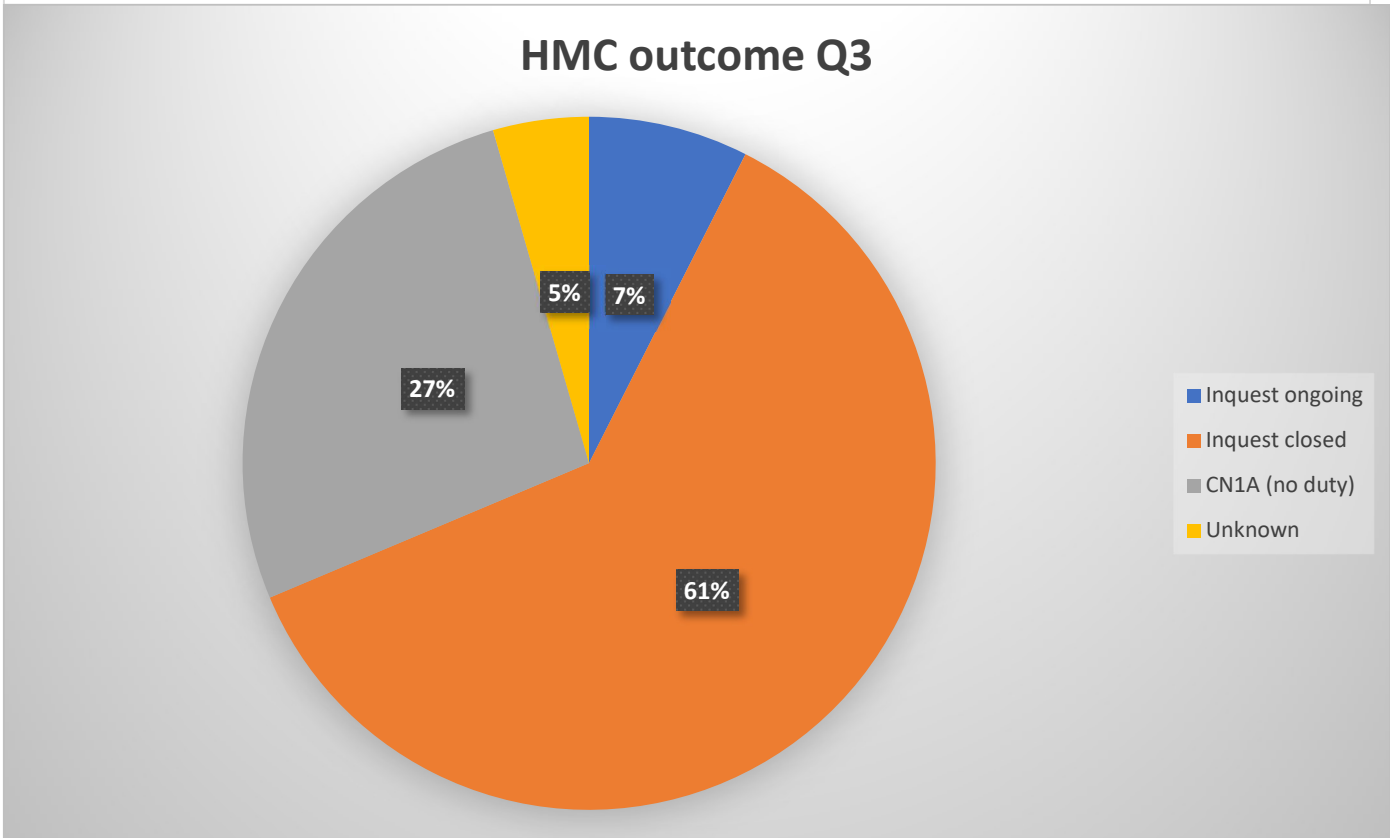
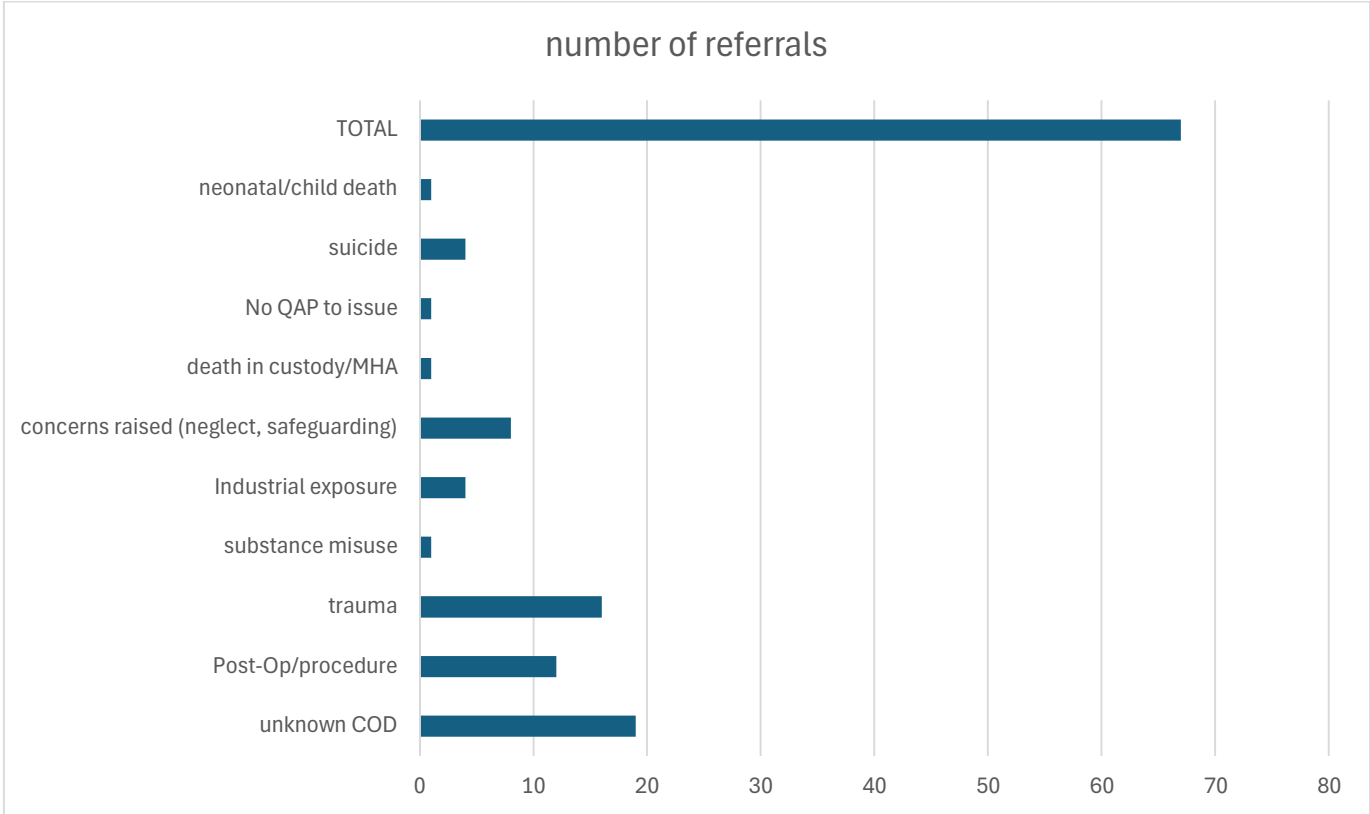
- There were no Section 28 Prevention of Future Deaths reports issued to the Trust in Q3 or Q4 2025/26.
- The Trust have not been asked to provide any additional assurances to the coroner, although the senior coroner for Sefton has raised concern over potential delays in obtaining a fully electronic patient record system.

Learning themes from inquests:

- Documentation - The accuracy of records on the EMIS system in relation to a community case. Changes are being made to allow better recording of signs of localised/systemic infection.

- Poor communication with care homes - How information is communicated to care homes when a patient is discharged back there from ED. The need to print and provide a written summary of treatment changes and plan of care to accompany the patient back to the care home has been reinforced to ED staff.
- Handover failures between services - The process by which mental health providers are notified if a patient under their care has attended ED but has not waited to be seen as they already have an appointment. Discussions have been had between ED departments and the mental health liaison providers to formalise this process as part of the wider work the Trust is undertaking to implement its Mental Health Strategy.

4.2 Reasons for His Majesty’s (HM) Coroner (HMC) referral and outcome



5. PSIRF (Patient Safety Incident Response Framework) Incidents

Reviews completed for fatal incidents closed in Q3 (October-December 2025) and Q4 (January-March 2026) 2025/2026.

Incident details	Cause of Death	Lessons Learned	Action taken
InPhase ID: 9713 Date of Death: June 2025 Date investigation completed: Falls Learning Review (FLR) completed on 16 October 2025	1a) Hospital Acquired Pneumonia 1b) Immobility 1c) Fracture Neck of Femur (operated) 2) Decompensated Heart Failure, Acute Kidney Injury, Multiple myeloma prostate cancer	Whilst admission falls assessments and care planning were completed within the required timeframe, the review identified gaps in the implementation and documentation of falls prevention measures. These included: -Incomplete post-fall documentation, omission of some prescribed interventions (e.g. non-slip footwear, crash mat and green wristband) -Lack of MCA assessment on admission, and incomplete recording of lying and standing blood pressure. This incident highlighted the need to strengthen compliance with falls prevention protocols and ensure clear documentation of clinical decision-making where assessments or interventions cannot be completed.	Findings and lessons learned from the FLR have been shared with clinical teams and incorporated into Trust-wide falls prevention learning. Compliance with falls prevention measures, including the availability and use of appropriate equipment, has been strengthened and monitored through routine falls audits and monthly nursing care indicator reviews. Targeted staff education has been undertaken to reinforce the requirements for Mental Capacity Act (MCA) assessments and consideration of Deprivation of Liberty Safeguards (DoLS) where appropriate. The FLR findings were presented through Harm Free Care Panel to support organisational learning and assurance.
InPhase ID: 16335 Date of Death: Sept 2025 Date investigation completed: Falls Learning Review completed on 03 October 2025	1a) Aspiration Pneumonia 1b) Hip fracture, rib fracture 1c) Trauma/Fall 2) Dementia, confusion, Community Acquired Pneumonia, Hypertension, CKD	This incident highlighted missed opportunities to identify, escalate and respond to increasing falls risk. Changes in the patient's condition, including confusion, increased care needs and postural hypotension, were not consistently escalated or reflected in updated risk assessments and care plans. The falls prevention measures were not fully implemented, communication of a previous fall was not effectively handed over,	This incident, including the lessons learned and the importance of placing patients with cognitive impairment on a low-rise bed, was highlighted at the monthly ward meeting. Staff reflections were undertaken in relation to communication. Falls risk assessments were audited to ensure all staff are appropriately assessing

Incident details	Cause of Death	Lessons Learned	Action taken
		and post-fall review processes were incomplete. The review also identified opportunities to strengthen the accuracy of cognitive assessments, documentation, and assurance of falls prevention equipment. Largely, learning focuses on improving risk recognition, escalation, communication, and the timely implementation of preventative interventions.	patients for the requirement for low-rise beds. A message was added to the monthly safety huddle message about the importance of moving patients into observable side rooms. The Housekeeper on the ward is to check the falls alarms daily to ensure they're working. Reflections with AMU staff on the need to ensure all information is included on the transfer of care form when patients are transferred to a new ward. The importance of escalating increases in supplementary oxygen requirements, and abnormalities in lying and standing blood pressure, was also highlighted.
InPhase ID: 14827 Date of Death: Aug 2025 Date investigation completed: 2nd March 2026	1a) Clostridium difficile infection 2) Frailty	The review identified opportunities to strengthen the timely recognition and management of suspected infectious diarrhoea, including improved completion of Bristol Stool Charts, prompt stool sample collection, and consistent implementation of IPC precautions on admission. Delays in patient isolation were influenced by communication gaps during transfer from the Emergency Department and limited side room availability due to capacity pressures. Learning has also highlighted the need for improved escalation and reporting of IPC concerns via InPhase to support organisational oversight and learning.	To ensure that all staff are aware of the Vital system and how to input bowel movements. To ensure that all patients admitted with loose stool are highlighted in the safety huddle and recorded on the flow board, along with when a stool sample was obtained. To ensure that patients requiring side rooms are identified and escalated during the safety huddle. To ensure that IPC issues continue to be highlighted at each board round and during twice-daily safety huddles. To ensure incidents are reported appropriately on

Incident details	Cause of Death	Lessons Learned	Action taken
			InPhase for all patients admitted into bay beds. The outcome and findings were shared teams following the Patient Safety Meeting.
InPhase ID: 13247 Date of Death: July 2025 Date investigation completed: 9 th February 2026	1a. Massive gastrointestinal haemorrhage 1b. Atrial fibrillation and permanent pacemaker in situ, on apixaban	The case has been discussed at divisional governance, highlighting the need for early haematology involvement in patients presenting with major bleeding while on anticoagulants. Reinforced with ED and surgical staff that the Major Haemorrhage Protocol (MHP) must be activated promptly where there is evidence of ongoing massive bleeding.	To reinforce early activation of the Major Haemorrhage Protocol (MHP) and haematology consultation for all patients with suspected or confirmed major bleeding while anticoagulated. The anticoagulant reversal guidance: DOAC (apixaban) reversal guidance was re-shared on Trust intranet and in ED/surgical safety briefs and re-circulated. Escalation to tertiary gastrointestinal (GI) bleed services: Pathway for referral to Aintree GI bleed rota re-issued, with on-call numbers added to ED/surgical escalation protocols.

5.1 Themes in learning from deaths Q3 and Q4 2025/26

- General quality of care in corridors and crowded ED spaces. UEC improvement plan in place.
- Recognition of sepsis and treatment. Sepsis group and action plans in place.
- Improving advance care planning. An ongoing DNACPR audit and a review of palliative care services are in progress.

6. Vulnerable Groups

Deaths of individuals in vulnerable groups are subject to additional review.

6.1 LeDeR (Learning from Lives and Deaths - people with a learning disability and autistic people programme)

All LeDeR deaths undergo a SJR. There were 10 deaths subject to a LeDeR review during Q3 and Q4; all were closed and graded GREEN or GREEN WITH LEARNING.

6.2 Child Deaths

The Trust has a process in place when there is a Sudden Unexpected Death in Childhood (SUDIC). The Department of Paediatrics undertakes a rapid review of every death, even if expected, to identify any learning. There is a statutory requirement for the Child Death Overview Panel (CDOP) to review every child death (Children Act 2004 and Working Together to Safeguard Children 2018) as an independent multidisciplinary process involving all those involved in the child's life.

There was one child death in Q3/Q4:

24996 – Child Death Notification completed, child known to Trust. PSIR completed as per child death policy. No lapses in care or learning identified.

6.3 Neonatal Deaths

There were seven neonatal deaths in Q3 and Q4 reviewed by MWL: four deaths at Whiston and three elsewhere. All seven patients received care at MWL.

Case number	Description	Outcome
19562	Term Antepartum Haemorrhage Unsuccessful resuscitation	Referred to Coroner and MNSI.
26262	Antenatal diagnosis of a lethal abnormality. A decision was made to end the pregnancy before the threshold of viability.	Baby born with signs of life with a plan for comfort care in place. Reported via SPEN to MBRRACE.
26714	Antenatal diagnosis of a lethal abnormality. A decision was made to end the pregnancy before the threshold of viability.	Baby born with signs of life with a plan for comfort care in place. Reported via SPEN to MBRRACE.
26715	Extreme prematurity	Baby born with signs of life with a plan for comfort care in place. Reported via SPEN to MBRRACE.
22596	Prematurity with a severe congenital abnormality. Planned delivery at a tertiary unit, but emergency LSCS was undertaken at MWL.	Death in another organisation.

Case number	Description	Outcome
24565	Neonatal death: extreme prematurity and congenital abnormality.	The patient was cared for at MWL and went on to deliver the baby at another Trust with signs of life. A plan for comfort care was in place.
30324	Term born by elective LSCS. Undiagnosed congenital heart disease, care withdrawn at 2 days of age	Reported to MBRRACE by AHCH as the unit where the baby died. As there was no labour, the case does not meet the requirement for MNSI.

During Q3, national reporting requirements for maternity services moved from individual portals for MBRRACE, CDOP and MNSI in October 2025 to SPEN as a single point of reporting in November 2025.

6.4 Learning from Neonatal Deaths

Learning is captured and monitored in the Maternity and Neonatal reports to Quality Committee and Trust Board.

6.5 Maternal Deaths

There were no maternal deaths in Q3 or Q4.

Appendix 1: Categories of death for SJR

- **Cardiac arrest** – Resuscitation team members review every cardiac arrest, if concerns are identified, a 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 the underlying indication for the surgery. Deaths triggering Patient Safety Incident Investigation are excluded.
- **Learning disability and Autism** – All deaths in a LeDeR category are referred.
- **Concern** – 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	30 September 2026
Agenda Item	TB26/065			
Report Title	Appraisals and Medical Revalidation Annual Report 2025/26			
Executive Lead	Simon Dowson, Chief Medical Officer			
Presenting Officer	Ash Bassi, Deputy Chief Medical Officer			
Action Required	X	To Approve		To Note
Purpose				
An annual report must be submitted to NHS England North West to provide assurance that the Trust has the proper process and support mechanisms in place to ensure that the medical appraisal and revalidation processes are properly embedded and deal with any issues raised in respect of doctors' performance in a timely and proper manner. The Board is required to confirm compliance with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).				
Executive Summary				
Overall, the Trust has maintained effective systems for medical appraisal, revalidation and professional standards during the 2025/2026 reporting period. The Responsible Officer is supported by established governance arrangements, a dedicated appraisal and revalidation team, regular case review structures and engagement with regional professional standards networks. Doctors are supported to complete whole-practice appraisal, revalidation recommendations are monitored and submitted in accordance with GMC requirements, and concerns are reviewed through multidisciplinary governance arrangements with appropriate escalation, external advice and Board assurance. The Trust's key achievements include continued maintenance of prescribed connection data, strengthened professional standards oversight, implementation of Patient Safety Incident Response Framework (PSIRF), improved focus on governance information for appraisal, continued development of support for locally employed doctors and international medical graduates, and embedding of MWL values of being kind, open and inclusive. The main challenges for the coming year relate to finalising the revised Medical Appraisal and Revalidation Policy, confirming appraiser capacity, completing peer review, improving consistency of appraisal supporting information across sites, and enhancing data analysis to support fairness and parity in professional standards processes. The Trust remains committed to continuous improvement, proportionate and fair professional standards processes, and a culture in which doctors are supported to reflect, learn and practise safely. The actions identified for the coming year provide a clear programme of improvement to strengthen compliance, assurance, consistency and organisational learning.				
Financial Implications				
Not Applicable				
Quality and/or Equality Impact				
Not Applicable.				

Recommendations	
The Board is asked to approve the Appraisals and Medical Revalidation Annual Report 2025/26.	
Strategic Objectives	
	SO1 5 Star Patient Care – Care
X	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	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

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required
to be submitted electronically to NHS England North
West at
england.nw.hlro@nhs.net
by **30 October 2026**

As this is a national deadline, failure to submit by this
date will result in a missed submission being recorded.
We are unable to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Mersey & West Lancashire Teaching Hospitals NHS Trust
What type of services does your organisation provide?	Acute and Community Services

	Name	Email
Responsible Officer	Dr Kathryn Clark	Kate.Clark@merseywestlancs.nhs.uk
Medical Director	Dr Simon Dowson	Simon.Dowson@MerseyWestLancs.nhs.uk
Medical Appraisal Lead	Dr Stephen Allsup	Stephen.Allsup@merseywestlancs.nhs.uk
Appraisal and Revalidation Manager	Kim Harrison	Kim.Harrison@MerseyWestLancs.nhs.uk
Additional Useful Contacts	Liam Horan	Liam.Horan@MerseyWestLancs.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes/ No

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance
Purpose of this template

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

- Section 1 – Qualitative/narrative
- Section 2 – Metrics
- Section 3 - Summary and conclusion
- Section 4 - Statement of compliance

Section 1 Qualitative/narrative
All statements in this section require yes/no answers. The intent is to prompt reflection on the state of each item, any actions taken by the organisation to improve it, and any further plans to move it forward. Concise narrative responses should be provided where appropriate.

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

Mersey and West Lancashire Teaching Hospitals NHS Trust

.....

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y	Yes Dr Kathryn Clark continues to fulfil the Responsible Officer role and is supported through a defined governance structure, including a dedicated Medical Appraisal and Revalidation Team, and regular engagement with NHS England Responsible Officer networks.
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Action from last year:	None identified
Comments:	Alternative Responsible Officer arrangements are now also in place through the Deputy Chief Medical Officer role. These arrangements provide resilience, continuity and succession planning.
Action for next year:	Continue to review Responsible Officer support arrangements, governance oversight and succession planning to ensure resilience and compliance with statutory requirements.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Continue to review resources and processes
Comments:	Trust has continued to review the capacity and resources available to support appraisal, revalidation and professional standards processes. Work has commenced to review the appraisal management system and associated administrative processes to support efficiency, reporting and compliance monitoring.
Action for next year:	Consider and, if appropriate, complete a business case for an alternative appraisal management system, while continuing to review workforce and administrative support requirements to ensure sustainable delivery of appraisal, revalidation and professional standards functions.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	To ensure the data is reviewed and kept up to date.
Comments:	Weekly GMC Connect reviews and monthly triangulation against ESR and the Trust appraisal system have continued throughout the reporting period, ensuring that prescribed connections remain accurate and that any anomalies are identified and addressed promptly.
Action for next year:	Continue routine data validation processes and explore opportunities for greater automation of prescribed connection monitoring and reporting.

a. 1a(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed

Y/N	Yes. The Medical Appraisal and Revalidation Policy remains in place and is currently under review following learning identified from peer review. The revised policy is due to progress through the relevant governance routes, including equality review and the People Policy Group. Additional policies supporting medical revalidation, including Maintaining High Professional Standards, Handling Medical Concerns, Disciplinary Policy, Remediation Policy and Grievance Policy, are monitored and reviewed in line with Trust governance requirements.
Action from last year:	Progress the roll-out of the revised MWL Medical Appraisal and Revalidation Policy for all non-training grade doctors, including communication through the Trust intranet, email updates and medical forums.
Comments:	The policy review remains outstanding and should be completed through the relevant governance routes. The highlighted status has been retained to make clear that this section requires final confirmation before submission.
Action for next year:	Complete approval and implementation of the revised MWL Medical Appraisal and Revalidation Policy, publish it through the Trust intranet, communicate it to doctors through established channels, and reference it within non-compliance escalation communications.
b. Action for next year:	Complete approval and implementation of the revised MWL Medical Appraisal and Revalidation Policy, publish it through the Trust intranet, communicate it to doctors through established channels, and reference it within non-compliance escalation communications.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y	No
Action from last year:	To support the peer review of Liverpool University Hospitals FT in October 2025 and incorporate further best practice in readiness for the MWL peer review which has been agreed to take place during October 2026.
Comments:	The planned peer review programme (2nd November 2026) has been rescheduled. Learning from participation in external peer review activity and regional Responsible Officer networks has continued to be incorporated into local appraisal and revalidation processes pending completion of the Trust peer review.
Action for next year:	Undertake the planned peer review and develop an action plan to implement recommendations and share learning across the organisation.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y	Yes The Trust has continued to strengthen arrangements for locum, bank and short-term doctors through standardised induction processes and governance oversight. The implementation of the InPhase incident management system provides an opportunity to further improve consistency in the provision of governance information to support appraisal, reflection and revalidation.
Action from last year:	To provide consistency across the whole of the organisation in how doctors are provided with governance information to support their appraisal and revalidation.
Comments:	Some inconsistency remains between sites regarding how supporting information in relation to any complaints and incidents is provided to doctors to enable reflection. The Trust has recently transitioned to a single incident management system (InPhase) and work is ongoing to standardise this.
Action for next year	Fully embed the InPhase system across all sites and establish a standardised process for providing governance information, including incidents, complaints and compliments, to support appraisal and revalidation for all doctors.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

	Yes
Action from last year:	Continue to improve governance processes so that information relevant to a doctor's fitness to practise, including complaints, incidents and clinical outcome information, is provided consistently to support reflection within appraisal.
Comments:	All doctors completing appraisal while working at the Trust are required to declare their whole scope of practice and provide supporting information for any external work undertaken during the appraisal period. The Trust provides relevant supporting information relating to work undertaken within the organisation, including complaints, incidents and clinical outcome information where available. Doctors are also asked to obtain appropriate assurance from external organisations, such as confirmation of no concerns, where applicable.
Action for next year:	Continue to strengthen processes to ensure all relevant supporting information, including complaints, incidents, clinical outcomes and external practice information, is provided consistently to doctors for reflection within appraisal.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes. A process is in place to identify, monitor and escalate doctors who do not complete appraisal in line with GMC and Trust requirements.
Action from last year:	Continue to review processes to ensure a consistent approach for all doctors across the Trust.
Comments:	Doctors who are delayed or non-compliant with appraisal requirements are monitored through the appraisal and revalidation process. Reasons for delay are recorded, and doctors are supported to complete appraisal wherever possible. Where required, concerns are escalated through the appropriate management and Responsible Officer routes, with clear expectations and timescales for completion.
Action for next year:	Continue to monitor appraisal compliance, record reasons for any missed or delayed appraisals, and further strengthen escalation arrangements to support timely completion across all divisions.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes. A Medical Appraisal and Revalidation Policy is in place for all MWL non-training grade doctors. The policy is currently under review and the revised version will be progressed through the relevant governance routes for review and ratification, including the Local Negotiating Committee, People Policy Group and People Performance Committee.
Action from last year:	Progress the roll-out of the revised MWL Medical Appraisal and Revalidation Policy for all non-training grade doctors, including publication on the Trust intranet and reference within relevant appraisal and revalidation communications.
Comments:	The existing policy remains in place while the revised policy is being finalised. The review is intended to ensure alignment with national requirements, learning from peer review activity and consistency of processes across the Trust following organisational integration.
Action for next year:	Complete review, approval and implementation of the revised Medical Appraisal and Revalidation Policy, ensuring communication through Trust governance routes, intranet updates and appraisal and revalidation communications.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y	Yes. As of 31 March 2026, the Trust has 168 trained medical appraisers, including consultants and specialty doctors, sufficient to support annual appraisal for doctors across the organisation.
Action from last year:	Ensure appraisers are utilised in accordance with their job-planned capacity, confirm divisional appraiser requirements and continue to encourage recruitment and retention of trained appraisers.
Comments:	Appraiser capacity continues to be monitored through the appraisal and revalidation team, with divisional engagement to support appropriate allocation of appraisees. Ongoing review of appraiser numbers, utilisation and job-planned appraisal time remains important to ensure timely completion of appraisals across the Trust.
Action for next year:	Confirm current appraiser and connected doctor numbers for the reporting period, review appraiser capacity against job-planned time and divisional requirements, and continue targeted recruitment and support for appraisers where gaps are identified.

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y	Yes. Medical appraisers are expected to maintain and develop their appraisal skills through ongoing professional development, participation in Appraiser Support Groups and access to refresher training. Appraisers also receive anonymised feedback from appraisees to support reflection and improvement.
Action from last year:	Continue to provide appraisers with feedback and ensure they remain up to date with refresher training and appraisal development requirements.
Comments:	Appraiser support arrangements are in place throughout the year and provide opportunities for updates, discussion of appraisal standards, peer learning and calibration of professional judgements. Feedback from appraisees is shared with appraisers in anonymised form to support quality improvement and individual development.
Action for next year:	Continue to monitor appraiser participation in support groups and refresher training, strengthen peer review and calibration opportunities, and review appraiser feedback to inform ongoing appraiser development.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y	Yes. Appraisal compliance and quality assurance are monitored through established governance routes. Appraisal compliance is reviewed regularly through the Medical Case Review Meeting and reported to the Strategic People Committee. The Annual Submission, Annual Board Report and Statement of Compliance provide formal assurance to the Board before submission to NHS England.
Action from last year:	Continue to monitor appraisal compliance and quality assurance through established governance and reporting arrangements.
Comments:	The Trust has a defined process for monitoring appraisal completion, identifying delays and escalating concerns where required. Monthly appraisal completion information supports local oversight, while formal reporting through Strategic People Committee and the Board provides assurance on appraisal system performance and compliance.
Action for next year:	Continue to strengthen appraisal quality assurance by reviewing compliance data, reasons for missed or delayed appraisals, appraiser feedback and governance reporting, ensuring that findings inform continuous improvement and Board assurance.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes. Revalidation recommendations are made to the GMC in accordance with GMC requirements and the Responsible Officer protocol. Doctors approaching revalidation are identified and monitored through the appraisal management system, with progress reviewed to support timely completion of all requirements.
Action from last year:	Continue to support doctors to meet revalidation requirements within expected timescales and ensure that reasons for any delayed, deferred or non-engagement recommendations are clearly recorded and understood.
Comments:	The appraisal and revalidation team maintains oversight of doctors due for revalidation and works with doctors, appraisers, clinical leaders and the Responsible Officer to ensure that supporting information is available and any gaps are addressed in advance of recommendation dates. Where recommendations cannot be made within expected timescales, the reasons are documented in the appraisal management system and appropriate follow-up actions are agreed.
Action for next year:	Continue proactive monitoring of doctors approaching revalidation, strengthen early identification of risks to timely recommendation, and ensure reasons for any deferral, delay or non-engagement are consistently recorded and reviewed.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes. Doctors are informed of the proposed revalidation recommendation before submission to the GMC, particularly where the recommendation may be for deferral or non-engagement. The reasons for the recommendation are discussed with the doctor and, where required, an action plan is agreed to support future revalidation. The discussion, recommendation rationale and any agreed actions are recorded in the appraisal management system. A Recommendation Assurance Form, signed by the Responsible Officer, is completed and retained on the system. Once the recommendation has been submitted, the doctor is informed promptly by the appraisal and revalidation team.
Action from last year:	Continue to provide support and assurance to doctors so that they are able to meet the requirements for a positive revalidation recommendation within the required timescales, avoiding deferral wherever possible.
Comments:	The Trust has a defined process for communicating with doctors before and after revalidation recommendations are made. This supports transparency, enables doctors to understand the basis of the recommendation and provides an opportunity to address outstanding requirements before submission wherever possible. Deferrals are supported by clear actions and timescales.
Action for next year:	Continue to ensure timely communication with doctors regarding revalidation recommendations, maintain clear documentation of discussions and recommendation rationale, and review deferral or non-engagement cases to identify any learning for the revalidation process.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y / N	Yes. The Trust has established clinical governance arrangements to support safe, effective and continuously improving care. Systems are in place for reporting, reviewing and learning from incidents, complaints, claims and clinical performance information. The Trust has implemented the Patient Safety Incident Response Framework, and the CMO chairs the Clinical Effectiveness Committee, with divisional reporting through this committee and the Quality and Safety Committee. Concerns relating to doctors are overseen by the Responsible Officer, with involvement from senior medical management and Human Resources in accordance with Trust policy.
Action from last year:	Continue to strengthen clinical governance arrangements, ensuring that learning from incidents, complaints, claims and clinical performance information is used to support medical appraisal, revalidation and professional standards processes.
Comments:	Clinical governance systems are embedded across the organisation and provide routes for oversight, escalation and learning. The implementation of PSIRF has supported a stronger focus on systems-based learning and proportionate response. Medical governance links are maintained through clinical leadership, divisional governance structures, the Clinical Effectiveness Committee, Quality and Safety Committee and Responsible Officer arrangements.
Action for next year:	Continue to embed PSIRF, strengthen triangulation of governance information for doctors, and ensure that learning from clinical governance processes informs appraisal, revalidation, professional standards and Board assurance.

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y	Yes. The Trust has a range of policies and governance processes in place to monitor conduct and performance, including Whistleblowing, Speaking Up Safely, PSIRF, Respect and Dignity at Work, Medical Appraisal and Revalidation, and Handling Medical Concerns. Medical Case Review Meetings are held regularly to review concerns and performance issues, involving the Responsible Officer, Head of Medical Workforce, relevant HR Business Partners and members of the Appraisal and Revalidation Team. Actions are tracked through this forum and escalated as required. The Responsible Officer also meets regularly with the GMC Employer Liaison Adviser and the Practitioner Performance Advice adviser to discuss concerns, performance and revalidation issues. Professional Support and Wellbeing meetings provide additional oversight and support, including for international medical graduates and locally employed doctors.
Action from last year:	Continue to maintain regular case review, professional support and escalation arrangements, ensuring that concerns are identified, monitored and acted upon in a timely and proportionate way.
Comments:	The Trust has established mechanisms for identifying and managing concerns about conduct, capability, health and performance. Regular multidisciplinary review supports consistency, documentation of agreed actions and timely escalation. External input from the GMC Employer Liaison Adviser and Practitioner Performance Advice provides additional assurance and expert advice where required.

Action for next year:	Continue to strengthen monitoring of conduct and performance concerns, improve consistency of recording and action tracking, and ensure learning from case reviews informs wider governance and professional standards processes.
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1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y / N	Yes. Doctors are supported to access relevant information for appraisal, including information relating to complaints, claims, incidents, compliments, clinical outcomes and other governance matters where applicable. This information can be uploaded to the appraisal system and used by doctors to support reflection across their whole scope of practice.
Action from last year:	Continue to provide doctors with relevant information to include and reflect upon within appraisal and align processes across sites where necessary.
Comments:	Processes are in place to provide doctors with governance information relevant to their appraisal and revalidation. Following organisational integration, work continues to improve consistency across sites and to ensure information is provided in a convenient, timely and usable format for reflection. The transition to a single incident management system provides an opportunity to further standardise reporting and information flows.
Action for next year:	Standardise the process for providing appraisal supporting information across all sites, including incidents, complaints, claims, compliments and clinical outcome information, and ensure doctors understand how to use this information for reflection.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes. The Trust has established processes for responding to concerns about medical practitioners, supported by relevant approved policies including Handling Medical Concerns, Disciplinary and Remediation policies. Concerns are reviewed through Medical Case Review and Strategic Case Review arrangements, enabling discussion with senior medical, workforce and HR colleagues. Cases are managed in accordance with policy, with investigation, intervention, support and escalation proportionate to the nature and seriousness of the concern.
Action from last year:	Continue to maintain robust arrangements for responding to concerns, ensuring that cases are reviewed regularly, actions are documented and escalation occurs where required.
Comments:	Concerns about doctors are considered through established governance routes to ensure appropriate oversight, fairness and consistency. The Responsible Officer, senior medical leaders and HR colleagues work together to determine whether concerns relate to conduct, capability, health or wider fitness to practise issues, and to identify the appropriate response. Advice from Practitioner Performance Advice and the GMC Employer Liaison Adviser is sought where appropriate.

Action for next year:	Continue to review and strengthen responding to concerns processes, including consistency of documentation, timeliness of case progression, use of external advice and learning from completed cases.
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1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes. The system for responding to concerns is subject to quality assurance through case review, escalation and reporting arrangements. Numbers, types and outcomes of concerns are reviewed through the Employer Relationship Oversight Group, which provides oversight of professional standards processes and reports onward through Trust governance routes. Demographic information and relevant protected characteristics are considered to support fairness, consistency and identification of any potential disproportionality. The Board also receives Workforce Race Equality Standard, Workforce Disability Equality Standard and gender pay gap reports.
Action from last year:	Continue to review concerns data, outcomes and demographic information through established governance routes to support fairness, consistency and learning.
Comments:	The Trust has arrangements to provide oversight of professional standards concerns, including review of themes, outcomes and potential equality considerations. This supports proportionate case management and enables learning to be identified and shared through appropriate governance structures.
Action for next year:	Continue to strengthen quality assurance reporting for concerns, including analysis of numbers, themes, outcomes, duration, protected characteristics and country of primary medical qualification, with learning reported through relevant governance routes.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes. Processes are in place to support timely transfer of relevant information between Responsible Officers and designated bodies. When a doctor joins the Trust, a Responsible Officer transfer of information request is made and any concerns identified are escalated to the Responsible Officer. Where a doctor connected to the Trust also works elsewhere, or a doctor connected elsewhere works within the Trust, relevant governance information is shared through Responsible Officer-to-Responsible Officer communication where appropriate. Information is transferred securely using monitored email arrangements. Where a doctor leaves the Trust with unresolved concerns and has not connected to a new designated body, the GMC Employer Liaison Adviser is informed and, where appropriate, a Health Professionals Alert Notice is considered.
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Action from last year:	Continue to maintain timely and effective information transfer arrangements with other Responsible Officers and designated bodies.
Comments:	Information transfer processes support continuity of governance oversight and patient safety where doctors move between organisations or work across more than one setting. The appraisal and revalidation team monitors incoming and outgoing transfer requests and escalates concerns to the Responsible Officer as required.
Action for next year:	Continue to review information transfer processes, ensure timely completion of transfer requests, and maintain clear documentation of Responsible Officer-to-Responsible Officer communications where concerns are identified.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes. Safeguards are in place to support fair, consistent and unbiased clinical governance and concerns processes. Concerns are reviewed through multidisciplinary governance forums, with oversight from the Responsible Officer, senior medical leadership, HR and, where appropriate, non-executive oversight. Equality and demographic information is considered through Employer Relationship Oversight Group arrangements, and cases may be discussed with Practitioner Performance Advice where external advice is required.
Action from last year:	Continue to monitor professional standards processes to ensure fairness, consistency and freedom from bias or discrimination.
Comments:	Governance arrangements provide multiple opportunities for scrutiny, challenge and review of professional standards processes. Consideration of protected characteristics, country of primary medical qualification and other demographic factors supports assurance that processes are applied fairly and that any areas of potential disproportionality are identified.
Action for next year:	Continue to strengthen equality oversight within professional standards processes, including review of demographic data, case outcomes and learning, and ensure findings inform improvement actions where required.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes. The Trust has systems in place to identify learning and development requirements from national reviews, reports, enquiries and wider system intelligence, and to integrate these into local governance, policy and culture. Relevant learning is considered through Trust governance routes including Executive Committee, Quality and Safety Committee and Strategic People Committee. Medical staff matters are also discussed through clinical leadership forums led by the Medical Director.
Action from last year:	Continue to review external learning, national reports and wider system intelligence through established governance routes and incorporate relevant learning into policy, procedures and leadership development.

Comments:	Learning from national and regional reviews is considered alongside local governance intelligence. Recent organisational work to develop and embed MWL values supports a shared culture of kindness, openness and inclusion. Strategic issues affecting governance are considered by Executive Committee, and professional standards learning is shared through medical leadership and workforce governance routes where relevant.
Action for next year:	Continue to ensure learning from national reviews, external reports, enquiries and regional professional standards networks is reviewed, communicated and incorporated into Trust governance, policy and leadership development where appropriate.

