Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09.30 on Wednesday 28 October 2026
Ruffwood Suite, Clinical Education Centre, Ormskirk Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
09.35	2.	**Employee of the Month (October 2026)** *Purpose: To **note** the Employee of the Month presentations for October*	Presentation	Chair *(10 mins)*
09.45	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	Chair *(10 mins)*
	4.	**TB26/071 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 30 September 2026*	Report	
	5.	**TB26/072 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
09.55	6.	**TB26/073 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*	Report	S O'Brien /S Dowson L Neary J Waldron G Lawrence *(30 mins)*

Committee Assurance Reports				
10.25	7.	**TB26/074 Committee Assurance Reports** 7.1. Executive Committee 7.2. Quality Committee 7.3. Strategic People Committee 7.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	R Cooper N Fletcher M Singh C Spencer *(30 mins)*
8. Other Board Reports				
10.55	9.	**TB26/075 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register*	Report	S O'Brien obo S Regan *(10 mins)*
11.05	10.	**TB26/076 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	R Cooper obo S Regan *(10 mins)*
11.15	11.	**TB26/077 Incidents, Complaints, Concerns, Claims and Inquests Report Q2 2026/27** *Purpose: To **note** the Incidents, Complaints, Concerns, Claims and Inquests Report Q2 2026/27*	Report	S O'Brien *(15 mins)*
11.30	12.	**TB26/078 Learning from Deaths Annual Report 2025/26** *Purpose: To **note** the Learning from Deaths Annual Report 2025/26*	Report	Simon Dowson *(10 mins)*
11.40	13.	**TB26/079 Provider Capability Self-Assessment** *Purpose: To **note** the Provider Capability Self-Assessment*	Report	R Cooper *(15 mins)*
11.55	14.	**TB26/080 Workforce Reports** 14.1. Workforce Race Equality Standard Report (WRES) (including action plan) 14.2. Workforce Disability Equality Standard Report (WDES) (including action plan) *Purpose: To **note** the Workforce Reports for assurance and to **approve** the action plans*	Report	J Waldron *(15 mins)*

12.10	15.	**TB26/081 Clinical Strategy 2024-2026 Review** *Purpose: To **note** the Clinical Strategy 2024-2026 Review*	Report	S Dowson *(10 mins)*
12.20	16.	**TB26/082 National Quality Board Nurse Establishment Reviews** *Purpose: To **note** the National Quality Board Nurse Establishment Reviews*	Report	S O'Brien *(15 mins)*
12.35	17.	**TB26/083 Update on Thirlwall Inquiry** *Purpose: To **note** the Trust's Response to the Thirlwall Inquiry Report and Recommendations*	Report	S O'Brien and S Dowson *(15 mins)*
Concluding Business				
12.50	18.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.05	19.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 25 November 2026 at 09:30		**13.05 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**	28 October 2026
Agenda Item	TB26/000			
Report Title	Employee of the Month (October 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 October 2026.

Executive Summary

The winner of the October Employee of the Month Award is James Williams, Litigation and Inquest Officer in the Legal Services Department. He was nominated by colleague, Chiara Larocca-Thomas.

James plays an important role in helping the Trust respond to legal claims and coroners' inquests. He works closely with colleagues and external partners to gather information, coordinate investigations, prepare documentation and ensure MWL meets its legal responsibilities. His work helps the organisation learn from incidents and continue to strengthen the care and services we provide.

Working in an area that is often complex and time critical, James consistently delivers work of the highest standard. Through his attention to detail and strong work ethic, he helps ensure important cases and requests are managed efficiently and effectively. His professionalism, reliability and expertise have earned him the trust and respect of colleagues across the organisation.

James is particularly recognised for the compassionate way he supports staff through what can be challenging and sometimes emotional situations. He takes the time to listen and provide guidance, ensuring colleagues feel informed and confident throughout the process, regularly going above and beyond what is expected of him.

A fantastic team player, James is always willing to help others and is known for his approachable nature. He brings a sense of calm and is a highly regarded member of the Legal Services Team.

James, your nomination states that you're an absolute pleasure to work with and this is evident in the positive impact you have on both your colleagues and the wider organisation. The kindness and professionalism you bring to your role each day truly embodies the values of MWL. Please accept your certificate and wear your badge with pride, congratulations!

Financial Implications

Not applicable

Quality and/or Equality Impact

Not applicable

Recommendations

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

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

Trust Board (Public)

Matters Arising Action Log (updated 19 October 2026)

Mersey and West Lancashire Teaching Hospitals NHS Trust

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

Action Log Number	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
29	26/11/2025	**TB25/093 Research and Development Annual Report and Capability Statement**	SD to develop a new MWL Research Strategy. Update (24/09/2026) An outline of research strategy and planning for 2027-28 was included in the research annual report presented to board in September. The full research strategy will be developed as part of the Clinical Service Strategy (2027-2031), a review of the existing clinical service strategy is on the agenda. Action completed.	SD	~~Jun 2026~~ Oct 2026		**Completed**
7	30/09/2026	**TB26/062 Integrated Performance Report** 7.3 Workforce Indicators	JWa agreed to review the Time to Hire data to determine whether delays in the onboarding process had resulted in candidates withdrawing. Update (19/10/2026) Candidates are asked for the reason for their withdrawal - numbers in the last 12 months relating to recruitment delays are extremely low. To support the time to hire metric and the recovery plan, the recruitment team agree a target start date with line managers at the point of offer and candidates are regularly updated on the progress of the checks to keep them engaged and to ensure that any outstanding checks (DBS, references) are picked up and any issues addressed.	JWa	Oct-26		**Completed**
8	30/09/2026	**TB26/067 Statutory Pay Gap Annual Declaration 2025/26**	JWa agreed to review anonymised recruitment data across all senior levels, including applicant and shortlisting profiles, to identify any under-represented groups and determine whether further encouragement or targeted action was required.	JWa	Nov-26		

Completed Actions

Action Log Number	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
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	**24/09/2026** - The revised action plan for 2026/27 as part of agenda item 13 (TB26/068 MWL Health Inequalities Strategy Annual Progress Review).	**Completed**
5	29/07/2026	**TB26/053 Corporate Risk Register**	SO to provide feedback to SRe regarding the points raised in the meeting.	SO	Sep-26	**24/09/2026** - SO has provided feedback to SRe.	**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.	SO	Sep-26	**24/09/2026** - this has been included on the agenda for the Board Away Day on 06 November 2026.	**Completed**

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	Trust Board		**Date**	28 October 2026
Agenda Item	TB26/073			
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 55 key metrics. Quality has 20 metrics, Operations 19 metrics, Workforce 6 metrics and Finance 10 metrics

Financial Implications

The forecast for 26/27 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

The 20 metrics for Quality provide an overview for summary across MWL

Recommendations

The Trust Board is asked to note performance for assurance.

Strategic Objectives

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

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

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

Quality	Period	Score	Plan	YTD
Never Events	Sep-26	1	0	1
Falls ≥ moderate harm per 1000 bed days	Sep-26	0.15	0.00	0.19
Nurse Fill Rates	Sep-26	91.1%	90.0%	93.4%
NEWS Obs on Time or Within Tolerance (A&E)	Sep-26	70.0%	80.0%	69.3%
% Screened using the MUST tool	Sep-26	81.9%	95.0%	80.1%
Fluid balance chart in place and accurately completed	Aug-26	86.7%	90.0%	60.2%
MRSA	Sep-26	0	0	0
C.difficile	Sep-26	14	97	63
MSSA	Sep-26	4	0	35
E.coli	Sep-26	16	145	113
Complaints Responded In 60 Days	Sep-26	83.9%	80.0%	72.9%
FFT - Inpatients % Recommended	Sep-26	91.8%	94.0%	93.0%
Mortality - HSMR	Jun-26	93.3	100	98.5
Mortality - SHMI	May-26	1.03	1.00	
Mortality - SMR - Sepsis	Jun-26	86.1	100	84.2
Neonatal Deaths	Sep-26	0	0	7
Stillbirths (intrapartum)	Sep-26	0	0	1
Sepsis: Admin of Antibiotics within agreed timescale	Aug-26	51.5%	80.0%	72.5%
Average instances of Corridor Care (ED)	Sep-26	38.8	0.0	51.6
Average instances of Corridor Care in (G&A) (IP)	Sep-26	0.3	0.0	0.7

Operations	Period	Score	Plan	YTD
Cancer Faster Diagnosis Standard	Aug-26	66.3%	80.0%	72.7%
Cancer 31 Days	Aug-26	96.2%	94.0%	95.6%
Cancer 62 Days	Aug-26	80.7%	80.0%	79.2%
A&E Triage: % < 15 mins	Sep-26	72.8%	95.0%	72.7%
A&E Standard (Mapped)	Sep-26	77.5%	82.0%	77.4%
% of patients spending more than 12 hours in A&E	Sep-26	18.1%	15.6%	18.9%
Ambulance Arrival to Vehicle Handover: % <45 mins	Sep-26	80.6%	100.0%	78.4%
RTT % less than 18 weeks	Sep-26	65.9%	70.6%	65.9%
18 weeks: % 52+ RTT waits	Sep-26	2.2%	1.0%	2.2%
Diagnostic Waits: % <6 weeks	Sep-26	84.9%	95.0%	84.9%
G&A Bed Occupancy	Sep-26	98.0%	92.0%	97.3%
Discharges Before Noon	Sep-26	19.6%	25.0%	19.3%
% of Patients With No Criteria to Reside	Sep-26	22.1%	15.0%	21.2%
Elective Actual Utilisation: Capped Orm & St.H	Sep-26	75.5%	78.7%	74.5%
Elective Actual Utilisation: Capped S'port & Whist	Sep-26	79.2%	84.5%	80.1%
Elective % time lost due to early finishes: Orm & St.H	Sep-26	11.8%	11.4%	11.9%
Elective % time lost due to early finishes: S'port & W...	Sep-26	13.1%	11.4%	12.1%
Elective % time lost due to late starts: Orm & St.H	Sep-26	5.9%	6.0%	6.5%
Elective % time lost due to late starts: S'port & Whist	Sep-26	5.7%	6.0%	6.2%

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	Plan	YTD
Mandatory Training	Sep-26	89.9%	85.0%	89.9%
Appraisals	Sep-26	82.8%	85.0%	82.8%
Sickness: All Staff Sickness Rate	Sep-26	7.1%	5.0%	6.8%
Sickness Rate - All Staff (Rolling 12 months)	Sep-26	7.1%	5.0%	
Average time to recruit (days) - All Staff	Sep-26	52.6	40	53.5
Staffing: Turnover rate	Sep-26	0.9%	1.1%	0.9%

Finance	Period	Score	Plan	YTD
Reported Surplus/Deficit (000's)	Sep-26		-6,104	-6,104
Forecast outturn surplus/(deficit) (£000)	Sep-26		16	16
Delivery of CIP savings (000's)	Sep-26		22,365	22,366
Cash Balances - Days to Cover Operating Expenses	Sep-26	2.6	1.5	
Capital Spend £ 000's	Sep-26		15,764	13,471
Value of aged debt >90days overdue £000's	Sep-26			16,786
Outpatients Activity v Plan	Sep-26	-10.5%	0.0%	-5.2%
Elective Activity & DC v Plan	Sep-26	9.4%	0.0%	4.2%
Non Elective Activity v Plan	Sep-26	-13.0%	0.0%	1.0%
A&E Activity v Plan	Sep-26	5.5%	0.0%	-0.7%

Board Summary - Quality

Quality

Never Events: One incident was reported on 3rd September 2026 was classified as a Never Event and was subsequently reported on StEIS on 9th September 2026.

Falls: There were 7 Falls with Harm (moderate and above) in August 2026 (2 moderate, 4 severe and 1 death). September data is yet to be validated for harm and learning reviews are currently underway for all falls with harm. T

NEWS: Whiston: During September, 26,667 observation sets were completed, with overall compliance reaching 65.05%. This represents a slight reduction compared to the previous month; however, several actions remain underway to support sustained improvement and address known challenges affecting performance.

Southport: Southport ED remains above 80% consistently since May 2026. The ED team continue to focus on the ambulatory majors streaming process and waiting room.

MUST: Completion of the Malnutrition Universal Screening Tool (MUST) assessment within 24 hours of admission to the ward increased to 82% in September 2026.

Divisions continue to review performance routinely through ward performance meetings, Matron reviews, and Divisional Governance forums. Ward-level improvement plans are in place across all Divisions to support ongoing improvement. Key Next Steps

- Continue implementation and monitoring of ward improvement plans for MUST compliance.
- Embed MUST screening within Surgical Admission Lounges.
- Include MUST performance within the Trust-wide Safety Huddle process.
- Focus improvement efforts on increasing compliance with 7-day MUST reassessments.

Fluid Balance: Patients identified with AKI Stage 2 or 3 are audited to assess whether fluid balance monitoring has been commenced within 6 hours of AKI detection and is being completed consistently thereafter.

Performance for August 2026 demonstrated a significant improvement across the Trust, increasing from 59% compliance to 87%. The Business Intelligence Team will provide Divisions with a more detailed breakdown of performance data at individual ward level to support targeted improvement actions.

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 was no healthcare-associated MRSA bacteraemia YTD. This is a reduction of 2 cases compared to last FY and a reduction of 5 cases compared to 2024/25.

Clostridium difficile infection: There were 14 healthcare-associated CDT cases at MWL in month, and the Trust is 15 cases above threshold, and 5 cases above the same period of 2025/26. However, the Trust is below the C&M rate when compared to other Trusts

MSSA: There were 4 healthcare-associated cases in month, which is the same as the previous month. There is a reduction of 3 cases compared to 2025/26.

Gram-negative bloodstream infections, E coli: There were 16 healthcare-associated E coli bacteraemia in September and the Trust is 41 cases above threshold.

Complaints: In September there were 72 new first stage complaints received compared to August when 56 were received. This illustrates a significant increase of 16 (29%) compared to last month which is the highest single month total across the preceding 10 months.
56 first stage complaints were closed in September 2026. 23 for Southport and Ormskirk sites and 33 at Whiston (inclusive of St Helens, Newton, and Community Services) and within the agreed Trust 60 working day target achieving 83.9% for September 2026, which is a further improvement in timeless of responses and above the Trust overall target.

HSMR: HSMR has fallen in June to within the expected range

Board Summary - Quality

Quality	Period	Score	Plan	YTD	Trend
Never Events	Sep-26	1	0	1	
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MSSA	Sep-26	4	0	35	
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Complaints Responded In 60 Days	Sep-26	83.9%	80.0%	72.9%	
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Mortality - HSMR	Jun-26	93.3	100	98.5	
Mortality - SHMI	May-26	1.03	1.00		
Mortality - SMR - Sepsis	Jun-26	86.1	100	84.2	

Board Summary - Quality

Quality	Period	Score	Plan	YTD	Trend
Neonatal Deaths	Sep-26	0	0	7	
Stillbirths (intrapartum)	Sep-26	0	0	1	
Sepsis: Admin of Antibiotics within agreed timescale	Aug-26	51.5%	80.0%	72.5%	
Average instances of Corridor Care (ED)	Sep-26	38.8	0.0	51.6	
Average instances of Corridor Care in (G&A) (IP)	Sep-26	0.3	0.0	0.7	

Board Summary - Operations

Operations

Urgent and Emergency Care & Patient Flow

Trust mapped performance achieved 77.5%, above the national position of 74.4% and the Cheshire and Merseyside average of 72.5%.

Performance continues to be significantly impacted by sustained patient flow pressures across both sites. Bed occupancy averaged 105.1% during September, equivalent to 82 patients above funded capacity, with a peak of 137 patients accommodated within acute beds, escalation areas and Emergency Departments awaiting admission. Admissions were 8% higher than September 2025, driven by increases in both same-day and overnight emergency activity. Average emergency length of stay remains elevated at 8.0 days across the Group (8.7 days at Southport and Ormskirk and 7.7 days at St Helens), with non-Criteria to Reside patients accounting for 22.1% of occupancy.