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Y/N	Yes. The Trust has systems in place to review professional standards arrangements across healthcare professional groups and to improve consistency wherever possible. Medical Case Review meetings, Professional Standards Group arrangements and the Employer Relationship Oversight Group support oversight, shared learning and fair application of professional standards processes. These arrangements align with the principles of collaborative, compassionate and inclusive leadership described in national reviews.
Action from last year:	Continue with regular Medical Case Review meetings, Professional Standards Group discussions and Employer Relationship Oversight Group review to support consistency, fairness and learning across professional standards arrangements.
Comments:	Professional standards processes are reviewed through both medical and organisation-wide governance forums. These arrangements provide opportunities to compare approaches across staff groups, identify variation, share learning and promote consistent application of policy. Ongoing oversight supports fairness, transparency and alignment with Trust values.
Action for next year:	Continue to review professional standards arrangements across healthcare professional groups, identify opportunities to improve consistency and fairness, and ensure learning is reported through appropriate workforce and governance routes.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes. The Trust has established recruitment and pre-employment checking processes for all doctors, including locum and short-term doctors. Recruitment is managed through Trac, which supports completion and recording of the six NHS Employment Check Standards before appointment. These include identity, right to work, professional registration and qualifications, employment history and references, criminal record checks where required, and occupational health clearance. Professional registration, qualifications and fitness to practise status are checked before commencement, and employment history and references are obtained in line with NHS employment checking requirements.
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Action from last year:	Continue to maintain robust pre-employment checking processes for all doctors and ensure that recruitment, medical workforce and temporary staffing teams remain aligned to NHS Employment Check Standards.
Comments:	Pre-employment checks are embedded within recruitment workflows and provide assurance that doctors have appropriate registration, qualifications, skills and clearance before commencing work. The process applies to substantive, locum, bank and short-term doctors, with oversight through recruitment and medical workforce governance arrangements. Any issues identified during pre-employment checks are reviewed and escalated as appropriate before appointment or deployment.
Action for next year:	Continue to review compliance with NHS Employment Check Standards, maintain evidence of completed checks before doctors commence work, and strengthen audit and escalation processes for substantive, locum, bank and short-term medical appointments.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes. Professional standards activities are aligned with the Trust's values of being kind, open and inclusive, and with the 5-star patient care framework. These arrangements support a culture in which high-quality clinical care, continuous improvement, innovation and professional accountability can flourish. Appraisal, revalidation, professional support and concerns processes are used to reinforce expected standards of behaviour and to support doctors to reflect, learn and develop.
Action from last year:	Continue to embed Trust values within appraisal, revalidation, professional standards and leadership processes, ensuring that these activities support improvement, accountability and excellence in clinical care.
Comments:	The Trust has engaged with staff groups to develop and launch MWL values, supported by leadership, appraisal and organisational development arrangements. Professional standards processes are intended to be fair, proportionate and developmental, while maintaining patient safety and public confidence. Staff appraisal and personal development planning provide further opportunities to align individual objectives with Trust priorities and clinical excellence.
Action for next year:	Continue to embed MWL values and the 5-star patient care framework within appraisal, revalidation, professional standards, leadership development and governance processes, ensuring that learning from these activities contributes to a positive organisational culture.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes. The Trust's values and vision promote compassion, fairness, respect, diversity and inclusion. Equality, diversity and inclusion are supported through Trust-wide policies, training, leadership development and staff engagement activities. Managers and staff have access to education and development programmes designed to improve understanding, inclusive practice and compassionate leadership.
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Action from last year:	Continue participation in the Compassionate Conversations pilot and incorporate learning into the clinical director development programme and wider leadership development offer.
Comments:	The Trust continues to promote an inclusive and respectful working environment through its values, leadership development, EDI training and staff support arrangements. Compassionate Conversations provides an opportunity to develop leadership capability in managing difficult conversations in a constructive, fair and supportive way. These arrangements support both staff experience and patient care.
Action for next year:	Continue to embed compassionate and inclusive leadership development, evaluate learning from the Compassionate Conversations pilot, and ensure EDI considerations are reflected in professional standards, appraisal and governance processes.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes. The Trust has policies and processes in place to support openness, transparency, freedom to speak up and a learning culture. These include Whistleblowing, Speaking Up Safely, PSIRF and Respect and Dignity at Work arrangements. Effectiveness is monitored through relevant governance routes, including reporting to Strategic People Committee. Information is promoted through Trust communication channels including the intranet, Trust Brief Live, posters, global emails, newsletters and staff engagement forums.
Action from last year:	Continue to promote openness, speaking up and learning culture through Trust policies, governance processes and staff communication channels.
Comments:	The Trust continues to encourage staff to raise concerns and share learning through formal and informal routes. PSIRF supports a proportionate and systems-based approach to learning from incidents, while speaking up and whistleblowing processes provide routes for concerns to be raised safely. Regular communication helps maintain awareness of available support and expected standards of behaviour.
Action for next year:	Continue to strengthen speaking up, openness and learning culture by monitoring themes from concerns, incidents and staff feedback, and ensuring learning is shared through appropriate governance and communication routes.

c. 1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors, including the existence of a formal complaints procedure.

Y/N	Yes. Mechanisms are in place for doctors to provide feedback on professional standards processes, including appraisal feedback, HR support during formal processes, wellbeing support, access to a support buddy where appropriate, and use of formal complaints or grievance routes. Where a doctor is subject to investigation, relevant policies are provided and a named HR contact is assigned. For MHPS cases, a Non-Executive Director is assigned to provide oversight and assurance that the process is followed appropriately and in a timely manner.
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Action from last year:	Continue to offer doctors clear routes for feedback and support during appraisal, revalidation and professional standards processes.
Comments:	Feedback from doctors is used to support improvement in appraisal and professional standards processes. Doctors involved in concerns processes are provided with information, support and named contacts to help them understand the process and raise issues if required. Non-executive oversight provides additional assurance in MHPS cases.
Action for next year:	Continue to strengthen feedback mechanisms for connected doctors, including appraisal feedback, feedback from doctors involved in professional standards processes, and review of themes through appropriate governance routes.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes. The Trust reviews information relating to doctors involved in concerns and disciplinary processes through Professional Support and Wellbeing meetings, Medical Case Review meetings and the Employer Relationship Oversight Group. This includes consideration of protected characteristics and country of primary medical qualification where data is available, to support fairness, identify potential disproportionality and inform improvement actions.
Action from last year:	Continue to review concerns and disciplinary data to identify any areas requiring improvement in support, fairness or parity, including support for locally employed doctors and international medical graduates.
Comments:	Two LED leads have been appointed to review and improve induction and support for locally employed doctors and international medical graduates. Analysis through PSW, Medical Case Review and EROG supports oversight of themes and helps identify whether additional support or changes to process are required. This is intended to promote fair access to support and consistent application of professional standards processes.
Action for next year:	Continue to develop analysis of concerns and disciplinary data by protected characteristics and country of primary medical qualification, review support for locally employed doctors and international medical graduates, and report learning through EROG and relevant workforce governance routes.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes. The Responsible Officer and members of the Medical Appraisal and Revalidation Team attend regional Responsible Officer network meetings and local appraisal and revalidation network meetings. These forums support calibration, sharing of best practice and alignment with NHS England professional standards requirements. The Trust has also participated in local peer
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	review activity with neighbouring designated bodies and continues to engage with higher-level Responsible Officer quality review processes.
Action from last year:	Continue participation in Responsible Officer networks, local appraisal and revalidation network meetings, peer review activity and higher-level Responsible Officer quality review processes to support consistency and shared learning.
Comments:	Network participation provides regular opportunities to benchmark local arrangements, review national and regional updates, discuss complex issues and incorporate learning into Trust appraisal, revalidation and professional standards processes. Local peer review activity has supported reflection on strengths, risks and improvement opportunities, with learning used to inform policy review, quality assurance and governance arrangements.
Action for next year:	Continue active engagement with regional Responsible Officer and appraisal networks, complete the planned peer review programme where scheduled, develop an action plan from any recommendations, and share learning through appraisal, revalidation and professional standards governance routes.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	709
Total number of appraisals completed	630
Total number of appraisals approved missed	33
Total number of unapproved missed	46
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	84
Total number of late recommendations	0
Total number of positive recommendations	68
Total number of deferrals made	16
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	48
Total number of trained case managers	6
Total number of concerns received by the Responsible Officer ²	18
Total number of concerns processes completed	26
Longest duration of concerns process of those open on 31 March (working days)	2073
Median duration of concerns processes closed (working days) ³	84
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	85
Total number of new employment checks completed before commencement of employment	85
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld ⁴	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Since the last Board report, the Trust has continued to strengthen arrangements for medical appraisal, revalidation and professional standards. Responsible Officer arrangements have remained in place, with additional resilience provided through alternative Responsible Officer support via the Deputy Chief Medical Officer role. Processes for maintaining prescribed connection data have continued through regular GMC Connect review and triangulation with ESR and the appraisal system. Appraisal compliance, missed or delayed appraisals, revalidation recommendations and professional standards concerns are monitored through established governance routes, including Medical Case Review, Strategic People Committee and Board reporting. The Trust has also progressed work to improve consistency across sites following organisational integration, including the implementation of InPhase as a single incident management system and continued development of processes to provide governance information to doctors for appraisal and reflection. Professional standards arrangements have been strengthened through regular case review, engagement with the GMC Employer Liaison Adviser and Practitioner Performance Advice, continued participation in regional Responsible Officer networks, and preparation for peer review activity.
Actions still outstanding
The main outstanding actions relate to finalising, approving and implementing the revised MWL Medical Appraisal and Revalidation Policy, completing the planned peer review process and developing an action plan from any recommendations; and continuing to standardise the provision of appraisal supporting information across all sites. Work is also ongoing to review the suitability of the current appraisal management system and to consider whether a business case for an alternative system is required.
Current issues
Current issues are focused on ensuring consistency, sustainability and assurance across a large and complex organisation. These include variation between sites in how governance information is provided to doctors for appraisal, the need to maintain sufficient trained appraiser capacity, ongoing review of appraisal system functionality and reporting, and the need to continue strengthening equality oversight within professional standards processes. The Trust has identified these issues and has actions in place to address them through policy review, data validation, governance reporting, peer review, professional standards oversight and continued engagement with regional networks.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Actions for next year are to continue reviewing Responsible Officer support arrangements and succession planning; complete the review, approval and implementation of the revised Medical Appraisal and Revalidation Policy; strengthen appraisal quality assurance and reporting; continue proactive monitoring of revalidation recommendations, deferrals and non-engagement; standardise the provision of governance information for appraisal across all sites; continue to embed PSIRF and use governance learning to inform appraisal, revalidation and professional standards; strengthen documentation, action tracking and equality oversight within concerns processes; maintain robust RO-to-RO information transfer arrangements; continue to embed MWL values, speaking up, compassionate and inclusive leadership and feedback mechanisms; review support for locally employed doctors and international medical graduates; and complete the planned peer review programme with an action plan to address any recommendations.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Overall, the Trust has maintained effective systems for medical appraisal, revalidation and professional standards during the 2025–2026 reporting period. The Responsible Officer is supported by established governance arrangements, a dedicated appraisal and revalidation team, regular case review structures and engagement with regional professional standards networks. Doctors are supported to complete whole-practice appraisal, revalidation recommendations are monitored and submitted in accordance with GMC requirements, and concerns are reviewed through multidisciplinary governance arrangements with appropriate escalation, external advice and Board assurance.

The Trust's key achievements include continued maintenance of prescribed connection data, strengthened professional standards oversight, implementation of PSIRF, improved focus on governance information for appraisal, continued development of support for locally employed doctors and international medical graduates, and embedding of MWL values of being kind, open and inclusive. The main challenges for the coming year relate to finalising the revised Medical Appraisal and Revalidation Policy, confirming appraiser capacity, completing peer review, improving consistency of appraisal supporting information across sites, and enhancing data analysis to support fairness and parity in professional standards processes.

The Trust remains committed to continuous improvement, proportionate and fair professional standards processes, and a culture in which doctors are supported to reflect, learn and practise safely. The actions identified for the coming year provide a clear programme of improvement to strengthen compliance, assurance, consistency and organisational learning.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of the designated body:	Mersey and West Lancashire Teaching Hospitals NHS Trust
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Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Title of Meeting	Trust Board		Date	30 September 2026
Agenda Item	TB26/066			
Report Title	Statement of Compliance with National Core Standards for Emergency Planning Response & Resilience (EPRR) for 2026/27			
Executive Lead	Lesley Neary, Chief Operating Officer (Accountable Emergency Officer)			
Presenting Officer	Lesley Neary, Chief Operating Officer (Accountable Emergency Officer)			
Action Required	X	To Approve		To Note
Purpose				
The Trust's annual statement of compliance for 2026/27 with EPRR National Core Standards is required to be approved by the Trust Board prior to submission to the Integrated Care Board (ICB) on 2 October 2026. This paper seeks approval from the Trust Board for submission.				
Executive Summary				
NHS England has a statutory requirement to formally assure both itself and the NHS in England of Emergency Preparedness, Resilience and Response (EPRR readiness). This is provided through the EPRR Core Standards self-assessment annual assurance process. There is a requirement that this Statement of Compliance is agreed by the organisation's Board. Following a Trust self-assessment, and in line with the definitions of compliance, the organisation currently declares that out of 62 areas applicable to acute trusts, the Trust is compliant with 60 areas, giving the Trust a total compliance level of 97%. The Trust is therefore able to declare that it is substantially compliant against the EPRR Core Standards. Whilst two standards remain partially compliant within the Business Continuity domain, mitigating controls are in place and actions to achieve full compliance are being delivered through established EPRR governance arrangements. This maintains the 97% substantially compliant position reported by MWL in 2025/26, following an improvement from 81% partially compliant in 2024/25 and 44% in 2023/24. The full statement of compliance, summary of the Trust position against each standard and an action plan to address areas of partial compliance are included in the supporting papers.				
Financial Implications				
No new financial implications as a direct result of this paper				
Quality and/or Equality Impact				
Not applicable				

Recommendations	
The Board is asked to approve the EPRR Statement of Compliance with National Core Standards for 2026/27.	
Strategic Objectives	
X	SO1 5 Star Patient Care – Care
X	SO2 5 Star Patient Care – Safety
X	SO3 5 Star Patient Care – Pathways
X	SO4 5 Star Patient Care – Communication
X	SO5 5 Star Patient Care – Systems
X	SO6 Developing Organisation Culture and Supporting our Workforce
X	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
X	SO9 Strategic Plans

Statement of Compliance with National Core Standards for Emergency Planning Response & Resilience (EPRR) for 2026/27

1. Introduction

1.1. The EPRR Core Standards self-assessment cover 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business Continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Material (HAZMAT).

1.2. Each year, alongside the annual assurance process, a 'deep dive' is conducted to gain valuable additional insight into a specific area. This year NHS England decided that there is to be no 'deep dive'.

2. Applicable Standards

2.1. Standards are applicable dependent upon the type of organisation. Acute providers, such as MWL are required to be compliant with 62 standards, whilst by comparison, Integrated Care Boards are required to be compliant with 47 standards.

Organisation Type	Applicable Standards
Acute Providers	62
Specialist Providers	59
NHS Ambulance Service Providers	58
Community Service Providers	58
Patient Transport Services	42
NHS 111 Service	43
Mental Health Providers	58
NHS England Region	47
NHS England National	45
Integrated Care Boards	47
Commissioning Support Unit	39

3. NHS England Compliance Process

3.1. The 2026/27 EPRR Annual Assurance Process remains unchanged from 2025/26 and continues to follow an evidence-based approach. The NHS England assurance framework requires organisations to demonstrate compliance against the 62 applicable EPRR Core Standards through robust supporting evidence. The process is designed to encourage open and transparent

dialogue, support continuous improvement, and facilitate the sharing of good practice. The following actions are required as part of this year's assurance process.

- 3.2. All NHS funded organisations should undertake a self-assessment against the organisation-relevant NHS core standards for EPRR. The compliance level for each standard is defined as:
- Fully compliant: 100% compliant with the core standards
 - Substantially compliant: 89 - 99% compliant with the core standards
 - Partially compliant: 77 - 88% compliant with the core standards
 - Non-compliant: < 76% compliant with the core standards
- 3.3. The outcome should then be presented and discussed at a public board meeting prior to submission and published in the annual report within the organisation's own regulatory reporting requirements.

4. Statement of Compliance 2026/27

- 4.1. Following the Trust's self-assessment and in line with the compliance definitions, the organisation can currently declare compliance and provide evidence for 60 out of the 62 areas applicable to acute trusts, resulting in **97% compliance**.
- 4.2. Although there has been no percentage increase since the previous year's submission, improvements have occurred over the past 12 months in relation to the 2 partially compliant standards. Further detail on actions to improve compliance is available in Appendix 1.
- 4.3. The Core Standards assessment is an annual process, and it should therefore be noted that the EPRR workstream's compliance level resets to 0% after each submission.
- 4.4. Based on these results, the Trust must declare **substantial compliance** with the EPRR Core Standards for the 2026/2027 period.
- 4.5. This declaration highlights the need for further efforts to address the gaps in compliance and strengthen the Trust's preparedness and resilience in alignment with the Core Standards.

5. Previous EPRR Compliance

- 5.1. Following the organisational merger and the harmonisation of EPRR arrangements across the Trust, significant work has been undertaken to establish consistent governance, policies, plans, training, exercising and assurance processes. This programme of improvement, led by the Head of EPRR and supported by the EPRR Manager has resulted in sustained progress and increased organisational resilience.
- 5.2. Despite increasingly rigorous assurance requirements, the Trust has maintained strong regional performance, achieving the highest compliance rating for 2023/2024 and remaining in the top 4 within the region thereafter.

5.3. The last 3 years have demonstrated a significant improvement in EPRR compliance:

- 44% (2023-2024): Mersey and West Lancashire Teaching Hospitals NHS Trust was found to be non-compliant.
- 81% (2024-2025): Mersey and West Lancashire Teaching Hospitals NHS Trust was found to be partially compliant.
- 97% (2025-2026): Mersey and West Lancashire Teaching Hospitals NHS Trust was found to be substantially compliant.

6. Summary Table 2026/27

Domain	Total standards applicable	Fully Compliant	2026-2027 Domain %	2025-2026 Domain %
Governance	6	6	100%	100%
Duty to risk assess	2	2	100%	100%
Duty to maintain plans	11	11	100%	100%
Command and control	2	2	100%	100%
Training and exercising	4	4	100%	100%
Response	7	7	100%	100%
Warning and informing	4	4	100%	100%
Cooperation	4	4	100%	100%
Business Continuity	10	8	80%	80%
Hazmat/ CBRN	12	12	100%	100%
Total	62	60	97%	97%

Appendix 1: Action plan to address the areas of partial compliance

Domain	Standard name	Standard detail	Self assessment RAG	Action to be taken	Lead	Timescale
Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially compliant	Compliance has risen to 48% despite increase in number of BCP's. Continue roll out of new BC Template and support departmental review process	AM	31/08/2027
Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Partially compliant	29% of submitted plans have been audited, giving a trust average compliance of 51% against the audit question set. Continue with roll out of monthly BC Plan audit and reporting through governance structure	AM	31/08/2027

Title of Meeting	Trust Board		Date	30 September 2026
Agenda Item	TB26/067			
Report Title	Statutory Pay Gap Annual Declaration 2025/2026			
Executive Lead	Jo Waldron, Acting Chief People Officer			
Presenting Officer	Jo Waldron, Acting Chief People Officer			
Action Required	X	To Approve		To Note
Purpose				
To report the Trust's Gender Pay Gap as per regulations, and the disability, ethnicity and sexuality pay gaps as per the NHS High Impact Actions				
Executive Summary				
This report outlines the Trust's statutory pay gaps for Gender, Disability, Ethnicity and Sexuality as of March 2026, in line with the Equality Act 2010 and NHS Equality, Diversity, and Inclusion (EDI) High Impact Actions. The 2026 analysis shows progress across several headline measures but also confirms that pay outcomes are not yet consistently equitable across the Trust. Improvements include reductions in the overall mean gender pay gap, both the mean and median disability pay gaps, and the overall sexual orientation pay gaps. Representation and declaration have also increased for Disabled, Ethnic Minority and Lesbian, Gay, Bisexual and 'Other' (LGBO) staff. The analysis demonstrates that the Trust's statutory whole-workforce pay gaps are significantly influenced by the different composition and pay structures of the Agenda for Change(AfC) and Medical and Dental workforces. When examined separately, aggregate Agenda for Change gaps are generally smaller or in favour of the relevant comparison group. Material differences remain within particular staff groups, pay bands, senior roles and the Medical and Dental workforce.				
Key Findings				
• Gender Pay Gap: Mean has reduced from 24.5% to 23.8% with the median increasing from 8.1% to 10.6%. For AfC, the mean and median are in favour of women (-0.8% and -4.1%). The bonus pay gap is in favour of men. • Disability Pay Gap: The Mean has reduced from 12.7% to 11.9% with the median reducing from 10.5% to 9.1%. For AfC the pay gaps increased to 3.3% and 3.7%. The bonus pay is significantly in favour of non-disabled staff. • Ethnicity Pay Gap: Mean has reduced from -33.1% to -27.5% with the median reducing from -20.0% to -19.5%. For AfC, the mean and median are in favour of ethnic minority staff (-1.1% and -12.1%). The mean and median bonus pay gap is effectively 0% • Sexuality Pay Gap: Mean has reduced from 5.5% to 4.9% with the median reducing from 5.5% to 2.4%. For AfC, the mean and median are in favour of heterosexual staff (3.4% and 2.7%). The bonus pay gap is significantly in favour of heterosexual staff.				
Analysis				
• Gender gaps are driven by underrepresentation of women in senior medical roles. • Ethnic minority staff are more represented in higher-paid medical roles. • Disability and sexuality gaps are affected by low disclosure rates and uneven distribution across pay bands. • Bonus gaps are influenced by the small eligibility pool of Clinical Impact Awards.				

Action Plan (2026–2027)

Actions include:

- Developing a MWL Education Strategy
- Launching career conversations toolkit
- Promoting the availability of career development courses and funding
- To review and standardise band 5/7 nurse job descriptions (JD) and Advanced Practice JD's
- Launch new EDI Governance and Staff Network structures

Financial Implications

None

Quality and/or Equality Impact

This report is a legal requirement under the specific equality duties of the Equality Act 2010.

Recommendations

The Board is asked to approve the Statutory Pay Gap Annual Declaration 2025/26

Strategic Objectives

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

Statutory Pay Gap Report

2026

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1. Introduction

In accordance with *The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017*, and the NHS EDI Improvement Plan (2023¹), Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) is pleased to report its annual Statutory Pay Gaps for Gender (Sex), Ethnicity, Disability, and Sexuality, for March 2026, specifically the:

1. mean pay gap,
2. median pay gap,
3. proportion of each comparison group in 4 equal population quartiles,
4. mean bonus pay gap,
5. median bonus pay gap,
6. proportion of each comparison group receiving a bonus payment.

The data reported in relation to the mean and median pay gaps and the population quartiles corresponds to the employee population as of the 31st March 2026; and the mean and median bonus pay gaps correspond to any bonus pay paid in the period of the 1st April 2025 to 31st March 2026 and where the recipients were still employed in March 2026.

1.1. About Mersey and West Lancashire Teaching Hospital NHS Trust

Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) provides acute and community healthcare services at Ormskirk and District General Hospital, Southport and Formby District General Hospital, St Helens Hospital, and Whiston Hospital; Community Intermediate Care services at Newton Community Hospital in Newton-le-Willows, and an Urgent Treatment Centre, operating from the Millennium Centre, in the centre of St Helens.

The Trust is also the “Lead Employer” for over 13,000 doctors in training who are employed by the Trust but are in placement across the country. *Lead Employer data is not included within this report.*

1.2. What is the Statutory Pay Gap

The statutory pay gap is defined in the Act as the difference between the average hourly rate of earnings between two population groups, expressed as a percentage.

For the purposes of this report the following comparisons are included:

1. Male v Female²,
2. No Known Disability v Known Disability,

¹ [NHS EDI High Impact Action 3](#)

² For the purposes of *The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017*, the term gender is synonymous with the protected characteristic of ‘Sex’ and as such a Gender Pay Gap is a comparison between Men/Male and Women/Female.

3. White v Ethnic Minority,
4. Heterosexual v Lesbian, Gay, Bisexual & Other sexuality (LGBO).

Where the pay gap is a **positive black** number, the pay gap is in favour of the baseline population group (men, no known disability, white, heterosexual); and where the pay gap is a **negative red** number, the pay gap is in favour of the comparator group (women, known disability, ethnic minority, and LGBO).

For the pay gap calculation, an employee means all **posts/assignments** that were paid in March 2026 and who received 100% of their expected hourly rate of pay (without deductions because they were on leave). These are known as the Full Pay Relevant Employees.

The Hourly rate of pay means the total amount of pay received by a post/assignment in March 2026, including enhancements, but excluding overtime. Any salary sacrifice payments are deducted, including pension, car loan scheme etc; and the final amount is divided by the number of hours worked to provide each post/assignment with an hourly rate of pay.

The Bonus Pay Gap is calculated from the total amount of Bonus Payments received in the 12-month period up to the snapshot date with the mean and median bonus pay gap calculated from the total value.

A pay gap of 5% or higher requires the Trust to take action to address the gap. A pay gap of 3-5% should be monitored, and if it persists action should be taken to reduce it. A pay gap of <3% is statistically insignificant and no action is required.

1.3. Bonus Payments

For this report, Bonus Pay is a reference to the National Clinical Impact Awards which replaced the local and national Clinical Excellence Awards (CEA) / Clinical Impact Awards (CIA) from 2024 onwards. The CIA are a bonus scheme that is limited to eligible consultants only, to recognise clinical excellence in delivering services, leadership, education, and research.

1.4. Data source for Pay Gap

The data for the Pay Gap is provided by an inbuilt report in the Electronic Staff Record (ESR). Once data categories are selected for inclusion, the report automatically provides the data used for all the pay gap data categories.

The ESR report only reports data based on employee sex. To enable the pay gap for other characteristics to be completed, the Trust ESR Team merges additional data categories with the ESR report.

The Ethnicity and Sexuality population have high levels of “unknown” and “decline” data records. To complete the calculation these are removed from the population. This

is sufficient to complete the mean, median, bonus mean, bonus median and quartile population calculations.

However, the Bonus Pay Population (Pay Relevant Employees) cannot be calculated from the report because it does not include the detailed population list from which the correct population can be identified.

Therefore, when calculating the bonus pay population, the relevant Full Pay Relevant Population is used instead. This is indicated by an asterisk (*).

2. Summary

The high-level figures for each pay gap are outlined in Table 1.

Table 1: High Level Summary Pay Gap Figures

	Male v Female	No Disability v Known Disability	White v Ethnic Minority	Heterosexual v LGBO
Total Workforce				
Mean	23.82%	11.87%	-27.52%	4.92%
Median	10.62%	9.09%	-19.50%	2.44%
Bonus Mean	20.51%	69.80%	-0.10%	80.59%
Bonus Median	8.75%	56.01%	0.00%	71.25%
Agenda for Change Only				
Mean	-0.80%	3.28%	-1.07%	3.39%
Median	-4.13%	3.69%	-12.12%	2.67%
Bonus Mean	-	-	-	-
Bonus Median	-	-	-	-
Medical & Dental Only				
Mean	8.72%	9.07%	4.66%	20.56%
Median	19.48%	12.39%	17.92%	41.10%
Bonus Mean	20.51%	69.80%	-0.10%	80.59%
Bonus Median	8.75%	56.01%	0.00%	71.25%

3. Gender Pay Gap

3.1. Population Summary

On the snapshot date of the 31st March 2026, the following number of full pay relevant employees (from now on 'employees') were included in the data analysis:

Table 2: Trust Population by Sex

	# Total	# Female	# Male	% Female	% Male
Total	11,538	9032	2506	78.3%	21.7%
AfC	10,377	8547	1830	82.4%	17.6%
M&D	1161	485	676	41.8%	58.2%

3.2. Mean Gender Pay Gap

The mean gender pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole male population, and the average hourly income of the whole female population expressed as a percentage.

Table 3: Mean Gender Pay Gap

	Trust	AfC	M&D
Female	£20.86	£19.50	£44.86
Male	£27.39	£19.35	£49.15
Difference	£6.53	£0.15	£4.29
% Pay Gap	23.82%	-0.80%	8.72%

3.3. Median Gender Pay Gap

The median gender pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole male population (from smallest to largest), and the middle value hourly income of the whole female population expressed as a percentage.

Table 4: Median Gender Pay Gap

	Trust	AfC	M&D
Female	£18.49	£17.86	£39.15
Male	£20.68	£17.15	£48.62
Difference	£2.19	£0.71	£9.47
% Pay Gap	10.62%	- 4.13%	19.48%

3.4. Proportion of males and females in each pay quartile

To calculate the population quartiles, and allow comparisons with other organisations, the total population is divided into 4 equal sizes, ranked from the smallest to largest by hourly rate of pay. Quartile 1 represents the lower and 4 the higher. The total number of men and women are counted in each quartile to produce the quartile populations.

Table 5: Quartile Populations (Sex)

	# Female	# Male	% Female	% Male
Quartile 1	2329	556	80.7%	19.3%
Quartile 2	2348	536	81.4%	18.6%
Quartile 3	2405	480	83.4%	16.6%
Quartile 4	1950	934	67.6%	32.4%

3.5. Mean and Median Bonus Gender Pay Gaps

For this report, Bonus Pay is a reference to the National Clinical Impact Awards (CIA). The CIA are a bonus scheme that is limited to eligible consultants only, to recognise clinical excellence in delivering services, leadership, education, and research.

The National CIA are awarded via a national competitive process and awarded via a regional/national assessment process. However, the payment of these awards is via the Trust payroll and are therefore included in the pay calculations.

The population used to calculate the Bonus Pay Gap is based on the total workforce, whether or not they are classed as Full Pay Relevant in the March snapshot date. This is to ensure that any person who received a bonus payment from the 1st April to the following 31st March, and where they are still employed on the 31st March, are included within the data. This group is known as the Pay Relevant Population.

Therefore, the total workforce population (Pay Relevant Employees) was 12,277 posts, of which 94 received a bonus payment. The mean and median bonus gender pay gaps were as follows:

Table 6: Mean Bonus Gender Pay Gap

Sex	Mean	Median
Female	£7,194.06	£5,504.22
Male	£9,049.92	£6,032.04
Difference	£1855.86	£527.82
% Pay Gap	20.51%	8.75%

3.6. Proportion of males and females receiving a bonus payment

Table 7 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were male and female.

Table 7: Number of Bonus Pay recipients.

Sex	MWL
% Female receive Bonus Pay	0.2%
% Male receive Bonus Pay	2.8%
% Bonus Pay recipients Female	21.3%
% Bonus Pay Recipients Male	78.7%

4. Disability Pay Gap

4.1. Introduction

The Disability Pay Gap is a comparison between the No Known Disability population v the Known Disability population. Where an employee is recorded as Unknown, Blank or Decline, these have been counted as No Known Disability.

The following calculations are based only on data held within the Electronic Staff Record, which is known to hold underreported disability figures.

4.2. Population Summary

On the snapshot date of the 31st March 2026, the following number of employees were included in the data analysis:

Table 8: Trust Population by Disability

	# Total	# Dis	# No Dis	% Dis	% No Dis
Total	11,538	794	10,744	6.9%	93.1%
AfC	10,377	764	9613	7.4%	92.6%
M&D	1161	30	1131	2.6%	97.4%

4.3. Mean Disability Pay Gap

The mean disability pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole No Known Disability population, and the average hourly income of the whole Known Disability population expressed as a percentage.

Table 9: Mean Disability Pay Gap

	Trust	AfC	M&D
Disability	£19.80	£18.88	£43.16
No Disability	£22.46	£19.52	£47.47
Difference	£2.66	£0.64	£4.31
% Pay Gap	11.87%	3.28%	9.07%

4.4. Median Disability Pay Gap

The median disability pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole No Known Disability population, (from smallest to largest), and the middle value hourly income of the whole Known Disability population expressed as a percentage.

Table 10: Median Disability Pay Gap

	Trust	AfC	M&D
Disability	£17.40	£17.13	£41.20
No Disability	£19.14	£17.78	£47.03
Difference	£1.74	£0.65	£5.83
% Pay Gap	9.09%	3.69%	12.39%

4.5. Proportion of No Known Disability and Known Disability staff in each pay quartile

To allow the Trust to compare the distribution of No Known Disability and Known Disability staff within its pay structure with those from different organisations, the population is ranked in order of pay and divided equally into 4 population quartiles, where quartile 1 is the lowest and 4 the higher.

The total number of No Known Disability and Known Disability staff are counted in each to produce the quartile populations.

Table 11: Quartile Populations (Disability)

	# Dis	# No Dis	% Dis	% No Dis
Quartile 1	243	2642	8.4%	91.6%
Quartile 2	199	2685	6.9%	93.1%
Quartile 3	208	2677	7.2%	92.8%
Quartile 4	144	2740	5.0%	95.0%

4.6. Bonus Disability Pay Gap

4.6.1. Mean and Median Bonus Disability Pay Gaps

The mean and median bonus disability pay gaps were as follows:

Table 12: Mean Bonus Disability Pay Gap

	Mean	Median
Disability	£2,653.35	£2,653.35
No Disability	£8,785.53	£6,032.04
Difference	£6132.18	£3378.69
% Pay Gap	69.80%	56.01%

4.6.2. Proportion of No Known Disability and Known Disability staff who received a bonus payment

Table 13 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were Known Disabled and No Known Disability.

Table 13: Number of Bonus Pay recipients.

	MWL
% Dis receive Bonus Pay	0.3%*
% No Dis receive Bonus Pay	0.9%*
% Bonus Pay recipients Dis	6.9%
% Bonus Pay Recipients No Dis	93.1%

Asterisk indicates the % is calculated from the Full Pay Relevant Population, and not the Pay Relevant Population.

5. Ethnicity Pay Gap

5.1. Introduction

The Ethnicity Pay Gap is a comparison between the White population v the combined Ethnic Minority population.

White includes White British, White Irish, Gypsy/Traveller, and Other White Background.

The Ethnic Minority population includes Bangladeshi, Chinese, Indian, Pakistani, White & Asian, Other Asian background; African, Caribbean, White & Black African, White & Black Caribbean, Other Black background; Arab, Other Mixed background, and Other Ethnicity.

369 pay records have no known Ethnicity (including 276 AfC, 93 M&D, and 2 Bonus pay records), accounting for 3.2% of the population. For the purposes of the following calculations these records have been omitted.

5.2. Population Summary

On the snapshot date of the 31st March 2026, the following number of employees were included in the data analysis:

Table 14: Trust Population by Ethnicity

	# Total	# EthMin	# White	% EthMin	% White
Total	11,169	2175	8994	19.5%	80.5%
AfC	10,101	1587	8514	15.7%	84.3%
M&D	1068	588	480	25.0%	70.0%

5.3. Mean Ethnicity Pay Gap

The mean ethnicity pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole White population, and the average hourly income of the whole Ethnic Minority population expressed as a percentage.

Table 15: Mean Ethnicity Pay Gap

	Trust	AfC	M&D
EthMin	£26.79	£19.68	£45.98
White	£21.01	£19.47	£48.23
Difference	£5.78	£0.21	£2.25
% Pay Gap	-27.52%	-1.07%	4.66%

5.4. Median Ethnicity Pay Gap

The median ethnicity pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole White population (from smallest to largest), and the middle value hourly income of the whole Ethnic Minority population expressed as a percentage.

Table 16: Median Ethnicity Pay Gap

	Trust	AfC	M&D
EthMin	£21.31	£19.36	£42.65
White	£17.83	£17.26	£51.95
Difference	£3.48	£2.10	£9.30
% Pay Gap	-19.50%	-12.12%	17.92%

5.5. Proportion of White and Ethnic Minority staff in each pay quartile

To allow the Trust to compare the distribution of White and Ethnic Minority staff within its pay structure with those from different organisations, the population is ranked in order of pay and divided equally into 4 population quartiles, where quartile 1 is the lowest and 4 the higher. The total number of White and Ethnic Minority staff are counted in each to produce the quartile populations.

Table 17: Quartile Populations (Ethnicity)

	# EthMin	# White	% EthMin	% White
Quartile 1	235	2558	8.4%	81.6%
Quartile 2	505	2887	15.9%	85.1%
Quartile 3	701	2091	25.1%	74.9%
Quartile 4	734	2058	26.3%	73.7%

5.6. Bonus Ethnicity Pay Gap

5.6.1. Mean and Median Bonus Ethnicity Pay Gap

The mean and median bonus ethnicity pay gaps were as follows:

Table 18: Mean Bonus Ethnicity Pay Gap

Ethnicity	Mean	Median
EthMin	£8,790.02	£6,032.04
White	£8,781.43	£6,032.04
Difference	£8.59	£0.00
% Pay Gap	-0.10%	0.00%

5.6.2. Proportion of White and Ethnic Minority staff who received a bonus payment

Table 19 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were White and Ethnic Minority.

Table 19: Number of Ethnicity Bonus Pay recipients.

Ethnicity	MWL
% EthMin receive Bonus Pay	1.8%*
% White receive Bonus Pay	0.6%*
% Bonus Pay recipients EthMin	41.3%
% Bonus Pay Recipients White	58.7%

6. Sexuality Pay Gap

6.1. Introduction

The Sexuality Pay Gap is a comparison between the known Heterosexual population v the combined Lesbian, Gay, Bisexual and Other sexuality population (LGBO).

1235 pay records have no known sexual orientation (of which 1044 AfC, 191 M&D, and 1 Bonus pay records), accounting for 10.7% of the population. For the purposes of the following calculations these records have been omitted.

6.2. Population Summary

On the snapshot date of the 31st March 2026, the following number of employees were included in the data analysis:

Table 20: Trust Population by Sexuality

	# Total	# LGBO	# Hetero	% LGBO	% Hetero
Total	10,303	415	9888	4.0%	96.0%
AfC	9333	367	8966	3.9%	96.1%
M&D	970	48	922	5.0%	95.0%

6.3. Mean Sexuality Pay Gap

The mean sexuality pay gap is a comparison between the average hourly income (before tax, but after salary sacrifice deductions) of the whole Heterosexual population, and the average hourly income of the whole LGBO population expressed as a percentage.

Table 21: Mean Sexuality Pay Gap

	Trust	AfC	M&D
LGBO	£20.98	£18.38	£37.35
Heterosexual	£22.06	£19.50	£47.02
Difference	£1.08	£1.12	£9.67
% Pay Gap	4.92%	3.39%	20.56%

6.4. Median Sexuality Pay Gap

The median sexuality pay gap is a comparison between the middle value of the hourly income (before tax, but after salary sacrifice deductions) of the whole Heterosexual population (from smallest to largest), and the middle value hourly income of the whole LGBO population expressed as a percentage.

Table 22: Median Sexuality Pay Gap

	Trust	AfC	M&D
LGB0	£18.43	£17.27	£27.87
Hetero	£18.90	£17.75	£47.31
Difference	£0.47	£0.48	£19.44
% Pay Gap	2.44%	2.67%	41.10%

6.5. Proportion of Heterosexual and LGB0 staff in each pay quartile

To allow the Trust to compare the distribution of Heterosexual and LGB0 staff within its pay structure with those from different organisations, the population is ranked in order of pay and divided equally into 4 population quartiles, where quartile 1 is the lowest and 4 the higher. The total number of Heterosexual and LGB0 staff are counted in each to produce the quartile populations.

Table 23: Quartile Populations (Sexuality)

	# LGB0	# Hetero	% LGB0	% Hetero
Quartile 1	107	2469	4.2%	95.8%
Quartile 2	107	2469	4.2%	95.8%
Quartile 3	108	2468	4.2%	95.8%
Quartile 4	93	2482	3.6%	96.4%

6.6. Bonus Sexuality Pay Gap

6.6.1. Mean and Median Bonus Sexuality Pay Gaps

The mean and median bonus sexuality pay gaps were as follows:

Table 24: Mean Bonus Sexuality Pay Gap

	Mean	Median
LGB0	£1,734.24	£1,734.24
Heterosexual	£8,936.11	£6,032.04
Difference	£7212.87	£4297.80
% Pay Gap	80.59%	71.25%

6.6.2. Proportion of Heterosexual and LGB0 staff who received a bonus payment

Table 25 reports the proportion of the total population who received a bonus payment, and the proportion of bonus recipients who were Heterosexual and LGB0.

Table 25: Number of Sexuality Bonus Pay recipients.

	MWL
% LGBO receive Bonus Pay	0.2%*
% Hetero receive Bonus Pay	0.7%*
% Bonus Pay recipients LGBO	1.5%
% Bonus Pay Recipients Hetero	98.5%

7. Discussion

The Trust's overall pay gaps continue to be significantly influenced by the inclusion of employees on different national pay frameworks within a single workforce calculation, particularly Agenda for Change and Medical and Dental terms and conditions.

The statutory whole-workforce calculation remains important, but it does not identify where differences arise. Separate analysis shows that the principal issues relate to workforce distribution, representation in senior and higher-paid roles, medical career structure, and access to Clinical Impact Awards (bonus pay), rather than a uniform pay difference across the workforce.

The analysis identifies four recurring themes:

- **Senior representation and progression** - Representation reduces at senior levels for several groups. Women are underrepresented in the highest-paid quartile, while there are no recorded Disabled or Ethnic Minority staff at Band 9 or VSM and no recorded LGBO staff at Bands 8d, 9 or VSM.
- **Medical workforce distribution** - Medical and Dental roles have a disproportionate effect on the statutory results because of their higher hourly rates and different grade, specialty and career structures.
- **Access to Clinical Impact Awards** - Bonus-pay outcomes are affected by both access to awards and award value. Women, Disabled doctors, Ethnic Minority doctors and LGBO doctors were less likely to receive an award than their comparator groups. Disabled and LGBO recipients also received materially lower-value awards.
- **Data quality and disclosure** - Improving disclosure is essential to reliable analysis. Disability disclosure remains below levels indicated through the NHS Staff Survey, and 1,235 staff have no recorded sexual orientation. Small cohorts, particularly among Disabled and LGBO medical staff and senior pay bands, can also produce substantial annual volatility.

The 2026 position demonstrates progress in several headline measures, particularly the disability and sexual orientation gaps and the overall gender mean gap. However, these improvements are not consistent across the workforce. The principal challenge is the unequal distribution of staff across occupations, bands and senior roles, compounded by differences in access to medical pay awards and incomplete workforce data.

Below we summarise the key results for each respective protected characteristic.

7.1. Gender Pay Gap

The overall mean gender pay gap continued to reduce and the Agenda for Change mean gap remained close to zero. However, the overall median gap increased, women's representation in the highest-paid quartile declined, and the Medical and Dental median and bonus pay gaps widened significantly.