Operational performance continues to be challenged by delays in patient flow through the Emergency Departments, resulting in sustained ambulance handover delays and a continued cohort of patients experiencing waits in excess of 12 hours. These pressures reflect ongoing whole-system flow constraints, with sustained demand placing continued pressure on urgent care, inpatient and discharge pathways. Performance remains particularly challenged during periods of peak demand, requiring continued focus on maintaining patient flow and discharge momentum throughout the week.

A range of recovery and transformation initiatives are underway to improve patient flow and reduce delays across the urgent and emergency care pathway. These include discharge improvement actions, strengthened escalation management arrangements, expansion of Same Day Emergency Care, development of clinical navigation models, front-door redesign and improvements to ward and discharge processes. Whilst operational pressures remain significant, these interventions are expected to support more timely patient flow, reduce avoidable delays and strengthen operational resilience across urgent and emergency care services.

Elective Recovery

The Trust had 1,881 patients waiting more than 52 weeks at the end of September (239 at Southport and Ormskirk and 1,642 at St Helens), alongside 46 patients waiting more than 65 weeks and one patient waiting over 78 weeks. The 52-week position increased by 129 compared with August, and the number of 65-week waiters increased by 16. Referral to Treatment performance was 65.9%, with Southport and Ormskirk achieving 66.5% and St Helens achieving 64.8%. Performance remains above the national position of 65.2% and in line with the Cheshire and Merseyside average.

Despite maintaining performance above the national average, elective recovery remains challenging, with continued growth in both overall waiting lists and long-wait cohorts. This has resulted in increased external scrutiny and reinforces the need for sustained recovery efforts. Recovery actions include specialty-level recovery plans, additional elective activity, waiting list validation and targeted management of long waits. These are supported by improvements in theatre productivity, workforce optimisation, pathway redesign, enhanced booking processes and improvements to patient communications. Collectively, these measures are intended to increase activity, improve access to care and support a sustained reduction in waiting list backlog.

Cancer Performance

Cancer performance demonstrated mixed progress during August. The 62-day standard improved to 80.7%, exceeding the national target of 80%, with performance of 84.3% at St Helens and 71.7% at Southport and Ormskirk. Performance against the 28-day Faster Diagnosis Standard was 66.3%, below both the 80% standard and national performance of 78.6%.

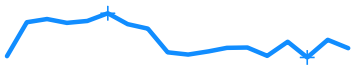
Tumour-site improvement plans remain in place and set out the actions required to deliver recovery against both the 28-day and 62-day standards during 2026/27. Current actions focus on reducing pathway delays, improving patient tracking and strengthening performance oversight. Additional work is underway to address diagnostic constraints and front-end pathway delays, including implementation of the 'First in 7' initiative. Whilst Faster Diagnosis Standard performance remains below trajectory, achievement of the 62-day standard and sustained delivery of the 31-day standard provide a stronger platform for continued improvement and earlier diagnosis.

Diagnostics

Diagnostic performance improved during September to 84.9%, with Southport and Ormskirk achieving 85.0% and St Helens 84.9%. Whilst performance remains below the 95% standard and the Cheshire and Merseyside average of 86.2%, it continues to compare favourably against the national position of 75.3%.

Diagnostic recovery remains a key organisational priority given its importance in supporting both elective and cancer pathways. Recovery actions include additional endoscopy provision, outsourced activity and targeted waiting list management, supported by workforce expansion, increased scanning capacity, service redesign and infrastructure development. Recovery trajectories are in place across key diagnostic services, with a number of specialties forecast to achieve recovery milestones before year-end. Continued improvement in diagnostic performance will be critical in enabling delivery of wider elective and cancer recovery objectives.

Board Summary - Operations

Operations	Period	Score	Plan	YTD	Trend
A&E Triage: % < 15 mins	Sep-26	72.8%	95.0%	72.7%	
A&E Standard (Mapped)	Sep-26	77.5%	82.0%	77.4%	
% of patients spending more than 12 hours in A&E	Sep-26	18.1%	15.6%	18.9%	
Ambulance Arrival to Vehicle Handover: % <45 mins	Sep-26	80.6%	100.0%	78.4%	
RTT % less than 18 weeks	Sep-26	65.9%	70.6%	65.9%	
18 weeks: % 52+ RTT waits	Sep-26	2.2%	1.0%	2.2%	
Diagnostic Waits: % <6 weeks	Sep-26	84.9%	95.0%	84.9%	
G&A Bed Occupancy	Sep-26	98.0%	92.0%	97.3%	
Discharges Before Noon	Sep-26	19.6%	25.0%	19.3%	
% of Patients With No Criteria to Reside	Sep-26	22.1%	15.0%	21.2%	
Cancer Faster Diagnosis Standard	Aug-26	66.3%	80.0%	72.7%	
Cancer 31 Days	Aug-26	96.2%	94.0%	95.6%	
Cancer 62 Days	Aug-26	80.7%	80.0%	79.2%	

Board Summary - Operations

Operations	Period	Score	Plan	YTD	Trend
Elective Actual Utilisation: Capped Orm & St.H	Sep-26	75.5%	78.7%	74.5%	
Elective Actual Utilisation: Capped S'port & Whist	Sep-26	79.2%	84.5%	80.1%	
Elective % time lost due to early finishes: Orm & St.H	Sep-26	11.8%	11.4%	11.9%	
Elective % time lost due to early finishes: S'port & Whist	Sep-26	13.1%	11.4%	12.1%	
Elective % time lost due to late starts: Orm & St.H	Sep-26	5.9%	6.0%	6.5%	
Elective % time lost due to late starts: S'port & Whist	Sep-26	5.7%	6.0%	6.2%	

Board Summary - Workforce

Workforce

Mandatory Training

Mandatory training compliance increased marginally to 89.9%, remaining comfortably above the Trust target of 85%. Performance has been consistently above target for several months, however the continue to be areas of not meeting the 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 increased substantially during September, rising from 67.7% to 82.8%. This reflects significant improvement and demonstrates the impact of divisional recovery actions and targeted management support during the appraisal window. Despite this progress, the Trust did not achieve its appraisal target of 85% by the close of the 2026/27 appraisal window on 30th September. Targeted support remains in place for the teams who have not met the target and a strategic review will be undertaken to understand any challenges and to ensure learning is captured to improve future appraisal cycles.

Sickness Absence

The overall sickness absence rate reduced slightly to 7.1% in September but remains substantially above the Trust target of 5.0%. The rolling 12-month rate increased to 7.1%.

Analysis continues to show that the areas with the highest levels of sickness continue to be across Nursing and Midwifery (8.6%), Additional Clinical Services (8.8%), Estates and Ancillary (8.55%) and Admin and Clerical (7%) staff groups, all of which are significantly above both the organisational average and target. Absence levels amongst Medical and Dental staff remain low and Allied Health Professionals has reduced to 4.1%. Health Care Support Worker absence has reduced by 1.1% in September to 9%.

Targeted support continues to be provided through the Health, Work and Wellbeing and HR teams, with a focus on high-absence areas, early intervention, management capability and robust attendance management processes. Sickness absence remains a key workforce priority for the Trust.

Turnover

Monthly turnover reduced to 0.9%, returning below the Trust target of 1.1% following the expected increase associated with medical workforce rotations during August.

Rolling 12 month position turnover remains stable, although Medical staff turnover remains above target and higher than other workforce groups.

Time to Hire

Average time to hire improved slightly from 52.9 days to 52.6 days. Whilst this represents continued movement in the right direction, performance remains above the Trust target of 40 days.

Recovery actions remain in place with the aim of improving performance. Recruitment activity continues to operate at higher levels than previous years, with sustained substantive recruitment demand and onboarding requirements continuing to impact overall recruitment timescales.

Board Summary - Workforce

Workforce	Period	Score	Plan	YTD	Trend
Mandatory Training	Sep-26	89.9%	85.0%	89.9%	
Appraisals	Sep-26	82.8%	85.0%	82.8%	
Sickness: All Staff Sickness Rate	Sep-26	7.1%	5.0%	6.8%	
Sickness Rate - All Staff (Rolling 12 months)	Sep-26	7.1%	5.0%		
Average time to recruit (days) - All Staff	Sep-26	52.6	40	53.5	
Staffing: Turnover rate	Sep-26	0.9%	1.1%	0.9%	

Board Summary - Finance

Finance

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

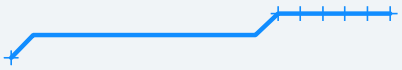
Surplus/Deficit – At the end of Month 6, the Trust is reporting an adjusted position of £6.1m deficit. Excluding deficit support funding, the adjusted position is £14.5m deficit, in line with plan. This includes the impact of the 2026/27 pay awards and industrial action costs which are mitigated within the overall position.

CIP - The Trust's CIP target for financial year 2026/27 is £49.7m, all if which is to be delivered recurrently. As at Month 6, the Trust has successfully transacted CIP of £22.4m year to date, in line with plan. The year to date efficiencies include £14.7m recurrent and £7.6m non recurrent.

Cash - At the end of M6, the Trust's cash balance was £6.8m. 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 additional PDC of £3.0m for Shaping Care Together and £3.2m from the Estates Safety Fund (now £4.6m), along with an additional £1.9m capital cover. The revised plan also includes an additional £0.7m for PFI MES Lifecycle and a PSDS Salix Decarbonisation Grant of £7.7m. The total revised plan is c. £58.9m. Capital expenditure for the year-to-date [including PFI lifecycle maintenance and lease remeasurements] totals £13.4m, which is £5.3m below plan.

Board Summary - Finance

Finance	Period	Score	Plan	YTD	Trend
Reported Surplus/Deficit (000's)	Sep-26		-6,104	-6,104	
Forecast outturn surplus/(deficit) (£000)	Sep-26		16	16	
Delivery of CIP savings (000's)	Sep-26		22,365	22,366	
Cash Balances - Days to Cover Operating Expenses	Sep-26	2.6	1.5		
Capital Spend £ 000's	Sep-26		15,764	13,471	
Value of aged debt >90days overdue £000's	Sep-26			16,786	
Outpatients Activity v Plan	Sep-26	-10.5%	0.0%	-5.2%	
Elective Activity & DC v Plan	Sep-26	9.4%	0.0%	4.2%	
Non Elective Activity v Plan	Sep-26	-13.0%	0.0%	1.0%	
A&E Activity v Plan	Sep-26	5.5%	0.0%	-0.7%	

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	**28 October 2026**
Agenda Item	**TB26/074 (8.1)**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in September 2026		
Committee Chair	Rob Cooper, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
The Executive Committee met on four occasions during September 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.		
03 September 2026		
Local to National Contract Transfer (SAS Level Doctors)	• The Chief People Officer presented a report outlining arrangements for the transfer of eligible locally employed doctors onto the nationally agreed SAS contract. • An initial review identified 19 eligible doctors, with a further cohort expected to become eligible during the six-month choice window commencing in October 2026. • The financial implications had been incorporated within national funding arrangements and implementation plans were being developed. • The Committee approved the proposed approach and requested updates on uptake and implementation.	Approval
Medical Professional Standards	• The Chief Medical Officer presented a draft Medical Professional Standards framework intended to support consistent professional standards and expectations for medical staff across the Trust. • Members supported the proposed framework and discussed arrangements for implementation, engagement and ongoing monitoring. • Subject to minor amendments and development of a launch programme, the Committee approved the document.	Approval
Employee of the Month (EOTM)	• The Committee reviewed the EOTM nominations and selected the EOTM for September 2026.	Approval

Freedom of Information Report	• The Director of Informatics presented the monthly Freedom of Information performance report. • Compliance remained below the required standard during the reporting period, although benchmarking and improvement work had commenced. • The Committee requested refinements to future reporting and noted the ongoing improvement actions.	Assurance
10 September 2026		
Enhanced Pharmacy Service Provision to Emergency Departments (EDs)	• The Chief Nursing Officer introduced a proposal to strengthen pharmacy provision within Emergency Departments following benchmarking against national standards. • The preferred option would improve medicines optimisation, patient safety and patient flow. • The Committee approved Option 2 and the associated recurrent investment of approximately £250k, noting the anticipated cash-releasing benefits.	Approval
Lost to Follow Up (LTFU) Update	• The Chief Operating Officer introduced an update on the Lost to Follow Up review. • As at the time of the report 96.8% of patients had been reviewed compared to 94% at the previous update. • One case of potential harm was still under review and the outcome of this would be reported through normal patient safety processes. • The Committee noted the report.	Assurance
Statutory Pay Gap Report 2026	• The Chief People Officer introduced the Trust's Statutory Pay Gap report which considers pay gaps in relation to Gender, Disability, Ethnicity and Sexuality. The report was based on data from March 2026. • Improvements had been noted since the last review. However, disparities remained within several workforce groups. • Actions to address the identified gaps would continue through delivery of the People Strategy. • The Committee noted the reports.	Assurance

Autumn/Winter Vaccination Campaign 2026/27	• The Chief People Officer introduced the report which detailed the proposed approach for delivery of the 2026/27 staff vaccination campaign. • The recommended model included divisional ownership and peer vaccinators to support achievement of the Trust's vaccination objectives. • Arrangements relating to eligible inpatients and long-stay patients were also reviewed and included within the proposal. • The Committee approved Option 2B at a net cost of ~£20k to the Trust, after ~£12.5k of funding was provided by NHS England.	Approval
Employment Rights Act 2025 Update	• The Chief People Officer introduced the report, which presented an update on the implications of the Employment Rights Act 2025 for the Trust. • Key areas of impact included probation arrangements, employment processes, trade union requirements and organisational governance. • The provisions of the Act would come into force over a phased two-year period, with most changes scheduled for 2026 and 2027. • Further policy development and implementation work would continue throughout this period, and further updates would be provided to the Committee. • The Committee noted the report.	Assurance
Financial Improvement Group (FIG) Update	• The Director of Strategic Resourcing presented the latest Financial Improvement Group assurance report. • Progress was reported across specialty improvement plans, workforce productivity initiatives and elective recovery actions. • Further improvements to the quality of reporting and supporting performance information were welcomed. • The Committee noted the report.	Assurance
NHS England Provider Capability Assessment	• The Director of Corporate Services presented the proposed approach to completion of the annual NHS England Provider Capability Assessment. • Revised assessment criteria and assurance requirements were reviewed. • The Committee approved the proposed process ahead of validation and final approval.	Approval

Board Visibility Arrangements	• The Director of Corporate Services presented proposals for Board visits at Southport Hospital. • The programme included a Freedom to Speak Up theme together with details of feedback arrangements for staff. • The Committee approved the proposed arrangements.	Approval
Nurse Safe Staffing Report	• The Chief Nursing Officer presented the July 2026 Nurse Safe Staffing Report. • Staffing pressures continued in several areas, driven predominantly by sickness absence, nursing vacancies and supplementary care requirements. • Recruitment and workforce actions were underway to strengthen resilience ahead of winter. • The Committee noted the report.	Assurance
17 September 2026		
Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports	• The Chief People Officer presented the annual Workforce Race Equality Standard and Workforce Disability Equality Standard returns. • Improvements had been reported across several workforce indicators, although disparities remained in relation to career progression, staff experience and senior representation. • Actions to improve disclosure rates, career development opportunities and workforce inclusion were discussed. • The Committee noted the reports.	Assurance
Month 5 Finance and Workforce Plan	• The Chief Finance Officer and the Chief People Officer introduced the Month 5 finance and workforce reports. • Delivery of the planned financial position remained dependent on successful implementation of productivity, workforce and elective recovery plans. • Temporary staffing expenditure, staff sickness absence and workforce growth remained key risks. • The Committee noted the reports and the actions to deliver the planned outturn position by the end of the financial year.	Assurance

Human Tissue Authority Compliance Assessment	• The Chief Medical Officer introduced the outcome of a review undertaken following a Human Tissue Authority (HTA) request for post-mortem licensed establishments to complete an Evidential Compliance Assessment covering 1 April 2015 to 30 June 2026. • Two historic incidents requiring retrospective reporting had been identified through the review, which were considered low risk. • Appropriate action had been taken and the incidents reported.	Assurance
Nursing Establishment Review	• The Chief Nursing Officer introduced the six-monthly Nursing Establishment Review. • The review identified several areas experiencing staffing pressures associated with patient acuity, workforce availability and service demand. • Members discussed the workforce and financial implications of the proposed recommendations. • Further work was requested in several areas before final recommendations were returned to the Committee for approval.	Assurance
Emergency Preparedness, Resilience and Response Core Standards Submission	• The Chief Operating Officer introduced the annual Emergency Preparedness, Resilience and Response Core Standards submission. • The Trust reported substantial compliance against the applicable standards, with improvement work underway in a limited number of areas. • The Committee approved the submission to Trust Board.	Approval
Integrated Performance Report	• The Committee discussed the latest Integrated Performance Report. • Members reviewed organisational performance and requested several amendments to the supporting narrative and metrics. • The Committee noted the report.	Assurance
Risk Management Council Assurance Report and Corporate Risk Register	• The Director of Corporate Services presented the Risk Management Council assurance report and Corporate Risk Register. • Risk review compliance had improved significantly during August. • 22 risks remained on the Corporate Risk Register. • The Committee noted the report.	Assurance

24 September 2026		
Closed System Devices for Systemic Anti-Cancer Therapy (SACT)	• The Chief Nursing Officer introduced a proposal to replace the current delivery mechanism used for administration of cytotoxic medicines with a membrane-to-membrane closed system device. • The proposal was intended to reduce the risk of staff exposure and improve safety during administration. • The Committee reviewed the associated health and safety risks, audit arrangements and reporting requirements. • The Committee approved the proposed change and associated recurrent cost increase of ~£60k annually.	Approval
Winter Plan 2026/27	• The Chief Operating Officer introduced the Trust's Winter Plan 2026/27 and provided an overview of the key delivery priorities and associated governance arrangements. • The plan focused on urgent and emergency care transformation, bed productivity and discharge, system partnership working and winter resilience. • Residual risks relating to patient flow, IPC outbreaks and bed capacity were discussed together with mitigation plans. • The Committee approved the plan, subject to agreed amendments being incorporated prior to submission to Trust Board.	Approval
Proposed FOI Operating Model and Improvement Plan	• The Director of Informatics introduced the report outlining a review of the Trust's Freedom of Information operating model and proposed improvement plan. • Benchmarking demonstrated that FOI compliance was below that achieved by comparable organisations and highlighted opportunities to streamline approval processes, improve the use of technology to support identifying previous requests, and publication of information. • The Committee approved a trial of the proposed approaches, with findings to be evaluated before implementation of a revised operating model.	Approval

Learning from Deaths Report	• The Chief Medical Officer presented the Q3 & Q4 2025/26 Learning from Deaths Report. • The report provided assurance regarding the review of deaths occurring within the Trust and the arrangements in place to identify learning and improvement actions. • The Committee requested that further assurances were included about the processes in place to address themes, actions and learning. • The Committee approved the report for submission to Trust Board subject to the agreed amendments.	Approval
Health Inequalities Strategy Mid-Year Review	• The Director of Integration presented a mid-year review of progress against the Trust's Health Inequalities Strategy. • The report highlighted inequalities associated with deprivation, ethnicity and service utilisation, including variation in did not attend (DNA) rates, emergency admissions and patient outcomes. • Members discussed priority areas for the remainder of the financial year to support targeted improvement activity. • The Committee approved the report subject to refinement of the priorities discussed ahead of submission to Trust Board.	Approval
NHS England Mid-Year Review	• The Chief Operating Officer presented the Trust's mid-year review self-assessment against NHS England operational planning requirements. • The report highlighted known challenges relating to urgent and emergency care, elective recovery and diagnostics, together with the actions being taken to mitigate them. • The Trust assessed itself as assured with managed risks for delivery of the 2026/27 Operational Plan and Winter Plan, and assured for 2027/28 Planning. • The Committee approved the report for presentation to Trust Board.	Approval
Trust Board Engagement Visits	• The Director of Corporate Services presented the proposed arrangements for the October 2026 Trust Board engagement visit at Ormskirk Hospital. • Members agreed to retain a consistent Freedom to Speak Up theme across sites to support comparison and organisational learning. • The proposed areas to be visited were discussed and agreed. • The Committee approved the arrangements.	Approval

NHS England Provider Capability Self-Assessment	• The Director of Corporate Services presented the final draft of the NHS England Provider Capability Assessment submission. • External review feedback had not identified any material inconsistencies and assurance was provided regarding the proposed assessment outcomes. • The Committee approved the proposed submission for consideration by Trust Board before submission to NHS England.	Approval
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. • The Committee noted the report.	Assurance
Mandatory Training and Appraisal Compliance Reports	• The Acting Chief People Officer presented the monthly appraisal and mandatory training compliance reports. • Appraisal compliance had improved during the reporting period but remained below the expected trajectory ahead of the window closing. Additional actions were being taken to improve this. • It was noted that mandatory training compliance overall was in line with the Trust's target but there were some subjects that needed improvement and prioritising. The Committee requested further work was undertaken to identify additional actions to improve compliance.	Assurance

Alerts:

None.

Decisions and Recommendations:

New investment decisions taken by the Committee during September 2026:

- The Committee approved the investment of ~£250k into Pharmacy provision at MWL Emergency Departments.
- The Committee approved the Autumn/Winter Vaccination Campaign arrangements at a cost of ~£20k.
- The Committee approved a change to a closed system device to improve safety in the administration of Systemic Anti-Cancer Therapy (SACT) at a cost of ~£60k.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	Trust Board	**Date**	28 October 2026
Agenda Item	TB26/074 (8.2)		
Committee being reported	Quality Committee		
Date of Meeting	20 October 2026		
Committee Chair	Neil Fletcher, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Quality Committee Corporate Performance Report (CPR).	• There had been one Never event in ophthalmology – no patient harm had occurred as a result, and a review and actions were underway in response. The committee requested consideration of previous similar incidents and the associated learning. • There had been a slight increase in the rate of falls, and this remained an area of ongoing focus. • Patient observations in the Emergency Department remained a continued area of focus with improvements noted. • MUST review at 7 days – improvements areas have been discussed within Divisional Performance Reviews (DPRs). • Nurse fill rate remained above the Trust 90% threshold but had reduced to 91%. The drivers included short term sickness and the opening of escalation areas due to operational pressures. • Stroke speech and language therapy (SLT) performance remained under review, with an update to be taken through Finance and Performance Committee. • C Difficile rates increased but remain below the Cheshire & Mersey target. Areas for improvement were being implemented and the gloves off campaign continues. • Level 1 complaints response within 60 days was within the Trust target noting that plans are in place to sustain the improvements. • HSMR had improved and was now within normal range.	Assurance

	• Sepsis results for August were below the expected performance, and all 20 cases were under review. • There had been improved performance in GP letters sent out within 7 days. Recruitment to vacant administration roles and a pilot of ambient voice technology were being utilised to support the backlog. • The deterioration in adult hearing performance was noted and was being monitored. • Four still birth cases had undergone PMRT review, no themes or lapses of care identified that would have affected outcomes.	
National Quality Strategy	• The Committee considered the National Quality Strategy for NHS funded care in England and its focus on the three dimensions of quality: Safety, effectiveness and patient experience, supported by priorities including health inequalities, continuous improvement, workforce, leadership and governance. • The Committee approved the Trusts high level plan with the addition of the 3 left shifts outlined in the 10 year plan and noted the 7 priority areas: - Safe Care - Effective Care - Person-Centred Care - Reduced Health Inequalities - A culture of continuous improvement - Our People - Leadership & Governance • The Committee supported a six-monthly reporting cycle, aligned where possible with the review of the Trust Quality Objectives.	Approval
Thirlwall Inquiry Action Plan	• The Committee undertook a substantial discussion of the Inquiry findings with particular focus on organisational culture, staff voice, senior leadership response to concerns, safeguarding, early warning indicators, governance and Board oversight. • The Committee noted the letter from NHSE to all Trusts regarding the immediate actions and timelines. • The Committee recognised that the Inquiry's implications extended beyond neonatal	Assurance

	services and require consideration across organisational leadership and governance. • A Trust action plan was being developed, but some actions remain dependant on national guidance and clarification. • The report would be shared at Trust Board and further discussion was planned.	
Patient Safety Report	• The Trust continued to report a high volume of incidents with established processes in place for reviewing incidents, falls, MNSI referrals, Martha's Rule activity and NatSSIPs/LocSSIPs compliance. • In August there were 7 new Patient Safety Incident Reviews (PSIR) discussed through Patient Safety Panel. • There was 0 STEIS in August and one MNSI reportable incident. • 2,717 incidents were reported Trust wide via InPhase in August. • 1.12% of patient affecting incidents were graded as moderate or above harm with the majority recorded as no or low harm (98.8%). • Falls per 1,000 bed days was 6.663 in August. • There were 246 inpatient falls reported in August of which seven were moderate harm and above. Falls within ED continued to be examined, including location, patient profile and activity levels. • Harm relating to medically optimised patients awaiting discharge requires continued review. • The Patient Safety Incident Response Framework priorities for the next two years were expected to return to the Committee. • The Patient Safety Council Assurance report was noted.	Assurance
Six Monthly Safer Staffing Establishment Reviews	• The Committee received assurance that the nationally recognised Safer Nursing Care Tool and professional judgement had been applied to assess inpatient nursing establishment reviews. • The Birthrate+ assessment was to follow in December. • There were 14 inpatient areas indicating adjustments were required to establishments, 9 of these required no additional expenditure, and 5 areas required investment in the staffing uplift.	Approval

	• Escalation areas were omitted from the establishment review. • The Committee supported the quality and safety elements of the proposals and noted the paper would be presented to Trust Board.	
Clinical Effectiveness Council Assurance Report	• The Committee noted the continued oversight of HSMR, Medical Emergency Team activity and VTE compliance. • VTE compliance was on an improving trend but remained slightly below the 90% target. • The improved HSMR position was noted and reviews had been undertaken when the previous increase had been noted, with no immediate learning identified. • A review of CEC was ongoing and the Committee discussed attendance and appropriate senior representation across council meetings.	Assurance
Learning from Deaths Annual Report 2025/26	• The annual report for 2025/26 provided assurance on mortality surveillance, Structured Judgement Reviews (SJR), Medical examiner scrutiny, ED death reviews. • The Committee discussed PSIRF learning and mortality review for vulnerable patient groups. • HSMR and SHMI were noted to be largely stable throughout the year. • ED deaths were reviewed with local learning and escalations by exception. • Medical examiners scrutinised 2,960 deaths, with 270 referred to the coroner. • There were no section 28 Prevention of Future Deaths reported for 2025/26. • Vulnerable groups - assurance of compliance against Learning from lives and deaths of people with a learning disability and autistic people (LeDer) reviews was provided. • There were no maternal deaths.	Assurance
CQC Quarterly report	• The Committee received assurance regarding continued engagement with CQC and timely organisational responses to CQC enquiries. • The September CQC engagement visit to Maternity at Whiston included 2 focus groups with staff. There were no issues for immediate escalation although staffing and the movement	Assurance

	of staff from the maternity ward were under review. • There had been an increase in enquiries from CQC in Q2 but responses remained timely. • Discharge improvements noted via concerns through safeguarding section 42 referrals.	
Mandatory Training compliance report	• Overall core mandatory training compliance was reported at 89.9%, with compulsory training at 86.9% using September updated data. • Medical and Dental staff compliance remained a key area of focus, although core compliance had improved to 81.1%. • The Committee recognised the work underway through the Mandatory Learning Oversight Group to harmonise legacy training needs analyses and ensure training was appropriately targeted. • Concerns were noted regarding persistent non-compliance in some subjects which had remained below the required standards and the Committee requested further assurances.	Assurance
Patient Experience Council assurance report	• The Committee received the assurance report for October 2026. • Patient story, procedural document reviews, Healthwatch Sefton ED corridor care report, Medical and Urgent Care patient experience, Patient Portal and Staff survey were noted providing triangulation with agendas aligned throughout the Quality Committee agenda. • The response to the Healthwatch visits were provided at the request of the previous Quality Committee meeting.	Assurance
Alerts:		
• Nil		
Decisions and Recommendation(s):		
The Trust Board is asked to note the report.		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	Trust Board	**Date**	28 October 2026
Agenda Item	TB26/074 (8.3)		
Committee being reported	Strategic People Committee		
Date of Meeting	21 October 2026		
Committee Chair	Mini Singh, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
SPC26/137 – Committee Performance Report (CPR	**Mandatory Training** Mandatory training compliance increased to 89.9%, remaining above the Trust target of 85%. While overall performance remained positive, compliance challenges persist within Medical and Dental and Estates and Facilities staff groups and in a number of modules. Targeted support continues through the Learning and Organisational Development Team to improve compliance. The Committee noted the discussions at Quality Committee and heard that targeted work is being undertaken to ensure that training needs analyses are appropriately aligned to clinical and operational need and that there are additional measures being considered to support further assurance and sustainable improvement. An update will be provided at the next Committee. **Appraisals** Appraisal compliance improved significantly from 67.7% to 82.8% during September, reflecting the impact of focused divisional recovery actions and management support. Although the Trust narrowly missed the 85% target, reporting delays are expected to improve the position in October. Targeted support remains in place for areas below target, alongside a planned review to identify learning and strengthen future appraisal cycles.	Assurance

	Sickness Absence Sickness absence reduced marginally to 7.1% but remained above the Trust target of 5.0%. The highest absence levels continued to be seen within Nursing and Midwifery where there was increasing bank usage, Additional Clinical Services, Estates and Ancillary, and Administrative and Clerical staff groups. Positive improvements were noted amongst Healthcare Support Workers and Allied Health Professionals. Targeted interventions remained focused on high-absence areas, management capability, early intervention and strengthening attendance management processes, supported by the development of automated workflow reminders. **Turnover** Monthly turnover reduced to 0.9%, returning below the Trust target of 1.1% following the anticipated increase associated with medical workforce rotations in August. The rolling annual position remained stable. **Time to Hire** Average time to hire improved slightly to 52.6 days, demonstrating continued progress but remained above the Trust target of 40 days. Recovery actions were in place, with performance expected to improve further towards the year-end target. Recruitment demand and onboarding activity continued to operate at sustained high levels, impacting overall timescales. The Committee received a detailed report later in the agenda. **Vacancies** Overall vacancy levels remained within target, indicating continued success in substantive recruitment activity. However, Healthcare Support Worker vacancies remained significantly higher than organisational averages. Focused recruitment and retention initiatives were underway, alongside work to develop career pathways and review workforce requirements to ensure establishments remained aligned to service needs.	