7.1.1. Population change

- The number of female staff increased from 8,940 to 9,032, an increase of 92 staff or 1.0% during 2025–2026. Between 2024 and 2026, the female workforce increased by 270 people.
- The number of male staff increased from 2,419 to 2,506, an increase of 87 staff or 3.6% during 2025–2026. Between 2024 and 2026, the male workforce increased by 295 people.
- Women represented approximately **78.3%** of the workforce in 2026, compared with 78.7% in 2025. Although women continue to form most of the workforce, the male workforce has grown at a faster rate.
- Women represented more than 80% of Quartiles 1, 2 and 3, but only **67.61%** of **Quartile 4**. The difference between Quartile 1 and Quartile 4 was **13.12 percentage points** in 2026.
- Female representation in Quartile 4 reduced from 69.50% in 2025 to 67.61% in 2026. This indicates a continuing reduction in women's representation among the highest-paid staff and is a key contributor to the overall mean gender pay gap.
- The reduction in Quartile 4 representation is likely to be associated with workforce composition in Medical and Dental roles and the distribution of women across senior Agenda for Change and VSM positions.

7.1.2. Overall workforce

- **Mean:** The overall mean gender pay gap reduced from 24.52% in 2025 and **23.82% in 2026**, representing an improvement of **0.70** percentage points.
- In 2026, female staff earned an average of **£20.86 per hour**, compared with **£27.39 for male staff**, an average difference of **£6.53 per hour**.
- Between 2025 and 2026, mean hourly pay increased by **4.6% for female staff** and **3.6% for male staff**. The faster percentage increase for women contributed to the reduction in the mean gap.
- The cash difference increased slightly from £6.48 in 2025 to £6.53 in 2026 because the male hourly rate started from a higher baseline.
- The mean gap remains substantial despite the improvement. The difference between the whole workforce mean gap of 23.82% and the AfC mean gap of 0.80% indicates that the overall result is principally associated with differences

in workforce distribution, particularly the lower representation of women in the highest-paid medical and senior roles.

- **Median:** The overall median gender pay gap increased from 8.11% in 2025 to **10.62% in 2026**, a deterioration of **2.51 percentage points**. It is also 1.06 points higher than the 2024 gap of 9.56%.
- In 2026, female staff earned a median of **£18.49 per hour**, compared with **£20.68 for male staff**, a difference of **£2.19 per hour**.
- Between 2025 and 2026, female median hourly pay increased by **5.4%**, while male median hourly pay increased by **8.3%**. The faster increase for men caused the median gap to widen.

7.1.3. Agenda for Change

- **Mean:** The AfC mean gender pay gap changed from **- 0.18%** in 2025 to **- 0.80% in 2026**, meaning that female AfC staff earned marginally more on average than male AfC staff.
- Female AfC mean pay increased from £18.51 to **£19.50**, while male AfC mean pay increased from £18.54 to **£19.35**.
- Between 2025 and 2026, female AfC mean pay increased by **5.3%**, compared with 4.4% for male AfC staff.
- **Median:** The AfC median gap changed from **- 4.80%** in 2025 to **- 4.13% in 2026**. This means that the median hourly rate remained higher for women, although the difference narrowed by 0.67 percentage points.
- Female AfC median pay increased from £16.97 to **£17.86**, while male AfC median pay increased from £16.20 to **£17.15**.
- The AfC findings indicate that the nationally determined pay structure generally results in limited gender differences within the overall AfC workforce. However, gaps remain within particular staff groups and pay bands because of differences in occupation, seniority, pay-point position and workforce distribution.
- At staff-group level, the largest mean gaps in 2026 were within Administrative and Clerical at **17.25%** and Additional Professional, Scientific and Technical at **11.58%**.
- The most significant staff-group median gaps were Additional Professional, Scientific and Technical at **13.04%** and Administrative and Clerical at **11.07%**,
- Allied Health Professionals recorded gaps in favour of women, with a mean gap of **-3.43%** and a median gap of **-7.93%**, and Nursing and Midwifery a mean gap of **-0.25%** and a median gap of **0.94%**.
- Within AfC pay bands, most 2026 gaps were below 3% or in favour of women. The exceptions were the Band 2 median gap of **5.69%**, Band 7 mean gap of **- 6.58%**, Band 8c median gap of **4.24%**, and Band 8d mean gap of **2.86%**.

7.1.4. Medical and Dental

- **Mean:** The Medical and Dental mean gender pay gap reduced from 9.21% in 2025 to **8.72% in 2026**, an improvement of 0.49 percentage points. The gap has reduced by 2.61 points since 2024.
- In 2026, female medical staff earned a mean of **£44.86 per hour**, compared with **£49.15 for male medical staff**. The cash difference was **£4.29 per hour**, compared with £4.48 in 2025.
- Between 2025 and 2026, female mean hourly pay increased by **1.5%**, while male mean hourly pay increased by **0.9%**. The faster increase for women contributed to the modest improvement in the mean gap.
- The 8.72% medical mean gap remains materially higher than the AfC mean gap of **-0.80%**. Medical workforce composition therefore remains an important contributor to the overall organisational gender pay gap.
- **Median:** The Medical and Dental median gap increased significantly from 13.21% in 2025 to **19.48% in 2026**, a deterioration of **6.27 percentage points**.
- Female medical median pay reduced from £42.17 to **£39.15 per hour**, a fall of 7.2%. Male median pay remained broadly unchanged, increasing from £48.59 to **£48.62**.
- The median hourly difference consequently increased from £6.42 in 2025 to **£9.47 in 2026**.
- The number of female medics reduced from 491 to **485**, while the number of male medics increased from 635 to **676**. Women therefore represented approximately **41.8% of the medical workforce in 2026**, compared with 43.6% in 2025.

7.1.5. Bonus Pay Gap

Overall, the bonus pay position deteriorated significantly during 2025–2026. The mean gap increased from **-2.18% to 20.51%**, a deterioration of 22.69 percentage points, while the median gap increased from **3.24% to 8.75%**, a deterioration of 5.51 points.

- In 2026, female recipients received a mean bonus of **£7,194.06**, compared with **£9,049.92 for male recipients**, a difference of **£1,855.86**.
- Female mean bonus pay reduced by **21.2%** between 2025 and 2026, while male mean bonus pay increased by 1.3%. This resulted in the substantial widening of the mean gap.
- Female recipients received a median bonus of **£5,504.22**, compared with **£6,032.04 for male recipients**, a difference of **£527.82**.
- Female median bonus pay reduced by 2.6%, while male median bonus pay increased by 3.2%, causing the median gap to widen.
- The number of female recipients reduced from 30 to **20**, while the number of male recipients reduced from 98 to **74**.
- Using the total Medical and Dental workforce figures, approximately **4.1% of female medics received a bonus**, compared with **10.9% of male medics** in 2026. In 2025, the equivalent proportions were approximately 6.1% and 15.4%.

- Women represented approximately **41.8% of the medical workforce**, but only **21.3% of bonus recipients** in 2026.
- The 2026 bonus gap therefore appears to result from two related factors:
 - Female doctors were substantially less likely than male doctors to receive an award.
 - Female recipients received lower-value awards on both a mean and median basis.
- Overall, there has been a reduction of recipients from 373 in 2024 to 128 in 2025 and 94 in 2026 as a result of changes to the clinical excellence awards / clinical impact award systems.

7.2. Disability Pay Gap

The 2026 data show overall progress for both the overall workforce and Agenda for Change mean and median gaps reducing to their lowest levels since the first MWL analysis was completed in 2024, with corresponding increases in disability disclosure throughout the pay distribution.

7.2.1. Population change

- The number of staff recorded as Disabled increased from 710 to 794, an 11.8% increase during 2025–2026. Between 2024– to 2026, the Known Disabled workforce increased by 201 people.
- Known Disabled staff represented approximately 6.88% of the recorded workforce in 2026, compared with 6.25% in 2025 and 5.40% in 2024. This reflects the year-on-year improvement in Trust declaration rates since 2021.
- Disabled representation increased in every pay quartile, with the largest increase in Quartile 3, up 1.08 percentage points; however Disabled representation remains substantially lower in Quartile 4, with a 3.4-point difference with Quartile 1, a reflection of the lower disclosure rates in Medical & Dental, and AfC Pay Band 9-VSM.

7.2.2. Overall Workforce

- **Mean:** The overall mean disability pay gap continued to reduce from 13.54% (2024) to 12.71% (2025) to 11.87% (2026).
- This is an improvement of 0.84 percentage points since 2025 and 1.67 points since 2024.
- In 2026, Disabled staff earned an average of £19.80 per hour, compared with £22.46 for staff with no known disability, an average difference of £2.66 per hour.
- Between 2025 and 2026, mean hourly pay increased by 5.5% for Disabled staff and 4.5% for staff with no known disability. The faster increase for Disabled staff contributed directly to the narrowing mean gap.
- **Median:** The overall median disability pay gap improved from 10.46% (2025) to 9.09% (2026), an improvement of 1.37 percentage points.

- In 2026, Disabled staff earned a median of £17.40 per hour, compared with £19.14 for staff with no known disability, a difference of £1.74 per hour.
- Between 2025 and 2026, median hourly pay increased by 7.7% for Disabled staff and 6.1% for staff with No Known Disability.

7.2.3. Agenda for Change

- **Mean:** The overall AfC mean Disability pay gap reduce from 4.38% (2025) to 3.28% (2026), an improvement of 1.10 percentage points
- Disabled AfC staff mean pay increased from £17.77 to £18.88, while pay for staff with No Known Disability increased from £18.59 to £19.52.
- **Median:** The AfC median gap reduced from 5.94% (2025) to 3.69% (2026), and improvement of 2.25 percentage points.
- Disabled AfC staff median pay increased by 8.1% during 2025–2026, compared with 5.5% for staff with No Known Disability.
- Within AfC the pay gaps are being caused by the lower declaration rates from band 7 upwards, in particular band 9 and VSM; as well as within Healthcare Scientists (3.5%), and the distribution of Disabled staff within Add Prof Scientific and Technic, Allied Health Professionals, and the Healthcare Scientists.

7.2.4. Medical & Dental

- **Mean:** The mean disability pay gap reduced from 10.13% in 2025 to 9.07% in 2026, an improvement of 1.06 percentage points.
- In 2026 Disabled medical staff earned a mean of £43.16 per hour compared to medical staff with no known disability earning £47.47 per hour. The cash difference was £4.31 per hour, compared with £4.74 in 2025.
- Between 2025 and 2026, mean hourly pay increased by 2.5% for Disabled medical staff and 1.3% for medical staff with no known disability
- The 9.07% gap is substantially higher than the 2026 Agenda for Change mean gap of 3.28%. Medical workforce composition therefore appears to remain an important contributor to the overall organisational disability pay gap.
- **Median:** The median gap increased significantly from 3.20% (2025) to 12.39% (2026), representing a 9.19 percentage points increase.
- In cash terms Disabled medical staff median pay reduced from £44.33 to £41.20 per hour, a fall of 7.1%, and the median for medical staff with no known disability increased from £45.80 to £47.03, an increase of 2.7%. The median hourly difference increased from £1.47 to £5.83.
- The significantly lower number of Known Disabled staff within the medical and dental workforce is having a significant impact on the pay calculations. The number of known Disabled medics increased from 29 (2025) to 30 (2026), compared with an increase in medics with no known disability from 1097 to 1131.

7.2.5. Bonus Pay Gap

Overall, the Mean decreased slightly from 71.6% to 69.8%, and the Median increased from 54.4% to 56.0%. The proportion recipients of bonus pay who are Disabled remained the same at 2 people, which represented a slight increase from 6.3% to 6.9% of recipients. The 2026 gap appears to result from two related factors:

- Disabled doctors were slightly less likely to receive an award.
- The two Disabled recipients received materially lower-value awards than the wider recipient population.

7.3. **Ethnicity Pay Gap**

Note: overall there are 369 (3.2%) employee pay records which do not have a recorded ethnicity.

Ethnic Minority representation continued to increase across the workforce and pay quartiles, and the overall mean and median hourly rates remained higher for Ethnic Minority staff. However, this overall position is strongly influenced by workforce distribution, particularly the high representation of Ethnic Minority staff in Medical and Dental roles. Within individual staff groups, significant gaps remain in favour of White staff, particularly in Medical and Dental, Allied Health Professionals, Nursing and Midwifery, Healthcare Scientists, and Administrative and Clerical roles.

7.3.1. Population change

- The number of staff recorded as Ethnic Minority increased from 1,966 to 2,175, an increase of 209 staff or 10.6% during 2025–2026. Between 2024 and 2026, the known Ethnic Minority workforce increased by 499 people.
- The number of White staff reduced slightly from 9,014 to 8,994, a reduction of 20 staff or 0.2% during 2025–2026.
- Ethnic Minority staff represented approximately 19.5% of staff with a recorded ethnicity in 2026, compared with 17.9% in 2025.
- Ethnic Minority representation increased in Quartile 1, 3 and 4, with Quartile 4, up 1.95 percentage points, closely followed by Quartile 3, up 1.94 points.
- Ethnic Minority representation remains substantially lower in Quartile 1 than in the other quartiles. In 2026, there was a 17.88-point difference between Quartile 1 and Quartile 4.

This distribution is an important contributor to the negative overall ethnicity pay gap. Ethnic Minority staff are proportionately more highly represented in the upper two quartiles, including within the comparatively highly paid Medical and Dental workforce.

7.3.2. Overall workforce

- **Mean:** The overall mean ethnicity pay gap changed from **-33.14%** in 2025 and **-27.52%** in 2026, representing a reduction in the gap in favour of Ethnic Minority staff of 5.62 percentage points.
- In 2026, Ethnic Minority staff earned an average of £26.79 per hour, compared with £21.01 for White staff, an average difference of £5.78 per hour in favour of Ethnic Minority staff.
- Between 2025 and 2026, mean hourly pay increased by 0.5% for Ethnic Minority staff and 5.0% for White staff. The faster increase for White staff reduced the size of the negative mean gap.
- **Median:** The overall median ethnicity pay gap changed from **-20.03%** in 2025 to **-19.50%** in 2026, reducing the gap in favour of Ethnic Minority staff by 0.53 percentage points.
- In 2026, Ethnic Minority staff earned a median of £21.31 per hour, compared with £17.83 for White staff, a difference of £3.48 per hour in favour of Ethnic Minority staff.
- Between 2025 and 2026, median hourly pay increased by 5.2% for Ethnic Minority staff and 5.6% for White staff. The slightly faster increase for White staff contributed to the modest narrowing of the negative median gap.
- The mean gap is substantially larger than the median gap. This indicates that higher-paid Ethnic Minority staff, particularly within Medical and Dental roles, have a significant influence on the overall average.

7.3.3. Agenda for Change

- The number of Ethnic Minority AfC staff increased from 1,406 to 1,587, an increase of 181 staff or 12.9%. The number of White AfC staff reduced from 8,559 to 8,514.
- Ethnic Minority staff represented approximately 15.7% of the recorded AfC workforce in 2026, compared with 14.1% in 2025.
- **Mean:** The AfC mean ethnicity pay gap changed from **-1.46%** in 2025 to **-1.07%** in 2026.
- Ethnic Minority AfC mean pay increased from £18.78 to £19.68, while White AfC mean pay increased from £18.51 to £19.47, a mean hourly pay increase of 4.8% for Ethnic Minority AfC staff and 5.2% for White AfC staff.
- **Median:** The AfC median ethnicity pay gap changed marginally from **-12.32%** in 2025 to **-12.12%** in 2026.
- Ethnic Minority AfC staff earned a median of £19.36 per hour, compared with £17.26 for White staff, a difference of £2.10 per hour in favour of Ethnic Minority staff.
- Between 2025 and 2026, median hourly pay increased by 4.7% for Ethnic Minority AfC staff and 4.9% for White AfC staff.

- Ethnic Minority representation increased in all four AfC quartiles, with Quartile 3 having the largest proportion at 27.21%.
- Ethnic Minority representation in AfC Quartile 4 remains less than half the level in Quartile 3. There were no Ethnic Minority staff recorded at Band 9 or VSM.
- By Staff Group the mean and median pay gaps are in favour of Ethnic Minority staff in Additional Professional, Scientific and Technical, Additional Clinical Services, and Estates roles. Nursing and Midwifery has the largest pay gap in favour of White staff, followed by Allied Health Professional, with the reverse for the median pay gap.
- By AfC pay band most results were either below 5% or in favour of Ethnic Minority staff. However, several areas require further review. There were no Ethnic Minority staff recorded at Band 1, Band 9 or VSM.

7.3.4. Medical and Dental

- Ethnic Minority medical staff increased from 560 in 2025 to 588 in 2026, an increase of 28 staff or 5.0%.
- White medical staff increased from 455 to 480, an increase of 25 staff or 5.5%.
- Ethnic Minority staff represented approximately 55.1% of the recorded Medical and Dental workforce in 2026, broadly unchanged from 55.2% in 2025.
- **Mean:** The Medical and Dental mean ethnicity pay gap increased from 4.00% in 2025 to 4.66% in 2026, a deterioration of 0.66 percentage points.
- In 2026, Ethnic Minority medical staff earned a mean of £45.98 per hour, compared with £48.23 for White medical staff, a difference of £2.25 per hour.
- Ethnic Minority mean pay reduced by 0.9%, while White mean pay reduced by 0.2%. This caused the mean gap to widen.
- **Median:** The Medical and Dental median gap increased significantly from 12.74% in 2025 to 17.92% in 2026, a deterioration of 5.18 percentage points.
- Ethnic Minority medical median pay reduced from £45.22 to £42.65 per hour, a fall of 5.7%. White medical median pay increased marginally from £51.82 to £51.95 per hour.
- The median hourly difference therefore increased from £6.60 in 2025 to £9.30 in 2026.

7.3.5. Bonus Pay Gap

- Overall, the 2026 ethnicity bonus pay position was close to parity in award value:
 - The mean bonus gap changed from **-5.54%** in 2025 to **-0.10%** in 2026.
 - The median bonus gap changed from **-3.24%** to **0.00%**.
- Ethnic Minority recipients received a mean bonus of £8,790.02, compared with £8,781.43 for White recipients, a difference of £8.59 in favour of Ethnic Minority recipients.
- Both groups received a median bonus of £6,032.04.

- The number of Ethnic Minority recipients reduced from 72 to 38, a fall of 47.2%, while the number of White recipients increased from 51 to 54.
- Using the total Medical and Dental workforce figures, approximately 6.5% of Ethnic Minority medics received a bonus, compared with 11.3% of White medics in 2026.
- In 2025, the equivalent recipient rates were approximately 12.9% for Ethnic Minority medics and 11.2% for White medics.
- Ethnic Minority medics represented approximately 55.1% of the medical workforce but only 41.3% of bonus recipients in 2026.
- The 2026 position therefore appears to arise from two distinct factors:
 - Ethnic Minority and White recipients received awards of broadly equal value.
 - Ethnic Minority doctors were materially less likely to receive an award.

7.4. Sexuality Pay Gap

Note: overall there are 1235 (10.7%) employee pay records which do not have a recorded sexual orientation.

The 2026 data show overall improvement, with the whole workforce mean gap reducing from 5.46% to 4.92% and the median gap reducing from 5.52% to 2.44%. The reported Agenda for Change gaps also reduced. However, LGBO representation remains lower in the highest pay quartile, and for Medical and Dental staff.

7.4.1. Population change

- The number of staff recorded as LGBO increased from 395 to 415, an increase of 20 staff or 5.1% during 2025–2026. Between 2024 and 2026, the known LGBO workforce increased by 73 people.
- LGBO staff represented approximately 4.0% of staff with a known sexual orientation in 2026, compared with 3.9% in 2025.
- As a proportion of the total workforce, including staff whose sexual orientation was unknown, LGBO staff represented approximately 3.6% in 2026, compared with 3.5% in 2025.
- The number of staff whose sexual orientation was unknown reduced from 1,295 to 1,235, a reduction of 60 staff or 4.6%. The unknown group represented approximately 10.7% of the workforce in 2026, compared with 11.4%.
- LGBO representation increased across all quartiles, with the largest proportion of LGBO staff in Quartile 1 and 2.
- Despite the improvement, LGBO representation remained lowest in Quartile 4, with the difference between Quartile 1 and Quartile 4 being 0.54 points.

This unequal distribution is likely to contribute to the overall mean pay gap. The continuing difference is particularly associated with the low representation and pay

distribution of LGBO staff within Medical and Dental and the absence of recorded LGBO staff at Bands 8d, 9 and VSM.

7.4.2. Overall workforce

- **Mean:** The overall mean sexual orientation pay gap reduced from 5.46% in 2025 to 4.92% in 2026, an improvement of 0.54 percentage points.
- In 2026, LGBO staff earned an average of £20.98 per hour, compared with £22.06 for heterosexual staff, an average difference of £1.08 per hour
- Between 2025 and 2026, mean hourly pay increased by 5.3% for LGBO staff and 4.7% for heterosexual staff. The faster percentage increase for LGBO staff contributed directly to the narrowing mean gap.
- **Median:** The overall median sexual orientation pay gap reduced from 5.52% in 2025 to 2.44% in 2026, a substantial improvement of 3.08 percentage points.
- In 2026, LGBO staff earned a median of £18.43 per hour, compared with £18.90 for heterosexual staff, a difference of £0.47 per hour.
- Between 2025 and 2026, median hourly pay increased by 9.3% for LGBO staff and 5.9% for heterosexual staff. This stronger increase for LGBO staff was the principal reason for the reduction in the median gap.
- The median gap is now below 3%, indicating a comparatively small difference around the centre of the overall pay distribution.

7.4.3. Agenda for Change

- The number of LGBO AfC staff increased from 350 in 2025 to 367 in 2026, an increase of 17 staff or 4.9%.
- The number of heterosexual AfC staff increased from 8,776 to 8,966, an increase of 190 staff or 2.2%.
- LGBO staff represented approximately 3.9% of AfC staff with a known sexual orientation in 2026, compared with 3.8% in 2025.
- The 2026 AfC data also record 1,044 staff whose sexual orientation was unknown. This continuing unknown population should be considered when interpreting the results.
- **Mean:** The reported AfC mean sexual orientation pay gap reduced from 4.27% in 2025 to 3.39% in 2026, an improvement of 0.88 percentage points.
- **Median:** The reported AfC median gap reduced from 3.44% in 2025 to 2.67% in 2026, an improvement of 0.77 percentage points.
- Within the AfC pay quartiles, LGBO representation reduced in Quartiles 1 and 2, and increased in Quartiles 3 and 4.
- By Staff Group the mean was in favour of LGBO staff in Admin, Estates, and Healthcare Scientists roles, but only Estates roles for the median. Except for Allied Health Professionals and Medical & Dental, the median pay gap was less than 3% for all staff groups.

- By Pay Band the mean and median were in favour of LGBO staff on band 1-3, 8a and 8c. Except for band 7, the median pay gaps in favour of heterosexual staff were larger than 3%.

7.4.4. Medical and Dental

- The number of LGBO medics increased from 45 in 2025 to 48 in 2026, an increase of three staff or 6.7%.
- The number of heterosexual medics increased from 893 to 922, an increase of 29 staff or 3.2%.
- LGBO staff represented approximately 4.95% of medical staff with a known sexual orientation in 2026, compared with 4.80% in 2025.
- **Mean:** The Medical and Dental mean sexual orientation pay gap reduced slightly from 20.74% in 2025 to 20.56% in 2026, an improvement of just 0.18 percentage points.
- In 2026, LGBO medical staff earned a mean of £37.35 per hour, compared with £47.02 for heterosexual medical staff, a difference of £9.67 per hour.
- Between 2025 and 2026, LGBO mean hourly pay increased by 1.4%, while heterosexual mean hourly pay increased by 1.1%. This produced only a marginal reduction in the gap.
- **Median:** The Medical and Dental median gap reduced from 42.62% in 2025 to 41.10% in 2026, an improvement of 1.52 percentage points.
- LGBO medical median pay increased from £26.53 to £27.87 per hour, an increase of 5.1% whereas the heterosexual medical median increased from £46.23 to £47.31 per hour, an increase of 2.3%.
- The median hourly difference remained exceptionally high at £19.44 per hour in 2026, compared with £19.70 in 2025.

7.4.5. Bonus Pay Gap

- Only one LGBO medic received a bonus in both 2025 and 2026.
- The mean bonus gap reduced marginally from 81.13% in 2025 to 80.59% in 2026, an improvement of 0.54 percentage points.
- The median bonus gap increased from 69.33% to 71.25%, a deterioration of 1.92 percentage points.
- The LGBO award remained unchanged at £1,734.24.
- In 2026, heterosexual recipients received a mean bonus of £8,936.11, producing a difference of £7,201.87.
- The heterosexual median bonus increased from £5,653.74 to £6,032.04, producing a 2026 median difference of £4,297.80.
- Using the total Medical and Dental workforce figures, approximately 2.1% of LGBO medics received a bonus, compared with 7.0% of heterosexual medics.
- In 2025, the equivalent receipt rates were approximately 2.2% for LGBO medics and 10.2% for heterosexual medics.

- LGBO medics represented approximately 4.95% of the medical workforce with a known sexual orientation but only 1.52% of known-orientation bonus recipients in 2026.

8. Cheshire & Mersey ICB Benchmarking 2025

In this section, MWL is compared against the other 15 Trusts within the Cheshire & Merseyside ICB area for the Gender Mean, Median, Bonus Mean and Bonus Median pay gaps in 2025, the most recent publication date.

When using this data, the following caveats need to be considered:

- The type of Trusts varies from Acute, Specialist and Community Trusts whose workforce profiles will differ based on the services they offer
- 10 of the Trusts have workforce profiles of between 1000-4999, and 5 Trusts have workforce profiles in the range of 5000 to 20,000 (as reported in the GPG Portal).
- Local Pay and Workforce Practices are not considered which may impact on the respective calculations and ranking. For example, the provision of salary sacrifice practices such as car loans and electric goods within each Trust is unknown, as well as the specific methodologies used to create their GPG data reports.

The ultimate target is to have a pay gap of 0% for all indicators. The following ranking is therefore based on 1st place being closest to or actually 0% and all Trusts ranked in order from lowest to highest, with 15th place having the highest pay gap.

Overall, when compared to the Trusts within the ICB, MWL ranked:

- 9 out of 15 for the Mean Pay Gap,
- 10 out of 15 for the Median Pay Gap,
- 1 out of 15 for the Mean Bonus Pay (closest to 0%)
- 5 out of 15 for Median Bonus pay (closest to 0%)

The lower the ranking the better the results when compared to other Trusts.

9. Action Planning

The following actions have been identified within the Trust's People Strategy Year 2 delivery plan (2026-2027):

Looking after our people

- Launch Cohort 2 of the Leading Operational Excellence programme (2.3),
- Launch the MWL Behavioural Framework to the Trust senior managers as part of the STAR conference and Objectives publication (3.2),
- Develop and introduce long term, Trust wide 'Culture reset' programme (3.3),
- Review and relaunch the exit questionnaire to allow better analysis alongside a toolkit for managers to conduct exit interviews (4.1),
- To create and publish a retention dashboard for divisions to be distributed and discussed at Divisional People Meetings including analysis of the workforce, workforce stability, leavers and exit feedback (4.2),
- Work with clinical and operational colleagues to maximise the use of CPD to create a package of learning and development opportunities which support the retention and engagement of our workforce (4.3),
- Embed one bank model across the Trust including monitoring and evaluating impact from a fill rate, stakeholder and quality perspective (4.4),
- Deliver the leading operational excellence programme for all band 8a-8d operational managers (5.1),
- Create a leading clinical excellence programme for all nurses in Year 1 in line with the leading operational excellence programme for operational managers (5.2).

Belonging in the NHS

- Review the medical leadership structure and Clinical Director recruitment process, including recent appointments, to identify and address any barriers to gender-balanced attraction, selection and progression, and assess the impact on the gender pay gap (7.4),
- To launch a revised EDI Governance Framework which provides focus, scrutiny and an opportunity for Senior Leaders to work collaboratively with the Trusts Staff Networks on creating meaningful change for our staff (8.1),
- Support the Network Chairs to increase the visibility of networks and in turn increase the membership and attendance at network meetings (8.2).

Growing our future

- Work in collaboration with finance and operations colleagues to create an annual planning cycle for workforce, finance and operations to create divisional operational plans including job planning, establishment reviews and workforce reviews which will be brought together to form the Trust Operational Plans (9.1),

- Support divisions through their people meetings to monitor and manage workforce numbers including workforce plan targets, vacancies, bank and agency usage (9.2),
- Promote the availability of courses for career development including NHSE funded programmes (Advanced Practice and CSP / SCPHN, RNDA programme) alongside apprenticeships (10.1),
- Scope work on career pathways for roles and staff groups ensuring we review existing published information such as the HEE role explorer (10.2),
- Write and publish an MWL Education Strategy (11.1),
- Launch career conversations toolkit (12.1),
- Revise programme of training for managers in delivery of effective appraisals to focus on the link between objectives and an individual's role, career and development aspirations and include guidance on how to access relevant development (12.2),
- Work with corporate nursing colleagues to review and standardise B5-6 Nurse JDs and Enhanced / Advanced Practice JDs for all staff groups across the Trust ensuring there are clear competency frameworks and expectations of roles (12.3).

10. Conclusion

The 2026 analysis shows progress across several headline measures but also confirms that pay outcomes are not yet consistently equitable across the Trust. Improvements include reductions in the overall mean gender pay gap, both the mean and median disability pay gaps, and the overall sexual orientation pay gaps. Representation and declaration have also increased for Disabled, Ethnic Minority and LGBO staff.

The analysis demonstrates that the Trust's statutory whole-workforce pay gaps are significantly influenced by the different composition and pay structures of the Agenda for Change and Medical and Dental workforces. When examined separately, aggregate Agenda for Change gaps are generally smaller or in favour of the relevant comparison group. Material differences remain within particular staff groups, pay bands, senior roles and the Medical and Dental workforce.

Pay Gap Report 2026

Gender, Disability, Ethnicity and Sexuality

What is reported

Mean Pay Gap

Median Pay Gap

Breakdown of
Population into
4 quartiles

Mean Bonus
Pay Gap

Median Bonus
Pay Gap

Proportion who
receive Bonus
Payment

Not an Equal Pay Audit!

Scope and Methodology

- Pay Gap is a **Tool**
- Statutory Pay Gap: Gender (M v F)
- NHS High Impact Actions:
 - Disability Pay Gap
 - Ethnicity Pay Gap
 - Sexuality Pay Gap
- Limited analysis

Aim to get <3% or <5%

Mean & Median

- **March 31st 2026**
- All Employees, Workers, Apprentices
- **Full Pay Relevant Employee**
- Post data, not People
- Calculated from **Hourly Rate of Pay**:

Bonus Mean & Median

- 1st April 2025 – 31st March 2026
- Everyone who receives a bonus
- Pay Relevant Employee
- Total Value used

Summary 2025 v 2026

Gender	2025	2026
Mean	24.52	23.82
Median	8.11	10.62
Bonus Mean	-2.18	20.51
Bonus Median	3.24	8.75

Disability	2025	2026
Mean	12.71	11.87
Median	10.46	9.09
Bonus Mean	71.62	69.80
Bonus Median	54.43	56.01

Ethnicity	2025	2026
Mean	-32.52	-27.52
Median	-19.98	-19.50
Bonus Mean	-5.54	-0.10
Bonus Median	-3.24	0.00

Sexuality	2025	2026
Mean	5.46	4.92
Median	5.52	2.44
Bonus Mean	81.13	80.59
Bonus Median	69.33	71.25

NB: Median is the figure by gov/press when talking about pay gap

AfC & M&D 2026

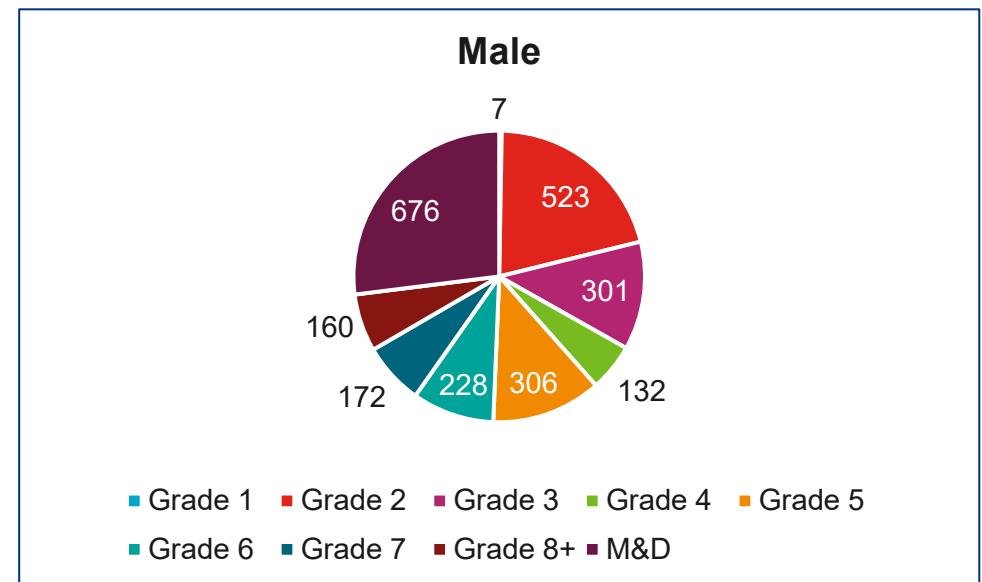
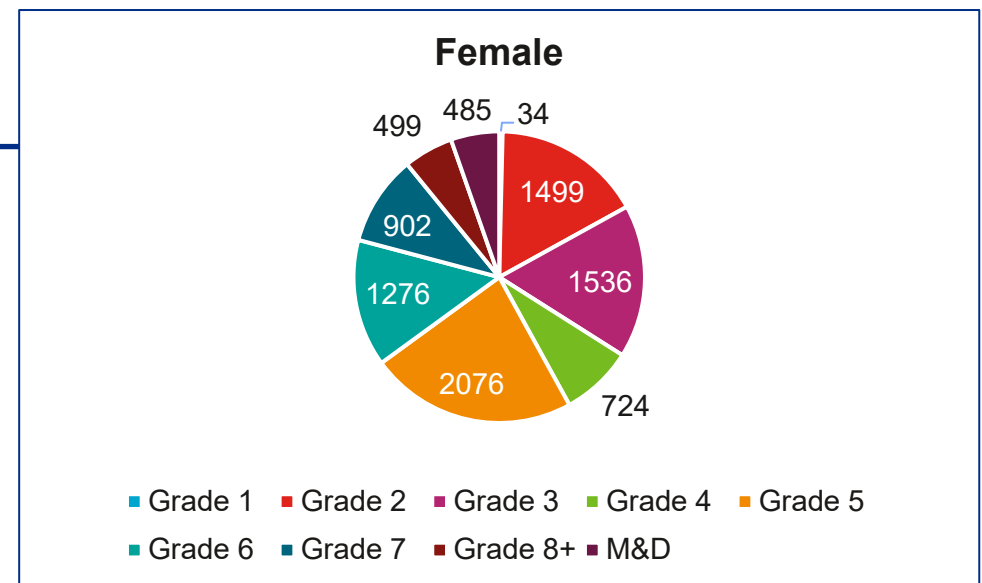
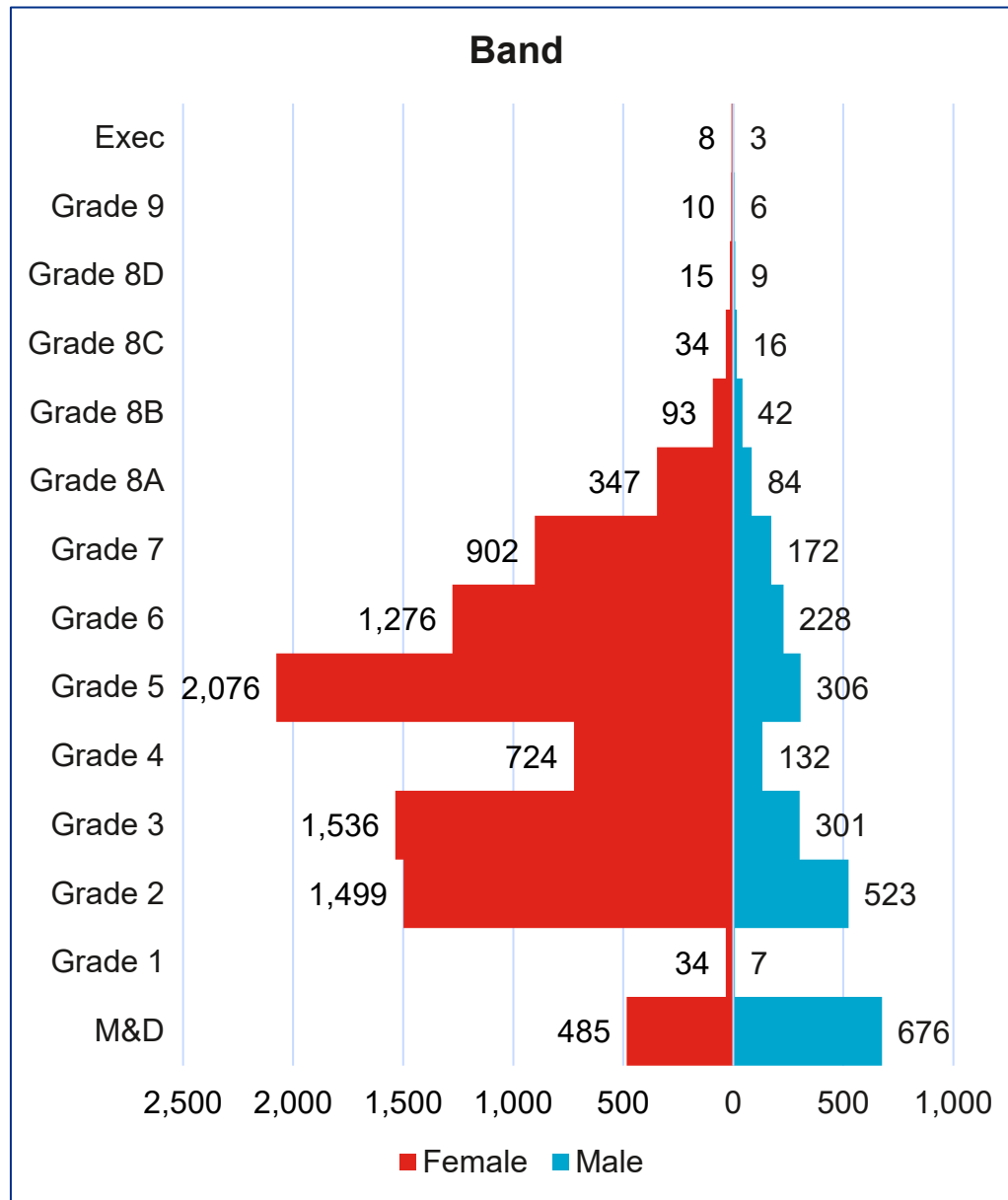
Gender	AfC	M&D
Mean	-0.80	8.72
Median	-4.13	19.48
Bonus Mean	-	20.51
Bonus Median	-	8.75

Disability	AfC	M&D
Mean	3.28	9.07
Median	3.69	12.39
Bonus Mean	-	69.80
Bonus Median	-	56.01

Ethnicity	AfC	M&D
Mean	-1.07	4.66
Median	-12.12	17.92
Bonus Mean	-	-0.10
Bonus Median	-	0.00

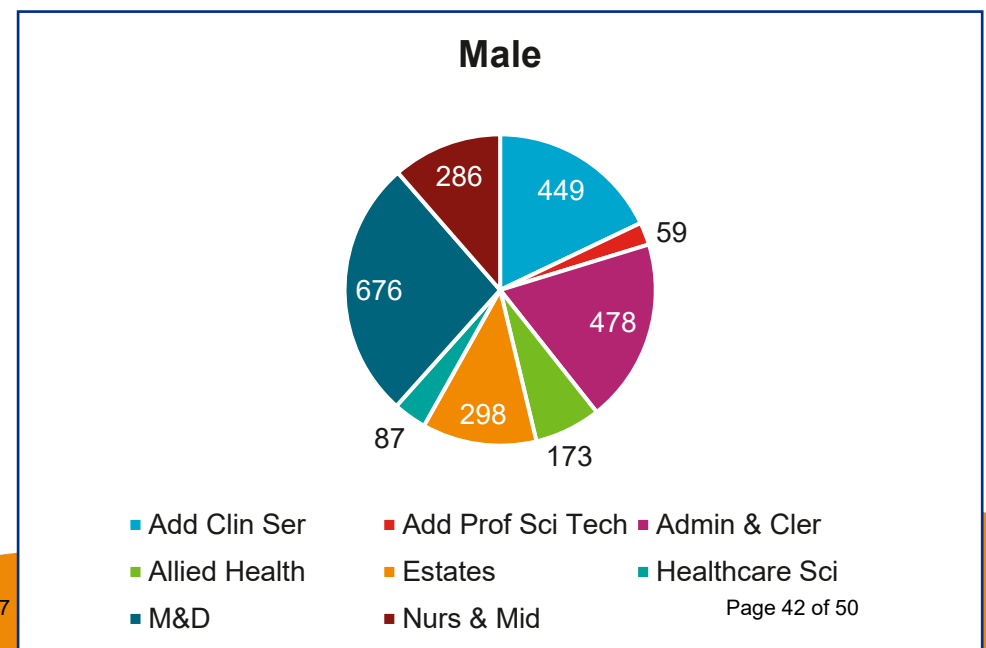
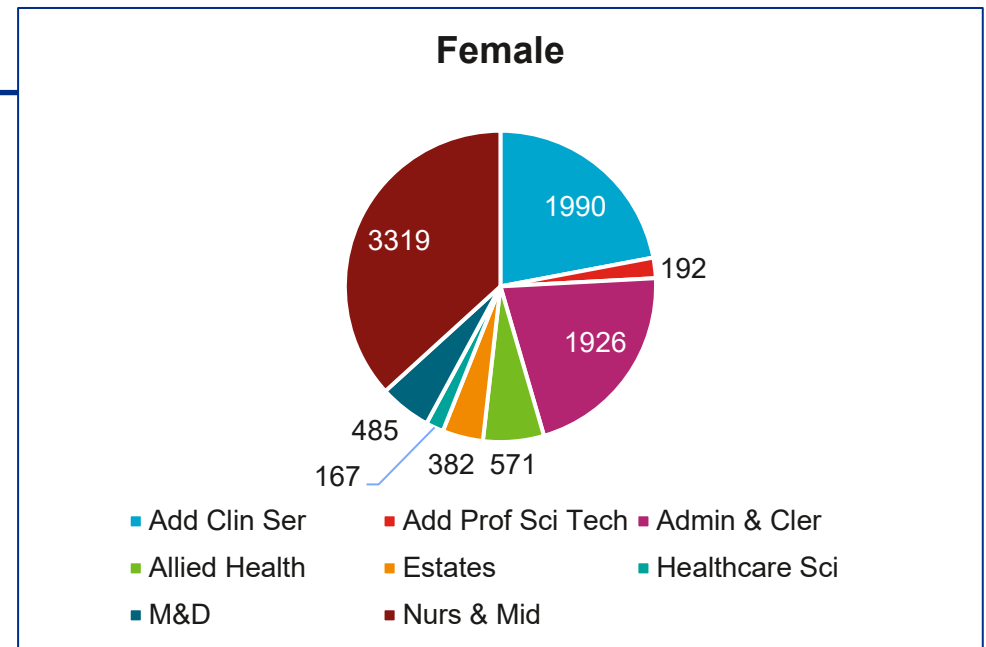
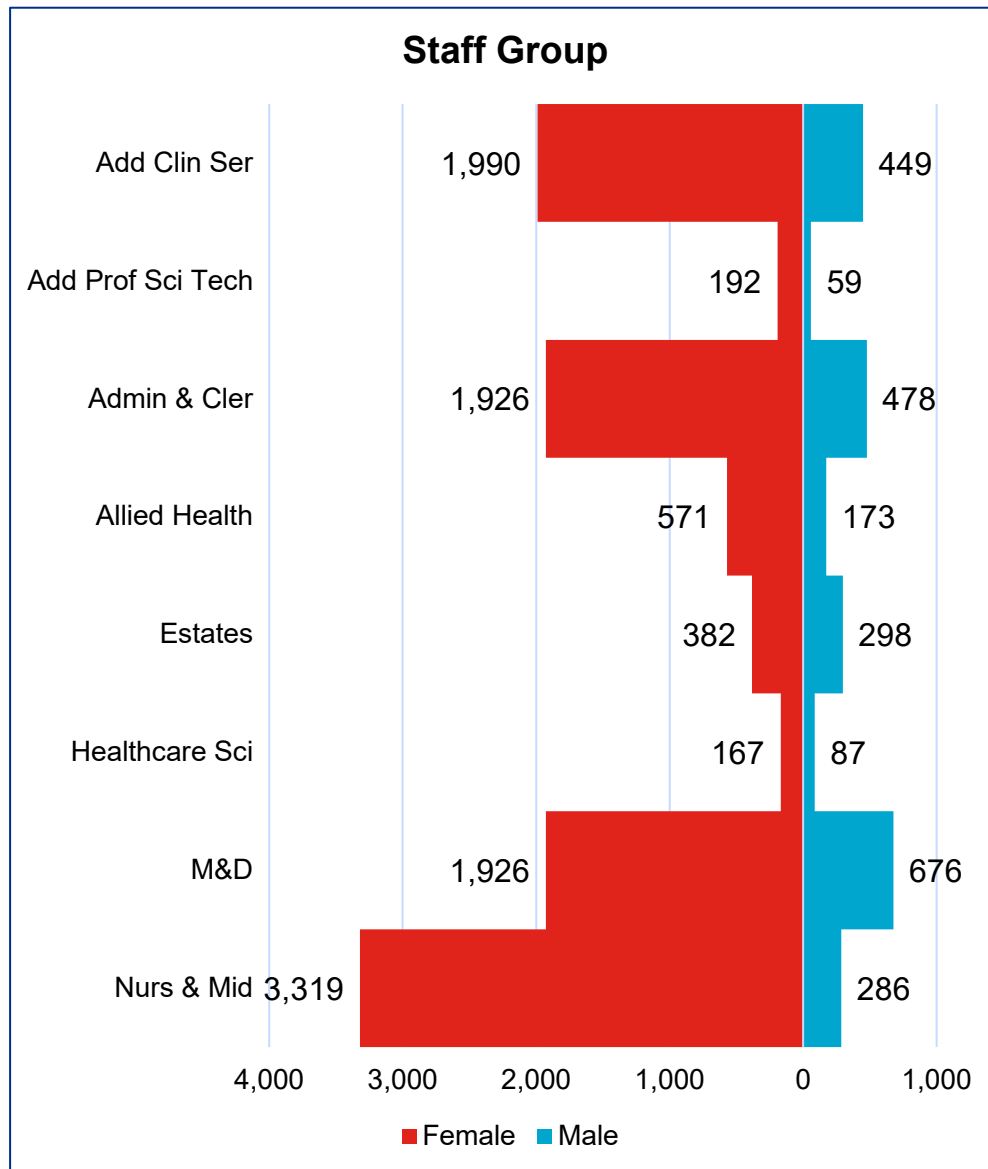
Sexuality	AfC	M&D
Mean	3.39	20.56
Median	2.67	41.10
Bonus Mean	-	80.59
Bonus Median	-	71.25

Key Observations (Gender)



Vertical Segregation

Key Observations (Gender)



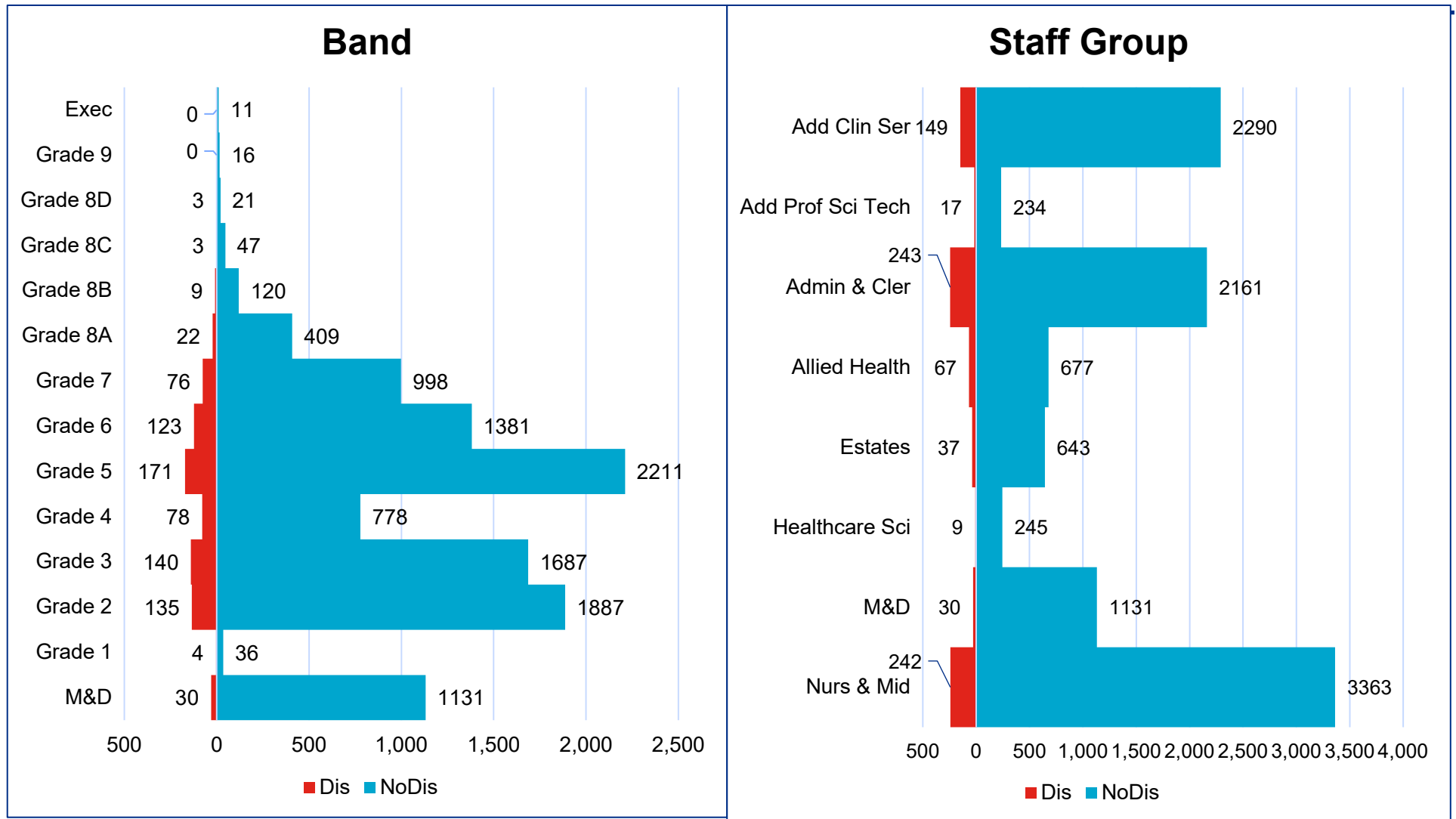
Horizontal Segregation

Clinical Directors

% FEMALE	Nov 2025	Aug 2026
Senior Medical Leadership Team	0% (0/8)	33% (6/18)
Clinical Directors	27% (10/37)	24% (6/25) NB: 12% Unknown
Deputy Clinical Directors	-	17%

% Ethnic Minority	Nov 2025	Aug 2026
Senior Medical Leadership Team	25% (2/8)	28% (5/13)
Clinical Directors	43% (16/37) NB: 8% Unknown	32% (8/25) NB: 12% TBC 12% Unknown
Deputy Clinical Directors	-	42% (5/12)

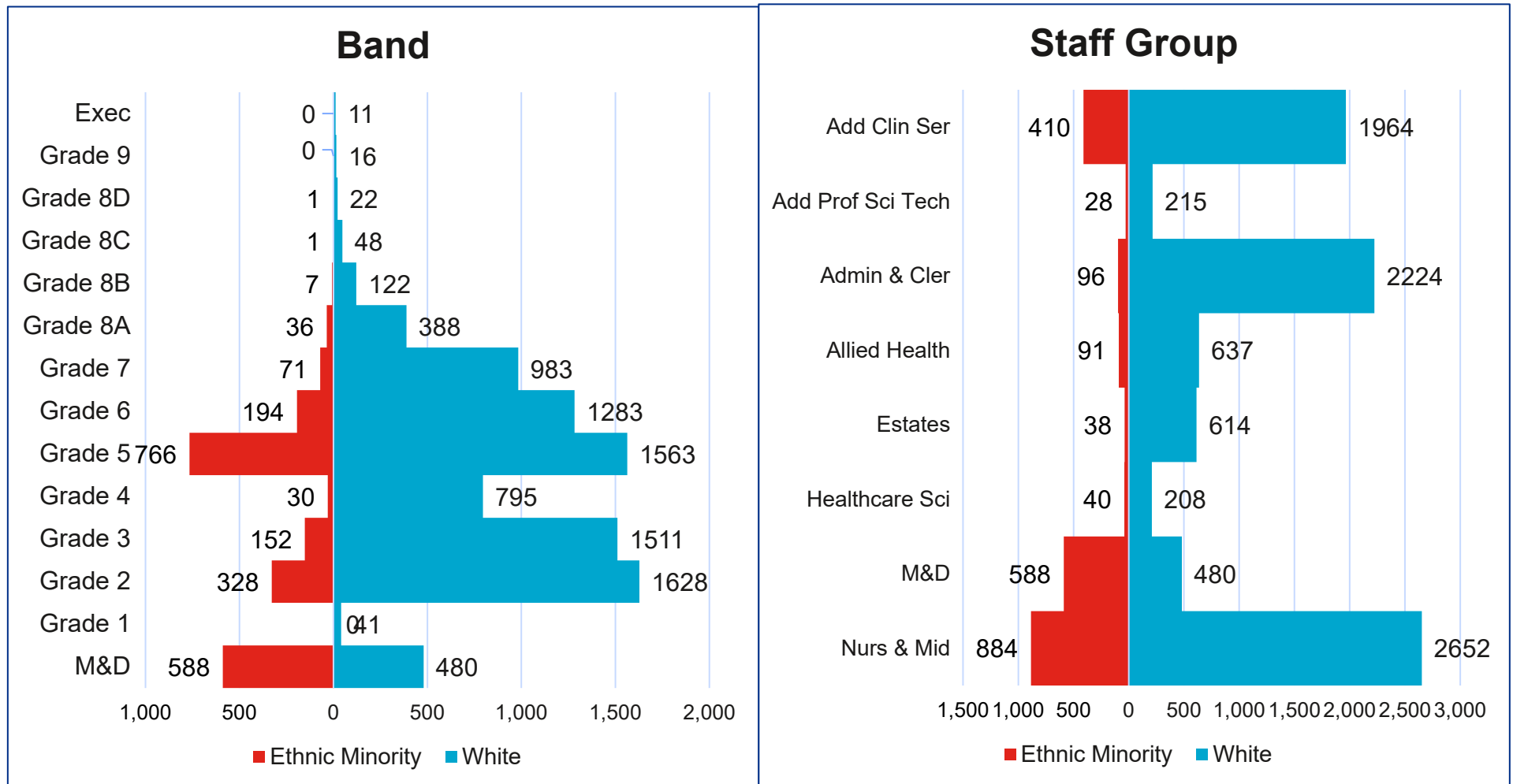
Key Observations (Disability)



Vertical Segregation

Horizontal Segregation

Key Observations (Ethnicity)



Vertical Segregation

Horizontal Segregation

Key Observations (Cont)

Trust:

- Gender & Ethnicity caused by AfC + M&D
- Mean: Ethnicity (in favour)
- Median: Ethnicity (in favour)

AfC Mean

- Women & Ethnicity Statistically Insignificant (in favour)
- Disability and Sexuality <4%

AfC Median:

- Women & Ethnicity (in favour)
- Disability <4%, Sexuality <3%

M&D

- **Mean and Median** in favour of majority
- **Mean:** Ethnicity 4.7% /

Bonus:

- Changes to Clinical Impact Awards
- Mean: in favour of majority
- Median: in favour of majority
- Ethnicity 0%

What else is it telling us ...

- Ongoing differences between AfC and M&D pay
- Stereotype/Biased Assumptions v Data
- Consequences of Overseas Recruitment Activities
- Pipeline Time Lag
- Medics Disability disclosure
- Bonus – decreasing population size
- Data v Experience v Perception
- No Simple solutions

2024 Action in review

- Exec SMART EDI objectives, and Senior Sponsor Roles
- Launch EDI Objective within the AfC
- EDI Training Programme 25-26
- New courses on Active Bystander, Cultural Competence, Race Awareness, LGBT Awareness,
- New Career Workshops – BAME, Disabled, EDI
- L&OD Career Workshops
- Career Conversations added to Appraisal for 26-27
- Disability disclosure and support campaign completed
- Anti-Racism Statement, Board Development, Bronze NWARF

2026 Actions

- Launch Cohort 2 of the Leading Operational Excellence programme
- MWL Behavioural Framework, Trustwide 'Culture reset' programme
- Exit Toolkit for Managers, Create a Retention Dashboard for divisions
- Maximise the use of CPD to create a package of L&D opportunities
- Embed one bank model across the Trust
- Band 8A-8D Leading operational excellence programme
- Clinical excellence programme Year 1 Nurses
- Review the medical leadership structure and Clinical Director recruitment process
- EDI Governance Framework and support the Network Chairs
- Develop Divisional Operational Plans and annual planning cycle for workforce, finance and operations (HR/Finance)
- Support divisions through their people meetings to monitor and manage workforce
- Promote career development offer
- Scope work on career pathways for roles and staff groups
- Write and publish an MWL Education Strategy
- Launch career conversations toolkit
- Revise Appraisal training programme for managers
- Review and standardise B5-6 Nurse JDs and Enhanced / Advanced Practice JDs

Questions

Title of Meeting	Trust Board			Date	30 September 2026
Agenda Item	TB26/068				
Report Title	Health Inequalities Strategy Mid-Year Review				
Executive Lead	Wayne Longshaw – Director of Integration				
Presenting Officer	Wayne Longshaw – Director of Integration				
Action Required		To Approve	X	To Note	
Purpose					
This report provides a short review of the 2026/27 mid-year progress of Trust’s Health Inequalities Strategy. The report also provides a reset to build a solid foundation for improvement in future years.					
Executive Summary					
This report provides a mid-year review of the Trust's Health Inequalities Strategy. During H1 2026/27, the focus has been on establishing a stronger evidence base through the development of patient and workforce Health Inequalities scorecards. Initial analysis identifies inequalities linked to deprivation and ethnicity, particularly in outpatient DNA (did not attend) rates and emergency readmissions.					
For the remainder of 2026/27, the Trust will move from baseline development to targeted action, focusing on reducing identified inequalities, embedding a health inequalities lens within transformation programmes, and delivering specific initiatives aligned to its roles as provider, partner, employer and anchor institution.					
Financial Implications					
None at this point.					
Quality and/or Equality Impact					
Not applicable					
Recommendations					
The Trust Board is asked to note progress made in delivering the Trust’s Health Inequalities Strategy for 2026/27 H1 and the delivery plan for 2026/7 H2.					
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				
x	SO9 Strategic Plans				

Health Inequalities Strategy Mid-Year Review

1. Introduction

This paper presents a review of progress made in delivering the Health Inequalities Strategy and building firmer foundations that is data driven to track improvement trajectories to be set in the current year and setting improvement targets going forwards.

The Trust Board approved the three-year Health Inequalities Strategy 2025-2028 in March 2025 which provides a road map to reducing to Health Inequalities. It was a call to action that recognises that our geographies are amongst the most deprived in the country.

Ethnic diversity is low in local communities, however, there are some interesting trends in our patient activity for younger people with increases in our patient population from ethnic minorities. The strategy has developed its approach accordingly with a vision and four objectives:

Health Inequalities Vision:

Reducing health inequalities by ensuring equitable access to our services and promoting preventable support in the community.

Health Inequalities Objectives:

The Trust will use its role to reduce health inequalities in the communities it serves by:

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

2. Progress Update

Since the previous Board paper in April 2026, the Trust's landscape continues to evolve:

- The Trust launched its Transformation Programme and whilst there is a strong productivity and quality improvement focus, there is a need to have a health inequalities lens to our improvement journey.
- Both of our ICBs have reduced their running costs and made a number of staff redundancies which has resulted in a significant loss of capacity locally. As the ICBs transition into the role of Strategic Commissioner, there is now a greater emphasis on an enhanced role for NHS providers.
- The Neighbourhood Health Agenda has experienced some delays due to the loss of key ICB staff due to the restructuring. There is now a requirement for providers to step into this space. There will be some capacity for Neighbourhood Health when the ICB fully recruits into vacancies, but this will be limited.
- The Trust has established a Community Division, and this has the potential to support both the neighbourhood health and health inequalities agendas.

It is recognised that Health Inequalities has been prevalent for generations and breaking this cycle is one of the most challenging issues facing societies. Any actions and initiatives taken often take time to embed and see the outcomes. This is why the focus of the work in the first part of 2026/27

has been to focus on developing some baselines to better understand our position, and identify gaps in access, experience or outcomes and then to develop interventions that could narrow and close those gaps.

The original health risk factors in our places are shown in Table 1.

Table 1

A Comparison of Places: Deprivation, Mortality, Risk Factors and Child Health

Place		England	North West	St Helens	Halton	Knowsley	Live pool	Sefton	West Lancs
Deprivation									
IMD (2019) Rank out of 317		-	-	26	22	2	3	89	155
% of people in lowest quintile		-	-	43.4%	48.6%	62.8%	62.0%		
Health Inequalities									
Life Expectancy: Most v Least deprived areas	Male	9.7 years	-	12.4 years	10.8 years	11.4 years	11.1 years	11.8 years	8.6 years
	Female	7.9 years	-	8.6 years	8.8 years	12.6 years	8.9 years	11.5 years	7.9 years
Causes of death (per 100k population)									
Under 75 mortality rate (all causes)		330.5	388.4	411.9	428.1	476.2	497.6	369.2	332.7
Mortality rate from CVD		71.7	86.6	85.8	88.4	98.9	106.1	76.9	74.3
Mortality rate from cancer		132.3	145.6	143.1	170.9	185.3	179.4	141.6	129.3
Suicide rate		9.64	10.4	16.1	11.4	11.5	9.54	11.5	13.3
Behaviour risk factors (per 100k population)									
Hospital Admissions for alcohol specific conditions (under 18 years)		31.6	45.9	100.2	58.6	45.4	51.7	52.9	37.8
Hospital Admissions for alcohol related conditions (under 18 years)		663.7	741.5	882.7	862.7	939.7	997.0	912.3	648.4
Smoking prevalence in adults (%)		14.4	14.7	15.8	17.9	18.1	14.7	11.1	14.1
% of physically active adults		66.3	64.7	61.7	62.8	63.3	66.4	63.7	70.6
% of adults overweight or obese		62	64.3	72.6	74.4	71.2	62.4	71.2	69.5
Child health									
Teenage conception rate (per 1k population)		17.8	21.9	37.1	34.9	27.6	28.1	17.4	19.5
% of smoking during pregnancy		10.6	12.7	16.2	17.3	14.6	13.0	12.9	12.6
% of breastfeeding initiation		74.5	64.5	55.3	54.6	48.4	55.0	57.9	62.4
Infant mortality rate (per 1k births)		3.93	4.62	3.50	3.40	3.36	6.12	4.20	4.95
Year 6: % prevalence of obesity		20.2	21.5	23.0	25.0	26.9	24.9	21.3	19.4
% of children in low income families		17.0	18.0	19.5	19.6	25.0	26.3	17.1	13.7

It is also known that local communities have low levels of diversity with people with a black and minority ethnic (BAME) heritage accounting for less than 10% of the population: St Helens 6.4%, Halton 3.5%, Knowsley 5%, Sefton 8%, West Lancashire 7%. However, our activity data shows a significant growth in the percentage of young people from BAME backgrounds that are accessing services and this will increase in the coming years for the adult population using our services. See Tables 2 and 3.

Table 2

Elective activity vs pre-pandemic levels for under 18s and over 18s

Activity by ethnicity	2025/26	2024/25	2019/20	
Male under 18 Minority Ethnic	22.3%	21.1%	22.3%	0%
Male under 18 White British	77.7%	78.9%	77.7%	
Male over 18 Minority Ethnic	13.1%	11.6%	9.5%	+38%
Male over 18 White British	86.9%	88.4%	90.5%	
Female under 18 Minority Ethnic	20.5%	19.9%	14.7%	+39%
Female under 18 White British	79.5%	80.1%	85.3%	
Female over 18 Minority Ethnic	11.7%	10.7%	8.8%	+33%
Female over 18 White British	88.3%	89.3%	91.2%	

Table 2 shows that the proportion of minority ethnic under 18 males receiving planned care has remained static over the past 6 years at around 22%, this is 3 times the proportion of the general population. However, in over 18 males and for females of all ages the growth in the proportion of the activity for minority ethnic populations has grown by more than a third in just 6 years.

Table 3

Emergency admissions for under 18s

Activity by ethnicity	2025/26	2024/25	2019/20	
Male under 18 Minority Ethnic	15.1%	14.0%	9.4%	+61%
Male under 18 White British	84.9%	86.0%	90.6%	
Female under 18 Minority Ethnic	13.6%	13.9%	8.8%	+55%
Female under 18 White British	86.4%	86.1%	91.2%	

When looking at emergency admissions, the growth of the proportion of minority ethnic patients has increased by more than 50% over this 6-year period.

In conclusion, the Trust understands that poverty is probably the biggest limiting factor to good health, but it is also clear that the population the Trust serves is more ethnically diverse and therefore Health Inequalities Scorecard has been designed to identify gaps in outcomes in both deprivation and ethnicity.

3. Building the Scorecard

The levels of poverty locally have been well understood and the disparities in health outcomes have been acknowledged by the Board with around 40% of our populations living in the lowest quintile for deprivation. We can also see that BAME communities are increasing using our services.

It is proposed that a Health Inequalities Scorecard be established and maintained for both the **services** we deliver and for our **workforce**. Both aspects have three domains with a gap analysis for deprivation and ethnicity for our services and for our workforce, this would also extend to disability and gender.

SERVICE EQUITY		WORKFORCE EQUITY	
ACCESS	Urgent Care 4 Hour Performance Urgent Care 12 Hour Waits RTT % Performance Outpatient DNA (did not attend) % Urgent Cancer Referrals	Disability (WDES)	Disability Workforce Representation Disability Non-Clinical Workforce Clinical: Non-Medical Workforce Disability Medical & Dental Workforce Disability Non-Clinical Disparity Ratio (Support v VSM) Disability Clinical Non-Medical Disparity Ratio (Support to VSM) Disability Staff at Senior Band (8C-VSM) Disability Recruitment Likelihood Ratio Disability Capability Ratio
EXPERIENCE	Corridor care Waits over 52 weeks Pressure Ulcers per 1,000 bed days Falls Complaints Maternity	Ethnicity (WRES)	EthMin Workforce Representation EthMin Non-Clinical Workforce EthMin Clinical Non Medical Workforce EthMin Medical & Dental Workforce EthMin Non Clinical Disparity Ratio (Support v VSM) Ethnic Clinical Non-Medical Disparity Ratio (Support to VSM) Ethnic Staff at Senior Band (8C-VSM) EthMin Recruitment Likelihood Ratio EthMin Disciplinary Ratio
OUTCOMES	Emergency Readmissions within 30 days of following elective PIFU % Discharge back to GP following DNA Outpatient DNA % Community outcomes metric	STAFF SURVEY	PP 1.1 Compassionate Culture score PP 1.3 Diversity & Equality Score PP 1.4 Inclusion Score PP 3.2 Raising a Concern score PP 4.3 Negative Experiences score PP 6.1 Work Life Balance score

3.1 Health Inequalities Scorecard - Services

The scorecard has three domains looking to identify gaps between the most and least deprived communities and White British and BAME populations. The Scorecard is still in development and will require some fine tuning. The scorecard is showing gaps between Access, Experience and Outcomes for our most deprived, and our more ethnically diverse communities. This is providing a baseline from which improvement opportunities can be targeted and interventions made to close the equity gap.

1. ACCESS	Transformation programme	Metric	Deprivation				Ethnicity			
			Most Deprived	Least Deprived	Gap	Rag	White British	BAME	Gap	Rag
	Urgent & Emergency Care	Type 14 Hour Performance	60.5%	64.5%	4%	O	61.8%	69.7%	8%	O
	Urgent & Emergency Care	12 Hour Waits	19.8%	16.4%	-3.4%	O	19.1%	11.8%	-7.3%	O
	Elective Care	RTT % Performance	Not found	Not found		O	Not found	Not found		O
	Outpatients	Outpatients: DNA Rate (All to All)	11.8%	5.5%	-6.4%	O	8.1%	9.8%	1.7%	O
	Community	DNA %	Not found	Not found		O	Not found	Not found		O
		Urgent Cancer Referrals % Of Population C&M	1.2%	1.3%	0.1%	O	1.5%	1.2%	-0.4%	O
2. OUTCOMES	Elective Care	Emergency Readmissions within 30 Days Following Elective - MWL	5.2%	3.4%	-1.8%	O	4.7%	3.0%	-1.6%	O
	Outpatients	PIFU %	Not found	Not found		O	Not found	Not found		O
	Outpatients	Discharges back to GP following DNA	45.4%	39.6%	-5.9%	O	41.5%	44.9%	3.4%	O
	Community	Community outcomes metric	Not found	Not found		O	Not found	Not found		O
		Maternity (TBC)	Not found	Not found		O	Not found	Not found		O
3. PATIENT SAFETY/ EXPERIENCE	Urgent & Emergency Care	Corridor Care	Not found	Not found		O	Not found	Not found		O
	Elective Care	Waits over 52 Weeks	Not found	Not found		O	Not found	Not found		O
		Pressure Ulcers per 1,000 Bed Days	0.06	0.07	0.01	O	0.07	0.00	-0.07	O
		Falls per 1,000 Bed Days	4.52	4.10	-0.42	O	4.56	2.56	-2.00	O
		Complaints Received	Not found	Not found		O	239	37	-202	O
		Maternity (TBC)	Not found	Not found		O	Not found	Not found		O

Completion of the data sets above is imminent, but the emerging picture shows the following:

ACCESS – Outpatients DNAs (did not attend) is twice that for the most deprived when compared with the least deprived communities. BAME communities also have a higher DNA prevalence (more than a fifth likely to DNA). For emergency care (4-hour performance and 12 hour waits), both deprived and BAME communities have less waits, which is positive.

OUTCOMES – Emergency Readmissions: Our most deprived communities are more than a third more likely to be readmitted within 30 days following elective treatment, interestingly BAME communities are around a third less likely. Discharges back to GPs following a DNA is higher for our most deprived communities.

EXPERIENCE – The majority of this data is still in development, it is notable that our BAME communities experience statistically less falls than White British patients.

There will be more statistical indicators behind these headline figures to support conclusions, and along with completing the data table, there will be engagement with colleagues involved with the transformation programmes to develop service improvement interventions.

For the remainder of 2026/27, the Trust intends to focus on the following areas to support improvements in Health Inequalities:

ACCESS - Outpatient DNA gaps are reduced for both communities in high impact specialities (volume and highest rates).

OUTCOMES - An improvement plan for elective waits should be developed in our priority improvement areas of trauma and orthopaedics (T&O), General Surgery, Gynaecology, Gastroenterology and Dermatology.

EXPERIENCE – More work is required to understand the gaps and their impact and as the data develops.

3.2 Health Inequalities Scorecard – Workforce

Work has been underway with colleagues from the Equality Diversity and Inclusion (ED&I) service to develop a Health Inequalities scorecard for workforce. Whilst the Trust has lots of data, consideration has been given to developing headline indicators to complement the patient services scorecard. The below is an initial template and will be developed further as the data becomes available:

	DEPRIVATION			Sex			Disability / Long Term Illness			ETHNICITY		
	20% Most Deprived	20% Least Deprived	Gap	Female	Male	Gap	Yes	No	Gap	White	EthMin	Gap
4. WORKFORCE EQUALITY												
Disability (WDES)												
Disability Workforce Representation												
Disability Non-Clinical Workforce												
Disability Clinical Non Medical Workforce												
Disability Medical & Dental Workforce												
Disability Non Clinical Disparity Ratio (Support v VSM)												
Disability Clinical Non-Medical Disparity Ratio (Support to VSM)												
Disability Staff at Senior Band (8C-VSM)												
Disability Recruitment Likelihood Ratio												
Disability Capability Ratio												
Ethnicity (WRES)												
EthMin Workforce Representation												
EthMin Non-Clinical Workforce												
EthMin Clinical Non Medical Workforce												
EthMin Medical & Dental Workforce												
EthMin Non Clinical Disparity Ratio (Support v VSM)												
Ethnic Clinical Non-Medical Disparity Ratio (Support to VSM)												
Ethnic Staff at Senior Band (8C-VSM)												
EthMin Recruitment Likelihood Ratio												
EthMin Disciplinary Ratio												
Staff Survey												
PP 1.1 Compassionate Culture score												
PP 1.3 Diversity & Equality Score												
PP 1.4 Inclusion Score												
PP 3.2 Raising a Concern score												
PP 4.3 Negative Experiences ascore												
PP 6.1 Work Life Balance score												

This domain has four domains of Deprivation, Sex, Disability and Ethnicity. The work will be taken forward through the ED&I Council and Strategic People Committee. It is envisaged that the scorecard with baselines will be completed for consideration at the ED&I Council in December 2026.

4. Work Plan for 2026/27 H2

The individual work areas will continue to be delivered, however as part of this mid-year reset the main focus will be on building the scorecard baselines, delivering some individual improvements aligned to the Transformation Programme and building a stronger delivery plan that works towards closing the gaps in service and workforce equity during 2027/28. The diagram overleaf articulates key priorities along with the completion of both scorecards.

Provider	Partner	Employer	Anchor
Embedding health and equity in our core activities	Integrating care around the needs of local communities through place-based partnerships	Focussing on our staff as a key part of our local population	Maximising our impact as an 'anchor' organisation in our local communities
Select three Outpatient Specialties to close the inequalities gap Healthwatch to capture issues re DNAs	Winter Planning communications targeting deprived postcodes Work with Public Health on Health Campaigns and Referral Pathways	Develop and launch a Car Leavers Scheme to provide employment support and guaranteed interviews for jobs in our Trust	Open and launch the Health and Care Careers Hub (HCCH) to grow health & care skills and employment opportunities, working with local partners

The delivery plan shows the timeline for action in the next six months:

Month	Milestones and expected outputs	Owner
October	- Complete Scorecard for Service Dimension - Select 3 Outpatient Specialties to close the inequalities gap - Work with Healthwatch to better understand issues around DNAs - Work with LAs to offer a Care Leavers employment support and interview guarantee	DoInt DDS DoInt ADHR (EDI)
November	- Establish baselines and project set up of Outpatient Project - Develop Care Leavers Scheme - Complete refurbishment of Health and Care Careers Hub (HCCH)	DDS ADHR (EDI) ADHR (EDI)
December	- Complete Scorecard for Workforce Dimension (EDI Council) - Work with Public Health on Health Campaigns and Referral Pathways - Share Gap analysis with Health Equities group to build a list of further interventions	ADHR (EDI) DoM DoInt
January	- Launch Health and Care Careers Hub (Volunteering recruitment event) - Outpatient project mid project PDS - Outpatient DNA insights from Health Watch report	ADHR (EDI) DDS DDS
February	- Formally launch Care Leavers Scheme and monitor uptake & outcomes - Explore the baselines and gap analysis for RTT and elective waiting lists	ADHR (EDI) DoInt
March	- Review 2026/27 Plan including scorecard movements - Build 2027/28 Plan (OP DNA wider roll out, RTT & waiting times, (WDES) Workforce wellbeing for disabled staff and (WRES) addressing inequalities in recruitment outcomes	DoInt DoInt/ ADHR

5. Conclusions

The revised approach advocated in this report will provide the firm foundations on which to deliver the Trust's Health Inequalities priorities.

The Trust will continue to refine our approach and become even more focused and intentional in our work to tackle Health Inequalities with stronger plans, metrics and systems throughout the life of the strategy.

Health Inequalities Strategy Mid Year Review & Reset Trust Board

30 September 2026

Wayne Longshaw

Health Inequalities - Strategic Themes



Health Inequalities Objectives:

The Trust will use its role to reduce health inequalities in the communities it serves by:

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

Deprivation a Dominant factor in Health Outcomes

A Comparison of Places: Deprivation, Mortality, Risk Factors and Child Health

Place	England	North West	St Helens	Halton	Knowsley	Liverpool	Sefton	West Lancs
Deprivation								
IMD (2019) Rank out of 317	-	-	26	22	2	3	89	155
% of people in lowest quintile	-	-	43.4%	48.6%	62.8%	62.0%		
Health Inequalities								
Life Expectancy: Most v Least deprived areas	Male	9.7 years	-	12.4 years	10.8 years	11.4 years	11.1 years	11.8 years
	Female	7.9 years	-	8.6 years	8.8 years	12.6 years	8.9 years	11.5 years
Causes of death (per 100k population)								
Under 75 mortality rate (all causes)	330.5	388.4	411.9	428.1	476.2	497.6	369.2	332.7
Mortality rate from CVD	71.7	86.6	85.8	88.4	98.9	106.1	76.9	74.3
Mortality rate from cancer	132.3	145.6	143.1	170.9	185.3	179.4	141.6	129.3
Suicide rate	9.64	10.4	16.1	11.4	11.5	9.54	11.5	13.3
Behaviour risk factors (per 100k population)								
Hospital Admissions for alcohol specific conditions (under 18 years)	31.6	45.9	100.2	58.6	45.4	51.7	52.9	37.8
Hospital Admissions for alcohol related conditions (under 18 years)	663.7	741.5	882.7	882.7	939.7	997.0	912.3	648.4
Smoking prevalence in adults (%)	14.4	14.7	15.8	17.9	18.1	14.7	11.1	14.1
% of physically active adults	66.3	64.7	61.7	62.8	63.3	66.4	63.7	70.6
% of adults overweight or obese	62	64.3	72.6	74.4	71.2	62.4	71.2	69.5
Child health								
Teenage conception rate (per 1k population)	17.8	21.9	37.1	34.9	27.6	28.1	17.4	19.5
% of smoking during pregnancy	10.6	12.7	16.2	17.3	14.6	13.0	12.9	12.6
% of breastfeeding initiation	74.5	64.5	55.3	54.6	48.4	55.0	57.9	62.4
Infant mortality rate (per 1k births)	3.93	4.62	3.50	3.40	3.36	6.12	4.20	4.96
Year 6: % prevalence of obesity	20.2	21.5	23.0	25.0	26.9	24.9	21.3	19.4
% of children in low income families	17.0	18.0	19.5	19.6	25.0	26.3	17.1	13.7

Diversity in Our Communities is becoming more significant

Census 2021 data

Borough	Minority Ethnic %
St Helens	6.4%
Halton	3.5%
Knowsley	5%
Sefton	8%
West Lancs	7%

Elective activity vs pre-pandemic levels for under 18s and over 18s

Activity by ethnicity	2025/26	2024/25	2019/20	
Male under 18 Minority Ethnic	22.3%	21.1%	22.3%	0%
Male under 18 White British	77.7%	78.9%	77.7%	
Male over 18 Minority Ethnic	13.1%	11.6%	9.5%	+38%
Male over 18 White British	86.9%	88.4%	90.5%	
Female under 18 Minority Ethnic	20.5%	19.9%	14.7%	+39%
Female under 18 White British	79.5%	80.1%	85.3%	
Female over 18 Minority Ethnic	11.7%	10.7%	8.8%	+33%
Female over 18 White British	88.3%	89.3%	91.2%	

- Male over18s Ethnic minority patients are x3 greater (proportionally) than general population
- Male <18 and females all has grown by more than a third (proportionally) i

Emergency admissions for under 18s

Activity by ethnicity	2025/26	2024/25	2019/20	
Male under 18 Minority Ethnic	15.1%	14.0%	9.4%	+61%
Male under 18 White British	84.9%	86.0%	90.6%	
Female under 18 Minority Ethnic	13.6%	13.9%	8.8%	+55%
Female under 18 White British	86.4%	86.1%	91.2%	

- Growth in the proportion of minority ethnic patients has increased as a proportion by more than 50% over this 6-year period.