	Health, Work and Wellbeing Health, Work and Wellbeing services continued to perform strongly, with pre-employment screening completed within 14 days, significantly exceeding the 25-day target. Demand for management referrals and wellbeing support had resulted in increased waiting times and report turnaround times. Appointment DNA (did not attend) rates improved to 10.1%, remaining broadly in line with target. The service continued to support workforce wellbeing, attendance management and timely onboarding of new starters.	
SPC26/138 - Workforce Operation Plan M6	The Committee received the Month 6 Workforce Operational Plan update and noted that the workforce position remained broadly aligned with plan, with overall workforce levels 86.1 WTE above target. Substantive staffing remained close to plan; however, bank staffing continued to exceed plan and remained the principal workforce risk. The Committee noted that increased bank utilisation was primarily driven by vacancy cover and sickness absence, particularly within Nursing and Medical workforce groups. Agency staffing remained below plan, reflecting the controls in place and reduced reliance on premium staffing routes. Assurance was provided that a range of mitigating actions were underway, including strengthened roster controls, review of retrospective shift bookings, temporary staffing reduction plans, targeted recruitment campaigns and attendance management interventions. Members requested greater clarity and assurance on the trajectory to year-end delivery, including milestones, risks and the impact of mitigating actions on both workforce and financial performance. Assurance was provided that workforce and finance bridging discussions had been undertaken and future reporting would strengthen the linkage between workforce assumptions, transformation plans and financial forecasts.	Assurance

SPC26/139 - Monitoring of Trust Objectives aligned to the Strategic People Committee	The Committee received a Quarter 2 update on delivery of workforce objectives and noted positive progress across leadership development, workforce wellbeing, inclusion, staff engagement, and career development priorities. Members received assurance regarding completion of the first cohorts of the Leading Operational Excellence and Triumvirate Development Programmes, development of nursing and multidisciplinary leadership programmes, strengthening of staff network governance and successful delivery of the Trust's first Race Conference. Progress was also noted in relation to career conversations, apprenticeships, enhanced and advanced practice development and implementation of the NHS Leadership and Management Framework. The Committee discussed the importance of strengthening assurance arrangements through the inclusion of measurable indicators and objective ratings to demonstrate progress and impact across each workforce objective. It was agreed that future reports would incorporate supporting metrics and assurance assessments alongside narrative updates.	Assurance
SPC26/140 - Monitoring of HR Commercial Services Objectives aligned to the Strategic People Committee	The Committee received assurance that HR Commercial Services continued to deliver against key contractual and operational objectives, with performance remaining on track across Lead Employer, Payroll and Employment Services functions. Members noted successful delivery of onboarding improvement actions, over 99% compliance with the NHS England escalation process, 97% clearance rates for August and September campaigns and continued positive feedback from client organisations. The Committee also noted substantial progress in digital transformation, including implementation of additional automation solutions generating productivity benefits, national recognition for innovation and expansion of shared services across Cheshire and Merseyside. The Committee received assurance that work continued to strengthen financial controls, reduce overpayments and aged debt, to explore	Assurance

	opportunities for wider system collaboration, digital maturity, and future transformational programmes aligned to the NHS Transforming People Services agenda.	
SPC26/141 – Lead Employer Stakeholder Survey Action Plan	The Committee received an update on progress against the Lead Employer annual survey action plan and noted significant improvements in onboarding processes, support for international medical graduates and engagement with host organisations. Assurance was provided that an end-to-end onboarding review had delivered tangible improvements ahead of the August rotation, with nearly 98% of doctors cleared and positive feedback received from host organisations and NHS England. Work was progressing to strengthen support materials for international medical graduates, improve work schedule processes and increase occupational health system access for host organisations. The Committee noted that the 2026 stakeholder survey was due to commence on 2 November 2026 and would provide an opportunity to assess the impact of implemented improvements and shape future priorities	Assurance
SPC26/142 – Employment Services Annual Report	The Committee received the annual report and noted substantial assurance from the Internal Audit review of payroll services, alongside continued growth and expansion of Employment Services across client organisations. Members noted national recognition through multiple digital transformation awards, expansion of payroll and pension services, and extension of services to Cheshire and Merseyside ICB. Assurance was provided that contractual KPIs continued to be achieved and that digital transformation activity was generating significant efficiencies across workforce services. The Committee acknowledged ongoing challenges relating to increasing service demand, digital maturity across client organisations and workforce capacity, while receiving assurance that risks continued to be actively monitored and managed through established governance arrangements	Assurance

SPC26/143 – Team MWL – Values/Culture	The Committee received an update on progress to embed the Trust's Values and Behavioural Standards and strengthen organisational culture, inclusion and staff engagement. Assurance was provided regarding the implementation of behavioural standards across workforce processes, leadership development, employee relations and appraisal arrangements. Progress was also noted in relation to cultural competence training, active bystander training, staff network development, Freedom to Speak Up activity and initiatives designed to strengthen staff voice and engagement. The Committee discussed how existing staff survey, Freedom to Speak Up, inclusion, leadership and culture metrics could be triangulated to provide a stronger assurance framework. It was agreed that further work would be undertaken to refine the culture assurance narrative and demonstrate the impact of interventions through measurable outcomes	Assurance
SPC26/144 – Time to Hire	The Committee received an update on recruitment performance and noted that Time to Hire improved marginally to 52.6 days in September, although remaining above both the recovery trajectory and Trust target of 40 days. The Committee noted that nine longstanding recruitment cases were resolved during the month and that underlying recruitment performance was materially improved when these cases were excluded. Assurance was provided that 91.6% of the July recruitment cohort and 83.7% of the August cohort had completed pre-employment checks. Members requested future reporting include greater visibility of the full recruitment journey from vacancy approval to start date, alongside analysis of delays that could be directly influenced by the organisation.	Assurance

Assurance Reports from Sub-groups	The Committee received and noted assurance reports from: • Equality, Diversity and Inclusion Council. • People Performance Council.	Assurance
Alerts:		
None		
Decisions and Recommendation(s):		
None to note		

Committee Assurance Report			
Title of Meeting	Trust Board Meeting	**Date**	28 October 2026
Agenda Item	TB26/074 (8.4)		
Committee being reported	Finance & Performance Committee		
Date of Meeting	22 October 2026		
Committee Chair	Carole Spencer, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Chief Finance Officer Update	• Update received on the Cheshire and Mersey System financial position, system deterioration remained a risk. • The Trust's productivity performance was highlighted positively, with MWL reported as achieving 2.4% productivity growth at June 2026.	Assurance
Committee Performance Report Month 6 2026/27	• Four-hour urgent care performance at 77.5%, remained below target but above local and national averages. Corridor care continued to reduce and averaged 38.8 instances. • 18-week performance in September was 65.9%. The Trust had 1,881 patients waiting more than 52 weeks, 46 waiting more than 65 weeks and one waiting more than 78 weeks. • Diagnostic six-week performance improved to 84.9% in September. This remained below the 95% standard and the Cheshire and Merseyside average of 86.2%, but above the national position of 75.3%. • The 28-day Faster Diagnosis Standard was 66.3% in August, below the 80% standard and national performance of 78.6%. Tumour-site improvement plans remained in place, supported by work to address diagnostic constraints and front-end pathway delays. • The 62-day cancer standard improved to 80.7%, above the 80% target. The 31-day standard was 96.2%, above the 94% target. • G&A bed occupancy averaged 98% in September against a 92% target.	Assurance
Finance Report Month 6 2026/27	• The Trust reported an adjusted deficit of £6.1m at Month 6. Excluding deficit support funding, the adjusted deficit was £14.5m, in line with plan. The annual plan was	Assurance

	balanced and included £16.7m deficit support and delivery of £49.7m recurrent CIP. • The Trust continued to forecast delivery of the plan, including £16.7m deficit support. • Agency expenditure was £4.1m year to date, equivalent to 1.2% of total pay expenditure. • Bank costs, income run rate, coding depth and the full-year recurrent effect of CIP required continued management. • Cash was £6.8m at Month 6 and further improvement to the cash forecast was expected as receipts and aged debt actions progressed. • Capital expenditure was £13.4m, £5.3m below plan, against a revised full-year programme of approximately £58.9m. Plans were in place to deliver the programme for the year.	
CIP Programme and CSS & Community updates	• The Trust's recurrent CIP requirement for 2026/27 was £49.7m. At Month 6, £22.4m had been delivered year to date, in line with plan, of which £14.7m was recurrent. • Schemes identified totalled £55.8m in year and £70.3m recurrently. The identified programme therefore exceeded the annual requirement, although delivery remained dependent on schemes being implemented. • CSS and Community Divisions reported their progress on CIP delivery of 2026/27 schemes, including work to further develop and deliver ideas.	Assurance
Forecast	• Committee received an update on the M6 forecast outturn position including the forecast run rate and associated actions to improve which are needed to meet the financial plan. • Executive ownership was assigned and the actions were reviewed through Executive Committee and Senior Leadership Group. • The underlying position was shared reflecting acute and block deconstruction, linked to the forecast outturn.	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. • Commissioning intentions had been received and were broadly aligned with the Trust Strategy and 10 year plan. • Current indications were that the three-year national submission would be required in December, subject to formal guidance and plans were in place to deliver this over the coming months.	Assurance

Benchmarking Update	• The Committee noted the National Cost Collection Index of 97, confirming that the Trust's cost base was below the national average and consistent with the previous year. • Published productivity metrics also showed a strong resource position. • Further specialty-level analysis would be brought through the established benchmarking programme to identify unwarranted variation and improvement opportunities.	Assurance
NHSE Access Tiering	• The Committee noted the updated regional performance process and received an update on the Trust's position.	Assurance
Elective Care Recovery Review	• The review included the governance for the strategic transformation programme and the elective care recovery plan. • Key interventions included targeted validation, clinical triage, expansion of tier 2 services, additional outpatient capacity, specialty recovery plans and improved theatre productivity. • The national GIRFT programme was feeding into the recovery plans to ensure patient care is undertaken in the most appropriate setting and with a positive patient experience and the best use of resources. • The Committee welcomed the link between immediate recovery and the longer-term surgical strategy.	Assurance
Assurance Reports from Subgroups	- MWL FC26/190 – Procurement Steering Group - MWL FC26/191 - CIP Council Update - MWL FC26/192 - Capital Planning Council Update - MWL FC26/193 - IM&T Council Update - MWL FC26/194 - Estates & Facilities Management Council Update	Assurance
Alerts		
None.		
Decisions and Recommendation(s):		
The Board is asked to note the report.		

Title of Meeting	**Trust Board**		**Date**	**28 October 2026**
Agenda Item	**TB26/075**			
Report Title	Corporate Risk Register			
Executive Lead	Simon Regan, Director of Corporate Services			
Presenting Officer	Sarah O'Brien, Chief Nursing Officer			
Action Required		**To Approve**	X	**To Note**

Purpose

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

Executive Summary

1. Risk Management Systems

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

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

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

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

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

2. Risk Registers and Corporate Risk Registers

This report is a snapshot of the risk registers on 07 October 2026 and reflects risks reported and reviewed during September 2026.

Risk Register Summary

The total number of risks on the MWL risk register was 969 compared to 979 in July 2026.

22 risks are escalated to the CRR, which is the same as in July 2026. Of the 22 risks escalated to the CRR, all are within review dates.

Four new risks have been escalated to the CRR since the July report and four have been closed or de-escalated. A further risk (ID 1617) was escalated and subsequently de-escalated during the reporting period.	
Financial Implications	
None as a direct result of this report.	
Quality and/or Equality Impact	
Not applicable	
Recommendations	
The Board is asked to note the Corporate Risk Register.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

1. Risk Register Summary for the Reporting Period

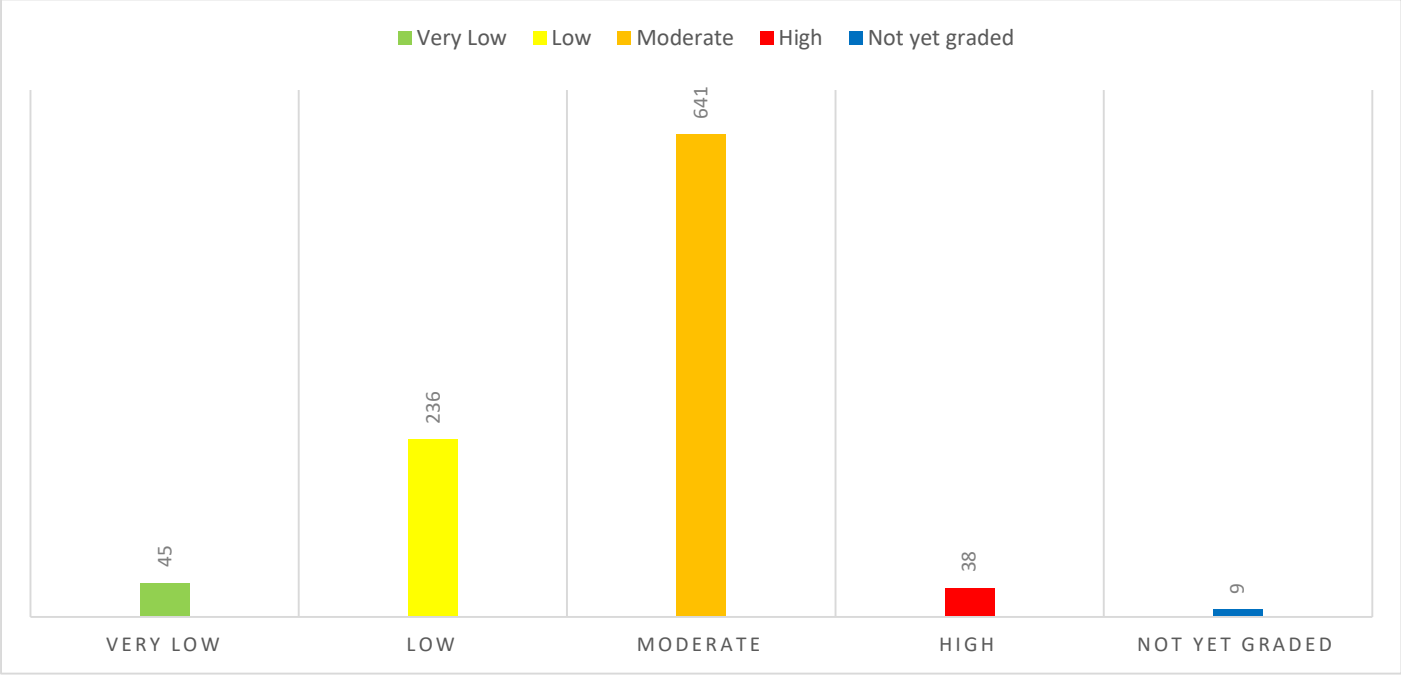
This table provides a high-level overview of the "turnover" in the risk profile of the **MWL** sites compared to previous reporting periods.

RISK REGISTER MWL SITES	Current Reporting Period (October 2026)	Reporting Period (September 2026)	Reporting Period (August 2026)
Number of new risks reported	30	25	35
Number of risks closed or removed	16	49	40
Number of risks overdue for review	79	91	249
Total Number of InPhase risks	**969**	**955**	**979**

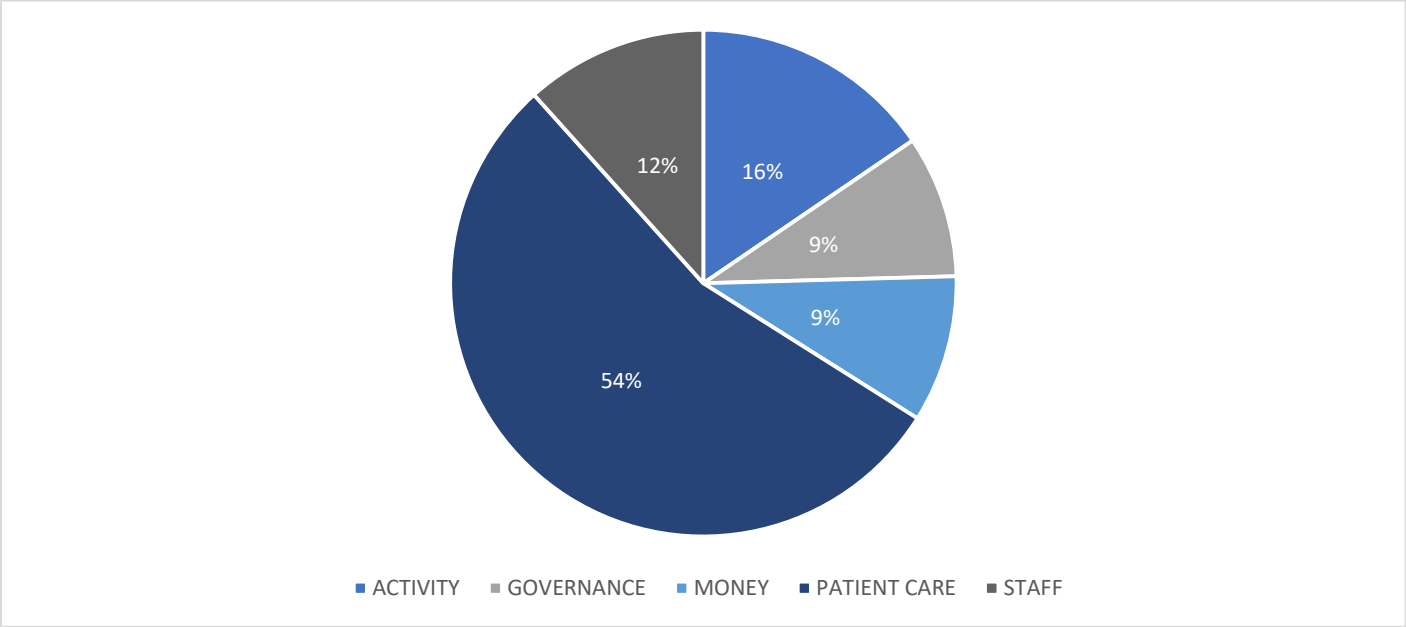
includes new risks, not yet scored (9**)*

2. Risk Profiles

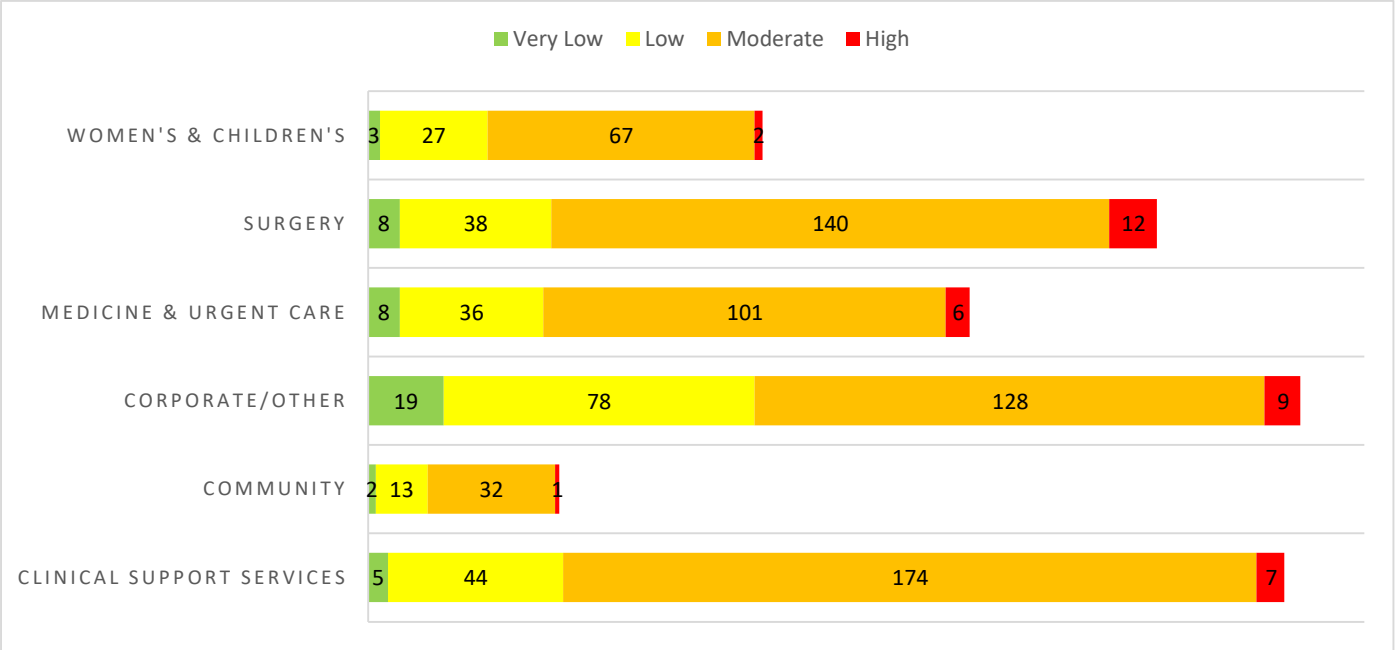
MWL Organisational Risk Profile



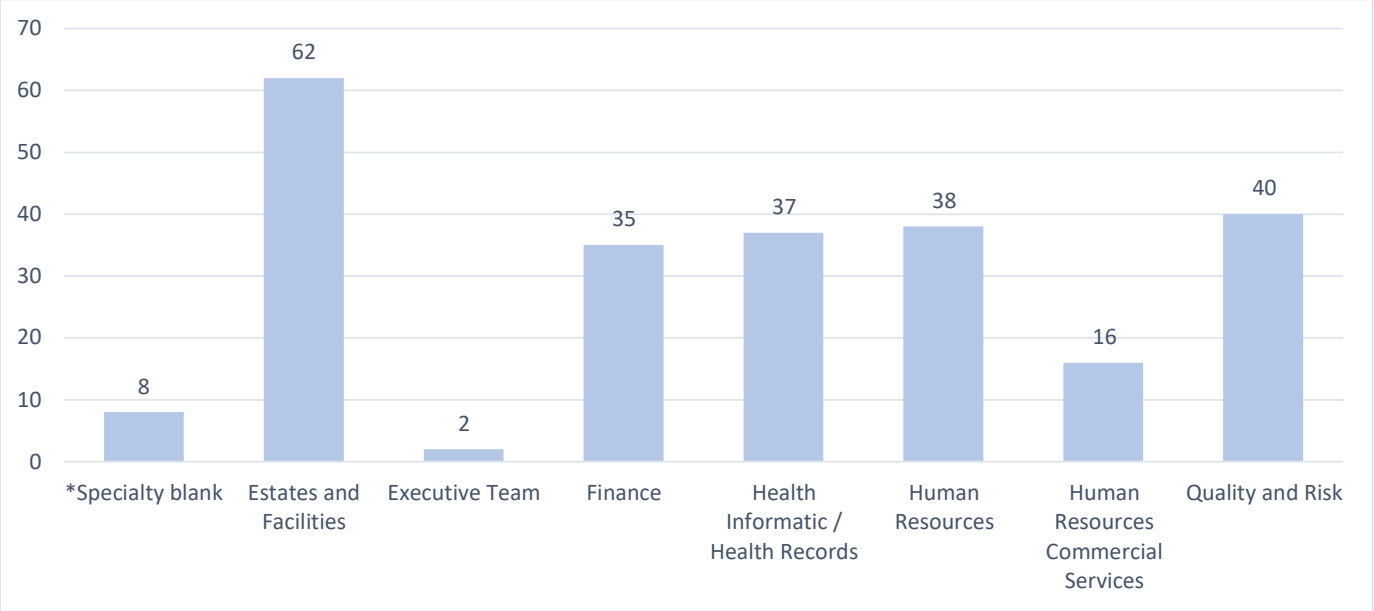
** 9 new risks awaiting review and control*



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



The split of the risks across the corporate departments is:



**Specialty blank refers to risks that are Trust-wide issues; not specialty specific.*

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

MWL Risk Id	Title	Risk Owner	Opened	Next review date	Grade	Specialty
30	If the Trust relies on bank and agency staffing then there is a risk to the quality of care, contract delivery and finance performance	Jo Waldron	29 Mar 2022	30 Oct 2026	16	Human Resources
47	If the trust cannot recruit and retain sufficient skilled staff, then there is a risk to safe staffing	Jo Waldron	07 May 2013	30 Oct 2026	16	Human Resources
80	If the critical estates infrastructure at the S&O hospital site fail, then there is a risk to delivery of services and the safety of staff and patients	Dyan Clegg	25 Mar 2025	30 Nov 2026	15	Estates and Facilities
361	If there is a malicious cyber attack that the Trust cannot block, then there is a risk to the delivery of services and patient / staff information	Malcolm Gandy	12 Oct 2016	30 Oct 2026	15	Health Informatic / Health Records
400	If obsolete audiology equipment is not replaced at Ormskirk Hospital, then there is a risk to continued service provision	Lesley Neary	04 Dec 2023	30 Nov 2026	15	Head and Neck
510	If obsolete, end of life HSDU equipment is not replaced, then there is a risk to the safe and sustainable delivery the elective surgical programme	Lesley Neary	21 Jul 2017	30 Nov 2026	16	Theatres
521	If the Trust cannot deliver sufficient out of hours anaesthetic support, then there is a risk to patients in a 2nd time critical maternity emergency at ODGH	Ash Bassi	25 May 2023	30 Nov 2026	20	Anaesthetics
587	If the Trust cannot recruit and retain Consultant ENT staff, then it would not be able to deliver the commissioned service	Lesley Neary	02 Nov 2023	30 Nov 2026	16	Head and Neck
591	If the Trust does not have effective booking and patient tracking systems in ophthalmology, then there is a risk of increased waiting times and patient harm	Lesley Neary	28 Apr 2025	30 Nov 2026	20	Head and Neck
630	If the Trust cannot move to a single EPR then there is a risk of duplication of effort, barriers to integrating clinical services and suboptimal use of available facilities	Malcolm Gandy	30 Apr 2025	30 Oct 2026	15	Health Informatic / Health Records
758	If the Trust cannot achieve sustainable solutions for the clinical services assessed as fragile, then patient access and safety will be at risk	Mike Roscoe	07 Feb 2025	31 Oct 2026	16	Executive Team

MWL Risk Id	Title	Risk Owner	Opened	Next review date	Grade	Specialty
914	If the Trust experiences increased demand and bed occupancy above planned capacity, then there will be reduced patient flow	Sarah O'Brien	13 Apr 2015	28 Oct 2026	20	General Medicine
978	If there is insufficient funding from NHS Wales, then there is a risk to the level of care MWL can deliver for plastic surgery patients in North Wales	Lesley Neary	15 Sep 2022	20 Nov 2026	16	Burns and Plastics
1125	If there are data quality errors and patient number mismatches due to legacy IT systems, then there is a risk to patient harm	Malcolm Gandy	04 Sep 2019	30 Oct 2026	15	Health Informatic / Health Records
1301	If there is a Lack of on site clinical services at MWL Ormskirk site then this will impact on the maternity service	Sarah O'Brien	28 Sep 2025	18 Dec 2026	15	Maternity and Obstetrics
1349	Maternity emergency cases out of hours	Sarah O'Brien	18 Oct 2025	01 Nov 2026	16	Theatres
1501	Telepath Support Contract (Dedalus) & Powerterm	Malcolm Gandy	28 Jan 2026	15 Oct 2026	16	Pathology
1573	Absence of Occupational Therapy in Critical Care Therapy Service	Sarah O'Brien	09 Feb 2026	22 Nov 2026	15	Therapies
209	The workforce within the District Nursing Service does not match the high demand	Sarah O'Brien	02 Feb 2021	16 Oct 2026	15	Community Nursing
1590	Dermatology Backlog Typing	Lesley Neary	28 Apr 2026	30 Nov 2026	16	Dermatology
1633	Maternal Diabetes service	Sarah O'Brien	01 Jun 2026	29 Oct 2026	15	Maternity & Obstetrics
1667	TIA service Southport	Simon Dowson	29 Jun 2026	16 Nov 2026	16	Medicine for Older People and Stroke

Blue Text = new CRR risks escalated since the July report

4. Closed/Removed from Corporate Risk Register

MWL Risk Id	Title	Risk Owner	Opened	Grade	Specialty	Comments
218	Lack of available Systemic Anti Cancer Treatment (SACT) treatment appointments	Sarah O'Brien	02 Apr 2025	12	Cancer	Risk score reduced to 12 from 15 following discussion at Departmental Governance meeting. Appointments are being scheduled and these are being closely monitored.
648	If the Trust under performs against the 2026/27 activity plan because of industrial action by the BMA, then it will not generate the expected income to deliver the agreed financial plan	Gareth Lawrence	24 Jul 2024	4	Finance	Risk reviewed and changed from 16 to 4. Risk closed 15 July 2026 due to BMA acceptance of pay award.
663	If the Trust under performs against the 2025/26 variable activity plan, then it will not generate the expected income to deliver the agreed financial plan	Gareth Lawrence	17 Oct 2024	6	Finance	Risk related to 2025/26 and therefore score reviewed and amended to 6 and closed.
1513	Insufficient Administration Staffing Levels	Sarah O'Brien	09 Feb 2026	12	Radiology	Risk rating reduced from 15 to 12 in August 2026 based on recent recruitment activity
1617	Lack of High Oxygen/Airflow in theatres	Ashlee Carr	20 May 2026	12	Southport Theatres	Risk was initially escalated to CRR with grade of 16 under L Neary. Controls have now been identified which mitigate the risk, reducing the risk score to 12. Risk will be managed in division until equipment is sought to provide high flow in theatres. Risk will then be closed.

END

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	Trust Board			**Date**	28 October 2026
Agenda Item	TB26/076				
Report Title	Board Assurance Framework				
Executive Lead	Rob Cooper, Chief Executive				
Presenting Officer	Rob Cooper, Chief Executive				
Action Required	X	**To Approve**		**To Note**	

Purpose

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

Executive Summary

The MWL BAF is reviewed four times a year, the last review was in July 2026, and this review captures the changes that have occurred during Q2 (2026/27).

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

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

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

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

Proposed changes to risk scores
BAF 3 – increase the risk score to 20 from 16 reflecting the observed increased operational pressures leading into winter 2026/27, and performance against operational targets.