Health Inequalities Scorecard

SERVICE EQUITY		WORKFORCE EQUITY	
ACCESS	Urgent Care 4 Hour Performance Urgent Care 12 Hour Waits RTT % Performance Outpatient DNA % Urgent Cancer Referrals	Disability (WDES)	Disability Workforce Representation Disability Non-Clinical Workforce Clinical: Non-Medical Workforce Disability Medical & Dental Workforce Disability Non-Clinical Disparity Ratio (Support v VSM) Disability Clinical Non-Medical Disparity Ratio (Support to VSM) Disability Staff at Senior Band (8C-VSM) Disability Recruitment Likelihood Ratio Disability Capability Ratio
EXPERIENCE	Corridor care Waits over 52 weeks Pressure Ulcers per 1,000 bed days Falls Complaints Maternity	Ethnicity (WRES)	<u>EthMin</u> Workforce Representation <u>EthMin</u> Non-Clinical Workforce <u>EthMin</u> Clinical <u>Non Medical</u> Workforce <u>EthMin</u> Medical & Dental Workforce <u>EthMin</u> <u>Non Clinical</u> Disparity Ratio (Support v VSM) Ethnic Clinical Non-Medical Disparity Ratio (Support to VSM) Ethnic Staff at Senior Band (8C-VSM) <u>EthMin</u> Recruitment Likelihood Ratio <u>EthMin</u> Disciplinary Ratio
OUTCOMES	Emergency Readmissions within 30 days of following elective PIFU % Discharge back to GP following DNA Outpatient DNA % Community outcomes metric	STAFF SURVEY	PP 1.1 Compassionate Culture score PP 1.3 Diversity & Equality Score PP 1.4 Inclusion Score PP 3.2 Raising a Concern score PP 4.3 Negative Experiences score PP 6.1 Work Life Balance score

SERVICE EQUITY SCORECARD

1. ACCESS	Transformation programme	Metric	Deprivation				Ethnicity			
			Most Deprived	Least Deprived	Gap	Rag	White British	BAME	Gap	Rag
	Urgent & Emergency Care	Type 1 4 Hour Performance	60.5%	64.5%	4%	O	61.8%	69.7%	8%	O
	Urgent & Emergency Care	12 Hour Waits	19.8%	16.4%	-3.4%	O	19.1%	11.8%	-7.3%	O
	Elective Care	RTT % Performance	Not found	Not found		O	Not found	Not found		O
	Outpatients	Outpatients: DNA Rate (All to All)	11.8%	5.5%	-6.4%	O	8.1%	9.8%	1.7%	O
	Community	DNA %	Not found	Not found		O	Not found	Not found		O
		Urgent Cancer Referrals % Of Population C&M	1.2%	1.3%	0.1%	O	1.5%	1.2%	-0.4%	O
2. OUTCOMES	Elective Care	Emergency Readmissions within 30 Days Following Elective - MWL	5.2%	3.4%	-1.8%	O	4.7%	3.0%	-1.6%	O
	Outpatients	PIFU %	Not found	Not found		O	Not found	Not found		O
	Outpatients	Discharges back to GP following DNA	45.4%	39.6%	-5.9%	O	41.5%	44.9%	3.4%	O
	Community	Community outcomes metric	Not found	Not found		O	Not found	Not found		O
		Maternity (TBC)	Not found	Not found		O	Not found	Not found		O
3. PATIENT SAFETY/ EXPERIENCE	Urgent & Emergency Care	Corridor Care	Not found	Not found		O	Not found	Not found		O
	Elective Care	Waits over 52 Weeks	Not found	Not found		O	Not found	Not found		O
		Pressure Ulcers per 1,000 Bed Days	0.06	0.07	0.01	O	0.07	0.00	-0.07	O
		Falls per 1,000 Bed Days	4.52	4.10	-0.42	O	4.56	2.56	-2.00	O
		Complaints Received	Not found	Not found		O	239	37	-202	O
		Maternity (TBC)	Not found	Not found		O	Not found	Not found		O

WORKFORCE EQUITY SCORECARD

	DEPRIVATION			Sex			Disability / Long Term Illness			ETHNICITY		
	20% Most Deprived	20% Least Deprived	Gap	Female	Male	Gap	Yes	No	Gap	White	EthMin	Gap
4. WORKFORCE EQUALITY												
<u>Disability (WDES)</u>												
Disability Workforce Representation												
Disability Non-Clinical Workforce												
Disability Clinical Non Medical Workforce												
Disability Medical & Dental Workforce												
Disability Non Clinical Disparity Ratio (Support v VSM)												
Disability Clinical Non-Medical Disparity Ratio (Support to VSM)												
Disability Staff at Senior Band (8C-VSM)												
Disability Recruitment Likelihood Ratio												
Disability Capability Ratio												
<u>Ethnicity (WRES)</u>												
EthMin Workforce Representation												
EthMin Non-Clinical Workforce												
EthMin Clinical Non Medical Workforce												
EthMin Medical & Dental Workforce												
EthMin Non Clinical Disparity Ratio (Support v VSM)												
Ethnic Clinical Non-Medical Disparity Ratio (Support to VSM)												
Ethnic Staff at Senior Band (8C-VSM)												
EthMin Recruitment Likelihood Ratio												
EthMin Disciplinary Ratio												
<u>Staff Survey</u>												
PP 1.1 Compassionate Culture score												
PP 1.3 Diversity & Equality Score												
PP 1.4 Inclusion Score												
PP 3.2 Raising a Concern score												
PP 4.3 Negative Experiences ascore												
PP 6.1 Work Life Balance score												

Delivery Priorities for 2026/27 H2

Provider

Embedding health and equity in our core activities

Select 3 Outpatient Specialties to close the inequalities gap

Healthwatch to capture issues re DNAs

Partner

Integrating care around the needs of local communities through place-based partnerships

Winter Planning communications targeting deprived postcodes

Work with Public Health on Health Campaigns and Referral Pathways

Employer

Focusing on our staff as a key part of our local population

Develop and launch a Care Leavers Scheme to provide employment support and guaranteed interviews for jobs in our Trust

Anchor

Maximising our impact as an 'anchor' organisation in our local communities

Open and launch the Health and Care Cares Hub (HCCH) to grow health & care skills and employment opportunities, working with local partners

Delivery Plan for 2026/27 H2

Month	Milestones and expected outputs	Owner
October	- Complete Scorecard for Service Dimension - Select 3 Outpatient Specialties to close the inequalities gap - Work with Healthwatch to better understand issues around DNAs - Work with LAs to offer a Care Leavers employment support and interview guarantee	DoInt DDS DoInt ADHR (EDI)
November	- Establish baselines and project set up of Outpatient Project - Develop Care Leavers Scheme - Complete refurbishment of Health and Care Careers Hub (HCCH)	DDS ADHR (EDI) ADHR (EDI)
December	- Complete Scorecard for Workforce Dimension (EDI Council - Work with Public Health on Health Campaigns and Referral Pathways - Share Gap analysis with Health Equities group to build a list of further interventions	ADHR (EDI) DoM DoInt
January	- Launch Health and Care Careers Hub (Volunteering recruitment event) - Outpatient project mid project PDS - Outpatient DNA insights from Health Watch report	ADHR (EDI) DDS DDS
February	- Formally launch Care Leavers Scheme and monitor uptake & outcomes - Explore the baselines and gap analysis for RTT and elective waiting lists	ADHR (EDI) DoInt
March	- Review 2026/27 Plan including scorecard movements - Build 2027/28 Plan (OP DNA wider roll out, RTT & waiting times, (WDES) Workforce wellbeing for disabled staff and (WRES) addressing inequalities in recruitment outcomes	DoInt DoInt/ ADHR

Title of Meeting	Trust Board		Date	30 September 2026
Agenda Item	TB26/069			
Report Title	MWL Communications and Engagement Strategy			
Executive Lead	Rob Cooper, Chief Executive			
Presenting Officer	Rob Cooper, Chief Executive			
Action Required	X	To Approve		To Note
Purpose				
To approve the MWL Communications and Engagement Strategy 2026-2031.				
Executive Summary				
MWL requires clear, consistent and purposeful communication and engagement to support the delivery of 5 Star Patient Care, strengthen staff engagement, build public trust and protect the Trust's reputation. This strategy responds to a complex operating environment, with a deliberately forward-thinking approach that matches the scale of the Trust's ambition and is fully aligned to MWL's 5-year strategy. The strategy provides a clear framework for how MWL will communicate and engage with staff, patients, communities and stakeholders. It prioritises building trust through clear and honest communication, strengthening staff voice and belonging, improving impact through insight and evaluation, supporting service change and transformation, growing digital capability and enhancing the Trust's reputation through both proactive and reactive media handling. This includes the capability to respond rapidly and transparently in a 24/7 media environment where silence can create risk. Staff engagement is central to this approach. When colleagues feel informed, valued and listened to, they are more motivated and better equipped to deliver safe, compassionate and high-quality care. Strong communication therefore directly supports better patient experience and outcomes. Delivering this strategy will require a review of the current team structure and capacity to meet rising demand and organisational expectations. It will also require visible leadership support, clear accountability, modern tools and strong cross-organisational partnerships. With these foundations, MWL will deliver communication that is proactive, responsive and impactful, supporting staff, strengthening trust and enabling the delivery of 5 Star Patient Care.				
Financial Implications				
Delivery of this strategy will require appropriate capacity, skills and resource; the financial implications will continue to be assessed as implementation plans are developed.				
Quality and/or Equality Impact				
Not applicable				
Recommendations				
The Board is asked to approve the MWL Communications and Engagement Strategy.				

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



Communications and Engagement Strategy

2026 - 2031

Foreword

Good communication and meaningful engagement are central to successful NHS organisations and integral to everything we do at Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).

How we communicate with our staff, patients and local communities matters. When we communicate clearly, honestly and consistently and take the time to listen we build understanding of our services, support confident and motivated colleagues, protect our reputation, and, most importantly, learn what truly matters to the people we serve.

There is strong evidence that effective communication and an engaged workforce are directly linked to better experiences and improved outcomes for patients. By strengthening how we communicate both internally and externally, we can build trust, encourage openness, and develop strong, successful relationships with our partners and communities.

The impact of our communications is significant, and it has never been more important that they sit at the heart of our organisation. The NHS is under unprecedented pressure, public confidence is challenged, and the communications landscape continues to evolve bringing many new opportunities, alongside heightened risks associated with the ability to instantly spread misinformation and fake news.

This Communications and Engagement Strategy sets out how we will meet those challenges. It provides clarity on what we communicate, how we communicate, and who we engage with, ensuring our messages are aligned with our vision, strategic objectives and the needs and expectations of our diverse communities. It also commits us to using the most effective, inclusive and accessible channels to reach them.

Above all, this strategy is underpinned by how we do things at MWL: being Kind, Open and Inclusive. It recognises the vital role of communication in delivering 5 Star Patient Care for every patient, every time.

Rob Cooper
Chief Executive



Why we need a Communications and Engagement Strategy

The purpose of this Communications and Engagement Strategy is to ensure our communications are clear, consistent and inclusive, actively supporting the delivery of the Trust’s priorities and strengthening relationships with our staff, patients, communities and stakeholders.

The strategy sets out clear expectations for how communication and engagement will create shared understanding, build trust, encourage involvement and enable positive, sustainable change across the organisation, our local communities and beyond.

It also reflects the Trust’s ambition to be bold, modern and influential. Drawing on the expertise, creativity and experience of our team, this strategy commits us to making best use of evolving channels, formats and approaches to strengthen our reputation, tell our story with confidence, and further develop the Trust’s profile and brand on the national stage.

In an increasingly complex and pressured NHS environment, this strategy provides a clear framework for communicating transparently and consistently. It supports effective decision making, helps manage risk, protects our reputation and enables us to respond confidently to misinformation and uncertainty.

As our workforce grows, delivering services across a wider geography, communication is becoming both more complex and more critical, especially as we continue our work to build one Trust culture. This strategy sets the direction needed to navigate that complexity and ensure communication genuinely supports delivery, engagement and a sense of belonging.



Modernising MWL Communications and Engagement

The world in which NHS organisations communicate has fundamentally changed.

Communications is no longer a 9-to-5 function. It is continuous, real-time and highly visible. Social media never stops, misinformation spreads at speed, and public expectations for transparency and responsiveness are higher than ever.

The number of channels, stakeholders and issues we must manage continues to grow at pace and the mismatch between demand and resource is unsustainable and creates significant organisational risk.

When communications fails, the consequences are immediate and far-reaching. Public trust is eroded, staff confidence declines, misinformation fills the vacuum and operational pressures intensify.

MWL faces constant communication pressures. Traditional media cycles have been replaced by a 24/7 information environment, where social media can amplify issues instantly and create the need for rapid, confident responses. In this context, silence is not neutral.

At the same time, changes in the media landscape, reduced newsroom capacity and increased competition for attention, mean stories can spread without full verification.

Engagement is not about broadcasting messages - it is about dialogue.

We need to move beyond one-way communication and create continuous, meaningful two-way conversations that build trust and understanding.

This is a complex and fast-moving space, often shaped by strong views and heightened emotions. It includes:



Large-scale public engagement



Rapidly shifting narratives



Diverse and sometimes challenging stakeholders



Ongoing misinformation

The NHS 10-Year Health Plan

The NHS has been moving toward prevention and tackling health inequalities. This requires a fundamental shift in communication, tailored messaging for different communities, deeper understanding of population insights and behaviours and delivering “every contact counts” messaging across multiple touchpoints. This is more sophisticated than traditional campaigns, it requires data, insight and time.

Alongside this, the NHS is rapidly adopting digital tools, from the NHS App to AI-enabled services. While these innovations offer huge potential, they also create complexity for patients. These include multiple systems and entry points, confusing or fragmented messaging, and risk of digital exclusion.

Without clear, integrated communication, these innovations risk underuse or misunderstanding.

Challenging internal communications

Clear, consistent and credible internal communication supported by an effective staff engagement programme is essential to workforce stability and morale, recruitment and retention.

MWL is an outstanding Trust, viewed by NHS England (NHSE) as one of the leading organisations in the country. But that reputation is being constantly challenged.

Reputation is shaped daily by:

- Patient experience
- Media narratives
- Social media conversations
- How we respond to crises

Every contact counts. From major incidents to high-profile cases, communications teams play a vital role in maintaining confidence, helping patients feel safe to access care, making our organisation somewhere people are proud to work, and supporting staff to stay and build their careers with us.



What good looks like

To meet these challenges, MWL communications must evolve. We need to become:



Modern

- Data-driven and insight-led
- More digitally integrated
- Skilled in new technologies, including AI
- Able to tailor communications to different audiences



Responsive

- Operating beyond traditional working hours
- Monitoring and responding to issues in real time
- Confident in fast-moving, high-pressure environments
- Equipped to manage misinformation quickly and effectively



Proactive

- Anticipating issues before they escalate
- Leading the narrative, not reacting to it
- Supporting prevention agendas through targeted campaigns
- Showcasing the positive impact of MWL services

At the centre of this approach is high-quality content. The way we explain, inform, reassure and tell our story will determine how effectively we build trust, support staff, engage communities and protect MWL's reputation.

High-quality, clear, consistent content underpins everything by:

- Helping patients make informed decisions
- Supporting staff understanding and engagement
- Ensuring stakeholders are informed and involved
- Combating misinformation with credible, accessible information
- Keeping our focus centred on delivering 5 Star Patient Care

Effective communication enables:

- Better patient outcomes
- Higher staff engagement
- Stronger public trust
- More successful transformation programmes

There is huge opportunity.
By developing a modern, responsive and proactive communications function, we can:

- Strengthen trust in MWL at a critical time
- Support staff when they need it most
- Enable transformation and sustainability across services
- Ensure patients can navigate an increasingly complex system

Failing to adapt, however, will mean:

- Growing reputational risk
- Increased operational pressure
- Widening health inequalities
- Missed opportunities to support prevention and digital adoption

Communications is not a support function. It is a strategic capability essential to the delivery of 5 Star Patient Care.



Our Communities and Stakeholders

Our communities and stakeholders fall into four broad categories, whose membership can overlap:

- 1. **Patients** – people who use our services
- 2. **The public** – everyone the Trust’s services are commissioned for
- 3. **Staff** – the people who work for and provide the Trust’s services
- 4. **Stakeholders** – organisations and institutions that are impacted by, have an interest in, share a responsibility with the Trust over the provision of its services, and those who fund, regulate and hold it to account, including democratic representatives.

Each of these groups has multiple divisions, definitions and nuances within them. They are also fluid. For example, when someone becomes a patient, they do not stop being a member of the public or a member of staff, and a member of staff may feel like a member of the public when using a part of the service they do not work in.

Much of the Trust’s public health agenda and long-term strategy is aimed at ensuring as few members of the public become patients. Effectively communicating with our communities and stakeholders is a key contributor to this outcome.

Crucially, to develop or strengthen relationships we need a much deeper understanding of these groups, their connections to us, and their values and priorities.

Stakeholder mapping needs to be developed to both identify communities and stakeholders and categorise them by importance to the Trust, but also to understand the Trust’s importance to each group, what their interest is, the pace they move at, and what style of communication and engagement is most suitable to their characteristics, including any barriers to engagement.

Understanding our communities and stakeholders is the first step in planning how to grow the quality of our relationships and enhance mutual understanding.

Our Communications and Engagement Principles

Our principles set the standard for how MWL communicates and engages with staff, patients, communities and stakeholders. They will help ensure everything we say is clear, consistent, inclusive and aligned to our values and strategic objectives.

Our communications will be:

- Clear** - plain English, purposeful and easy to understand
- Consistent** - aligned to Trust priorities, values and strategic objectives
- Inclusive** - accessible and relevant to diverse audiences
- Honest** - open, transparent and timely, especially during periods of change or challenge
- Two-way** - creating opportunities to listen, respond and close the feedback loop
- Evidence-led** - shaped by insight, feedback, data and evaluation
- Ambitious** - telling MWL’s story with confidence locally, regionally and nationally



Sharing Our Story

This strategy sets out how we will deliver a more focused and effective approach to communications and engagement over the next five years. Our priority is to ensure that everything we do is purposeful, aligned and delivers real value.

We are guided by our strategic objectives to clearly position the Trust in the areas that are important to us, to tell our stories, and promote the breadth of activity, achievements, ambition and opportunity from across the Trust.

Strategic objective	Core narrative	Communication approach
We will provide services that meet the highest quality and performance standards	How we deliver safe, reliable, high quality care and continuously improve services.	Plain English, transparent updates; timely communication; consistent messages; patient and staff focused storytelling.
We will work in partnership to improve health outcomes for our population	How partnership working improves health outcomes and supports prevention and early intervention.	Joint messaging with partners; community engagement; shared campaigns; clear explanations of benefit and impact.
We will provide the services of choice for our patients	What patients can expect from our services, how to access them, and how feedback drives improvement.	Patient centred language; accessible formats; clear service information; visible "You said, we did."
We will respond to local and individual health needs and reduce health inequalities	How we tailor services and engagement to meet diverse needs and reduce inequalities.	Targeted, inclusive communications; accessible channels; tailored engagement; acting on lived experience.
We will attract and develop caring, highly skilled staff	Why MWL is a great place to work and how we support recruitment, development and wellbeing.	Two way internal communications; visible leadership; consistent cascade; recognition and staff voice.
We will work in partnership to create sustainable and efficient health systems	How transformation, efficiency and sustainability support long term, high quality care.	Early, honest communication; clear explanations of change; joint partner messaging; focus on patient and system benefit.

Our Communication Priorities

Centred around delivering 5 Star Patient Care, we will focus on:


Care

Strengthen staff voice, engagement and belonging


Safety

Support service change, improvement and transformation


Pathways

Use insight and evaluation to improve impact


Communication

Build trust through clear, honest and accessible communication


Systems

Grow our digital presence and creative capability

These priorities will be delivered through the core areas of activity set out on the following pages.

Brand and Service Communications

Our communications will bring to life what matters most at MWL: our people, our patients and the impact of the care we provide by delivering a consistent and compelling narrative across all our strategic priorities.

We will develop coordinated brand and service communications activity that informs, connects and involves our stakeholders, ensuring that everything we say reflects both our progress and our purpose. Alongside sharing achievements, we will stay anchored in what defines MWL - our values, our ambition and the difference we make to the communities we serve.

We will prioritise real stories that show the impact of our work in practice. This means using the voices and experiences of our staff and patients, linking our communications to current issues and priorities, and presenting our messages in ways that are relevant, clear and engaging.

Our use of visual content will be central to this approach. We will increasingly use video, photography and graphics to make our communications more accessible, engaging and meaningful for different audiences.



Brand communications will focus on our long term direction, how we are growing, improving and shaping the future of healthcare. This includes showcasing major programmes, innovation and areas of excellence across the Trust, strengthening our reputation and positioning MWL as an outstanding organisation on both the regional and national stage.



Service-level communications will focus on what is changing now, supporting delivery of our annual objectives and day to day improvements. This includes service developments, performance improvements, patient experience, staff achievements and local initiatives that directly impact care.

Together, this approach ensures we tell a clear, balanced story demonstrating both immediate progress and long term ambition, while consistently reflecting who we are as an organisation.

Internal Communications and Engagement

Strong internal communication is fundamental to building trust, supporting our culture and enabling high quality care. When staff feel informed, involved and listened to, it directly supports engagement, innovation and patient outcomes.

We will:

- Develop fresh, engaging content that reflects our values and celebrates the contribution of our staff
- Ensure communications are accessible and relevant to all staff, whatever their role, location or working pattern
- Strengthen two way engagement, with a clear focus on listening, responding and closing the feedback loop
- Work closely with Clinical Divisions and Corporate Teams to provide tailored communications support, tools and guidance
- Create a single, modern staff intranet that is clear, accessible and up to date, and that staff can rely on as their primary source of information
- Regularly gather staff feedback to continuously improve how we communicate and engage

Staff Engagement, Recognition and Events

Recognising, engaging and celebrating our staff is essential to building a positive culture and supporting the delivery of 5 Star Patient Care. We will use communications, campaigns and events to help staff feel informed, involved, valued and proud to work at MWL. This will include supporting key organisational priorities, such as winter vaccination and appraisal compliance, while recognising and celebrating staff achievements across the Trust.

We will:

- Develop clear, engaging communications that explain what is being asked of staff and why it matters
- Support campaigns that encourage staff participation in key organisational priorities
- Support staff engagement events to ensure they are purposeful, visible and effective, helping colleagues feel informed, listened to and connected to MWL's culture and ambitions
- Recognise and celebrate staff achievements through events, awards and recognition schemes, ensuring recognition is inclusive, visible and reflects the breadth of roles, teams and sites across MWL

Patient, Public and Community Engagement

Meaningful engagement with patients, families, carers and local communities helps us build trust, improve services and understand what matters most to the people we serve. We will make engagement more inclusive, accessible and two-way, using feedback and lived experience to shape how we communicate, involve people and support service improvement.

We will work with the Trust's Patient Experience Team as well as partners, voluntary organisations and community groups to:

- Strengthen how we listen to and involve patients, families, carers and local communities including those whose voices are less often heard
- Use insight, feedback and lived experience to shape communications, campaigns and service change
- Make engagement more inclusive, accessible and representative of the communities we serve
- Support clear, honest and timely communication around service developments, transformation and improvement
- Close the feedback loop by showing how people's views have influenced decisions and improvements



Brand Identity and Consistency

We will build a clear and consistent narrative for MWL that reflects our direction, values and ambition.

We will:

- Develop and embed a strong visual identity and brand framework that is applied consistently across the organisation and supported by clear user guidelines
- Ensure all communications reflect our values of being Kind, Open and Inclusive, supporting a culture that is visible in everything we do
- Strengthen how we position MWL externally, ensuring our reputation reflects the quality and ambition of our services
- Support the development of commercial activity through a clear and aligned brand structure where required

Social Media and Digital Communications

Digital channels are essential to how we connect with our audiences and tell our story at scale.

We will:

- Grow our presence across key platforms through a focused and evidence based content strategy
- Create engaging content that tells our stories, showcases our expertise and strengthens our reputation through video, storytelling and thought leadership.
- Strengthen our digital capability to ensure consistency and quality across all channels
- Explore emerging platforms and formats where these will add value and reach new audiences
- Develop a modern, user focused website that is accessible, easy to navigate and supports interaction
- Build a strong suite of digital content, including podcasts and multimedia formats, to showcase our work and expertise
- Expand our digital storytelling through channels such as YouTube, short-form video and collaboration with trusted NHS content creators, helping us reach new audiences and bring our work to life in more engaging and accessible ways

Media Relations

Proactive, professional media engagement plays a key role in building trust and protecting MWL's reputation.

We will:

- Deliver a consistent programme of proactive media activity aligned to Trust priorities
- Maintain a responsive, transparent press office function that supports timely and accurate communication
- Strengthen relationships with local, regional and national media to extend our reach and influence
- Position MWL as a source of expertise by promoting clinical and professional voices across the organisation
- Use multimedia content to enhance media engagement and maximise coverage in a changing media landscape

Stakeholder Communications

Strong relationships with our stakeholders are essential to how we deliver services and improve outcomes.

We will:

- Maintain regular, proactive communication with stakeholders, ensuring they are informed and engaged
- Create opportunities for stakeholders to see our work first hand and connect with our teams
- Use targeted channels and tailored briefings, to reach key audiences
- Seek feedback to continually improve how we communicate and engage

Communicating in a Crisis

As a Category 1 responder, we have a clear responsibility to communicate effectively in times of pressure or emergency.

We will:

- Maintain robust processes and channels to ensure clear, timely communication during incidents
- Monitor and respond to misinformation where it may affect public confidence, staff morale or the safe delivery of services
- Work closely with partners to deliver consistent public messaging
- Use campaigns to support key public health messages when needed
- Learn from experience and continuously strengthen our approach



Evaluation

We will measure the impact of our communications to ensure our work is meaningful, targeted and effective.

We will move beyond measuring activity alone and focus increasingly on the impact of our communications - including whether people feel informed, whether messages are understood, whether engagement influences decisions, and whether campaigns support measurable change.

We will use a focused set of indicators, including:

Reach - who we reached

Engagement - how people responded

Understanding - whether messages were clear

Impact - what changed as a result

Trust and reputation - how MWL is perceived

This approach will provide assurance while remaining proportionate and focused on what matters most.

Making It Happen

Delivering this strategy will require the right capacity, skills, systems and partnerships. The Communications Team will lead and coordinate delivery, but success will depend on communication being recognised as a shared responsibility across the Trust.

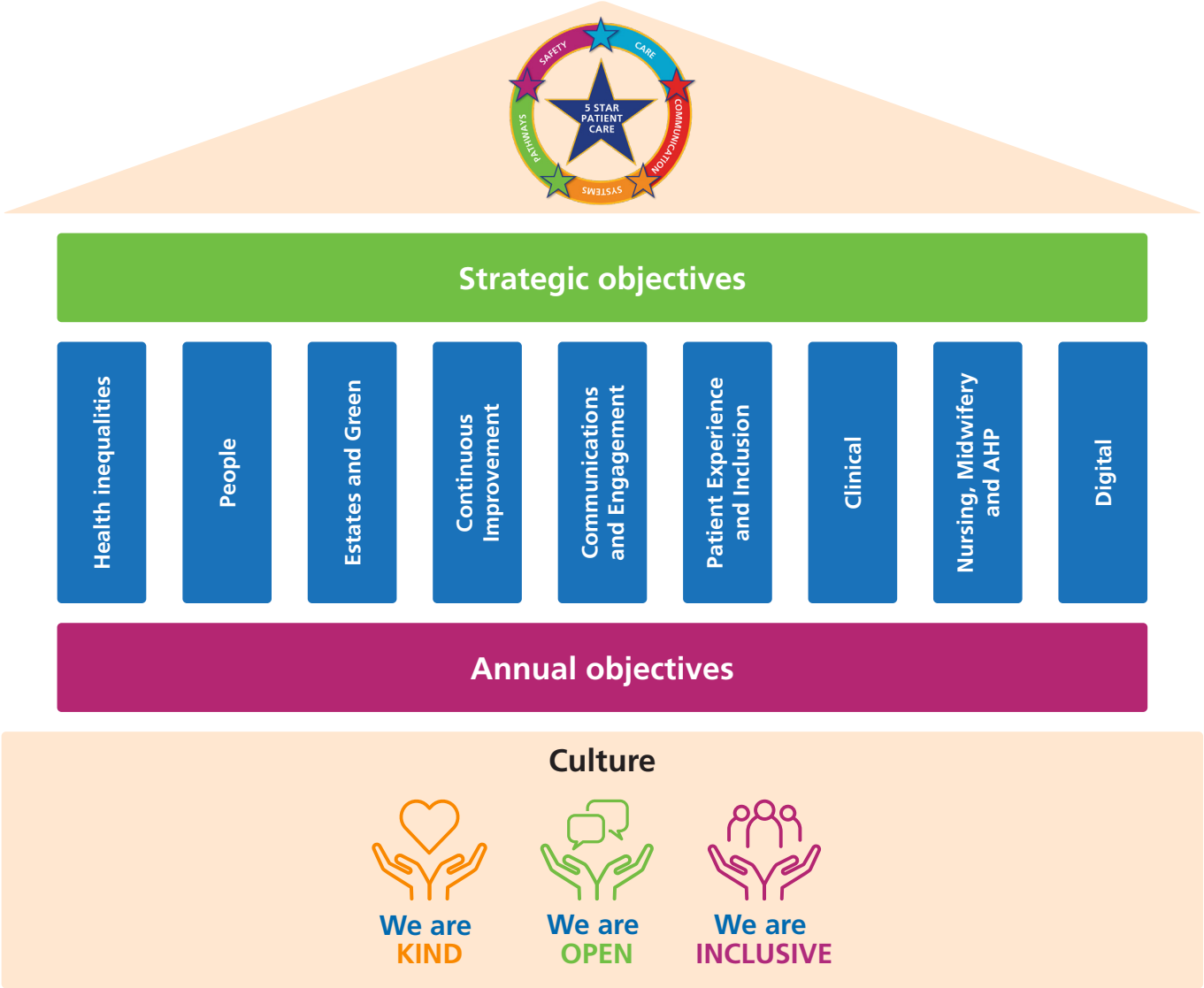
We will:

- Ensure the Communications Team has the capacity, resilience and specialist expertise required to meet rising demand, manage organisational risk and deliver MWL’s ambitions
- Invest in the tools, platforms and insight needed to deliver modern, accessible and measurable communications
- Continue to develop expertise in digital content, media relations, internal communications, engagement, design, evaluation and strategic communications
- Strengthen the network of media spokespeople and contributors across divisions, services and corporate teams
- Support colleagues across the organisation to communicate confidently and effectively
- Build strong internal and external partnerships to maximise opportunities
- Develop annual delivery plans with clear actions, measures and governance so progress can be tracked and priorities remain focused

Above all, we will create a culture where achievements are recognised, stories are shared, and our people feel proud of the difference they make every day.

Strategic Context

MWL is an ambitious organisation with a clear vision to provide 5 Star Patient Care. Our vision, values and strategic objectives are summarised in our strategic house



At its peak sits our vision of 5 Star Patient Care, the purpose that connects every role, team and site across the Trust.

Our strategic objectives provide clarity on our long-term direction and define what matters most for the future of the organisation. They are:

- We will provide services that meet the highest quality and performance standards
- We will work in partnership to improve health outcomes for our population
- We will provide the services of choice for our patients
- We will respond to local and individual health needs and contribute to reducing health inequalities
- We will attract and develop caring highly skilled staff
- We will work in partnership to create sustainable and efficient health systems

The supporting pillars represent the enabling strategies that help us deliver our vision. They are aligned to the overall Trust strategy and updated as needed to reflect our priorities.

The annual objectives are the practical priorities and deliverables for the next 12 months, ensuring sustained progress against our longer-term ambition.

Underpinning the entire framework are our foundations, which are essential to success: our culture, MWL values, expected behaviours, leadership approach, and staff networks and communities.

This Communications and Engagement Strategy is one of the ways we will bring the strategic house to life, helping staff, patients, partners and communities understand our direction, see the progress we are making, and feel part of the journey.



Title of Meeting	Trust Board			Date	30 September 2026
Agenda Item	TB26/070				
Report Title	MWL Perinatal Oversight Report Q1 2026/27 with inclusion of the 10-point Baseline Assessment Tool				
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 Trust Board with an overview of Quarter 1 2026/27 performance across Maternity and Neonatal Services, encompassing quality, safety, workforce, and patient experience.					
Executive Summary					
The new National Perinatal Oversight Report template has been utilised to present the Perinatal information across MWL Maternity and Neonatal services.					
It presents progress against locally and nationally agreed maternity and neonatal safety measures, aligned to the NHS England (NHSE) Perinatal Quality Oversight Model (August 2025), and highlights areas of assurance, emerging risks, and opportunities for improvement.					
The report supports effective governance by providing Trust Board with a clear assessment of current and developing safety concerns, ensuring a robust two-way flow of intelligence from ward to Board, and reinforcing multidisciplinary oversight of safe, high-quality maternity and neonatal care.					
This report includes a baseline assessment against the 10-point action plan, which was reviewed by Quality Committee on 22 September 2026. As the submission deadline of 25 September 2026 preceded the next scheduled meeting of the Trust Board, approval to submit the assessment to NHSE was obtained from the voting members of the Board by written resolution. The baseline assessment is included with this paper for completeness					
Alert					
During Q1 2026/27, three moderate harm maternity incidents were reported, comprising of two cases at Ormskirk Hospital and one at Whiston Hospital. Reviews identified issues relating to communication of care plans, consent processes, and delays associated with treatment administration. Learning has been shared across services and targeted improvement actions implemented, including enhanced training on consent, perineal care, and documentation standards.					
One Strategic Executive Incident System (STEIS)-reportable incident occurred following a temporary suspension of maternity services at Ormskirk Hospital due to the on-call consultant being required to attend Southport Hospital due to a gynaecology emergency presenting in the Emergency Department (ED). No Maternity and Newborn Safety Investigation (MNSI)-reportable incidents were recorded.					
There were no reportable perinatal deaths of babies at MWL during the quarter. Seven neonatal deaths occurred following transfer to specialist tertiary services or after in-utero transfer to Level 3 Neonatal Intensive Care Unit (NICU) centres. All cases have undergone multidisciplinary review, and Perinatal Mortality Review Tool (PMRT) processes have commenced with MWL contributing to these reviews. To date, no concerns regarding the care provided by MWL have been identified and no themes have emerged indicating avoidable factors contributing to outcomes.					

Advise

Maternity has commenced its response to the findings of the Independent National Maternity and Neonatal Investigation and the associated NHS England Ten-Point Plan. A baseline assessment has been undertaken and an action plan is being developed in response, which will be monitored at Quality Committee and Trust Board meetings.

Quality improvement activity remains strong, including successful implementation of transitional care at Whiston Hospital, continued delivery of Saving Babies' Lives Care Bundle Version 3.2, development of the Maternal Care Bundle implementation plan, and collation of evidence for Maternity Incentive Scheme (MIS) Year 8 compliance.

Workforce planning remains a key priority. A Birthrate Plus review establishment review is underway, whilst neonatal nursing workforce capacity continues to be reviewed through the British Association of Perinatal Medicine (BAPM) staffing assessment process. Maternity services continue to maintain low midwifery vacancy rates.

Twelve maternity and four neonatal complaints were received during the quarter. The principal themes related to communication, feeling heard and involved in decision-making, perceived delays in discharge, and staff behaviours.

Learning has been incorporated into service improvement plans and governance processes.

Assure

Safe maternity and neonatal services have been maintained throughout Q1. There were no reportable perinatal deaths within Trust maternity units, no MNSI-reportable incidents, and no Coroner's Prevention of Future Death reports or Regulation 28 notices received.

Maternity triage performance remained strong, achieving 100% compliance at Ormskirk Hospital and over 98% compliance at Whiston Hospital despite rising activity levels and periods of high acuity. All reported delays were reviewed through established governance processes, with no harm identified.

Training compliance remains high across maternity, obstetric, anaesthetic, and neonatal staff groups, supported by multidisciplinary simulation programmes across hospital and community settings.

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:

1. The MWL Perinatal Oversight Report Q1 2026/27
2. The submission of the Maternity and Neonatal 10-point Baseline Assessment Tool

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

1. Ten-Point Plan for Maternity and Neonatal services

The Independent National Maternity and Neonatal investigation led by Baroness Amos was published on 30 June 2026, with NHS England subsequently issuing its national response and associated 10-Point Plan on 01 July 2026. The Trust has commenced work to review the findings and recommendations and has assessed current compliance against the requirements of the 10-Point Plan baseline assessment tool published on 12 August 2026.

The Trust's baseline assessment against the 10-point action plan, was reviewed by Quality Committee on 22 September 2026. As the submission deadline of 25 September 2026 preceded the next scheduled meeting of the Trust Board, approval to submit the assessment to NHS England (NHSE) was obtained from the voting members of the Board by written resolution. The baseline assessment is included with this paper for completeness.

An action plan is being developed in response to the baseline assessment, which will be monitored at Quality Committee and Trust Board meetings.

2. Reported Incidents

Issues identified during Q1 reported incidents included documentation issues relating to the completion of all clinical records during emergency situations. In addition, a small number of incidents related to delays in treatment or investigations which included delays in the administration of intravenous (IV) antibiotics due to patient identification labels on babies. Initial name bands are applied stating 'baby of' which require changing following allocation of baby's own hospital and NHS number which had not been undertaken and resulted in delays until rectified. All incidents have been reviewed locally to identify learning opportunities and support improvements in clinical processes and documentation standards.

Overview of any reported Maternity Outcomes Signal System (MOSS), PMRT, MNSI, Patient Safety Incident Response Framework (PSIRF) findings.

Incident Type	Incident	What action has been implemented	Family views/DOC	External reviewer
PSIR	Return to theatre for secondary repair of perineum 10 days post birth following IV and oral antibiotics	Targeted education and training by Pelvic health team to ensure consistent provision of evidenced based perineal care and required compliance with prophylactic antibiotic guidance	DOC undertaken. N/A for family views	N/A
PSIR	Issue raised of lack of explicit consent for an episiotomy in a previous pregnancy	No documentation of the indication, counselling, and verbal consent for the episiotomy in health records. Additional consent training in partnership with the Trust's legal team undertaken with staff, shared learning and conversations with individuals and the wider maternity team of findings. Audits to be undertaken of births involving interventions to review documentation and consent compliance.	Family views Incorporated into PSIR following debrief which identified incident. DOC undertaken	N/A
IPLR	Pseudomonas aeruginosa confirmed on blood cultures following admission for preterm prelabour rupture of membranes, TOP, and PPH.	IPLR currently underway. No source of infection has currently been identified and no similar cases. No current further actions or learning identified from IPC team.	DOC undertaken. N/A for family views	N/A

Incident Type	Incident	What action has been implemented	Family views/DOC	External reviewer
MNSI	MNSI report received in Q1 Emergency CS for fetal compromise resulting in likely hypoxic brain injury	Ensuring use of interpreter services. Introduction of Maternity Triage passport for all women who do not speak English. Current review of estates to explore availability of a separate space for telephone triage.	DOC undertaken and family views considered	N/A
MNSI	MNSI report received in Q1. NND following transfer to hospital during a homebirth for placental abruption	Implementation of an SBAR proforma for delivery suite staff receiving emergency calls that is relayed in a standardised and systematic way to all staff.	DOC undertaken and family views considered	N/A

In Q1 2026/27, a total of three moderate harm incidents relating to maternity services were reported, with two occurring on the Ormskirk site and one at Whiston site. Each incident has been reviewed through the Trust's incident management processes to identify contributory factors, required actions, and opportunities for learning. Any learning and improvement actions identified are monitored through the Division's governance and Quality meetings to support continuous quality improvement and enhance patient safety across maternity services. All moderate harm incidents were managed in accordance with Duty of Candour requirements, including holding conversations with those affected and providing written correspondence in line with Trust guidance.

Case 1 (Maternity, Ormskirk) A woman attended Maternity Triage three days following a forceps birth reporting perineal pain, following review oral antibiotics were prescribed. The woman was subsequently readmitted three days later with a breakdown of the perineal repair and required intravenous (IV) antibiotics and a return to theatre for a secondary repair, seven days later.

The Patient Safety Incident Response (PSIR) investigation identified missed opportunities to communicate and verify the requirement for prophylactic antibiotics following birth. The review also found that inconsistent advice had been provided regarding postnatal perineal care. Learning from the incident has been shared across the maternity service. The Pelvic Health Team is delivering targeted education and training to clinical staff through the Quality Bus, with a focus on ensuring consistent provision of evidence-based perineal care information and advice to women during the postnatal period. This action aims to improve communication, strengthen compliance with prophylactic antibiotic guidance, and enhance patient experience and outcomes following operative vaginal births.

Case 2 (Maternity, Ormskirk) During a debrief appointment for a previous pregnancy it was reported that an episiotomy had been undertaken without explicit consent which subsequently resulted in the development of a perineal infection.

The Patient Safety Incident Response (PSIR) identified that there had been no documentation of the indication, counselling and verbal consent for the episiotomy and subsequently performing of the episiotomy. Actions implemented include additional consent training in partnership with the Trust's legal team, sharing learning with individuals and the wider maternity team, reviewing perineal trauma guidance, and auditing births involving obstetric interventions to improve documentation and consent practices.