Financial Implications

None directly because of this report

Quality and/or Equality Impact

Not applicable

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

Board Assurance Framework Quarterly Review – Q2 2026/27

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

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

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

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

Risk Scoring Matrix

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

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

Key to proposed changes:

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

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Chief Medical Officer/Chief Nursing Officer

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

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

BAF 2 Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners — Exec Lead: Chief Finance Officer

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

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

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

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

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

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

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff. • Increased external scrutiny/review. **Impact:** • Reduced financial viability and sustainability. • Reduced service safety and sustainability • Reduced operational performance. • Increased intervention	• Updated Communication, Media and Public Engagement Strategy & action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Public Consultations • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR/FOI • Board media roundups and flash briefings • Work with ICB and NHSE communications teams • Trust leadership of CMPC workstreams and professional groups	**LEVEL 1** Operational Assurance • Winter plans and awareness raising campaigns • Daily/weekly media briefings and board flash reports for urgent issues • Quarterly communications and media reports • Communications plans in relation to service change proposals • MWL UEC Recovery Programme • Healthwatch attendance at Patient Experience Council **LEVEL 2** Board Assurance • Finance and Performance Committee • Patient Experience Council • Integrated Performance Report • Annual Operational Plan/objectives **LEVEL 3** Independent Assurance • NHSE & ICB monitoring and escalation returns/sit-reps • NHSE NOF Segmentation • Representation and participation across system forums – HWBB, Place and Neighbourhood • System winter resilience plan • CQC System Reviews/Reports • Provider Collaboratives/Alliance • Patient survey results	Optimise opportunities for Neighbourhood Healthcare Hubs and Integrated Healthcare Organisations for the local population in partnership with Place/LA's and other key stakeholders	~~Creation of good working relationships with new Healthwatch/PBP areas post transaction.~~	Continue programme of CQC site visits to maintain understanding of the Trust's issues and responses (On-going) Demonstrate impact of Neighbourhood Health interventions for Wave 1 of NNHIO (December 2026) Targeted engagement with key partner organisations (February 2027)

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Chief People Officer

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

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

BAF 6 Failure to attract and retain staff with the skills required to deliver high quality services — Exec Lead: Chief People Officer

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

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

BAF 7 Major and sustained failure of essential assets or infrastructure — Exec Lead: Chief Executive

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

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

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

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

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Cyber Incident Response Plan (tested) • Information asset owner/administrator register • Service improvement plans • MWL Digital Strategy 2024-2027 • Microsoft Defender for Endpoints • Clinical & Digital Design Authority (CDDA) • MFA protection for confidential data – enforced on non-Trust devices • Annual DSPT self-assessments • C&M Major digital Incident planning exercises • Microsoft Secure Score / Exposure Management • Critical services list	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Comprehensive monitoring of systems and services • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring • Monthly cyber security operational meeting • Digital Transformation Steering Group • EPR Programme Delivery Group • MMDA Strategy Board • Programme/Project Groups • Information Governance Group • Information Security Group • AI and RPA Group • Business continuity testing **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan • Audit Committee • Executive Committee • Risk Management Council • IM&T Council • EPR Executive Steering Group • MMDA Service Operations Board • Quarterly Board Cyber Security Reports • Shared EPR Programme Executive Board **LEVEL 3** Independent Assurance • Internal/External Audits • Cyber Essentials Plus accreditation - MMDA. • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments • Data Security & Protection Toolkit	Annual IT Corporate Governance Structure review Technical Development of staff Joint EPR Programme Board Assurance Reports EPR Optimisation Council Assurance Reports	IT Communications Strategy Digital Maturity Assessment	Achieve HIMMS EMRAM Level 5 equivalent ~~2018~~ standards and core digital capability requirements and WGLL ~~standards~~ objectives (revised to ~~September 2028~~ March 2029 due to impact of extended EPR replacement programme) Complete retirement and replacement of all remaining Windows Server 2016 infrastructure ~~are being retired and being replaced~~ (January 2027) Delivery of the Frontline Productivity Programme to optimise Careflow EPR and implement new functionality to meet the core digital capability standards (full implementation will only be delivered when the new single EPR is in place (February 2029). ~~Delivery of Community EPR (revised to March 2027)~~ Identify preferred EPR solution and migration approach and timetable option for STHK Community Services for decision (March 2027) ~~Implementation of Maternity Information System. following changes in service delivery model that have been reassessed and the implementation plan updated (revised to November 2026~~) Complete Executive review and agree Maternity Information System's future direction, implementation plan, and timetable aligned to the revised service model (March 2027) ~~Implement EPMA at the Southport and Ormskirk Hospital sites (revised to June 2026)~~ Complete Southport ITU EPMA deployment following the planned EPMA upgrade to achieve full coverage across all inpatient areas (March 2027) Deliver the 2026/27 IT Capital expenditure plan (March 2027)

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**	**Date**	**28 October 2026**
Agenda Item	**TB26/077**		
Report Title	Incidents, Complaints, Concerns, Claims and Inquests Q2 2026/27		
Executive Lead	Sarah O'Brien, Chief Nursing Officer		
Presenting Officer	Sarah O'Brien, Chief Nursing Officer		
Action Required		**To Approve**	X **To Note**

Purpose

The aim of this paper is to provide the Board with an update report on the management of incidents, complaints, concerns and claims during Quarter 2 2026/27

Executive Summary

Incidents

- A total of 8,724 incidents were reported across MWL in Q2 2026/27.
- Of these, 6,417 were patient safety incidents.
- 86 patient safety incidents were classified as moderate harm or above.
- The most frequently reported patient safety incidents in Q2 were:
    - Pressure Ulcers, including those not acquired under Trust care (699), were the highest reported Trust wide (941)
    - Accidents including slips, trips, falls, and collisions were the second highest reported incidents in Q2 (805)

Complaints & PALS

- The Trust received 186 first stage complaints in Q2.
- The Trust received 26 stage 2 complaints in Q2.
- The Trust closed 170 complaints in Q2.
- The Trust's complaint compliance was **80%** in Q2.
- Clinical treatment was the main theme for complaints, in line with previous quarters.
- Emergency Departments remained the main areas to receive complaints.
- The Trust received 1020 PALS contacts in Q2 (not including Ask Rob or Compliments).

Claims & Inquests

- In Q2 the Trust received 34 new claims; more than previous quarters. 21 were closed
- The Trust received 34 new inquests, and 20 inquests concluded
- No Prevention of Future Death (PFDs) were issued during that period

Financial Impact

There are no direct financial implications arising from this report. Financial liabilities associated with clinical negligence claims are managed through the established claims and NHS Resolution arrangements.

Quality and/or Equality Impact

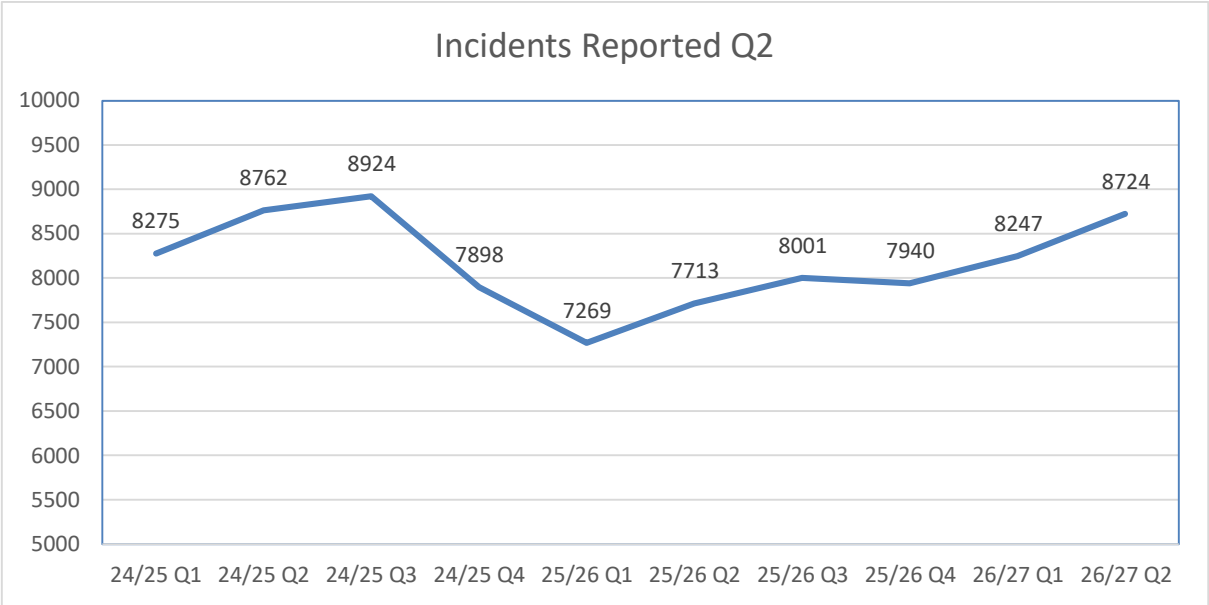
The report provides assurance on the Trust's management of patient safety incidents, complaints, concerns, claims and inquests and identifies themes and learning relevant to the quality and safety of care. No specific equality impacts arising from this report have been identified.

Recommendations	
The Board is asked to note the Incidents, Complaints, Concerns, Claims and Inquests Report Q2 2026/27	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

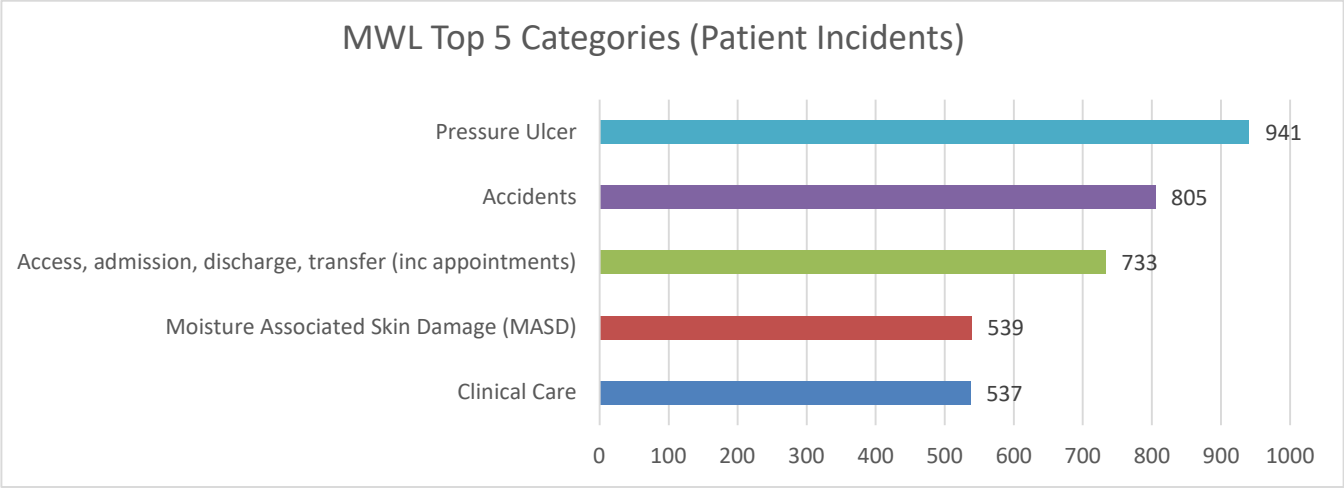
This paper includes reported incidents, complaints, PALS contacts, claims, and inquests during Quarter 2 2026/27, highlighting any trends, areas of concern and the learning that has taken place. In March 2025 the Trust moved to a new Incident Reporting System, InPhase, which brought all sites onto one reporting platform to record incidents, complaints, PALS, claims and inquests.

2. Incidents



MWL Q2 incidents reported	
6,417	**Incidents affecting patients**
703	**Incidents affecting staff**
1,518	**Incidents affecting the Trust or other organisation (examples include bed availability; notifications of staffing levels; delayed discharges; equipment issues and queries raised by system partners)**
49	**Incidents affecting visitors, contractors or members of the public**
37	**Martha's Rule / Call for Concern**

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



There were 8,724 incidents reported across MWL during Q2, which is a 5.8% increase on Q1 26/27 (8,247). Patient related incidents accounted for **73.6%** of these (6,417)

Among the highest categories for patient-related incidents:

- **Pressure ulcers** – including both those acquired while under MWL care including Community Nursing **(242)** and those acquired externally **(699)** – were the most frequently reported in Q2, with 941 cases, which is an increase on Q1 (819)
- **Accidents** – including slips, trips, falls, and collisions – were the second highest reported patient events (805) which remains consistent with the previous quarter (803 in Q1).

2.1 Incidents by harm category

The table below illustrates patient incidents by harm category for Quarter 2 2026/27.

In Q2 there were four deaths across all sites which is an increase on the previous quarter. The percentage of severe and death incidents against the total of all patient incidents is **0.31%** for Q2 2026/27 compared with **0.23%** for Q1. This will continue to be monitored in the coming quarters.

The deaths reported in Q2 fell under the sub-categories of: Cardiac arrest, a fall incident, known / recognised complications, and unexpected death. All incidents are subject to Trust review to identify learning and improvement.

MWL	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	26/27 Q1	26/27 Q2
Moderate	33	54	67	38	45	49	39	66
Severe	9	6	14	14	6	6	13	16
Death	4	2	4	4	7	1	1	4
Total	46	62	85	56	58	56	53	86

2.2 PSII Incidents and Learning

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

Q2 2026/27 – Discussed at Patient Safety Panel	Total
Patient Safety Incident Reviews	22
Learning Reviews including – MDT - Multi-Disciplinary Team (MDT) / After Action Review (AAR)	13
Patient Safety Incident Investigations (PSII) / (including Maternity and Newborn Safety Investigations (MNSI)	1

There were three Strategic Executive Information System (StEIS) reportable incidents recorded for Q2 2026/27. Two were agreed for PSII review, the first of which related to care of a deteriorating patient, and the second was an alleged patient-on-patient assault. The third StEIS reported incident was a Never Event involving an injection into the incorrect eye, which has been agreed for an MDT review.

2.3 Duty of Candour

The Duty of Candour process has been commenced or completed for all incidents where harm has been confirmed as moderate or above. The investigation and validation of some Q2 reported incidents is still ongoing. In accordance with policy, Duty of Candour will be initiated following confirmation of harm.

Duty of Candour is required for all incidents where harm has been identified and validated by the responsible manager as moderate or above, or where an incident has been identified for a PSII. Under the Health and Social Care Act 2008 Regulations 2014: Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires NHS providers to comply with the Duty of Candour as soon as reasonably practicable after becoming aware of a notifiable safety incident. This includes notifying the affected person and providing appropriate support. A notifiable safety incident is any unintended or unexpected incident that occurs during the provision of a regulated activity and results in, or appears likely to result in, death, severe harm, moderate harm, or prolonged psychological harm.

3. Complaints

The Trust received 186 new complaints in Q2; 170 first stage complaints were closed in the same period. 9 of the complaints received did not progress through the formal complaints process. 30 Complaints were upheld in full, and 25 were not upheld. Across Q2 the Trust closed 202 complaints in total (second stage, out of time, other trust leading).

During Q2 34 first stage complaints breached the 60 day target.

Closed Complaints	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27
Not Upheld	22	17	20	16	12	25		
Partially Upheld	89	86	127	90	120	107		
Upheld	24	17	22	41	24	30		
Total	**135**	**120**	**169**	**147**	**156**	**161**		

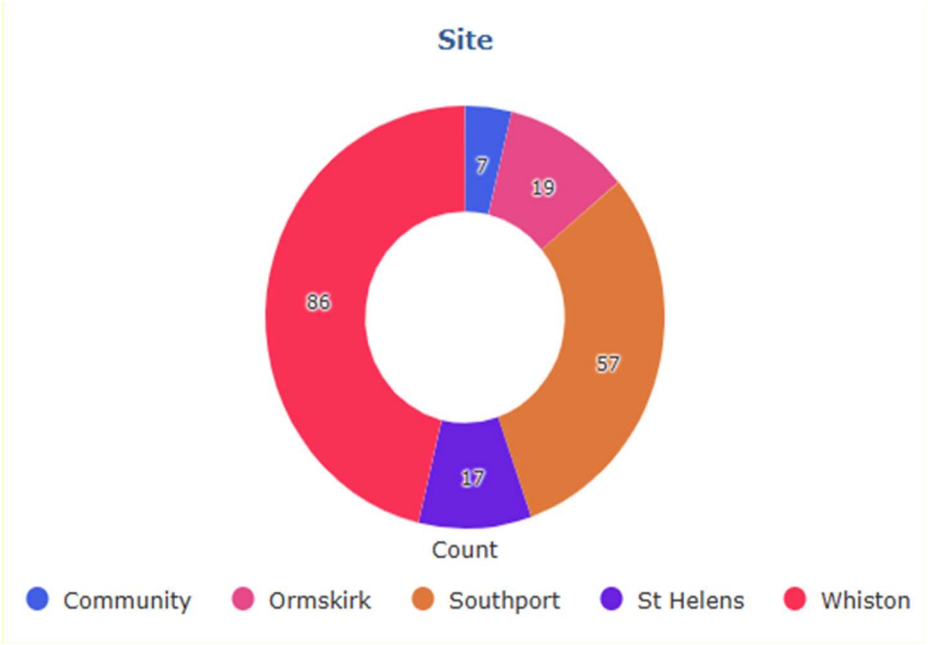
Themes of Closed Complaints	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27
Clinical Treatment	61	54	65	73	79	93		
Patient Care (Nursing)	19	17	29	27	26	23		
Values & Behaviours	2	5	8	13	9	8		
Communication	14	21	26	20	14	14		
Admission & Discharge	9	4	7	25	25	15		

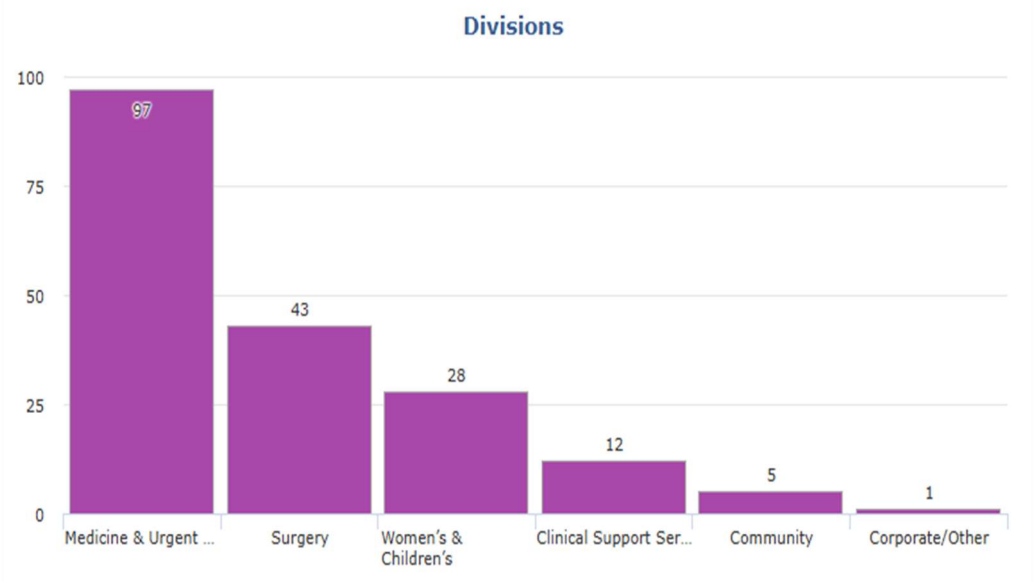
Figures correct at time of reporting from InPhase – (15.10.26)

The Trust achieved 80% compliance of complaints being responded to within 60 working days in Q2. This is an improvement on the figure from the previous year and quarter 1.

Quarterly comparison of 60 working day compliance	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	26/27 Q1	26/27 Q2	26/27 Q3	26/27 Q4
MWL First stage complaint	115	161	145	157	156	186		
Second Response Trust Target Less than 12 per Q	16	16	18	20	15	26		
Response Compliance Trust Target 80%	50.7%	71.6%	65%	64.8%	69.2%	80%		
MWL number of complaints breached 60 working timeframe	57	34	60	77	49	34		

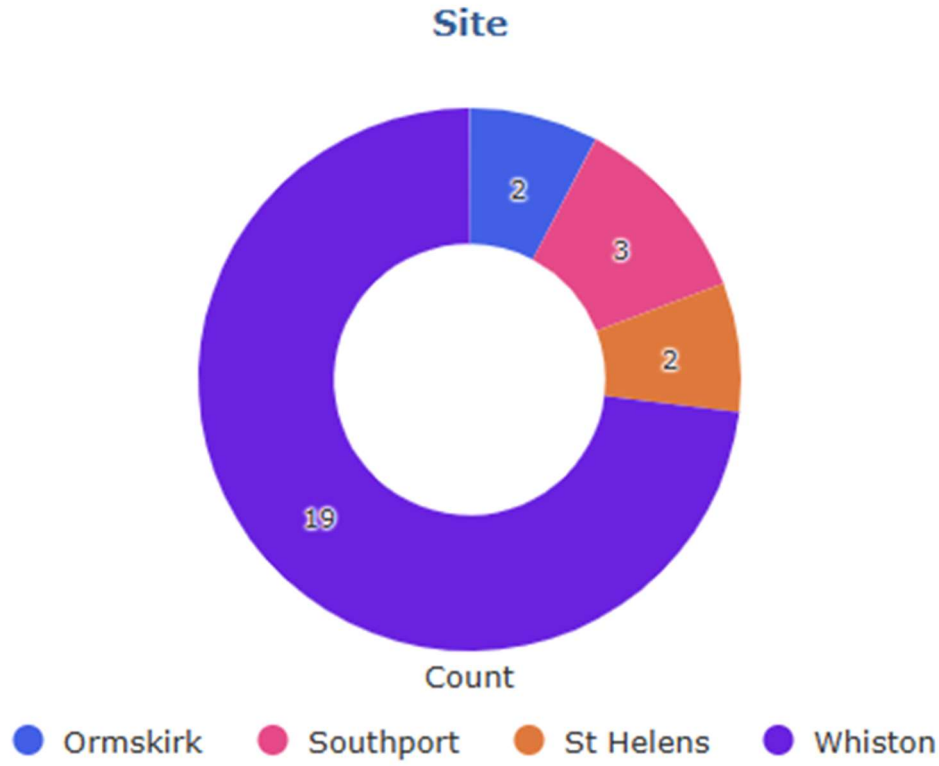
The charts below depict the specific Trust sites and divisional breakdown of the 186 first stage complaints received in Q2.

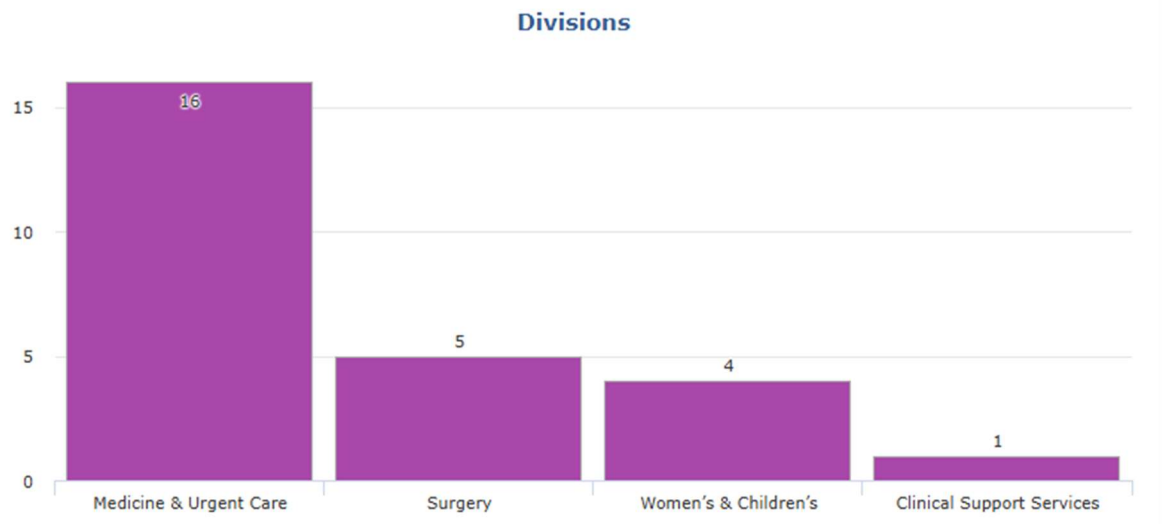




Medicine received the majority of the new complaints in Q2. (60.2%)

The Trust received 26 second stage complaints in Q2. This is a marked increase on the previous quarter of 10.





Medicine also received the majority of the second stage complaints. (61.5%)

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

PALS Contacts	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	26/27 Q1	26/27 Q2	26/27 Q3	26/27 Q4
Number of contacts received	1131	1232	1112	1157	1028	1020		

Figures at time of reporting from InPhase (15.10.26)

PALS Contacts by Themes Q1

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

PALS Contacts by Themes Q2

Q2 2026/27 PALS Themes by Division	Comm	CSS	Corp	M&UC	Surgery	W&C	Total
Communication	8	32	26	184	161	57	487
Appointments	4	21	4	49	112	38	235
Clinical Treatment	0	4	0	31	14	10	61
Admissions and Discharges	1	0	0	13	23	7	44
Patient Care/ Nursing Care	0	1	2	27	3	8	41
Access to Treatment or Drugs	1	0	1	19	10	9	41
Values & Behaviours	3	1	2	12	4	1	23
Waiting Times	0	0	0	5	12	0	17

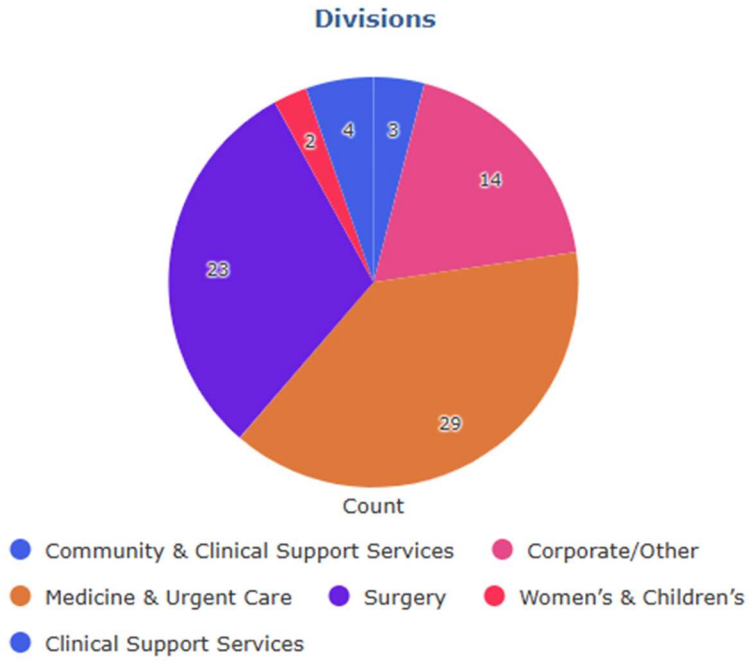
In Q2 there were 75 **Ask Rob** concerns received.

Ask Rob Contacts	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27
Number of contacts received	31	37	32	87	62	75

The top five themes for Ask Rob contact in Q2 were:

1. Communication (main theme)
2. Appointments
3. Admission & Discharge
4. Access to Drugs/Treatment / Patient/Nursing Care and Wait Times
5. Clinical Treatment

The chart below displays the Ask Rob concerns received by division in Q2.



4.1 Compliments

Quarter 2 26/27	C &CSS	Corporate/Other	M&UC	Surgery	W&C	Total
	403	16	183	161	40	803

4.2 Parliamentary and Health Service Ombudsman (PHSO)

The table below displays the number of PHSO cases the Trust currently has ongoing in Q2 of 2026/27.

Current PHSO cases open to date

PHSO formal investigation	4
PHSO proposal to investigate	0
Primary investigation enquiry / Prelim enquiries open	12
Awaiting outcome report	0
Total	16
Closed	1

Closed Public Service Ombudsman Case – closed no fault found – not upheld.

NB. From 1 October 2026 the PHSO has rebranded as the Public Service Ombudsman.

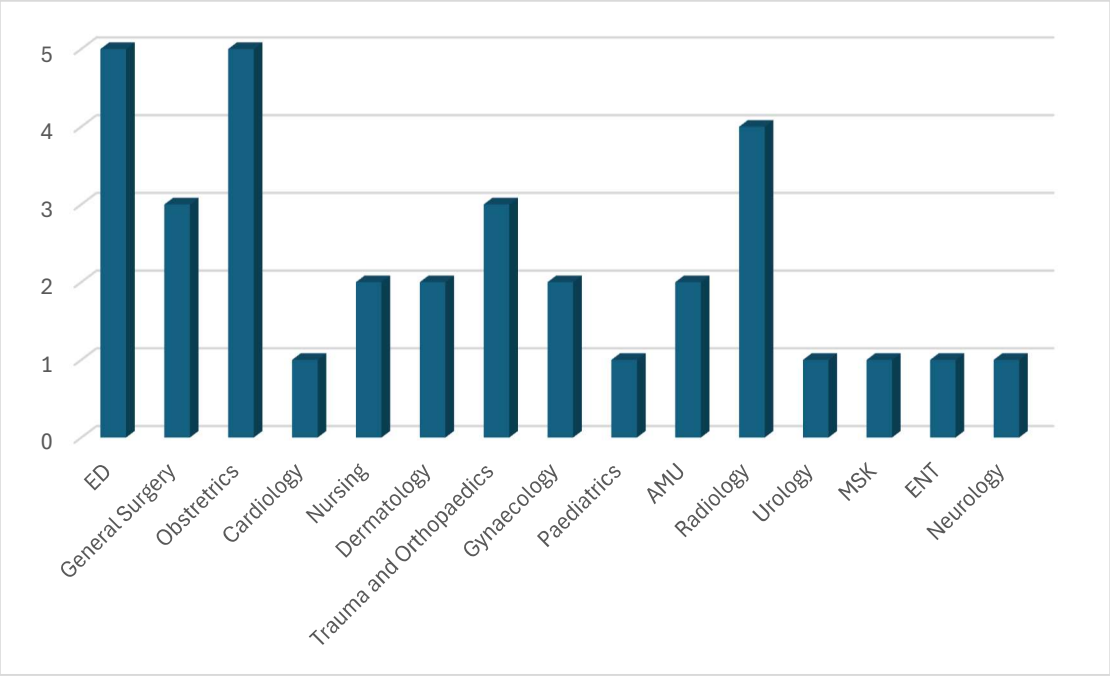
5. New Clinical Negligence Claims

The Trust received 34 new claims in Q2, which followed an increase in Q1 above usual numbers (31). 16 were received in July, 12 in August, and 6 in September. 20 claims related to the Whiston/St Helens sites; 14 related to Southport and Ormskirk. There were no community claims.

This would appear to be a sustained increase, although it is of note that unlike the previous quarter, the claims are not evenly spread cross the 3 months. Anecdotally we are seeing more "Litigant in Person" claims, which appear to have used AI tools to assist in the drafting of Letters of Claim.

The Trust is required to report all Letters of Claim to NHS Resolution, irrespective of potential merit.

5.1 New claims by speciality



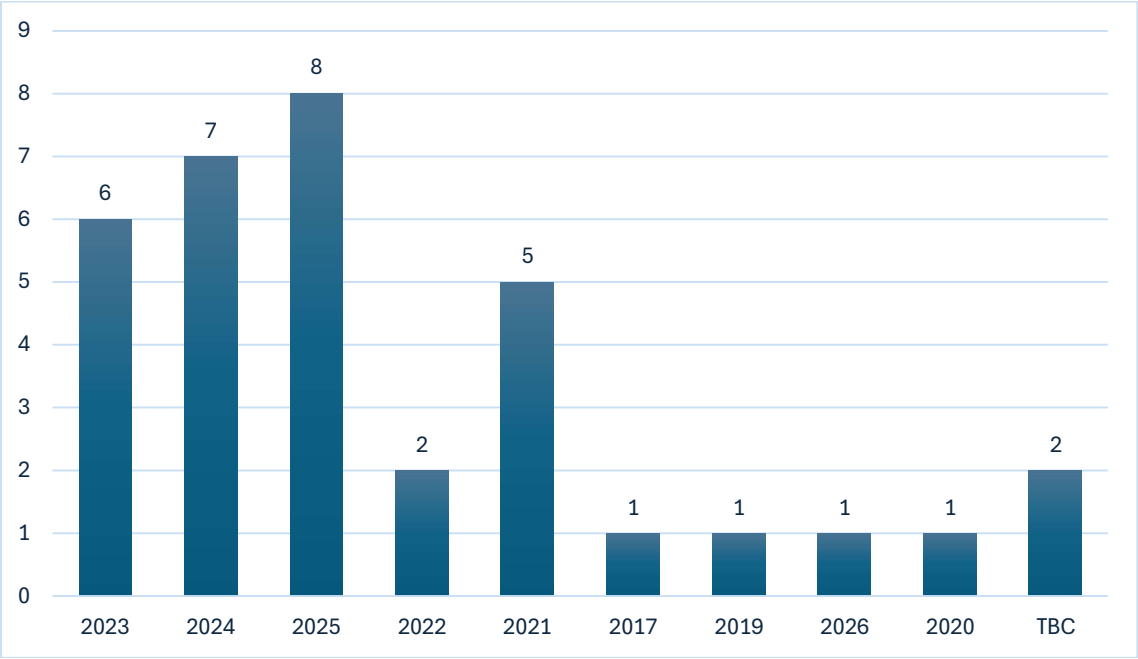
Although there are a higher number of claims than the previous quarter, no single speciality had more than 5 claims. In the previous quarter Trauma and Orthopaedics had 7 and ED had 6.