Case 3 (Maternity, Whiston) A woman attended Maternity Triage at 19 weeks' gestation with confirmed preterm prelabour rupture of membranes. Following review, a decision was made to end the pregnancy. A manual removal of the placenta was required and a postpartum haemorrhage (PPH) of 1,100ml occurred.

Following theatre, the woman remained on Delivery Suite and became unwell, developing a pyrexia and tachycardia and Enhanced Maternity Care was provided. Blood cultures subsequently identified *Pseudomonas aeruginosa*.

An Interprofessional Learning Review (IPLR) is currently underway. To date, no source of the infection has been identified, and no similar cases have been reported within the maternity service. Ongoing work with the Infection Prevention and Control (IPC) team is underway to investigate potential sources and identify any learning arising from the incident if required.

STEIS

In Q1 2026/27 there was one STEIS reportable incident.

In May 2026, a Maternity unit divert was implemented at the Ormskirk site after the on-call consultant was required to attend Southport hospital to undertake an emergency gynaecology procedure following presentation to the ED. The unit remained on divert for approximately three hours, during which one woman required redirection to maternity triage at the Whiston site for assessment and care. The incident is currently subject to formal investigation. Given the wider system factors involved, the review is being undertaken collaboratively with the Medicine division.

MNSI

There were no MNSI reportable incidents for Q1 2026/27 on either Ormskirk or Whiston sites. There is currently one ongoing MNSI investigation which was reported during Q4 and formally accepted in Q1 by MNSI and related to a baby that required cooling following birth at Whiston.

Two completed MNSI reports were received by the Trust in Q1.

Case 1

Category 1 caesarean section for fetal compromise that required neonatal resuscitation and therapeutic cooling. Magnetic resonance imaging (MRI) imaging of the baby at 28 days of age demonstrated likely hypoxic brain injury. Baby discharged home at 35 days and remains under developmental follow-up.

MNSI identified good practice in antenatal care planning, neonatal resuscitation, and timely initiation of therapeutic cooling.

Key findings related to inconsistent use of interpreter services for a mother whose first language was Tamil, and a gap in a telephone triage assessment asking about fetal movements as the call was made by the husband. The patient was requested to attend triage during a second call when reporting pain and bleeding. Environmental distractions of the call being taken in a shared office was identified as a contributory factor. Upon attendance at triage, Cardiotocography (CTG) abnormalities were promptly recognised, and delivery was achieved within 12 minutes of the Category 1 decision.

Two safety recommendations were made: Implementation of protected, dedicated maternity telephone triage arrangements and ensuring passive cooling is not commenced without continuous rectal temperature monitoring. Since this case Maternity have implemented a Maternity Triage passport for all women who do not speak English who are advised to present without any prior telephone contact with any concerns during their pregnancy. Review of maternity estate to determine options for a separate area for telephone triage and associated staffing.

Case 2

A term infant born following an emergency transfer from a planned homebirth who died at one hour old despite prolonged neonatal resuscitation.

MNSI identified a number of areas of good practice, including effective communication and teamwork within the community midwifery team, timely recognition, and escalation of maternal deterioration in the home environment, rapid transfer by North West Ambulance Service NHS Trust (NWAS) and prompt attendance by obstetric and neonatal teams on arrival to hospital. Care

provided by the community midwives as the emergency developed was recognised as being of a high standard.

Findings relating to clinical information regarding a suspected placental abruption became diluted through multiple verbal handovers although the community midwife provided a detailed and comprehensive Situation, Background, Assessment, Recommendation Tool (SBAR) handover, resulting in some delivery suite staff being unaware of the full level of risk. A documented SBAR proforma is now in use for delivery suite staff receiving the call that is relayed in a standardised and systematic way to staff. The SBAR tool is filed in the medical records upon arrival at the unit.

Following emergency transfer, the mother underwent a rapid assessment on delivery suite by the obstetricians and transferred to theatre however the baby could not be resuscitated. Case was reviewed by coroner who agreed the cause of death was acute placental abruption.

Perinatal Mortality

For Q1 2026/27 there were no reportable perinatal deaths of babies born on either Ormskirk or Whiston sites.

There were three babies born at Whiston Hospital and one baby born at Ormskirk Hospital that were transferred to a Level 3 NICU and subsequently died.

Three women received antenatal care from the maternity service at Whiston Hospital required transfers antenatally to maternity units with a Level 3 NICU, where the babies were born and died at the receiving unit. The Trusts where the babies died have the responsibility for reporting to Mothers and Babies: Reducing Risk through Audits (MBRRACE), managing the perinatal mortality reporting tool and liaising with the Whiston Hospital in order to fully complete the reports.

Q1 2026/27	Total	
April	0	No cases
May	3	1 NND of a 32+5 gestation baby born at Whiston that died at another unit. (Case 1) 2 NND of babies at 31 weeks and 26 weeks gestation where antenatal care was provided by Whiston maternity. In-utero transfer to another unit for birth with the NND's occurring at other unit. (Cases 2 and 3)
June	4	1 NND of a baby born at 36 weeks at Ormskirk that died at another unit. (Case 4) 2 NND's of born at Whiston that died at another unit. 34+3 and 39 weeks gestation. (Cases 5 and 6) 1 NND of a baby at 23 weeks gestation where antenatal care was provided by Whiston maternity. In – utero transfer to another unit for birth with the NND occurring at the other unit. (Case 7)

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.

Case 1: Baby born at Whiston Hospital at 32+5 gestation following spontaneous rupture of membranes to a mother assessed as low risk at booking. The neonatal team attended the birth and no resuscitation was required. Following admission to the Neonatal Unit (NNU), the baby's condition deteriorated and transfer to a Level 3 Neonatal Intensive Care Unit was required. The baby subsequently died at 15 days of age and was diagnosed with non-ketotic hyperglycinaemia. A multidisciplinary review has been undertaken which did not identify any concerns regarding the care provided or any factors that would have altered the outcome.

Case 2: Monochorionic diamniotic (MCDA) twin pregnancy conceived through IVF. At the 20-week anomaly scan, Twin B was diagnosed with congenital cardiac abnormalities, and care was referred to the regional fetal medicine unit for ongoing management.

The mother later attended the tertiary referral unit with vaginal bleeding and delivered both babies at 31 weeks' gestation. Twin B subsequently died at one day of age. A multidisciplinary review of the case has been undertaken and did not identify any concerns regarding the care provided or any factors that would have altered the outcome.

Case 3: High-risk pregnancy. Booking Body Mass Index (BMI) of 55 and a diagnosis of gestational diabetes at 22 weeks' gestation. Preterm prelabour rupture of membranes occurred at 22+1 weeks and following multidisciplinary discussion a decision was made to continue the pregnancy with close monitoring. Attendance to maternity triage at 26 weeks gestation with abdominal and back pain. Transfer to a maternity unit with Level 3 Neonatal Intensive Care Unit facilities was undertaken with the baby delivering the following day and sadly died at eight days of age. A multidisciplinary review of the case has been completed and did not identify any concerns regarding the care provided by MWL or any factors that would have altered the outcome.

Case 4: Baby born at Ormskirk Hospital at 36 weeks' gestation and subsequently required transfer to a Level 3 Neonatal Intensive Care Unit due to an increasing need for respiratory support and subsequently diagnosed with Edwards' Syndrome. Following discussions regarding ongoing care, a transfer to a hospice was arranged where the baby died at 11 days of age. A multidisciplinary review of the case has been completed and did not identify any concerns regarding the care provided by MWL or any factors that would have altered the outcome.

Case 5: Baby delivered at Whiston Hospital by Category 2 caesarean section at 34+3 weeks' gestation. Following birth, the baby was admitted to the Neonatal Unit with suspected sepsis and subsequently transferred to a Level 3 Neonatal Intensive Care Unit for ongoing specialist care. The baby's condition deteriorated and investigations, including an extended viral Polymerase Chain Reaction (PCR) panel which confirmed enterovirus infection. The baby subsequently died at 27 days of age.

Case 6: Baby delivered at Whiston Hospital by Category 2 caesarean section at 39+1 weeks' gestation. Following birth, the baby developed a severe rash, which was escalated to the paediatric team for assessment. Sepsis screening was undertaken and intravenous antibiotics were commenced. The baby initially remained with the mother on the postnatal ward receiving transitional care; however, further clinical deterioration necessitated transfer to the Neonatal Unit. Ongoing deterioration and the requirement for ventilatory support led to transfer to a specialist Paediatric Intensive Care Unit (PICU). Following transfer, investigations confirmed enterovirus infection. The baby died at 23 days of age.

Cases 5 and 6 have been reviewed collectively as both neonatal deaths were associated with enterovirus infection. A comprehensive review was undertaken in conjunction with the IPC Team, including assessment of all maternity and neonatal clinical areas where the families received care, alongside UK Health Protection Agency (UKHPA). National data suggested an increase in enterovirus infections during early 2026. Further information from the Viral Reference Lab was inconclusive in determining a link between the cases and recommended to continue with enhanced enterovirus testing of mothers and babies who deteriorate unexpectedly with suspected infection until at least the end of September 2026.

Case 7: Admission to Whiston Hospital at 21+3 weeks' gestation in threatened preterm labour where the woman remained an inpatient until 23 weeks' gestation, when she was accepted for transfer to a maternity unit with Level 3 Neonatal Intensive Care Unit facilities due to the risk of an imminent preterm birth. The baby was delivered shortly after transfer and subsequently died at nine days of age. A multidisciplinary review of the case has been completed and did not identify any concerns regarding the care provided by MWL or any factors that would have altered the outcome.

3. Risk

A comprehensive review of all maternity risks was undertaken to ensure the risk profile remains contemporaneous, accurately reflects current service pressures, and aligns with emerging themes. As a result, 21 risks were closed and three new risks were identified and opened. At the end of the Q1 reporting period, the maternity services had 37 active risks on the divisional risk register. The exercise also enabled the rationalisation and consolidation of risks into a single maternity risk register, enhancing oversight, reducing duplication, and providing clearer divisional assurance.

The service continues to report two high-scoring risk (≥ 15):

- Risk 1301 relates to the limited availability of some maternity services at the Ormskirk site, which may result in delays or gaps in care delivery for women requiring specific elements of the maternity pathway. This risk remains scored at 15 and continues to be monitored through existing governance processes.
- Risk 1633 relates to the Maternity Diabetes service capacity and the need to support a business case to increase the capacity to provide the recommended standards for service provision which is underway. A diabetes gap analysis was completed and submitted on the 15th May using the C+M gap analysis tool and submitted to the Local Maternity and Neonatal System (LMNS) and will form the basis of the required business case.

4. Claims

One new maternity claim was received in Q1 2026/27 relating to the management of an elective caesarean section in a woman diagnosed with a pulmonary embolism at 37+2 weeks' gestation. The claimant alleges inadequate advice regarding administration of treatment-dose low weight molecular heparin (LWMH) prior to delivery, resulting in the requirement for a general anaesthetic rather than regional anaesthesia causing subsequent psychological distress.

A review of the clinical records found that the woman was appropriately risk assessed and managed throughout pregnancy with LWMH prescribed in line with clinical requirements. Documentation also demonstrated ongoing communication and agreement regarding the birth plan and the rationale for general anaesthesia. Given the anticoagulation requirements and clinical circumstances at the time of delivery, general anaesthesia was considered the only safe and clinically appropriate option and therefore unavoidable.

This claim is consistent with the Trust's claims profile, where psychological injury remains the most common category of claim. There are no other cases known relating to anticoagulant therapy or options for anaesthesia.

4.1 Coroners reports

None to report

4.2 Regulation 28 report issued.

None to report

5. Complaints

There were twelve formal complaints received in Q1 for maternity. Analysis identified themes relating to clinical care and treatment, perceived delays in appointments and the values and behaviours of staff. Complainants reported experiences where they felt interactions lacked sensitivity, compassion, and empathy, adversely affecting their overall experience of care.

All complaints received during Q1 that remain open are progressing in line with agreed timescales and are on track for completion within the Trust's complaint management framework.

Maternity	April 2026		May 2026		June 2026		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of complaints	1	5	1	0	3	2	5	7

6. Learning and Actions from Closed Complaints

There were nine Maternity complaints completed during Q1 2026/27. Of these, three complaints were upheld and six were partially upheld.

The issues identified from complaint investigations primarily related to

- Communication: Concerns relating to the quality, consistency, and timeliness of communication between staff and parents.
- Feeling heard and involved: Women and their partners reported occasions where they did not feel listened to, involved in decision-making, or adequately supported in expressing their concerns.
- Delays in care: Complaints highlighted delays in the provision of care, assessment, treatment, and communication regarding planned interventions.

Actions implemented have focused on strengthening communication with women, families, and carers, promoting personalised and compassionate care, and reviewing processes to minimise delays and improve the overall patient experience.

Communication in triage has been strengthened; calls are monitored and can be used for learning opportunities. The triage lead undertakes a minimum of ten random call audits per week which enables assurance that the information, actions, and outcomes are appropriate and in accordance with Birmingham Symptom Specific Obstetric Triage System (BSOT) guidance alongside the tone, support and compassionate of the person providing telephone triage. Call listened is also available if a complaint is made or if the family have any concerns re the advice provided.

A maternity daily cross site huddle has been introduced, to ensure maternity oversight of activity, acuity, staffing, concerns etc and provides the facility to support and share resources or provide mutual aid if appropriate.

There is one complaint, received in Q4 2025/26, that remains open at the time of reporting. The delay relates to the request for a debrief to provide feedback on the findings of the associated incident investigation relating to perineal trauma which was the content of the complaint. There were difficulties in arranging a mutually suitable date which was not completed until August 2026. Following the debrief, the complaint response has now been drafted and is progressing through the Trust's approval process prior to issue.

7. Neonatal

There were four formal complaints received in Q1 for Neonatal services.

Neonatal	April 2026		May 2026		June 2026		Total	
Site	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of complaints	0	1	2	1	0	0	2	2

Three of the four complaints were closed in Q1. One complaint was upheld locally, one complaint was partially upheld locally, and one complaint was not upheld. The complaints related to

communication between family and staff, perceived lack of support and delay in diagnosis and observations. The fourth complaint required involvement from services outside of the NNU, Draft report is in progress.

Learning and Actions from Closed Complaints

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

8. Compliments

Maternity Services received 13 formal expressions of positive feedback ("InPraises") during Q1. The majority were submitted via PALS and specifically recognised individual members of staff for their compassion, professionalism, and support. Feedback frequently highlighted positive experiences where care had not proceeded in line with the woman's original birth plan, with families expressing appreciation for the communication, reassurance and personalised care provided by staff during unexpected or complex clinical circumstances.

9. Friends and Family Test

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 rather than in the touch point specific area.

Overall, feedback remains largely positive; however, several recurring themes were identified that impacted patient and family experience during Q1.

Key themes identified:

- Travel and access to the Whiston site: Several respondents commented on the need to travel to the Whiston site following pathway changes. Feedback highlighted concerns regarding increased travel times and the inconvenience experienced by some women and their families.
- Delays in consultant clinics: Patients reported frustrations with waiting times and delays within consultant-led clinics. Whilst care was generally perceived as good once received, prolonged waiting periods negatively affected the overall experience.
- Perceived discharge delays: Some families described delays in the discharge process, particularly following birth, which contributed to dissatisfaction at the point of transition from hospital to home. Comments received suggested strengthening discharge time frames. Communication. The Maternity and Neonatal Voices Partnership (MNVP) is supporting by providing a focus on postnatal care and determining exact issues. The ward area is focussing on preparing for discharge upon admission especially around To Take Out (TTO) Medication prescriptions and commencing discussions re discharge for mum and baby as both may not be fit for discharge at the same time.
- Environmental concerns during periods of hot weather: During the summer heatwave, several respondents highlighted that postnatal ward environments became uncomfortably warm. This was reported as affecting both women and their families and contributed to discomfort during the postnatal stay. During the period of extreme hot weather, more frequent changing of water jugs was undertaken, several areas received portable air conditioning units where air conditioning was not available alongside following the recommendations of keeping windows and blinds closed etc to try to keep the areas as cool as possible.

Maternity MWL	April 26	May 26	June 26	Trust Target
Antenatal	92%	100%	92%	95%
Birth/Delivery	95%	95%	91%	93%
Maternity Ward	98%	85%	85%	92%
Postnatal Community	100%	100%	100%	91%

10. Maternity & Neonatal Voices Partnership (MNVP) Feedback

During Q1, the MNVP leads engaged with 94 families and received feedback on experiences across antenatal, intrapartum, postnatal, and neonatal services, highlighting several recurring themes including challenges with induction of labour experiences and variation in partner stay arrangements, perceived postnatal discharge delays and neonatal communication issues. Families reported that these issues contributed to reduced confidence and a perception of fragmented care.

Consistent positive feedback was also received regarding compassionate midwifery care, supportive labour and birth communication, excellent theatre staff, and high-quality neonatal care.

In response, the MNVP has identified several co-production priorities for Q2, focusing on practical improvements to patient information and experience around preparing for induction of labour and discharge processes on the postnatal ward. These initiatives are aligned with Trust priorities and aim to improve communication, consistency, and family-centred care.

Qualitative feedback from various sources, including Friends and Family Test (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 meetings.

11. Review of NHS Resolution Scorecard

The claims scorecard is produced annually in September and currently contains data for both MWL sites for the years 2015/16 until the end of 2024/25.

A quarterly review of claims scorecard triangulated alongside incident and complaint data and any learning from investigations is required to be discussed at a trust level quality meeting.

Themes identified from Claims Scorecard (10 years)	Themes identified from Claims and Complaints (current)
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.	Communication concerns with families Women and partners reporting not being listened to. Perceived delays in care provision for women and babies
Themes identified from Maternity Patient Safety Incidents	Themes identified from other sources

Delay in providing IV antibiotics to babies due to updated baby ID bands not being applied once the baby's own NHS number has been generated. Gaps in clinical documentation around emergencies situations	Family feedback via MNVP and FFT included: Distances to travel due to pathway changes. Provision of information prior to IOL Postnatal Discharge delays Communication Environmental temperature
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Failure or delay in treatment is the top cause by volume identified in the score card. The themes from the maternity safety incidents have identified delays in administration of IV antibiotics for babies on the maternity ward. Initial name bands are applied a birth stating 'baby of' which require changing following allocation of baby's own hospital and NHS number. It has been identified that this has not always been undertaken resulting in delays in administration until rectified. Awareness has been raised with staff of the importance of adding the additional name band after birth following generation of the NHS number, staff informed of the requirement to ensure bedside handover is undertaken which includes checking that these bands are in place upon admission to the ward by the transferring and receiving staff members of staff and if not in place immediate application in order to complete handover. Daily audits undertaken initially to ensure compliance which have been reduced to weekly as 100% compliance and no further incidents reported.

12. Perinatal Improvement plan

The maternity service remains on the LMNS Joint Oversight Support (JOS) programme following the changes to the maternity high-risk pathways. A meeting with the LMNS has been scheduled for 11 November 2026 to review certain recommendations following the Maternity Safety Support Programme (MSSP) visit in October 2026.

13. Service Suspensions

2026/27	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Maternity unit: Whiston	0	0	0									
Maternity unit: Ormskirk	0	1	0									
Homebirth service:	0	0	0									
NNU: Whiston (Internal)	0	0	0									
NNU: Ormskirk (Internal)	0	0	0									
NNU: Whiston (External)	0	0	0									
NNU: Ormskirk (External)	0	0	0									

In May 2026, a Maternity unit divert was implemented at the Ormskirk site after the on-call consultant was required to attend Southport to undertake an emergency gynaecology procedure for a patient in the emergency department. The unit remained on divert for approximately three hours, during which one woman required redirection to maternity triage at Whiston Hospital for assessment and care. The Divisional Medical Director is working to develop a dedicated second on-call consultant rota. The purpose of the rota is to provide resilient senior medical cover across both sites, with specific provision for consultant deployment to the Southport site when required.

14. Women experiencing delays to induction >6hrs

There were two women whose commencement of induction of labour (IOL) was delayed >6 hours from the point of admission for induction of labour from home or requiring admission from another clinical area.

Month	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Delayed inductions >6hrs	1	1	0									

Month	Site	Length of Delay	Reason
April	Whiston	7hr 20mins	Acuity
May	Whiston	7hr 30mins	Acuity

All delays >2hrs between admission and commencement of Induction of Labour (IOL) are reported as Midwifery Red Flags. Every maternity red flag undergoes an incident review. In both cases identified in Q1, the delay from admission to commencement of IOL was deemed clinically appropriate and safe due to the current intrapartum acuity within the unit at the time and the requirement to prioritise one-to-one midwifery care for women who were already established in labour. Both admissions had been planned for commencement of induction of labour within the intrapartum area rather than the ward area. Clinical assessment to determine maternal and fetal wellbeing was undertaken and reasons for the delays explained to the family. No adverse maternal or neonatal outcomes occurred due to the delays.

15. Women experiencing delays in elective caesarean sections >24 hours.

Month	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Delays to C-section >24hrs	0	1	1									

May: One elective caesarean section on the Whiston site was unable to be undertaken on the day scheduled due to theatre time constraints following complications with a patient earlier in the list. Following confirmation of the delay, the woman was admitted to the maternity ward and rescheduled for the following morning and the CS was undertaken.

June: One elective caesarean section at Whiston site was unable to be performed on the day scheduled. The decision to postpone the procedure was made due to significant clinical acuity across the site and the need to prioritise theatre capacity for several emergency cases that had occurred. At the time, the service was operating in full escalation. Mutual aid arrangements were explored to facilitate the procedure at an alternative provider; however, no capacity was available across the Region. The woman received a full explanation regarding the delay and was subsequently reclassified as a Category 3 case. Her caesarean section was successfully performed the following morning by the resident Consultant Obstetrician.

A review of Elective Caesarean Section (ELCS) demand and capacity across all sites is currently underway, utilising activity data from July 2025 to July 2026 and considering the implementation of maternity pathway changes. The review includes assessment of workforce, pre-operative assessment, theatre, and recovery capacity, together with associated clinical risks. Emerging capacity constraints associated with an increasing requirement for complex and repeat Caesarean birth have been noted. Recommendations from the review will inform service planning, risk mitigation, and actions to optimise patient flow to ensure safe service delivery across sites.

16. Home births: Q1 2026/27

	No of Homebirths community midwives attended	No. of Homebirths achieved	No. birthing at home against medical advice	No. births at home with an MDT plan in place	No. transferred into an acute unit during labour/ postnatal	No. of transfers with a delay
Total Q1	24	18	11	11	6 Intrapartum 9 Postnatal	0

All births at home undergo a retrospective review to identify areas of good practice and if there are any opportunities for learning or service improvement. During the reporting period, six intrapartum transfers to hospital occurred. Reasons for transfer included maternal request for transfer to access additional analgesia not available at home, challenges in monitoring the fetal heart rate and failure to progress in labour. No adverse maternal or neonatal outcomes were identified in relation to these transfers.

Nine postnatal transfers were required, predominantly relating to babies requiring neonatal observations and assessment, or where women required complex perineal suturing that could not be safely managed in the home setting.

MWL maternity education and community leads are continuing the ongoing development and delivery of community-specific homebirth emergency training scenarios in collaboration with NWAS, utilising the dedicated simulation facility in Lymm. Initial sessions have been positively evaluated from candidates, particularly for enhancing consideration of environmental factors, situational awareness, and clinical decision-making during homebirth emergencies. The team have been invited to present the innovative work at the Royal College of Paramedics National Conference in October 2026.



MWL has a ratified Standard Operating Procedure (SOP) to support women whose birth preferences fall outside local clinical guidance. Women are offered review with our Consultant Midwife, where risks, benefits, alternatives, and available options are discussed to facilitate informed and shared decision-making. Personalised care plans are developed collaboratively with the woman and relevant multidisciplinary team (MDT) members, documented on the maternity information system, shared with the woman and appropriate senior leaders.

All enhanced personalised care plans are reviewed throughout pregnancy and communicated to relevant maternity, obstetric and neonatal teams, and the Trusts legal team. The Nursing and Midwifery Council (NMC) at times is contacted for support in very complex cases. This approach aims to balance maternal autonomy with safe, coordinated care and effective risk management.

17. Maternity Triage

Ormskirk Site	Attendances	Triage Breaches >15mins	Performance
April	386	0	100%
May	407	0	100%
June	436	0	100%

Whiston Site	Attendances	Triage Breaches >15mins	Performance
April	610	1	99.83%
May	737	12	98.37%
June	766	8	98.96%

Women are encouraged to contact maternity triage prior to attending wherever possible; telephone triage assessments incorporate a closed-loop communication process, whereby staff clarify presenting concerns, repeat and confirm key information, summarise the agreed plan of care and ensure the woman understands the advice and recommendations provided. Where appropriate, women are offered attendance for further assessment. Additionally, women and families are advised that if they feel attending would be beneficial or required to provide reassurance, they are welcome to attend for review. This approach promotes safe, effective communication, supports shared decision-making, and helps ensure women feel listened to, informed and reassured regarding their care, however, it is recognised that some women prefer to present in person without contacting the service and undergo the routine triage assessment upon presentation.

All delays in maternity triage on the Whiston site were due to high acuity and capacity and numerous women attending simultaneously. Targeted training was undertaken in 2025 regarding the requirement to escalate and seek clinical support when simultaneous attendances occur and incident report. Following this training, an increase in reporting occurred thereby improving reporting culture and allowing the identification of themes and trends. The central telephone system has had a positive impact in ensuring all calls are answered with appropriate support and action and has the capability to identify number of calls waiting to provide the opportunity to obtain support if required. An emerging theme of high volume of calls is being monitored by the department leads. It is noted that the attendances through Triage continue to increase.

The attendance to Triage breaches of >15mins are all recorded as Midwifery Red Flags (MRFs) and are all incident reported. Any learning is disseminated via ward meetings, safety huddles, and the Maternity Clinical Governance & Quality meetings. All MRFs were reviewed by the clinical lead and matron for the area and there were no associated clinical incidents related to triage delays.

NHS England published the National Maternity Triage Specification on 07 July 2026 (updated 29 July 2026), setting out a national framework to support safe, consistent, and equitable maternity triage services across all provider organisations. The specification requires immediate action by trusts, including completion of a Board-level audit of current maternity triage services within three months of publication, undertaking a gap analysis against the specification, and developing a comprehensive implementation plan to address any identified areas of non-compliance. Trusts are also required to report progress through a public Trust Board meeting and share assurance, and implementation plans with their regional NHS England team. Full implementation of the specification is expected within 12 months of publication.

18. Transitional Care

The Transitional Care model has been well established on the Ormskirk site and formally launched on the Whiston site on 07 April 2026, meaning that any babies meeting the transitional care framework can be cared for on the maternity ward alongside their mother by a neonatal nurse supported by a maternity support worker. Qualitative feedback has been received from families about their experience, and we continue to monitor admissions and report externally to North West Neonatal Operational Delivery Network NWN ODN).

19. Annual Training for all staff groups for Perinatal Safety training Q1 (compliance as of 30 June 2026)

Ormskirk Site	Midwives	Obstetricians		MSWs	Anaesthetists		Neonatal medical		Neonatal nursing	
		Cons	Other		Cons	Other	Cons	Other	Nurses	ANNP
Obstetric emergency training (PROMPT)	92.9%	100%	95.5%	95.5%	83.3%	93.3%				
Fetal monitoring and surveillance	99.2%	100%	100%							
Neonatal Resus	92.4%						100%	100%	96.6%	100%
% QIS (Compliance>70%)									80.0%	
Whiston Site	Midwives	Obstetricians		MSWs	Anaesthetists		Neonatal medical		Neonatal nursing	
		Cons	Other		Cons	Other	Cons	Other	Nurses	ANNP
Obstetric emergency training (PROMPT)	98.8%	95.0%	93.8%	100%	80.0%	96.1%				
Fetal monitoring and surveillance	99.3%	90.0%	100%							
Neonatal Resus	96.6%						100%	96.7%	91.7%	100%
% QIS (Compliance>70%)									54.9%	

The team is working closely with the surgical division to support the scheduling of anaesthetists on the Practical Obstetric Multi-Professional Training (PROMPT) programme throughout the year in order to increase and maintain compliance.

Qualified in Speciality (QIS) compliance on the Whiston site has decreased due to staff turnover within the unit and the recruitment of several newly qualified nurses. The Foundations in Neonates (FIN) course has now been completed, with a planned trajectory for nurses to undertake the QIS programme during 2026/27, with a projected compliance rate of 76.9% by end of Q4 2027/28.

19.1 Simulation Training

	Date & Location of latest Q1 simulation	MDT teams involved	Key Learning Objective
Ormskirk Hospital In situ multi-disciplinary emergencies simulations	None undertaken in Q1. Scheduled for Q2.		
Whiston site In situ multi-disciplinary emergencies simulations	23 June 2026 Anaphylaxis Maternity Ward	Midwives Obstetricians Anaesthetists MET Team	Management of anaphylaxis and ongoing perinatal care involving wider hospital teams.
Community In situ multi professional perinatal emergencies simulations	19 May 2026 Out of Hospital Birth Neonatal Resus and Transfer	Midwives Paramedics (NWS) Neonatal Nursing Neonatal Medical	Facilitate the transfer of a patient from community to Hospital using ABC approach, appropriate SBAR, safe transfer. Management of ongoing neonatal concerns.

20. Maternity Staffing Vacancy Rates at end of Q1 2026/27

Staff group	Vacancy rate	Vacancy (WTE)
Midwifery	1.2%	3.29
Midwife Support workers	14.9%	10.33
Obstetric consultants	3.03%	1.0
Neonatal Nurses	1.4%	0.90
Neonatology consultants	4.8%	1.0

MWL Maternity Services reported 3.29 Whole-time equivalent (WTE) midwifery vacancies with further new starters planned on the Whiston site for July as agreed to establish up to 6.0 WTE over to mitigate maternity leave. Work to address Band 2–3 vacancies have progressed through the current re-banding and consultation process launched across MWL on 31 May 2026. Support worker vacancy at the end of June was 10.33 WTE which will be resolved within the consultation, and additional advertised vacancies were required.

Biannual Midwifery Staffing papers demonstrating that budgeted establishment is in line with Birthrate Plus recommendations for Ormskirk and Whiston sites and are attached in Appendix 1 and Appendix 2.

There is a requirement for maternity services to undertake a Birthrate Plus workforce review every three years. Birthrate Plus is the only nationally recognised, evidence-based workforce planning tool specifically designed for midwifery services and is used to determine the total midwifery establishment required across both hospital and community maternity services. Planning meetings between with the Birthrate Plus team commenced in May 2026, with the assessment phase involving live case-mix data collection July to September 2026 with the final report anticipated in December 2026. This review represents the first comprehensive Birthrate Plus workforce planning exercise undertaken across the integrated MWL Maternity Service, with previous assessments having been completed separately within the legacy organisations.

At the end of Q1 there was a WTE gap in Consultant Obstetrician due to a member of the team taking a career break. The post is advertised for recruitment to the fixed term vacancy with interviews scheduled in Q2.

The neonatal unit on the Whiston site completed the Q1 2026/7 BAPM nursing workforce calculator tool which was submitted to the operational delivery networks (ODN) in July 2026. The workforce tool identifies a 1.17 WTE of neonatal nurse variance in post against required. An action plan has been developed which includes the requirement to review the nursing establishment, which is underway, 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.

Maternity services at both Whiston and Ormskirk are supported by consultant obstetric anaesthetists, with a dedicated duty anaesthetist available 24 hours a day, 7 days a week, in accordance with Anaesthesia Clinical Services Accreditation (ACSA standards).

21. Safety Champions meetings

Monthly Trust Safety Champions meeting occurs attended by Trust Board Executive and Non-Executive safety champions and the Maternity and Neonatal safety champions enabling two-way communication and escalation to the Trust Board

Feedback raised by staff	Action and progress
The colour of the new midwives' uniform has raised concerns in that it is very similar to that of the Medirest staff. A suggestion was made that 'Midwife' could be stitched on to the uniform to better identify them.	Colour aligned to national uniform midwife profile. National estates and facilities uniform review is ongoing which will involve domestic staff. Midwives wearing ID badges on lanyards and clips and updated about uniform.
NNU there were concerns raised about the cots and raising them up as they cause back issues and make it more difficult for parents and staff to lift babies out.	For review by the ward leadership team to explore height adjustable cots
Feedback raised by service users	Action and progress
All parents were extremely complementary regarding the care their baby had received at Ormskirk Neonatal Unit. They rated the staff as 'excellent.' Extremely warm day and no water coolers on unit	Issue in several areas and it is due to IPC restrictions. Same situation on Whiston site, however bottles of water are obtained from catering to give out to parents and to keep in the parent's fridge. Same actioned at Ormskirk.

22. Themes and progress with Perinatal Cultural Improvement Plan

Theme	Progress	Support requirements
Leadership Visible and compassionate leadership	- Listening events established with HR and FTSU support established - Monthly engagement sessions in place - Monthly unit meeting established on Ormskirk site to replicate whiston site process. - Divisional culture plan developed and monitored at DMG and DPR. - All managers and leaders to complete the NHSE self-assessment (by March 2027) on the leadership and management framework	
Communication & Staff Engagement	- Re-introduction of monthly divisional newsletter - To Implement 'Ask the Leadership Team' sessions quarterly. - Star of the month for staff recognition implemented. - Display 'you said, we did' feedback on communal noticeboards. - Cross site daily maternity huddles implemented. - Promote use of wellbeing conversations	
Respect, Civility & Team Culture	- Promote Behavioural Framework - Complete roll-out of Respect & Civility sessions - Promotion of Trust thank-you cards with consideration to reading thank you's out at team huddles	

Safe Staffing	• BR+ review in progress and enact findings once report received. • Rolling recruitment programme successful with minimal maternity vacancies • Align headroom across all legacy sites. • Monitoring of staff breaks. • Pilot of unlimited roster requests in DS (Whiston) which has been replicated across W+C. • Training plan for QIS compliance in NNU. • Review opportunities to support development roles for succession planning.	
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23. Saving Babies Lives V3.2

	Compliance / progress/ action	Responsible role	By when
Element 1 Reducing smoking in pregnancy	All guidelines in place and harmonised. Dashboard monitors compliance with screening at booking, 36/40 and delivery. Continuous audits in place to reflecting compliance. Recent recruitment of permanent staff to Stop Smoking in Pregnancy role, training certificates required as evidence.	Outpatient Matron	30/09/2026
Element 2 Fetal growth	All guidelines in place and harmonised. Dashboard monitors missed SGA and FGR numbers. GROW 2.0 now in use and will be interfaced with BadgerNet.	Fetal surveillance midwives	15/10/2026
Element 3 Reduced fetal movements	Guideline in place and harmonised. RFM audits on-going compliance remains good.	RFM Leads	15/10/2026
Element 4 Fetal monitoring in labour	Guideline in place and harmonised. Audits remain compliant. All required staffing posts remain in place with no vacancies. No action required.	Fetal surveillance	N/A
Element 5 Preterm birth	Guidelines in place and harmonised. All required posts remain in place with no vacancies. Audits continue	Preterm Birth Leads	15/10/2026
Element 6 Diabetes	Compliant guidelines in place on both sites. Harmonised guidance in progress. All required staffing posts remain in place with no vacancies. Continuous audits in place	Diabetes specialist Midwives	15/10/2026

What is going well	Specialist teams for stopping smoking in pregnancy now substantive roles. Fetal surveillance team undertaking live audits for fetal monitoring.
What is of concern	Impact of long-term sickness on non-clinical roles to support audits across all elements
What are the top contributors to over / under achievement	Permanent funding now available for specialist roles who were previously externally funded roles will ensure consistency in ensuring compliance with all audits

24. Maternal Care Bundle Implementation Plan

The Maternal Care Bundle (MCB) is a national quality improvement framework that establishes best practice standards for NHS providers and commissioners to reduce maternal mortality, maternal morbidity and health inequalities which was developed in response to the rising maternal mortality

rates and persistent inequalities in outcomes. The bundle aims to promote consistent, evidence-based, and equitable care across maternity services and the wider healthcare system.

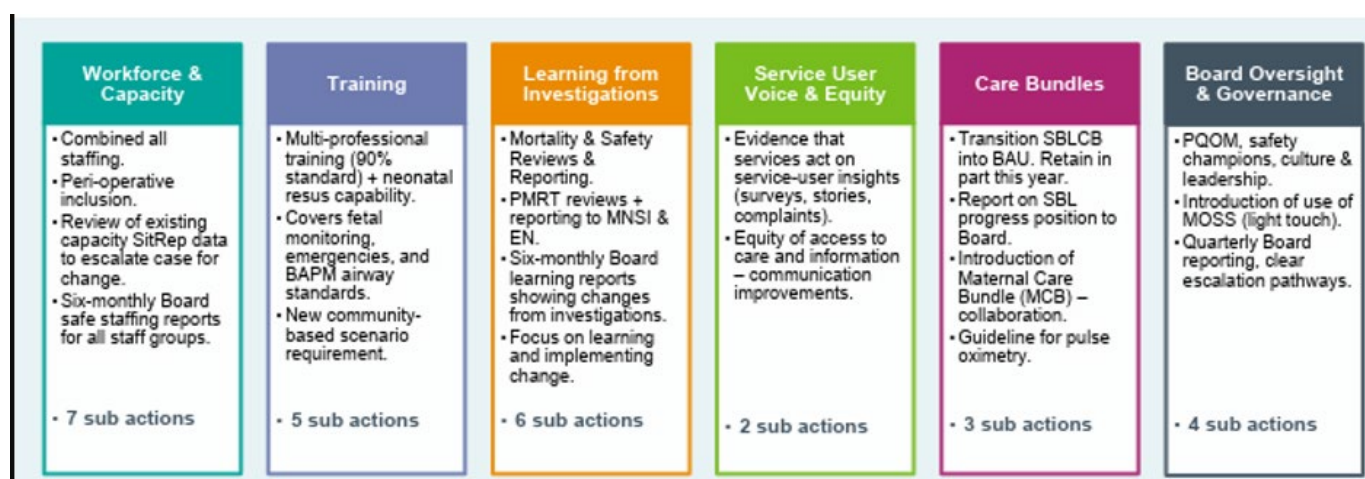
The MCB is structured around five key clinical areas associated with increased maternal mortality and morbidity:

- Venous Thromboembolism (VTE): prevention, risk assessment, and management of thrombosis in pregnancy and the postnatal period.
- Pre-hospital and Acute Care: ensuring timely recognition, assessment, and escalation of acutely unwell pregnant and postnatal women across healthcare settings.
- Epilepsy in Pregnancy: supporting safe and effective management of women with epilepsy before, during and after pregnancy.
- Maternal Mental Health: improving identification, assessment, and management of perinatal mental health conditions.
- Obstetric Haemorrhage: strengthening prevention, early recognition, and management of major haemorrhage to reduce associated morbidity and mortality.

The bundle promotes a whole-system approach, recognising that improving maternal outcomes requires coordinated working across maternity services, primary care, ambulance services, emergency departments, medical specialties, and mental health services. A baseline assessment against the Maternal Care Bundle standards for MWL has been completed, with an accompanying action plan submitted to the LMNS on 03 August 2026. Feedback is currently awaited.

25. Progress to achieve NHS Resolution Maternity Incentive Scheme Year 8

Published on 31 March 2026, Year 8 of the Maternity Incentive Scheme introduced a revised and streamlined framework, comprising six core safety actions (A–F), replacing the previous ten. Safety Actions relating to Maternity Services Data Set reporting and transitional care provision have been removed, reflecting their position as established elements of routine practice. The remaining actions have been consolidated, where appropriate, to provide a more focused and coherent set of requirements.



	Assessment of compliance	Is there clear evidence to support compliance	Gaps requiring action
A - Workforce and capacity	Partially met- Ongoing collation	Neonatal Workforce ODN returns Q1. Neonatal Nursing ongoing action plan. Obstetric services supported 24/7 by duty anaesthetists.	Ongoing audits re Obstetric Consultant attendance. MWL Currently engaged in Midwifery Establishment review with Birthrate Plus (report expected 1 Dec 2026).

	Assessment of compliance	Is there clear evidence to support compliance	Gaps requiring action
		Biannual Midwifery Staffing Paper Q4/Q1.	Annual Capacity and demand mapping for caesarean births July2025-June 2026 commenced. Integrated workforce report
B-Training	Partially met- Ongoing collation	TNA in place In-Situ simulations in both hospital and community NLS taught to BAPM standards	MIS Checkpoint Date 1: 31 July 2026 MIS Checkpoint Date 2: 30 November 2026
C-Learning from reviews and investigations	Partially met- Ongoing collation	All eligible events to date notified via SPEN. Parents invited to participate with questions. 100% PMRT reviews currently have minimum one external members.	
D-Service User Voice and Equity	Partially met- Ongoing collation	MNVP capacity strengthened. Core member of LW Forum/ Governance/ TSC. Monthly feedback report from service users developed. Coproduction of service improvement.	
E-Care Bundles	Partially met- Ongoing collation	SBL and MCB implemented monitored in quarterly perinatal oversight. Guideline for Pulse Oximetry in place for MWL inclusive of homebirth in accordance with BAPM standards.	
F- Board Oversight, Governance, Culture & Leadership	Partially met- Ongoing collation	Board Oversight of Maternity Quality and Safety through Perinatal oversight reports. MOSS completed with oversight of CNO, CMO Board Level Safety champion	Perinatal Culture plan to be reviewed by Trust Board six monthly

Based on the evidence collated to date, there are no concerns requiring escalation in relation to compliance with the scheme standards at the present time. Progress is being demonstrated across all domains, with the majority assessed as partially met due to ongoing evidence collation, review activity, and planned assurance processes rather than identified safety concerns.

Training is required to have a mid-point check date pre agreed with the regional team which is required to meet the 90% compliance. The first agreed checkpoint date is 31 July 2026. Currently anaesthetic consultants are the only staff group below this compliance at the end of Quarter 1. Liaison with the surgical division to ensure allocation and attendance before the end of July 2026.

26. Additional information

The information contained in this report provide data and assurances pertaining to Q1 2026/27. The following updates relate to significant publications/ events occurring after the reporting period but before the presentation of the report. The maternity and neonatal services will provide updates I subsequent reports.

- 10-point urgent action plan for maternity and neonatal services. Assurance tool received 29 August 2026 with an update required to NHSE Regional team by 25 September. Completed baseline tool and associated presentation provided to Quality Committee on 22 September 2026. An action plan is being developed in response.
- National Maternity triage specification published 07 July 2026 and updated on 29 July 2026 with the tool kit received in August 2026. Baseline assessment required to be returned 25 September 2026.

- Postnatal care self-assessment toolkit was submitted on 11 September 2026. There are four domains: Listening to women, addressing inequalities, Workforce/ training and public health with 33 individual Trust sections. The baseline assessment identifies 19 blue fully completed actions, ten green and four amber areas. The amber areas relate to the full implementation of the maternity care bundle, data relating to readmissions and reattendances, pregnancy passports outlining postnatal care plans, and outlining future risks and the requirement for care records that follow women through their maternity journey avoiding the need to repeat information which will be achievable with the new maternity information system once Badgernotes are in use.
- MIS Year 8, training check point 1. Check point 1 was undertaken as scheduled on 31 July 2026 and all staff disciplines achieved the required 90% compliance to perinatal safety training.
- The maternity service on the Whiston site received a Maternity Outcomes Signal system (Moss) Level 1 signal on 07/08 regarding a potential intrapartum safety issue due to three term stillbirths.

This required the service to undertake a critical safety check list and submission for Executive sign off by the 14 August 2026 (five working days) to NW Regional team which was completed. All three cases were antenatal stillbirths with deaths confirmed upon presentation at the Trust and not during intrapartum period. The National team advised that the system did not differentiate between term intrapartum stillbirths and term intrauterine antenatal stillbirths and requested completion of the safety check.

Following completion, the service declared green/amber status following discussion with the regional team due to data relating to category 2 CS compliance rates of 73.46% average over the preceding three months. The criteria for category 2 CS is a timing of decision to deliver interval of 75 minutes with the definition being CS required which require delivery but is not immediately life threatening. All incidents are reviewed and causes for deliveries outside of the required time frame noted to identify any learning. There were some cases of theatre capacity and prioritisation affecting the delays and current capacity and demand for CS is underway. There were no adverse outcomes in the woman that experienced a delay. Incident reviews and audits continue with monthly monitoring at the maternity forum and Divisional Management Group.

27. Recommendations

The Trust Board is asked to note the contents of the report and take assurance from the progress against maternity and neonatal quality, safety, workforce, and patient experience measures, with ongoing monitoring of identified improvement actions through existing governance arrangements.

The baseline assessment against the 10-point action plan was reviewed by Quality Committee on 22 September 2026. As the submission deadline of 25 September 2026 preceded the next scheduled meeting of the Trust Board, approval to submit the assessment to NHS England was obtained from the voting members of the Board by written resolution. The baseline assessment is included with this paper for completeness.

28. Appendices

- Appendix 1 Whiston Midwifery Staffing Report
- Appendix 2 Ormskirk Midwifery Staffing Report
- Appendix 3a Completed 10-point action plan baseline assessment
- Appendix 3b Evidence Log
- Appendix 4 10-Point Action Plan Presentation



Maternity Safer Staffing Oversight Report Q4 2025/26 and Q1 2026/27 (1 Jan 2026- 30 June 2026) Whiston Site

Purpose:

CNST MIS Safety Action A requires submission to Trust Board of biannual midwifery staffing oversight report that covers staffing/safety issues (in line with NICE midwifery staffing guidance). The previous report received by the Quality Committee on 17 February 2026.

This report provides the continued assurance of safe staffing within MWL Maternity Services between 1 Jan 2026- 30 June 2026. Included in the report is a breakdown of Birth Rate+ (workforce planning tool for midwifery) and funded establishment for financial year 2026/27 demonstrating compliance with outcomes of Birth Rate+ audit received in 2022. Additionally included in the report is the midwife to birth ratio, evidence from the maternity clinical dashboard demonstrating compliance with supernumerary Delivery Suite co-ordinator on duty at the start of every shift, and the provision of one-to-one midwifery care in active labour.

Maternity services are currently in the process of completing a BR+ establishment review, with live case mix analysis being undertaken in Q2 2026/27. The final report is expected by December 2026.

Corporate objectives met or risks addressed:

Care, Safety, Pathways

Financial implications:

None as a direct consequence of this paper.

Stakeholders:

The Trust, Staff, Patients

Recommendation(s):

It is recommended that the Trust Quality Committee receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.

Report Author:

Alison Murray, Divisional Deputy Director of Midwifery Whiston Site

Background

Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Central to the development of safe maternity staffing has been the overarching policy publications; '*Safe Midwifery Staffing for Maternity Settings*' (NICE 2015), '*Better Births*' (NHS England 2016) and '*Safe, Sustainable and Productive Staffing 'An Improvement Resource for Maternity Services*' (NQB 2018).

Safe and effective midwifery staffing is fundamental to the delivery of high-quality maternity care and to ensuring positive outcomes for women, babies, and families. Adequate staffing levels support timely, compassionate, and evidence-based care across the maternity pathway, while also enabling midwives to work safely and sustainably.

This report has been developed in line with NICE (2019) *Safe Midwifery Staffing for Maternity Settings* and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), specifically Safety Action A: Workforce and Capacity. NICE recommends that organisations responsible for maternity services undertake a systematic review of the midwifery staffing establishment at least every six months, covering all areas of service provision, including preconception, antenatal, intrapartum, and postnatal care.

The purpose of this report is to present the outcomes of the most recent safe staffing review, consideration of service activity and acuity, and identification of risks associated with staffing capacity and capability. The report provides assurance that workforce planning processes are robust, evidence-based, and meet the minimal evidential requirements of CNST MIS, supporting effective governance, quality improvement, and ongoing patient safety.

A meeting with the BR+ team took place in September 2025 to agree the requirements for MWL to undertake an establishment review in line with the three year cycle 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. However, the BR+ assessment did not commence at that time due to the decision to implement pathway changes between the Ormskirk and Whiston sites and 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 confirmed that BR+ remains a credible and robust approach to midwifery workforce planning, supporting safe and sustainable maternity services. However, it identified 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.

BR+ have advised that the findings of the independent review have now been considered and as such re-engagement was commenced in May 2026, with data collection and case mix analysis being undertaken in Q2 2026/27. A full report is expected by 1 December 2026.

Birth Rate at Whiston Maternity Site

MWL maternity services utilises scenario-based forecasts based upon the previous years and projected births as per national recommendations (NICE 2015). The rationale for utilising projected birth rates to plan for midwifery staffing is to estimate the potential resource impact associated with recommendations regarding midwifery staffing ratios and

provide a woman in established labour with supportive one-to-one care, that is essential for safe midwifery care.

Births

The number of births at MWL Whiston site between 1 Jan 2026- 30 Jun 2026 was 1842 which was a decrease of 5 births (0.2%) from the previous six-month reporting period and an increase of 5.6% compared to the same reporting period in 2025.

Month	Jan	Feb	Mar	Apr	May	Jun	Total
2026 Births	304	260	338	292	322	326	1842
2025 Births	279	261	326	265	310	302	1743
Variance	25	-1	12	27	12	24	99

Bookings at MWL Whiston site between 1 Jan 2026- 30 June 2026 were 2079 which identifies a decrease of 23 bookings (1.1%) compared to the previous six-month period, with a 4.8% increase compared to the same reporting period in 2024.

Month	Jan	Feb	Mar	Apr	May	Jun	Total
2026 Bookings	360	340	371	349	319	340	2079
2025 Bookings	357	311	341	309	327	331	1976
Variance	3	29	30	40	-8	9	103

Workforce Planning - BIRTHRATE PLUS® and Maternity Staffing Establishments

The Maternity Incentive Scheme (MIS) Year 8 Safety Action A requires that Trusts demonstrate an effective system of midwifery workforce planning. Birthrate Plus® (BR+) is a recognised tool for workforce planning and strategic decision-making.

The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

BR+ is the only nationally endorsed tool for calculating maternity staffing levels. The methodology is based on an assessment of clinical risk and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-delivery period, and the postpartum period utilising the accepted safe standard of one Midwife to one woman in labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives safe care in labour. BR+ determines the total midwife hours needed and therefore the staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice based on clinical complexity of women who use the service.

Each individual service has their case mix identified using 5 different categories (Cat 1- V) with the lower the score the more normal the processes are for labour and birth and the higher scores indicating when a mother and/or baby require a very high degree of support or intervention. Together with the case mix, the number of midwife hours per patient/client category plus extra midwife time needed for the complicated categories of III, IV & V and

calculates the clinical staffing for the annual number of women delivered. Additionally included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The most recent BR+ workforce review was commissioned for Whiston, with a final report being received in October 2022. The report was based on the annual activity of the FY 20/21- and three-months case mix data obtained for the months of August – October 2020.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and the report recommended a clinical workforce establishment of 175.47wte inclusive of 9% for non-direct clinical midwifery roles. The report also details that the addition of other support staff that do not contribute to the clinical establishment will be necessary (e.g. Band 2 HCAs for the effective functioning of the ward).

The report also identified that the proportion of the case mix had shifted from the previous BR+ study undertaken in 2016, with more women in the higher categories which reflected an increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions: as such this demonstrated an increase in the clinical workload hours required to provide safe care for each woman. This is consistent with the national trend of intervention as providers have implemented the recommendations of Saving Babies Lives Care Bundle and greater maternal choice.

STHK	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2020 DS % case mix	0.5%	6.5%	32.1%	27.9%	33%
	39.1%			60.9%	
2016 DS % case mix	7.7%	17%	23.4%	29.2%	22.7%
	48.1%			51.9%	
2020 Generic % case mix	3.7%	11.2%	29.5%	25.6%	30%
	44.4%			55.6%	

The report highlighted that the Generic case mix in 2020 indicated that 55.6% of women were in the 2 complex categories IV and V, which was below the average for England of 58%. There was no comparative data in the 2016 report for this.

The establishment figures provided to BR+ were correct at the time of submission of the data, however changes to the funded establishment occurred in 2022 following the TUPE transfer of staff from the Bridgewater Community Trust that increased staff, activity, and the respective budgets. Additional changes were implemented in 2023 thereby increasing the funded establishment because of adding Ockenden funded monies following this transfer and by reorganisation and realignment of existing vacancies.

The below table provides the funded and contracted establishment for the midwives/ MSW providing direct and non-direct clinical midwifery care as of 30 June 2026.

Direct clinical care

Midwives	Funded (WTE)	Contracted (WTE)	Variance (WTE)
Band 7	19.00	17.33	-1.67
Band 5/6	123.26	120.48	-2.78
Band 3 MSW	30.17	26.29	-3.88
Total	172.43	164.10	-8.33

Non-direct clinical care

Midwives	Funded (WTE)	Contracted (WTE)	Variance (WTE)
8 and above	5.00	5.00	0
Band 7/6	19.20	14.20	-5.00
Total	24.20	19.20	-5.00

The BR+ report identified that the required WTE for the provision of direct maternity care was 160.98 WTE with a recommended ratio split between Midwives and Maternity support workers working on the postnatal ward and in community. The current funded clinical establishment is 172.43 WTE with changes due to the realignment of support worker roles in line with the Trust wide Band 2/3 consultation.

The Trust Board has agreed to substantively over establish by an additional 6.00 WTE to cover maternity leave, and therefore the maternity funded establishment for the provision of direct midwifery care as of the 30 June 2026 is above the recommendations of the BR+ workforce review.

At the time, the BR+ report identified that 14.49 WTE is recommended as the staffing requirement for non-direct clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is currently 24.20 WTE which does include 0.8 WTE internal funding received for fixed term contract of Digital Midwives specifically for the BadgerNet project up to 31 December 2026. Previously externally funded posts including Preceptorship, Bereavement and Pre Term Birth have been excluded from the overall funded establishment, however following receipt of a letter at the end of Q1 where external monies have now been given to permanently fund and enhance these roles they are included overall. The vacancy in the non-clinical roles is predominantly driven by additional vacancies created following receipt of these monies which includes expanding the Bereavement service to a 7-day service, and further support for Preceptorship and other specialist roles. In conjunction with Ormskirk site service reviews are now underway to implement a model for MWL with recruitment to be undertaken.

The funded establishment as of 30 June 2026 is 196.63WTE which is above the recommendations of previous BR+ report, but recognises the changing complexity as highlighted in the national review.

The 2022 BR+ report analysed data and acuity for the current model of care provided within the Whiston maternity service and did not reflect any future or continuity of carer caseload teams. The maternity service may need to consider utilising the Continuity of Carer deployment tool to assist with determining the required additional number of midwives needed to deliver MCoC at full scale as we progress through the revised MCoC action plan which is currently paused following executive agreement. At present this tool is not endorsed by NHS England.

Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing. Additionally, twice weekly meetings are held to monitor staffing fill rates and to allocate bank shifts to ensure consistent and safe staffing levels and mitigate staffing shortages.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline is followed which includes the redeployment of staff. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address periods of high acuity in clinical activity to maintain a safe clinical staffing ratio.

The Maternity bleep holder documentation contains comprehensive accounts of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation. A daily national and local sit rep are also completed each day to provide system overview. This identifies current activity, escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid to other providers at a system level.

Maternity Workforce Measures

Recruitment

There is an ongoing rolling recruitment programme to address any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave, requests to reduce contracted hours and retirements.

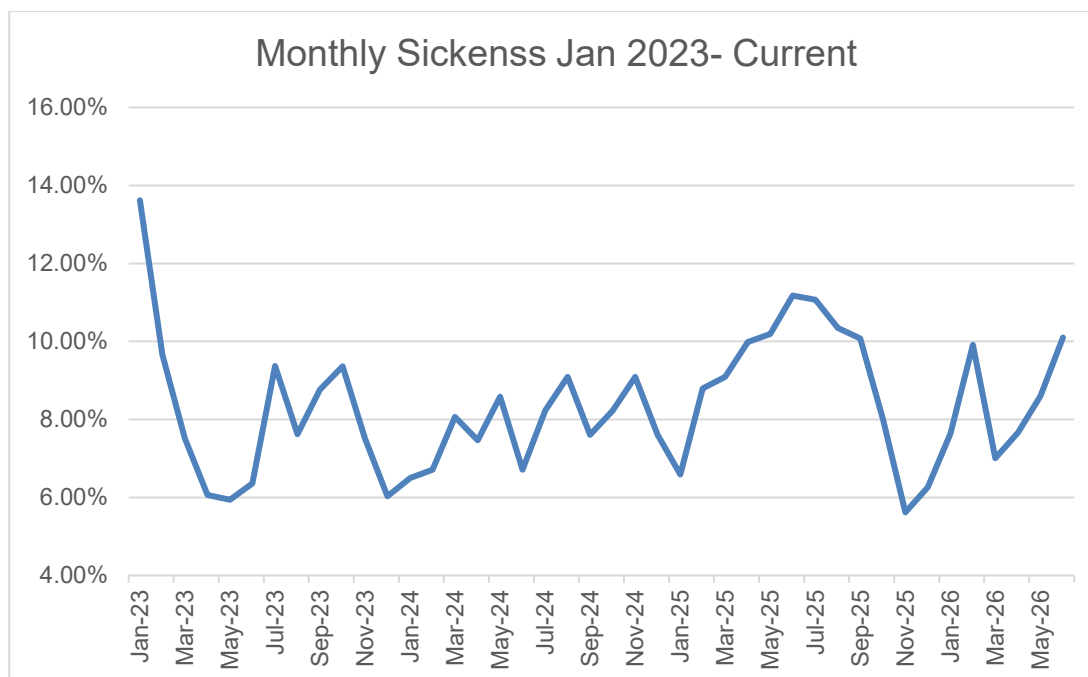
Proactive recruitment has occurred to ensure those who have been promoted, reduced hours, submitted notice of retirement or are leaving the organisation are being replaced. This has included 5.56WTE Midwives who are currently in recruitment processes with anticipated start dates planned in July with a further advert posted to ensure recruitment of NQM for October start date to ensure establishment of 6.0WTE above funded for Maternity leave cover is maintained.

There are currently MSW posts being advertised. Positively, four MSWs within the service have successfully secured places to commence nursing or midwifery training in September, demonstrating the service's contribution to developing the future healthcare workforce

Sickness Absence

	Jan	Feb	Mar	Apr	May	June
Sickness 26	7.64%	9.91%	7.01%	7.66%	8.60%	10.10%
Sickness 25	9.99%	10.19%	11.18%	11.07%	10.35%	10.08%

There has been a reduction in the level of sickness in 2023 since the 13.62% rate in January 2023 for all Maternity staff including Covid-19 related sickness figures, however seasonal fluctuations continue to occur, and sickness remains above trust target of 4.5% which has been allocated as part of the headroom uplift. At the end of Month 3 sickness was 10.10% It is noted that sickness in North West for Maternity Services is higher than other staff groups.



Sickness and absence management is monitored in accordance with policy supported by HR and HWWB. Divisional sickness reviews continue as does the emphasis on completing return to work interviews. Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy with the majority of current LTS cases in the 0–3-month timescale.

Age Profile of Midwifery Staff

The table below indicates the age profile for Midwifery staffing with the largest staff group currently being aged 26-30 years of age. The maternity service had a number of leavers in FY 23/24 due to retirement which has impacted on the experienced skill mix, and subsequent recruitment has employed predominantly newly qualified midwives. More than 50% of the Midwifery workforce are now 40 yrs or younger and therefore it is anticipated that overcoming years we will see a greater impact of maternity leave unavailability on the establishment.

Age Band	Headcount	%
<=20 Years	1	0.38
21-25	15	5.77
26-30	35	13.46
31-35	37	14.23
36-40	44	16.92
41-45	33	12.69
46-50	20	7.69
51-55	25	9.62
56-60	35	13.46
61-65	14	5.38
66-70	1	0.38

Whilst there is currently an agreement to over-recruit to BR+ recommended establishment by 6.00WTE Midwives, this may need to be reviewed in view of a changing demographic of an entirely female workforce.

At the end of Q1 4.25 WTE Midwives were unavailable and on maternity leave, with an additional further 4.03WTE due to commence in Q2. The table below demonstrates the actual and continued predicted Maternity Leave within the service for the remainder of the FY based upon what has been shared with the leadership team to date.

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
WTE	5.86	4.25	4.25	6.48	7.28	8.28	8.28	8.28	7.48	7.48	7.48	7.48

Quality of Care Measurements

Midwife to Birth ratio

MWL currently use the formula and methodology suggested by BirthRate Plus to produce the calculation. The LMNS have been asked to support in looking at a review across C&M to ensure that the calculation of the midwife to birth ratio is standardised and consistent for all providers, specifically relating to non-direct care giving staff, DS shift coordinators and ward managers and if they are included or excluded in the calculation.

Date	Midwife to Birth ratio
Jan 26	1:26
Feb 26	1:23
Mar 26	1:29
Apr 26	1:27
May 26	1:27
Jun 26	1:27

Supernumerary Shift Coordinator on Delivery Suite

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area and are present 24/7 and are a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. The shift co-ordinator is rostered independently from the core midwifery staffing, and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Date	Supernumerary Shift Coordinator
Jan 26	100%
Feb 26	100%
Mar 26	100%
Apr 26	100%
May 26	100%
June 26	100%

One to One Care in Labour

Safe Staffing for Maternity Setting (NICE 2015) stipulates that care should be provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same Midwife for the whole of labour). Compliance is monitored monthly on the maternity dashboard and compliance for the period was 100% and there have not been any occurrences where this has not been achieved in the previous 12 months.

Date	One to One Care in Labour
Jan 26	100%
Feb 26	100%
Mar 26	100%
Apr 26	100%
May 26	100%
June 26	100%

Midwifery Red Flag Events

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.

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

The following are the recommended red flags which require documenting via the Datix Incident Reporting System.

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an 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 (BSOTS)
- 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 beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Red Flag Event	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Total
Delayed or cancelled time critical activity	0	0	0	0	0	0	0
Missed or delayed care	0	0	0	0	0	0	0
Missed medication	0	0	0	0	0	0	0
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	0
Delay of 15 minutes or more between presentation and triage	11	2	8	1	13	8	42
Delay of 30 minutes or more between presentation and triage	4	0	0	0	0	0	4
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	0
Delay of 2 hours or more between admission for induction and commencing the process	0	0	0	1	1	0	2
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0
Any occasion when 1 Midwife cannot provide continuous 1:1 care in labour	0	0	0	0	0	0	0

There were 46 Midwifery Red Flags reported in Q4/Q1, 42 which related to a delay in 15 Minutes or more from presentation to triage. The NICE reporting standard Red Flag is a woman to be triaged within 30 minutes of attending the maternity unit, but as a maternity service we have chosen to reduce this to the 15 minutes as recommended within BSOTS (Birmingham Symptom specific Obstetric Triage System) which in line with Cheshire and Mersey LMNS providers as a local Midwifery Red Flag.

Red Flag delays reported in relation to attendance to commencement of induction of labour when women were booked to attend Delivery Suite directly from home, and due to high acuity at the time, commencement of induction was delayed in order for midwives to continue to appropriately prioritise the provision of continuous 1:1 midwifery care. Induction was commenced as soon as practicable, and apologies offered to the women.

All delays in triage were due to a high acuity and capacity and numerous women attending simultaneously. Following targeted training in 2025 around how to address and seek clinical support when simultaneous attendances occur, the department initially saw an increase in red flags which represented an improved reporting culture, allowing the identification of themes and trends as systems and processes regarding escalation have now been embedded within the department. The new central telephone system has had a positive impact in ensuring all calls are answered with appropriate support and action taken at times, however an emerging theme of high volume of calls alongside triage breaches has been highlighted in the analysis and is being monitored by the department leads. It is noted that the attendances through Triage continue to increase and during the reporting period the service experienced at 14.2% increase in the number of attendances.

The Red Flags are all incident reported, and any learning from Red Flag incidents is disseminated via ward meetings, safety huddles and the Obstetrics & Gynaecology Clinical Governance & Quality meetings. All midwifery red flags were reviewed by the Clinical Lead and Matron for the area and there were no additional incidents related to these delays in undertaking triage or commencement of induction, and no harm occurred.

Continuity of Carer

Whiston developed revised plan for the delivery of a Maternity Continuity of Carer model in line with delivering 'Maternity Continuity of Carer Model at Full-Scale' guidance which identified that a whole new model of care is required utilising a mixed risk model providing enhanced midwifery care to women and babies of Black, Asian and mixed ethnicity and those living in the 10% decile of deprivation, which has previously been submitted to Quality committee, Trust Board and to the LMNS in 2022.

The current homebirth team provides full continuity of care to women once a decision has been made to birth at home which can be undertaken at any stage of a woman's antenatal pathway. The amethyst team continues to provide continuity to the most vulnerable women although they are currently unable to provide the intrapartum element of the model currently with the intrapartum support coming from the Delivery suite.

Following the formation of MWL the current MCoC position and expansion at both legacy sites is currently on hold which has previously been agreed at Board level. The Maternity service formally began to align community Midwifery services across MWL footprint in readiness for a whole scale re-review of the plans for MCoC as part of Community Midwifery Matron portfolio in April 2025. During the alignment and wholesale review of the MCoC plan as an MWL maternity service the current MCoC teams from the legacy organisations will remain operational.

The BR+ report reflects the current traditional model of care and does not provide any recommendations for the delivery of CoC. A full review using the National CoC workforce tool will be required to determine what additional staffing will be required to fully implement CoC, however this tool is not currently endorsed by NHSE as evidence based.

Summary

The number of births at MWL Whiston site between 1 Jan 2026 - 30 June 2026 was 1842 which was a decrease of 0.2% from the previous six-month reporting period. It is important to not see the activity as numbers alone and recognise increasing complexities and shifts in case mix of women with increasing induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions. It is anticipated in the BR+ establishment review currently being undertaken we are likely to see a greater shift in women categorised as IV and V.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and identified that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment at the end of June 2026 is 24.20WTE following the receipt of the recurring Ockenden monies and is inclusive of additional 0.8WTE for the BadgerNet project and is therefore above the recommendations.

The BR+ report concluded that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 172.43 WTE due to changes following TUPE transfer, conclusion of Band 2/3 establishment reviews which have positively impacted the postnatal ward, and a continued agreement to establish by substantively an additional 6.0 WTE to cover maternity leave.

The total funded establishment as of 30 June 2026 is 196.63 WTE which is above the recommendations of the previous BR+ assessment and includes the additional Ockenden funded posts.

Headroom for the service is currently factored at 22%. This is inclusive of annual leave, sickness; however, this may need to be revisited in view of the increasing demand on the requirements of maternity safety training.

Midwife to Birth ratio is between 1:23 and 1:27. The LMNS have been requested to review how this is calculated to ensure consistency across Cheshire and Mersey providers and consistent benchmarking. MWL currently uses the calculation recommended by BR+.

There has been 100% compliance noted for the provision of one-to-one care in labour and the availability of a supernumerary Delivery Suite shift coordinator for this six-month reporting period.

In the six-month period there were 46 Midwifery Red Flag events reported, which was a increase from previous reporting period. All were reviewed by the Clinical Lead and Matron for the area and there were no additional incidents related to these delays in undertaking triage and no harm occurred.

The current Birthrate plus report was provided in 2022. Planning meetings with the Birthrate Plus team commenced in May 2026, with the assessment phase involving live case-mix data collection commencing between July to September 2026 with a final report anticipated in December 2026. This review represents the first comprehensive Birthrate Plus workforce planning exercise undertaken across the integrated MWL Maternity Service, with previous assessments having been completed separately within the legacy organisations. Findings will be reviewed, shared and actioned accordingly when received.

Appendix:
BirthRate Plus Report STHK Oct 2022



St Helens &
KnowsleyTeaching Hc



Maternity Safer Staffing Oversight Report Q4 2025/26 and Q1 2026/27 (1st January 2026- 30th June 2026) Ormskirk Site

Purpose:

CNST MIS Year 8 Safety Action A requires submission to Trust Board of biannual midwifery staffing oversight report that covers staffing/safety issues (in line with NICE midwifery staffing guidance). The previous report received by the Quality Committee on 17 February 2026.

This report provides the continued assurance of safe staffing within MWL Maternity Services between 1st January 2026- 30th June 2026. Included in the report is a breakdown of Birth Rate+ (workforce planning tool for midwifery) compared to the findings of the Birth Rate+ report received in 2022. Additionally included in the report is the midwife to birth ratio, evidence from the maternity clinical dashboard demonstrating compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one midwifery care in active labour.

Maternity services are currently in the process of completing a BR+ establishment review, with live case mix analysis being undertaken in Q2 2026/27. The final report is expected by December 2026.

Corporate objectives met or risks addressed:

Care, Safety, Pathways

Financial implications:

None as a direct consequence of this paper.

Stakeholders:

The Trust, Staff, Patients

Recommendation(s):

It is recommended that the Trust Quality Committee receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.

Report Author:

Background

Maternity services in the NHS have seen notable change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies, and families. Central to the development of safe maternity staffing has been the overarching policy publications; '*Safe Midwifery Staffing for Maternity Settings*' (NICE 2015), '*Better Births*' (NHS England 2016) and '*Safe, Sustainable and Productive Staffing 'An Improvement Resource for Maternity Services*' (NQB 2018).

Safe and effective midwifery staffing is fundamental to the delivery of high-quality maternity care and to ensuring positive outcomes for women, babies, and families. Adequate staffing levels support timely, compassionate, and evidence-based care across the maternity pathway, while also enabling midwives to work safely and sustainably.

This report has been developed in line with NICE (2019) Safe Midwifery Staffing for Maternity Settings and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), specifically Safety Action A: Workforce and Capacity. NICE recommends that organisations responsible for maternity services undertake a systematic review of the midwifery staffing establishment at least every six months, covering all areas of service provision, including preconception, antenatal, intrapartum, and postnatal care.

The purpose of this report is to present the outcomes of the most recent safe staffing review, consideration of service activity and acuity, and identification of risks associated with staffing capacity and capability. The report provides assurance that workforce planning processes are robust, evidence-based, and meet the minimal evidential requirements of CNST MIS, supporting effective governance, quality improvement, and ongoing patient safety.

A meeting with the BR+ team took place in September 2025 to agree the requirements for MWL to undertake an establishment review in line with the three year cycle 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. However, the BR+ assessment did not commence at that time due to the decision to implement pathway changes between the Ormskirk and Whiston sites and 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 confirmed that BR+ remains a credible and robust approach to midwifery workforce planning, supporting safe and sustainable maternity services. However, it identified 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.

BR+ have advised that the findings of the independent review have now been considered and as such re-engagement was commenced in May 2026, with data collection and case mix analysis being undertaken in Q2 2026/27. A full report is expected by 1 December 2026.

Birth Rate at Ormskirk Maternity Site

Births

The number of births at MWL Ormskirk site between 1st January 2026 – 30th June was 978 which was almost the same (-1) as the previous six-month reporting period and a decrease of 28 births (2.78%) from the same reporting period in 2025.

Month	Jan	Feb	March	April	May	June	Total
Q4 2025 and Q1 2026 Births	173	172	143	159	158	173	978
Q4 2024 and Q1 2025 Births	158	148	153	180	184	183	1006
Difference per month	+15	+24	-10	-21	-26	-10	-28

Month		July	Aug	Sept	Oct	Nov	Dec	Total
Q2 - Q3 2025 Births		183	169	151	173	158	145	979

Bookings

Bookings at Mersey and West Lancashire (MWL) Ormskirk site between 1 January 2026 and 30 June 2026 totalled 1,249, representing an increase of 60 bookings (5%) compared with both the preceding six-month period and the corresponding reporting period in 2025, which recorded the same number of bookings.

Month	Jan	Feb	March	April	May	June	Total
Q4 2025 and Q1 2026 Bookings	223	211	205	201	196	213	1249
Q4 2024 and Q1 2025 Bookings	186	177	206	211	194	215	1189
Difference per month	+37	+34	-1	-10	+2	-2	+60

Month	July	Aug	Sept	Oct	Nov	Dec	Total
Q2 2025 and Q3 2025 Bookings	225	213	181	198	177	195	1189

Workforce Planning - BIRTHRATE PLUS® and Maternity Staffing Establishments

The Maternity Incentive Scheme (MIS) Year 8 Safety Action A requires that Trusts demonstrate an effective system of midwifery workforce planning. Birthrate Plus® (BR+) is a recognised tool for workforce planning and strategic decision-making.

The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Birthrate Plus is a framework for workforce planning based on an understanding of the total midwifery time required to care for women with a minimum standard of the provision of one-to-one midwifery care to women throughout their established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Birthrate Plus® is the only nationally endorsed tool for calculating maternity staffing levels. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-

delivery period and the postpartum period utilising the accepted standard of 1 Midwife to 1 woman in labour. This determines the total midwife hours needed and therefore the staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice.

Each individual service has their case mix identified using 5 different categories (Cat 1- V). The lower the score the more normal the processes are for labour and birth and the higher scores indicating when a mother and/or baby require a very high degree of support or intervention. Together with the case mix, the number of midwife hours per patient/client category plus extra midwife time needed for the complicated categories of III, IV & V and calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in the community for those birthing at Ormskirk, or neighbouring units or at home.

S&OHT	% Cat I	% Cat II	% Cat III	% cat IV	% Cat V
2021 DS % case mix	4.1%	14.1%	23.6%	27.5%	30.7%
2018 DS % case mix	4.1%	14.1%	30.8%	23.2%	27.8%

The most recent BR+ report was completed on 9th January 2022 and was based on the births and forward bookings for 2021/2022 which was 2387 births. The recommendation for the funded establishment for the provision of direct midwifery care included a 25% uplift for annual leave, sickness, and study leave.

The Maternity funded establishment for the provision of direct midwifery care at the time of this staffing report is above the recommendations of the current Birthrate plus assessment. Following publication of the report and a serious incident within the Maternity service the Trust Board agreed to increase the funded establishment by 5.55 WTE to provide separate cover for elective caesarean section lists, increased training as a result of Ockenden requirements followed by a further number of externally funded posts.

A staffing review in 2023 also resulted in an increase of the funded establishment for direct midwifery care to include an average uplift representative of the previous 3 years annual leave, sickness, training, and maternity leave as per Ockenden essential safety action one. The previous uplift for midwifery staffing of 25%, was subsequently increased to 30%.

The below table demonstrates the funded and contracted establishment for the midwives providing direct and non-direct clinical midwifery care.

Direct care

Midwives	Funded establishment	Contracted	Variance (WTE)
Band 7	17.34	16.81	-.053
Band 5/6	90.97	87.25	- 3.72
Band 3 MSW	5.28	5.28	0
Total	113.59	109.34	-4.25

Non direct clinical care

Senior management and specialist midwives	Funded establishment	Contracted	Variance (WTE)
8 and above	5.00	3.9	-1.1
Band 7	11.10	11.1	0
Band 5/6	0.7	0.1	-.6
Total	16.8	15.1	-1.7

The above band posts include 3.6WTE wte externally funded posts of which there are 0.4wte additional hours for the Bereavement midwife, 1wte preceptorship/workforce midwife, 0.2wte pre-term birth and multiple pregnancy midwife, 1wte digital midwife (funded by Digital transformation team until 31st December 2026) and 1 wte Smoking Cessation midwife. In addition, there is 0.6wte externally funded band 6 hours for MSW support midwife which equate to a total of 4.2wte.

The BR+ report identified that 9.51wte is recommended as the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical whole time equivalent (wte). The current funded non-direct care equates to 16.8wte. The contracted establishment is currently 15.1wte and slightly below the funded establishment due to a vacancy for 0.1wte matron hours which has not been increased following a pension draw down and 1wte risk and Governance Lead. In addition, there is a 0.6wte vacancy for the MSW support midwife.

The current funded establishment relates to 14.8% 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 report concluded that the required whole-time equivalent for the provision of direct maternity care was 105.63wte which, included a 25% uplift for annual leave, sickness, and study leave based on the births which was 2387 and forward bookings for 2021/2022.

The funded clinical midwife establishment for the reporting period is 113.59wte inclusive of 5.28wte MSW's. This is a positive variance of 7.96wte to the birthrate plus recommendation due to the increased 30% uplift, additional provision of cover for elective caesarean section list, 0.2wte specialist multiple birth midwife and increased training due to Ockenden recommendations.

The total workforce requirements based on BR+ recommendations was 115.14wte and the current funded establishment is 130.39wte.

The staffing position at the end of June 2026 identified that the unit was above the BR+ funded establishment recommendations for the maternity workforce based on our current modelling ratio of midwife to MSW and inclusive of additional funding since the workforce assessment.

The current vacancy is 5.95wte across all midwifery posts.

The BR+ report highlights the required additional support for Band 2 support workers whose roles are essential to the service but are not included in the midwifery ratio calculations, the requirement for these support staff to be decided by professional judgement. Currently there are sufficient band 2 and 3 support workers funded across the service to provide support for midwives however, there is a current vacancy of .64wte band 3 and 5.49wte band 2. The vacancy is largely due to the band 2/3 review.

The BR+ report analysed data and acuity for the current model of care provided within the Southport and Ormskirk maternity service and did not reflect any future plans or continuity of carer caseload teams. The maternity service may need to consider utilising the Continuity of Carer deployment tool to assist with determining the required additional number of midwives needed to deliver MCoC at full scale as we progress through the revised MCoC action plan which is currently paused following executive agreement. At present this tool is not endorsed by NHS England.

Maternity Staffing (Planned versus Actual)

Maternity services has an established process for the daily review of planned versus actual staffing levels. In addition, regular staffing meetings are held to monitor fill rates and allocate bank shifts where required, ensuring consistent and safe staffing levels while mitigating the impact of workforce shortages.

A dedicated 24/7 maternity bleep holder is in place. This role is undertaken by a senior midwife at Band 7 or above, who has oversight of staffing levels and clinical activity across the service and coordinates any necessary redeployment of staff to maintain safe midwifery staffing levels. This may include the redeployment of members of the senior management team and specialist midwives, as well as the implementation of the maternity escalation process, to maintain safe staffing levels and clinical care standards.

Designated overnight bleep holder cover was introduced as a pilot on a number of nights each week from 1 June to evaluate the effectiveness and added value of this role within the smaller maternity unit.

Maternity bleep holder documentation is completed a minimum of four times daily and includes a record of planned versus actual staffing levels, together with an assessment of service activity and capacity. Any staff redeployment, escalation actions, or mitigation measures are documented by the bleep holder. Should staffing fall below the numbers of midwives to provide safe care, the Maternity Escalation Guideline is followed which includes the redeployment of staff.

The Maternity bleep holder documentation contains comprehensive accounts of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation.

A daily national and local sit rep are completed each day to provide system overview. This identifies current activity, escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid to other providers at a system level.

Maternity Workforce Measures

Recruitment

There is an ongoing rolling recruitment programme in place to address workforce vacancies at the earliest opportunity and to proactively mitigate anticipated staffing gaps arising from maternity leave, retirements, and other workforce changes.

The preceptorship development pathway for Band 5 midwives has been revised and harmonised across MWL to support transition to Band 6 for those who demonstrate the required competencies and readiness, typically at around 12 months post-qualification.

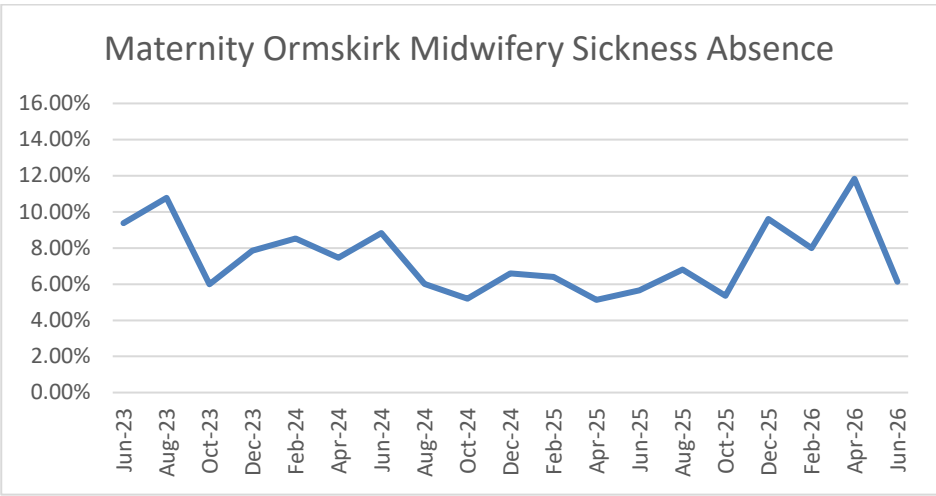
Preceptorship midwives rotate through clinical areas every three months, enabling them to gain a broader range of experience across the service and supporting a timelier development of knowledge, skills, and competence.

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.

Sickness Absence

	Jan	Feb	March	April	May	June
Sickness	10.6%	8%	6.94%	11.83%	8.03%	6.13%

Over the past 6 months Midwifery sickness levels have varied between 11.83% and 6.13% with the sickness rate in June being at the lowest rate. There have been no trends to the sickness with the majority being due to short term sickness. There have been 23 episodes of sickness extending over a month during this period. The themes for this have been predominantly pregnancy related, musculoskeletal and anxiety and depression. At the end of this reporting period 9 midwives remain on long term sickness absence. Staff shortages have been mitigated by offering bank hours. Maternity staffing and activity are monitored frequently every day with staff being redeployed to the clinical area of greatest need.



Sickness and absence management is monitored in accordance with policy supported by HR and HWWB. Divisional sickness reviews continue with an emphasis on completing welcome back conversations. Robust sickness management are managed in line with policy with the majority of current LTS cases being in the 0–3-month timescale.

Age Profile of Midwifery Staffing

The table below illustrates the age profile of the midwifery workforce, with 43.9% of staff aged between 36 and 50 years. The most recent workforce data shows that recruitment undertaken during 2024 and 2025 has resulted in a changed age distribution across the service. 20.21% of midwives are now aged under 36 years, while 28.77% are aged over 50 years, indicating a broader spread of experience and supporting future workforce sustainability.

There are a small proportion of staff approaching or exceeding the current State Pension age. 1.44% of the midwifery workforce are aged over 66 years. This suggests that the risk of significant workforce loss due to retirement in the immediate future is limited, although continued workforce planning remains essential to maintain a sustainable staffing profile.

Age Band	Headcount	%
21-25	11	7.91
26-30	13	9.35
31-35	14	10.07
36-40	24	17.3
41-45	21	15.1
46-50	16	11.5
51-55	8	5.75
56-60	20	14.4
61-65	10	7.18
66-70	2	1.44
Grand Total	139	100%

The NHS Pension Scheme retirement age is now aligned with the State Pension age, which is likely to result in an increasing number of staff remaining in employment beyond the age of sixty. However, recent changes to pension arrangements have also led to a growing number of midwives aged 55 years and over choosing to access their pension benefits while continuing to work on a reduced-hours basis.

This flexible approach to retirement has supported workforce retention by enabling experienced midwives to remain within the service and continue contributing their knowledge and expertise. Combined with the recruitment of a significant proportion of younger staff, the majority of whom are under 35 years of age, has helped maintain a balanced age profile across the workforce.

At the end of Q1 2.80 WTE midwives were unavailable and on maternity leave, with this figure increasing to 5.24WTE in Q2. The table below demonstrates the known actual and continued predicted maternity leave within the service for the remainder of the financial year based upon what has been shared with the leadership team to date.

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
WTE	2.80	2.80	2.80	4.44	5.24	5.24	5.24	5.24	5.24	5.24	5.24	4.24

Quality of Care Measurements

Midwife to birth ratio

MWL currently uses the formula and methodology suggested by BirthRate Plus to produce the calculation. The LMNS have been asked to support in looking at a review across C&M to ensure that the calculation of the midwife to birth ratio is standardised and consistent for all providers, specifically relating to non-direct care giving staff, DS shift coordinators and ward managers and if they are included or excluded in the calculation but to date this work has not been undertaken.

The midwife to birth ratio recommended by Birthrate plus was 1:22.6.

Month	Ratio
January 2026	20.79
February 2026	20.75
March 2026	20.86
April 2026	20.1
May 2026	18.67
June 2026	19.09

Supernumerary Shift Coordinator on Delivery Suite

The role of the Delivery Suite Shift Coordinator is integral to the safe and effective management of the intrapartum service. The position is staffed 24 hours a day, 7 days a week, and is a recommendation of the Ockenden Report. The Delivery Suite Shift Coordinator is a supernumerary role, which is essential to enable the postholder to provide effective leadership, maintain an overarching view of clinical activity, offer expert clinical support, facilitate communication between professionals, and oversee the appropriate allocation and utilisation of resources.

The Shift Coordinator is rostered separately from the core midwifery workforce, with supernumerary status clearly identified within the e-roster through a designated marker against each shift. Failure to maintain the supernumerary status of the Delivery Suite Shift Coordinator is classified as a Midwifery Red Flag Event. During the reporting period, there were no red flag events relating to this indicator.

Date	Supernumerary Shift Coordinator
Jan 2026	100%
Feb 2026	100%
Mar 2026	100%
April 2026	100%
May 2026	100%
June 2026	100%

One to One Care in Labour

Safe Staffing for Maternity Settings (NICE, 2015) stipulates that women in established labour should receive one-to-one care from a midwife who is solely dedicated to their care throughout labour, although this does not necessarily need to be the same midwife for the entire duration of labour. Compliance is monitored monthly through the maternity dashboard. During the reporting period, compliance was 100%, and there have been no instances of non-compliance in the preceding 12 months.

Date	One to One care in Labour
Jan 2026	100%
Feb 2026	100%
Mar 2026	100%
April 2026	100%
May 2026	100%
June 2026	100%

Midwifery Red Flag Events

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.

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

The following are the recommended red flags which require documenting via the Datix Incident Reporting System.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or Midwifery-Led Unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- 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 beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

All red flag events are reported via InPhase, and any learning identified from red flag events and InPhase incidents are shared through ward meetings, safety huddles, and the Maternity Governance and Quality Committee to support continuous learning and service improvement.

In addition, Midwifery Red Flag Events are recorded within the Birthrate Plus® acuity tool, which is completed every four hours on the Delivery Suite. This supports the ongoing assessment of workload, staffing requirements, and service acuity, enabling timely escalation and the implementation of appropriate mitigation measures where required.

Theme	Total for Q4 2025/26 & Q1 2026/27							
	JAN	FEB	MAR	APR	MAY	JUN	Total	
Delayed or cancelled time critical activity	0	1	0	0	1	0	2	
Missed or delayed care	0	0	0	0	0	0	0	
Missed medication	0	0	0	0	0	0	0	
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	0	

Theme	Total for Q4 2025/26 & Q1 2026/27								
	JAN	FEB	MAR	APR	MAY	JUN	Total		
Delay of 15 minutes or more between presentation and triage	0	0	0	0	0	0	0		
Delay of 30 minutes or more between presentation and triage	0	0	0	0	0	0	0		
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	0		
Delay of 2 hours or more between admission for induction and commencing the process	2	1	0	0	0	0	3		
Delayed recognition of and action on abnormal vital signs	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		
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	0		
TOTAL	2	2	0	0	1	0	5		

At Ormskirk, a total of five red flag events were reported across Q4 and Q1. Four of these events occurred in January and February and related to delays within the induction of labour pathway. In this reporting period, In February, Ormskirk aligned the red flag reporting process for delay of 2 hours or more between admission and commencing the process with Whiston and National standards to ensure those directly attributable to midwifery staffing are reported, there has subsequently been one red flag event.

During the reporting period from January to June 2026 there were two suspensions of maternity services on the Ormskirk site. Both incidents were STEIS reported, investigated and after-action reviews undertaken.

The first suspension of services was for a period of 2 hours due to a short-term medical staffing issue. No patients were affected by this suspension.

A second divert occurred in May 2026 after the on-call consultant was required to attend Southport to undertake an emergency gynaecology procedure for a patient in the emergency department. The unit remained on divert for approximately three hours, during which, one woman required redirection to maternity triage at Whiston for assessment and care. The Divisional Medical Director is working to develop a dedicated second on-call consultant rota. The purpose of the rota is to provide resilient senior medical cover across both sites, with specific provision for consultant deployment to the Southport site when required.

Continuity of Carer

The Trusts current position for Continuity of carer remains on hold pending evaluation of the community service across MWL The Sapphire Team, our current CoC team remains operational. The Team consists of 7.96 WTE midwives providing antenatal, parent education, intrapartum and postnatal care for women living outside the West Lancs area but choosing to deliver at Ormskirk. Their caseload is calculated at 1:36 with a working pattern of 9-5 on community days and long day/nights on Delivery suite to provide intrapartum care for women booked under the care of the team.

The BR+ report reflects the current traditional model of care and does not provide any recommendations for the delivery of CoC. A full review using the National CoC workforce tool will be required to determine what additional staffing will be required to fully implement CoC, however this tool is not currently endorsed by NHSE as evidence based.

Summary

Births within Ormskirk maternity site or the period January to June 2026 was 978 which is aligned with the previous 6 months. Bookings at MWL Ormskirk site were 1249 which is an increase of 60 bookings compared reporting period.

The Birthrate plus report identified that the DS case mix was that 58.2% of women are in the 2 highest categories of care required which is in line with the average for England of 58%. which is an increase of 7% from the previous Birthrate plus assessment in 2018. This reflects the increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

9.51wte (9% of total clinical time) is the recommended BR+ establishment for non-direct staff The current funded non-direct care equates to 16.8wte which is above the BR+ recommendations and is due to additional funding from Ockenden and externally funded posts.

The BR+ report concluded that the required whole-time equivalent for the provision of direct maternity care was 105.63wte which included a 25% uplift for annual leave, sickness, and study leave. The funded clinical midwife establishment for the reporting period is 113.59wte inclusive of 5.28wte MSW's. This is a positive variance of 7.96wte to the birthrate plus recommendation due to the increased uplift, additional provision of cover for elective caesarean section list, 0.2wte specialist multiple birth midwife and increased training due to Ockenden recommendations.

The staffing position at the end of June 2026 identified that the unit was above the BR+ funded establishment recommendations for the maternity workforce based on our current modelling ratio of midwife to MSW and inclusive of additional funding since the workforce assessment.

The service utilises an ongoing rolling recruitment programme to reduce any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave and retirements. The vacancy rate at the end of Quarter 1 was 5.95wte midwifery posts.

Over the past 6 months Midwifery sickness levels have increased up to a maximum of 11.83% in April, improving in June with the lowest rate at 6.13%. Staffing is monitored daily; the use bank is utilised to cover deficits. Non clinical midwives are utilised if staffing and acuity indicate insufficient staffing.

A 24/7 maternity bleep holder is available who has oversight of the staffing and clinical activity and oversees any redeployment and utilising escalation guidance as required.

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

There were 5 Midwifery red flags events, 3 related to delays in commencing induction of labour and 2 relating to delay in transfer to Delivery Suite for the next stage of induction. All triage attendances were seen within 15 minutes of arrival.

There were 2 maternity suspension of services during this reporting period due to short term medical gaps with one requiring the on call consultant to attend Southport to attend to a gynaecology emergency. The suspension required 1 woman to be redirected to Whiston triage for assessment and care. Work in progress to develop a dedicated second on-call consultant rota in order to provide resilient senior medical cover across both sites with specific provision for consultant deployment to the Southport site when required.

The current Birthrate plus report was provided in 2022. Planning meetings with the Birthrate Plus team commenced in May 2026, with the assessment phase involving live case-mix data collection commencing between July to September 2026 with a final report anticipated in December 2026. This review represents the first comprehensive Birthrate Plus workforce planning exercise undertaken across the integrated MWL Maternity Service, with previous assessments having been completed separately within the legacy organisations. Findings will be reviewed, shared and actioned accordingly when received.

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)



This template should be completed once and submitted on the Friday 25th September 2026. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a green rating if significant residual risk remains.

Baseline compliance definitions

The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore

'Not applicable' would apply.

Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec):

Sarah O'Brien, Chief Nursing Officer and Simon Dowson, Chief Medical Officer

Trust Board sign off date:

24/09/2026

Trust Board Assurance Template						
No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference Please input reference number as listed in 3. Evidence Log tab	Gaps in Assurance Please provide detail of any gaps in assurance	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant	EV-01	Launch date of martha's rule call for concern to be confirmed but anticipated end of October 2026. Rollout of deteriorating patient questions and the process for a second clinical review is under development.		Trust leads have been identified for Martha's Rule and are leading on deteriorating patient questions. Task and finish groups have been established and are attended by maternity and neonatal services. Next meeting 29th september. Maternity call for concern flow charts have been drafted for ratification at Clinical Effectiveness council on 12th october 2026. Plan for launch end October 2026
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Compliant	EV-02 EV-03 EV-04 EV-05 EV-06 EV-07			Monthly FFT data included in Trust IPR Monthly MNVP reports of patient feedback, engagement in inpatient, outpatient and outreach areas. Monthly speciality reports presented at Divisional management group In house maternity surveys conducted by Trust patient experience team Trust Safety champions meetings Dashboards presented monthly at Quality Committee
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Compliant	EV-08 EV-09			Board reports and minutes Link to website confirming public access to Board agenda and minutes
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant		Current quarterly maternity and neonatal (Perinatal report) report does not specifically identify variation in outcomes and experience by ethnicity and deprivation. NHSE Maternity and neonatal equality dashboard is now available with 2025 data which for future reports could be included as retrospective data analysis. This dashboard has the functionality to link outcomes to ethnicity and social deprivation. The maternity information system collates clinical outcomes and has the functionality to look at ethnicity, age, protected characteristics etc that can be collated manually if required but not routinely analysed.		NHSE Maternity and neonatal equality dashboard available with 2025 data which will be utilised in future reports. PMRT and PSIR reports routinely identify ethnicity, disabilities, age, gender etc as part of the process and considered within the outcome context. MSDS data provides information on compliance to collection of ethnicity at booking and delivery (96.6% and 100% respectively).
Use of perinatal equities dashboard						

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference Please input reference number as listed in 3. Evidence Log tab	Gaps in Assurance Please provide detail of any gaps in assurance	Improvement Actions (Including Temporary Mitigations)	Comments
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant	EV-10 EV-11 EV-12 EV-13 EV-14	Executive minutes confirming agreement of joint responsibility QC minutes with details of discussions undertaken Board minutes with details of discussions and agreement required Board TOR required with confirmation of agreement of dual responsibility Job descriptions of Chief Medical Officer and Chief Nurse to include dual responsibility roles		Recent CNO & CMO appraisals with CEO discussed dual accountability and included this as an objective for this year
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant	EV-15	Attendance at Board of the Divisional Medical Director and Divisional Director of Midwifery		Agreement received that the Divisional Director of Midwifery and Divisional Medical Director will attend Board when maternity and Neonatal agenda items are listed. Currently the Divisional Director of Midwifery attends monthly Quality Committee meetings. TOR for QC detailing attendance by DOM QC minutes identifying DOM as an attendee every month irrespective of if maternity and neonatal reports are due to be presented
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Partially compliant	EV-16	Next steps to identify 7 leaders per site and 2 implementation leads to attend with an introductory call to be confirmed in October 2026.		MWL has commenced intake 4 of the Perinatal Equity and Anti Discrimination programme (PEADP) and attended the launch event on 4th September 2026. Programme will run until January 2028.
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant	EV-32 EV-33 EV-34 EV-35 EV-38			MWL Maternity Equity Action Plan: September 2025 Maternity and neonatal quarterly reports to QC PMRT, MNSI, SBL audits all consider smoking, age, ethnicity, language and targeted support as part of their reviews.
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant	EV-17	Requirement to present the full benchmarking tool and action plan to QC and Board in October 2026		MCB benchmarking tool completed and submitted on 03/08/26. To be discussed at QC on 22/09/26 Discussed at Executive Divisional performance review on 07/09/26
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant	EV-18 EV-19			Monthly audits which are presented at Governance and Quality meetings
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Partially compliant		Requirement to complete and present full audit outlining compliance to this requirement as yet not completed. Presentation of database		Processes in place to ensure requirement of short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas in line with MIS Year 8 and continued from previous years.
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	Compliant	EV-20 EV-21	Updated action plan following submission of recent workforce tool calculator and input into the Trust nurse establishment review required to be presented to executive team.		Quarterly monitoring using ODN workforce tool calculator undertaken to monitor requirements in accordance with BAPM standards. Updated action plan to reflect the deficit in nursing workforce on Whiston site with actions included in the recent workforce establishment review. Fixed term post currently covering medical staffing gaps
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	Compliant	EV-22 EV-23 EV-24 EV-25 EV-26 EV-27 EV-28 EV-29	Current Birthrate Plus workforce assessment is in progress and currently in the data collection phase, with a draft report anticipated in December 2026.		Current Birth rate plus reports were undertaken in 2022 for both maternity sites and both services are either in alignment or above the current Birthrate plus recommendations. Birthrate plus was intended to commence in Q4 25/26 but was deferred due to BR+ reviewing their workforce calculation model and discussions recommenced in May 2026. Data collection phase between July - September and will be an MWL collaborative report. Biannual staffing papers and associated QC and Board papers
6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? (In line with MIS Year 8)	Compliant	EV-30 EV-31			Rotas demonstrate compliance to this requirement for anaesthetists and trained anaesthetics assistants

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference Please input reference number as listed in 3. Evidence Log tab	Gaps in Assurance Please provide detail of any gaps in assurance	Improvement Actions (Including Temporary Mitigations)	Comments
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Compliant	EV-32 EV-33 EV-34 EV-35			Board oversees BR+ reports and compliance towards recommendations which includes Biannual establishment papers. Maternity has a 24 hour bleepholder and any escalations can be raised via an on call system. An executive (board member) is sighted on escalations Neonatal workforce included in quarterly maternity and neonatal update papers
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Compliant	EV-12 EV-13 EV-14 EV-32 EV-33 EV-34 EV-35			Provision of quarterly maternity and Neonatal update reports with Biannual staffing reports submitted to QC and Board. These papers include processes for redeployment of staff in times of escalation. There is a 24/7 maternity bleepholder who has oversight of the maternity services daily staffing, activity and acuity and will if required redeploy staff including non direct care giving staff to the areas of clinical need to ensure safety. The bleepholder undertakes a minimum of 4 hourly reviews and documents activity and actions taken. If redeployment of specialist midwives is required, consideration of their daily activities is undertaken as they may have direct care responsibilities which will continue to be undertaken. Training and education is detailed in the training needs analysis document, this includes all staff attending 2 day infant feeding on commencement within the Trust. Maternity specific training includes updates on, bereavement care, infant feeding, diabetes, perinatal mental health, brief intervention for smoking, preterm birth, safeguarding and antenatal and newborn screening.
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant	EV-39			A Northwest Regional Homebirth Scoping Tool was developed to establish a baseline regional risk profile and inform the development of minimum regional standards to ensure consistency, safety, and quality across the region. MWL homebirth provision review undertaken in December 2025 using the Regional tool and submitted on 22/12/25. Areas of strength identified and shared alongside areas for consideration. 1) Harmonisation of homebirth guideline which has been completed and 2) Consideration of a homebirth team across the MWL footprint. Whiston dedicated homebirth team remains in place. Changes on hold due to the 2 current maternity information system. Homebirth briefing paper presented to Trust Board on 28/01/26
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Not applicable				
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Compliant	EV-32 EV-33 EV-34 EV-35 EV-40			The Maternity and Neonatal quarterly updates as identified in Action 6.6 additionally cover this element Patient Safety Incident Response Policy PMRT/ MNSI shared with women and families
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Compliant	EV-32 EV-33 EV-34 EV-35			The Maternity and Neonatal quarterly updates as identified in Action 6.6 additionally cover this element
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Compliant	EV-32 EV-33 EV-34 EV-35			DOC provided to families in accordance with guidance. Duty of candour is undertaken verbally and followed up with a formal letter with copies stored on Inphase linked to the incident as evidence. The maternity and neonatal updates document that DOC has been completed. Debriefs facilitated by senior medical and maternity staff supported by anaesthetists, neonatal staff etc as required with families receiving formal outcome letters following these meetings. The service has Professional Midwifery and Nursing Advocates to support staff and promote learning.
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant	EV-36	Triage audit required to be completed within 3 months		National Maternity triage specification published 07/07/26 and updated on 29/07/26 with the tool kit received in August 2026. Baseline assessment required to be returned 25/09/26 and in progress. Triage audit will be completed within the required timeframes and reported to NHSE accordingly
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant	EV-32 EV-33 EV-34 EV-35	Maternity update papers require strengthening to include clinical capacity assessments, review times and a greater focus on inequalities.s		The maternity and Neonatal updates provide data on admission to triage times which are consistently high. A delay of more than 15 minutes or more between admission and triage is a midwifery red flag and reported within these reports and the Biannual staffing papers. Each delay is reported on the Inphase system and reviewed to determine causes and to provide opportunities to improve services.

No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference Please input reference number as listed in 3. Evidence Log tab	Gaps in Assurance Please provide detail of any gaps in assurance	Improvement Actions (Including Temporary Mitigations)	Comments
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant		A full action plan will be developed following completion of the triage specification baseline assessment for both maternity triages.		Requirement to consider staffing increase to ensure a midwife is solely dedicated to telephone triage. Liaison has commenced to review estates in order to provide a separate dedicated telephone triage space.
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant	EV- 37			MWL Fuller Inquiry Board Assurance Statement submitted to NHSE on 29/07/26 signed by CEO and Trust Chair
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant	EV-41	Biannual Board reports Board minutes for Biannual reports and review of incident records over the past 10 years in mortuaries		Routine bi-annual Board reporting has now been agreed to be established to provide assurance and monitor progress where actions are in place. Human Tissue Act Evidential Compliance (ECA)- Post mortem presented to Executive committee on 15/09/26

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	1.1	Draft Call for concern flowchart	Document	18/09/2026	Assistant medical director of patient safety	Futures platform. Folder 1.1 marthas rule	Ratified version will be uploaded after 19th september and launch date confirmation	
EV-02	2.1	Monthly FFT data	Document	30/08/2026		Futures platform. Folder 2.1	Monthly FFT data provided to QC via IPR submission at 22/09/26	
EV-03	2.1	MNVP patient feedback	Document/ Meeting	30/08/2026	MNVP leads	Futures platform. Folder 2.1	Feedback presented at Monthly Trust safety champions meeting and discussed at Monthly meeting with MNVP leads and DDOM/N	
EV-04	2.1	Divisional speciality reports presented at Divisional Management Group meeting	Document/meeting	03/09/2026	DDOM/N	Futures platform. Folder 2.1	Speciality reports include the latest available maternity and neonatal information collated regarding FFT, CQC survey and updates and local intelligence from MNVPs	
EV-05	2.1	In house patient feedback	Data set	30/06/2026	Corporate Quality matrons	Futures platform. Folder 2.1	Quarterly service user feedback collated from the corporate quality matrons to source information independent to the maternity service to enable feedback and service improvement	
EV-06	2.1	Trust Safety champions meetings	Meeting	27/07/2026	DDOM	Futures platform. Folder 2.1	Trust safety champion meetings receive updates on service user feedback and required actions / learning	
EV-07	2.1	Monthly dashboards presented at Quality committee	Data set/ meetings	21/07/2026	DOM	Futures platform. Folder 2.1	Monthly dashboards presented at Quality Committee	
EV-08	2.2	Board reports	Document/meeting	Various	CNO	Futures platform. Folder 2.2	Board papers with evidence of maternity and neonatal reports	
EV-09	2.2	Public Board report agenda and minutes available via Trust website	Document	Various	Trust secretary	Futures platform. Folder 2.2	Weblink provided to website for public board papers	
EV-10	3.1	Discussion of dual accountability at Executive committee	meeting minutes	17/09/2026	CNO/CMD	Futures platform. Folder 3.1	Documented evidence of discussion and agreement of dual accountability	
EV-11	3.1	Documentation of discussion of dual accountability at Quality committee	Meeting minutes	22/09/2026	CNO/CMD	Futures platform. Folder 3.1	Documented evidence of discussion and agreement of dual accountability scheduled for 22/09/26 at Quality committee	
EV-12	6.7	Staffing document and escalation	Document	In place	Divisional Deputy Directors of Midwifery	Futures platform: Folder 3.1	Updated version due to be ratified on 30/09/26 and will be uploaded following ratification	
EV-13	6.7	TNA	Document	27/08/2025	Divisional Deputy Directors of Midwifery/Practice educators	Futures platform: Folder 3.1		
EV-14	6.7	Bleepholder SOP	Document	In place	Maternity matrons	Futures platform: Folder 3.1	Updated version due to be ratified on 30/09/26 and will be uploaded following ratification	
EV-15	3.2	TOR and minutes for attendance by Director of Midwifery at Quality Committee	Meeting	21/07/2026	Chair of Quality committee	Futures platform. Folder 3.2	Minutes and TOR of Quality Committee to confirm monthly attendance by DDOM	
EV-16	5.1	Introductory presentation meeting slides for Perinatal Equity and Anti Discrimination programme (PEADP)	Document	04/09/2026	DDOM	Futures platform. Folder 5.1	MWL has commenced intake 4 of the PEADP and attended the launch event on 4th september. Plans in progress for the full programme and attendance until Jan 2028	
EV-17	5.3	Maternal care bundle	Document	03/08/2026	Consultant leads for maternal medicine	Futures platform. Folder 5.3	MCB benchmarking tool completed and submitted on 03/08/26	

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-18	6.1	Audits of consultant presence attendance in defined clinical situations	Document/ meeting	31/05/2026	Obstetric and Gynaecology Clinical Director	Futures platform. Folder 6.1	Monthly audit data collected with quarterly reports of consultant attendance at clinical situation	
EV-19	6.1	Governance and Quality minutes reflecting presentation of consultant presence audits	Meetings	30/09/2026	Obstetric and Gynaecology Clinical Director	Futures platform. Folder 6.1	Minutes of Governance and Quality meetings presenting audit outcomes of consultant presence attendance	
EV-20	6.3	ODN workforce calculator tool	Document/Data	06/26	Divisional Deputy Director of Nursing for Neonatal and Paediatric services/ CD for neonatal and paediatric services	Futures platform. Folder 6.3		
EV-21	6.3	Neonatal nurse staffing action plan	Document	02/26	Divisional Deputy Director of Nursing for Neonatal and Paediatric services	Futures Platform. Folder 6.3	Action plan identifying actions for nurse deficit compared to BAPM workforce calculator including actions incorporated into the Trust nursing workforce report	
EV-22	6.4	Ormskirk 2022 BR+ report	Document	2022	DOM	Futures Platform. Folder 6.4		
EV-23	6.4	Whiston 2022 BR+ report	Document	2022	DOM	Futures Platform. Folder 6.4		
EV-24	6.4	Whiston: July- December 2025 Biannual staffing report	Document	17/02/2026	DOM	Futures Platform. Folder 6.4	Provides evidence of funded and current establishment compared to BR+. Service in alignment with BR+ recommendations	
EV-25	6.4	Whiston: January - June 2026 Biannual staffing report	Document	22/09/2026	DOM	Futures Platform. Folder 6.4	Provides evidence of funded and current establishment compared to BR+. Service in alignment with BR+ recommendations	
EV-26	6.4	Ormskirk: July - December 2025 Biannual staffing report	Document	17/02/2026	DOM	Futures Platform. Folder 6.4	Provides evidence of funded and current establishment compared to BR+. Service above BR+ recommendations.	
EV-27	6.4	Ormskirk: January - June 2026 Biannual staffing report	Document	22/09/2026	DOM	Futures Platform. Folder 6.4	Provides evidence of funded and current establishment compared to BR+. Service above BR+ recommendations due to an increase with Ockenden funding and additional midwives for elective CS pathway.	
EV-28	6.4	Quality committee minutes	Meeting/ Document	17/02/2026	CNO	Futures Platform. Folder 6.4	Quality Committee minutes detailing presentation of Biannual staffing papers for both maternity services	
EV-29	6.4	Board minutes	Meeting/Document	25/02/2026	CNO	Futures Platform. Folder 6.4	presentation of Biannual staffing papers for both maternity services	
EV-30	6.5	Duty anaesthetist rota demonstrating 24/7 availability in line with ACSA standards	Document	08/26	Clinical Director for anaesthetics	Futures Platform. Folder 6.5	Rotas demonstrate compliance	
EV-31	6.5	Rota demonstrating availability of a trained anaesthetic assistant available 24/7 in line with ACSA standards	Document	08/26	Clinical Director for anaesthetics	Futures Platform. Folder 6.5	Rotas demonstrate compliance	
EV-32	6.6	Maternity and Neonatal quarterly updates. Q2: 2025/25	Document	18/11/2025	DOM	Futures Platform. Folder 5.2		
EV-33	6.6	Maternity and Neonatal quarterly updates. Q3: 2025/26	Document	17/02/2026		Futures Platform. Folder 5.2		
EV-34	6.6	Maternity and Neonatal quarterly updates. Q4: 2025/26	Document	19/05/2026		Futures Platform. Folder 5.2		
EV-35	6.6	Maternity and Neonatal quarterly updates. Q1: 2026/27	Document	22/09/2026		Futures Platform. Folder 5.2		
EV-36	9.1	Maternity triage specification benchmark tool	Document	25/09/2026	DDOM's	Futures Platform. Folder 9.1		
EV-37	10.1	MWL Fuller Inquiry Board Assurance Statement	Document	29/07/2026	CEO	Futures Platform. Folder 10.1		
EV-38	5.2	MWL Maternity Equity Action Plan	Document	29/09/2025	DOM	Futures platform. Folder 5.2		
EV-39	7.1	Homebirth briefing paper to Board	Document	28/01/2026		Futures platform. Folder 7.1		

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-40	8.1	Patient Safety Incident Response Policy	Document	In date	Patient Safety Manager	Futures platform. Folder 8.1		
EV-41	10.2	Human Tissue Act Evidential Compliance (ECA)- Post mortem	Document	15/09/2026	CMO	Futures platform. Folder 10.2	Presented to Executive committee on 15/09/26	



**Mersey and West Lancashire
Teaching Hospitals**
NHS Trust

Maternity and Neonatal 10 Point Action Plan

21st September 2026

Introduction

Following the publication of Baroness Amos' independent investigation and Donna Ockenden's independent review, the CEO of NHSE, CNO for England and the National Medical Director came together to identify a 10-point plan of urgent actions for maternity and neonatal services which should be the focus of local leadership, improvement activity and board oversight whilst the Maternity and Neonatal Taskforce develops a comprehensive national action plan which is expected by the end of 2026

- 10-point plan aligns with Maternity Incentive Scheme (MIS) Year 8.
- Baseline assessment tool received 29/08/26 with an initial baseline assessment required by 25 September 2026
- Progress update required by 31 December 2026

Both submissions require approval by Trust board.

Boards should provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated through ICB and regional

Introduction

- Regional teams will review returns, feedback on quality of evidence submitted, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.
- ‘Amos into action’ (Action 4: Not included in the baseline assessment tool) will launch an NHS-wide opportunity for open conversations for all maternity and neonatal staff to help shape real and sustainable change in services. Trust Boards should ensure staff are supported and enabled to engage with this work.

Compliance definitions:

Non complaint: None, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Action 1: Has the Trust commenced rollout of Martha's Rule across maternity and neonatal services?

- Trust leads identified for Martha's rule and leading on development of deteriorating patient questions and documentation. Task and finish groups established attended by maternity and Neonatal services. Next meeting 29th September.
- Launch date of Martha's rule, call for concern anticipated end of October 2026 including introduction of formal daily questions to support deteriorating patients.
- Maternity call for concern flow charts have been drafted for ratification at Clinical Effectiveness Council on 12th October 2026 to support October implementation plan

1 maternity request using Martha's rule logged as a Call for concern. Related to a delay with an ongoing IOL. Woman had declined transfer to continue IOL due to high acuity. Did not meet the criteria for a call for concern but discussed further with the family and resolution.

Partially Compliant

Action 2: Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.

2.1: Established monthly cycle of collecting and analysing the latest available maternity and neonatal patient outcome & experience data

- FFT data included in monthly Trust IPR
- Monthly MNVP reports with patient feedback. Engagement in inpatient, outpatient and outreach areas.
- Trust and maternity and Neonatal safety champion walkabouts
- Monthly maternity and neonatal speciality reports presented at Divisional management group detailing feedback, experience, audits and actions.
- In house maternity surveys conducted by Trust patient experience team
- Maternity Quality and Governance agendas highlighting reports
- Monthly dashboards presented at Quality Committee

COMPLIANT

2.2: Trust board receives and publish regular summary reports bringing sources together including how progress and impacts are tracked.

- Board reports and minutes
- Link to website confirming public access to Board agendas and minutes

COMPLIANT

Action 2: Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level. Cont:d

2.3: Report identifies variation in outcomes and experience by ethnicity and deprivation, including important gaps or limitations in available data. Can the board demonstrate how the trust is responding to the variation identified?

- Current quarterly maternity and neonatal (Perinatal) report does not specifically identify variation in outcomes and experience by ethnicity and deprivation.
- NHSE Maternity and neonatal equality dashboard now available with 2025 data which will be utilised in future reports using retrospective data which can link outcomes to ethnicity and social deprivation
- PMRT and PSIR reports routinely identify ethnicity, disabilities, age, gender etc as part of the process and considered within the outcome context.
- MSDS data provides information on compliance to collection of ethnicity at booking and delivery (96.6% and 100% respectively).
- The maternity information system collates clinical outcomes and has the functionality to look at ethnicity, age, protected characteristics etc that can be collated manually if required but not routinely analysed. **Partially Compliant**

Action 3: Use of perinatal equities dashboard

3.1: Trust board has established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding shared responsibility

- Recent CNO & CMO appraisals with CEO discussed dual accountability and included this as an objective for this year
- Evidence following submission will include Executive minutes confirming agreement of joint responsibility, QC and Board minutes detailing discussions undertaken and agreement
- Board TOR with confirmation of agreement of dual responsibility
- Job descriptions of Chief Medical Officer and Chief Nurse to reflect dual responsibility

Partially compliant

3.2: Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?

- Agreement that DOM and DMD will attend Board in future when maternity and Neonatal agenda items are listed.
- DOM currently attends Quality Committee (QC) every month
- QC TOR and minutes

Partially Compliant

Action 5: Addressing inequalities in maternity and neonatal outcomes

5.1: Trust board ensures provision in place to allow staff to attend the Perinatal Equity and Anti-Discrimination Programme (PEADP) with full participation across MDT teams.

- MWL commenced intake 4 of PEADP and attended launch event on 4/09/26. Programme runs until January 2028.
- Next steps. Identify 7 leaders per site and 2 implementation leads to attend. Introductory call to be confirmed in October 2026.

Partially Compliant

5.2: Trust board to demonstrate regular reviewing and acting on trends identified by inequalities data dashboards every 6 months

- MWL Maternity Equity Action Plan: Last presented September 2025
- NHSE Maternity and neonatal equality dashboard now available with 2025 data which will be utilised in future reports using retrospective data which can link outcomes to ethnicity and social deprivation.

Partially compliant

5.3: Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?

- MCB benchmarking tool completed and submitted on 03/08/26. QC discussion 21/09
- Discussed at Executive Divisional performance review on 07/09/26
- Presentation of full benchmarking tool/action plan to QC and Board in October 2026

Partially Compliant

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Action 6: Ensuring 24/7 safety and responsiveness of services (1)

6.1-6.5 all align with MIS Year 8

6.1: Trust compliance with RCOG “Roles and Responsibilities of the Consultants providing acute care” standard. Minimum $\geq 80\%$ compliance.

- Monthly audits presented at Governance and quality meetings. **Compliant**

6.2: Trust ensures locum certification/ maintenance database of all short-term locums (≤ 2 weeks) working on tier 2/3 obstetric rotas.

- Processes in place continued from MIS Year 7
- Requirement to complete and present full audit. **Partially compliant**

6.3: Trust has a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards and neonatal nursing workforce calculator.

- Quarterly ODN workforce tool calculator returns.
- Updated action plan to reflect the deficit in nursing workforce on Whiston site with actions included in the recent workforce establishment review.
- Fixed term posts currently covering medical staffing gaps

Compliant

Action 6: Ensuring 24/7 safety and responsiveness of services (2)

6.4: Trust has a fully funded midwifery establishment that aligns with a BR+ completed within the last three years with further adjustments based on the professional judgement of the Director and Head of Midwifery.

- Current Birth rate plus reports were undertaken in 2022 for both maternity sites and both services are either in alignment or above the current Birthrate plus recommendations.
- Birthrate plus intended to commence in Q4 25/26 but was deferred due to BR+ reviewing their workforce calculation model. Discussions recommenced in May 2026. Data collection period July – Sept. Will be an MWL collaborative report anticipated in December 2026
- Biannual staffing papers and associated QC and Board papers

Compliant

6.5: Trust's obstetric services have a duty anaesthetist available 24/7 in and a trained anaesthetic assistant available 24/7

- Rotas demonstrate compliance for anaesthetists and trained anaesthetics assistants

Compliant

Action 6: Ensuring 24/7 safety and responsiveness of services (3)

6.6: Trust board oversees workforce acuity, service pressures and escalation ensuring, a) Response to periods of increased demand, reduced workforce availability/changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families

- Board oversees BR+ reports and compliance towards recommendations which includes Biannual establishment papers. Maternity has a 24-hour blepholder and any escalations can be raised via an on-call system. An executive (board member) is sighted on escalations
- Neonatal workforce status included in maternity and Neonatal update papers

Compliant

6.7: Trust board has undertaken a review of internal resource deployment, including, a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.

- Quarterly maternity and neonatal reports
- Biannual staffing papers that include redeployment and escalation processes
- Blepholder SOP
- Staffing and escalation guideline
- TNA that includes specialist training, bereavement, preterm birth, infant feeding, diabetes, perinatal mental health, smoking, safeguarding and ANNB screening

Compliant

Action 7: Trust review of homebirth services

7.1: Trust board has received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the CMO and the regional chief midwife of 26 November 2025?

- A Northwest Regional Homebirth Scoping Tool was developed to establish a baseline regional risk profile and inform the development of minimum regional standards to ensure consistency, safety, and quality across the region.
- MWL homebirth provision review undertaken in December 2025 using the Regional tool and submitted on 22/12/25. Areas of strength identified and shared alongside areas for consideration. 1) Harmonisation of homebirth guideline which has been completed and 2) Consideration of a homebirth team across the MWL footprint. Whiston dedicated homebirth team remains in place. Changes on hold due to the 2 current maternity information system.
- Homebirth briefing paper presented to Trust Board on 28/01/26

Compliant

7.2: Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?

- Not applicable as there were no significant risks or mitigations identified

Action 8: Responding to incidents, complaints and concerns with humanity and candour

8.1: Does the trust have an embedded Patient Safety Incident Response Framework (PSIRF) through clearly defined governance processes? Is learning, actions and outcomes regularly reviewed, shared with women and families and routinely monitored at Trust board

- Maternity and Neonatal quarterly updates
- Patient Safety Incident Response Policy
- PMRT/ MNSI shared with women and families

Compliant

8.2: Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?

- Maternity and Neonatal quarterly updates

Compliant

8.3: Does the Trust have embedded processes for open learning and compassionate debriefing, staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?

- DOC to families in accordance with guidance. Verbally and followed up with a formal letter. Copies stored on Inphase. Maternity and neonatal updates document that DOC has been completed.
- Debriefs facilitated by senior medical and maternity staff supported by anaesthetists, neonatal staff etc as required with families receiving formal outcome letters following these meetings.
- Professional Midwifery and Nursing advocates to support staff and encourage learning.

Compliant

Action 9: Deliver safe and effective triage in maternity services

9.1: Has Trust board completed and reported to NHSE an audit, including dedicated staffing/clinical capacity with a focus on ensuring maternity triage services are consistently safe, responsive and appropriately resourced?

- National Maternity triage specification published 07/07/26 and updated on 29/07/26. Tool kit received August 26. Baseline assessment submission date 25/09/26 and currently in progress.
- Triage audit will be completed within required 3 months and submitted to NHSE

Partially compliant

9.2: Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?

- Maternity and Neonatal updates provide data on admission to triage times which are consistently high over 98%. A delay of >15 minutes between admission and triage is a midwifery red flag and included within these reports and the Biannual staffing papers. Each delay is reported on the Inphase system and reviewed to determine causes and to provide opportunities to improve services.
- Maternity update papers require strengthening to include clinical capacity assessment and review times and a focus on inequalities

Partially compliant

9.3: Is Trust on track to implement improvements in line with national triage guidance to ensure consistent access to high-quality, responsive triage within 12 months?

- Requirement to consider staffing increase to ensure a midwife is solely dedicated to telephone triage.
- Liaison has commenced to review estates in order to provide a separate dedicated telephone triage space.
- A full action plan will be developed following completion of the triage specification baseline assessment for both maternity triages.

Partially compliant

Action 10: Post death care

10.1: Has the trust board completed an assurance statement and submitted it by 31 July 2026?

- MWL Fuller Inquiry Board Assurance Statement submitted to NHSE on 29/07/26 signed by CEO and Trust Chair

Compliant

10.2: Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?

- Routine bi-annual Board reporting has now been agreed to be established to provide assurance and monitor progress where actions are in place.
- Review of incidents relating to mortuary incidents over the past 10 years required to be undertaken and presented at QC and Board
- Human Tissue Act Evidential Compliance (ECA)- Post mortem presented to Executive committee on 15/09/26

Partially compliant

Overview of compliance

Action	Total No actions	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	0	1	0
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	0	1	2
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	2	0
5. Addressing inequalities in maternity and neonatal outcomes	3	0	0	3	0
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	1	6
7. Trust review of homebirth services	2	1	0	0	1
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	0	3
9. Deliver safe and effective triage in maternity services	3	0	0	3	0
10. Post death care	2	0	0	1	1
Totals	26	1	0	12	13