5.2 New claims by main reason

Failure/Delay in diagnosis and Failure/Delay in treatment are the largest causes of claims. Both nursing claims relate to falls. The MSK claim relates to an outpatient clinic provided by another Trust's staff at MWL, but where the secretarial support was provided MWL. A claim is also pursued against the other Trust in that case.

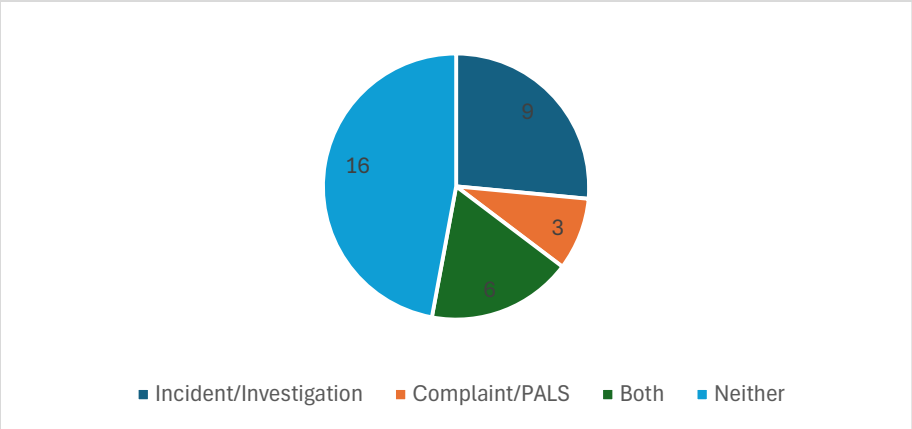
5.3 Year to which claims relate

Although these claims were formally notified in Q2, the date of the incidents to which the claim relates can vary significantly. The graph shows the year in which the incident took place – where there is more than one incident the earliest that relates to this trust is used.



5.4 Prior knowledge of issues causing claims

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



47% of claims had no previous investigation, which is broadly in line with the previous quarter.

All claims that have not been investigated at all are reviewed at Claims Governance Group to see if an investigation should take place. The August claims were reviewed on 21 October (outcome not available at time of writing) and the September claims will be reviewed on 18 November.

5.5 Lessons Learned/Actions taken from Closed Claims

The Trust closed 21 claims in Q2. 11 of these concluded without a payment being made to the claimants.

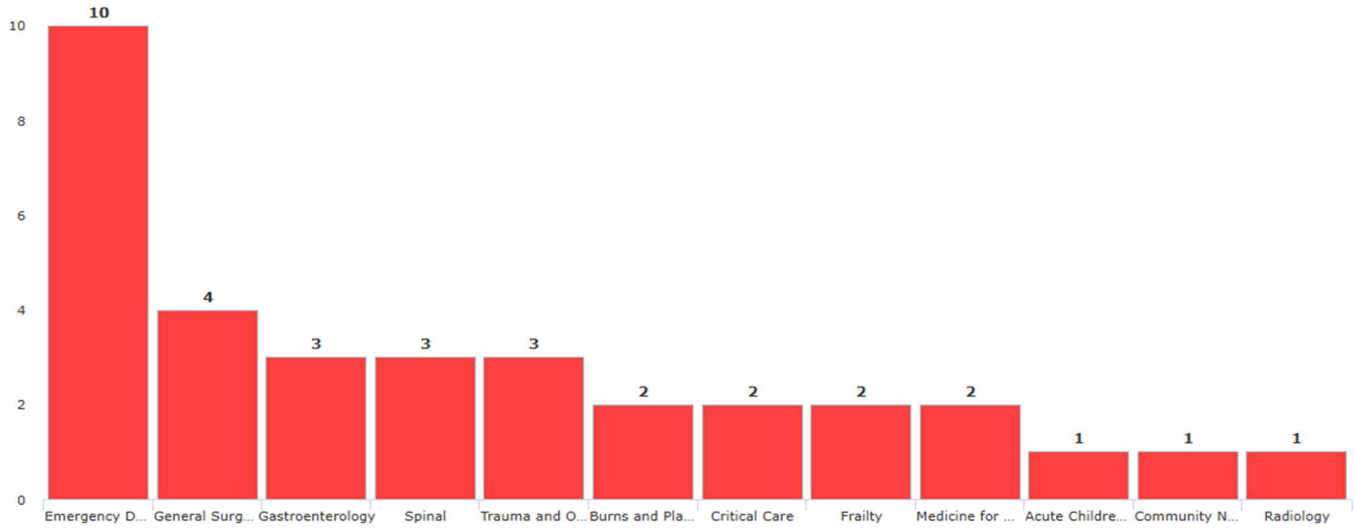
Of the 10 claims closed in Q2 with damaged payments no learning specifically identified as a result of the claim process. There are often occasions where claims are settled on a litigation risk basis, even where the Trust has not formally accepted fault.

6. Inquests

6.1. New Inquests

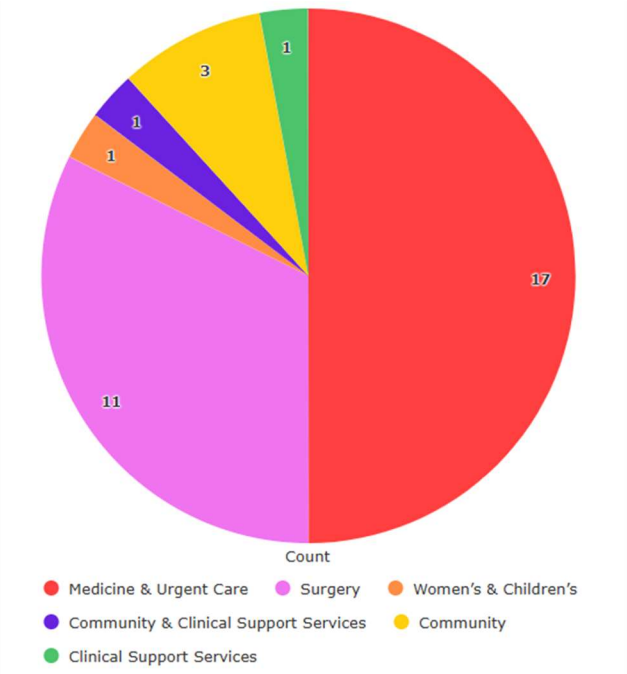
34 new inquests were opened in Q2. This is a significant increase following relative stability for a number of the previous quarters.

These inquests are broken down by department as follows:



ED received the most inquests, which is not unexpected and is consistent with previous quarters. General Surgery received 4, and Gastroenterology, Trauma and Orthopaedics and the Spinal Unit all received 3. It should be noted that this does not mean that the patients died within that department.

And by division as follows:

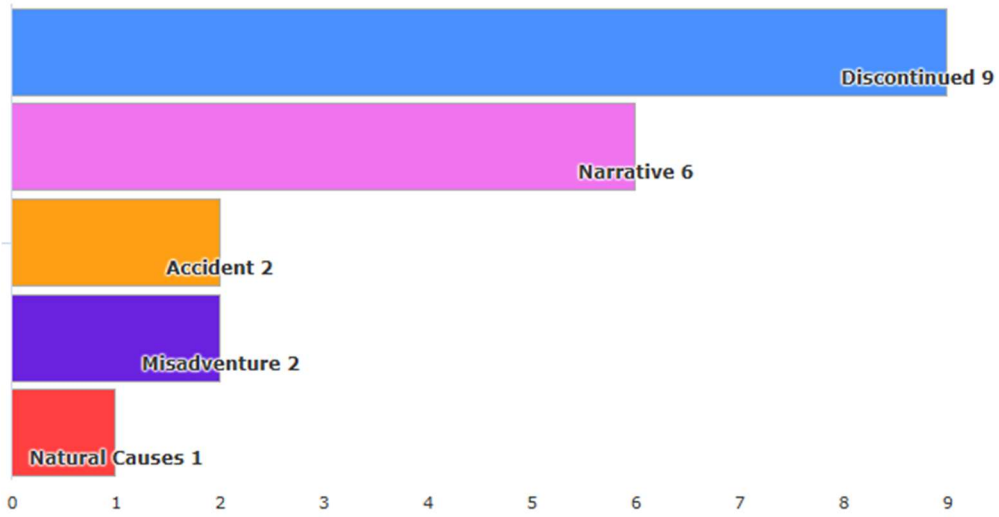


6.2. Closed inquests

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

The Trust closed a total of 20 inquests in quarter 2.

The graph below shows the outcome of those inquests:



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

Of those 20 inquests:

- 12 involved medicine and urgent care, 4 involved surgery, and Community and CSS (as was) and Women's and Children's had 2 each.
- Half did not proceed to a formal hearing
- None involved a jury.
- The coroner did not find any neglect in any of them.
- 2 matters attracted some press interest.
- No Prevention of Future Death (PFD) notices were issued.
- The coroner did not require further assurance/information in any of them.

7. Recommendations

It is recommended that the Board note the report and the learning and actions from incidents; complaints; inquests and claims for Quarter 2

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	Trust Board		**Date**	28 October 2026
Agenda Item	TB26/078			
Report Title	Learning from Deaths Annual Report 25/26			
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.

Changes for 2025/26 include the addition of learning from ED deaths, Medical Examiner scrutiny data, improvements to Legal InPhase (Inquests/HMC outcomes) data collection, and the expansion of LFD reports to cover deaths of vulnerable groups, children, neonates and maternal deaths and the inclusion of PSIRF LFD outcomes.

Further developments for 2026/27: Continued improvement in data collection, more contemporaneous review and expanded processes for sharing learning from deaths.

Financial Implications

None

Quality and/or Equality Impact

The report provides assurance on mortality review and the identification and dissemination of learning to support improvements in patient safety, clinical effectiveness and quality of care. Reviews include specific consideration of deaths within vulnerable groups.

Recommendations	
The Board is asked to note the Learning from Deaths Annual Report 25/26.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. 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 Surveillance Group, 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 Q1 to Q4 2025/2026.

2. Mortality Statistics

	S&O	STHK	MWL
HSMR*	107.0	93.8	97.4
All diagnosis SMR	103.0	93.8	96.3
SHMI	0.98	1.03	1.01

Overall MWL performance is within the statistically acceptable range.

For 2025-26 the MWL crude mortality rate, HSMR and all diagnosis SMR are within acceptable parameters. There are no concerning differences for emergencies, elective cases or maternity/births. Specific diagnostic criteria outliers have been scrutinised through appropriate channels and no concerns in care have been identified.

Factors found to contribute to statistical outlying diagnoses included clinical documentation/coding practices, contributory medical conditions such as frailty and palliative care and low sample sizes. Ongoing work through the mortality lead and ME offices will ensure any HSMR triggers get scrutinised in a timely way.

*There was an increase in HSMR at S&O site between November 25 to March 26, 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 Assistant 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 these factors can influence the HSMR by changing the estimated risk of death and therefore, the number of expected deaths.

3. 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.

2025/26 deaths in ED

Quarter	Deaths in ED (Whiston)	Deaths in ED (Southport)
Q1	X	X
Q2 (Sep only)	27	X
Q3	92	56
Q4	67	54

Comments:

The full year's data is unavailable because the review of ED deaths was introduced during the year.

Review of the learning did not reveal any significant or specific concerns during the quarters covered. All cases were discussed at ED PSM (Whiston) or had a peer case review (Southport). Cases were referred to the coroner when unexpected or an unknown cause of death.

4. 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 25/26

Completed (2025/2026)	154
Open and allocated	40
Completed awaiting MSG review	15
Open and unallocated	11
Pending input into Mortality InPhase (25/26) (Q1 26/27)	(0) (29)

Number of SJR requests 25/26*

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red	**TOTAL**
Q1 (0)	43	6	6	1	0	**56**
Q2 (0)	29	12	5	0	1	**47**
Q3 (5)	26	10	2	1	0	**44**
Q4 (35)	21	6	2	2	0	**66**

(*Excluding HMC Outcomes – see s.4.1)

Comments:

All cases scoring Amber or Red are automatically referred for consideration as patient incidents.

The Red case in Q2 involved a missed opportunity to perform surgery, which developed into metastatic disease. This case is under investigation (with actions outstanding) and has been referred to the coroner.

The number of outstanding SJRs, and time to SJR completion have reduced, reflecting a more targeted approach and expansion of the Mortality Group.

5. Medical Examiner Service and Coronial Review

All deaths not investigated by a coroner are scrutinised by a Medical Examiner as a statutory function (The Medical Examiners (England) Regulations 2024). Medical Examiners are senior, independent NHS doctors who scrutinise all causes of death on the MCCD, including those who did not receive care at MWL (community deaths).

Medical Examiner Services are in place at both Whiston and Southport Hospitals, with learning shared at the Mortality Operational 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. As an independent service, the ME office does not perform further reviews but will refer on to Coronial or Trust processes.

An overview of the total Medical Examiner reviews undertaken in 2025/26 are shown in the table below. The total number of deaths referred by MWL ME offices for clinical governance review or patient safety investigation during 2025/26 was 71.

STHK site	Q1	Q2	Q3	Q4	TOTAL 25/26
ME reviews	395	430	494	503	**1822**
Coronial referrals	54	55	67	17	**193**
S&O site					
ME reviews	218	197	200	250	**865**
Coronial referrals	20	24	19	17	**80**

5.1 Learning from Coronial Review and Inquests

There were **no** Section 28 Prevention of Future Deaths reports issued to the Trust in 2025/26.

The Trust has 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. Actions taken from learning include:

- Changes on EMIS to allow for improved recording of signs of infection;
- Introduction of Care Home Discharge Summaries for patients returning home from ED;
- Formalised process of communication between ED and Mental Health Teams for patients who self-discharge as part of the Trust wide Mental Health Strategy implementation

There was a total of 42 Inquests opened during Q1-4 2025/26. Of these, 26 are closed and 16 remain open pending hearings. Inquests by site: Whiston (30); Southport (10); Newton (1); Ormskirk (1).

Of these, there have been 11 SJRs completed with an HMC outcome coded for 25/26:

Reason (number)	SJR grade (number)	Action/Learning
Post-operative Neck of Femur Fracture (6)	Green (5) Green with Learning (1)	No concerns about care raised Falls in hospital causing NOF# during admission for aspiration on background of severe frailty and dementia. Falls risk assessments completed, no concerns found, referred to HMC (Inquest closed)
Post-operative General Surgery (1)	Red (1)	Red case: Referred for review under PSIRF #: missed opportunity for earlier diagnosis progressing to emergency surgery. Referred to HMC (discontinued with natural cause of death issued)

Reason (number)	SJR grade (number)	Action/Learning
Trauma related (1)	Green (1)	Attributable to historic traumatic brain injury requiring HMC involvement.
Article 2 (MHA) inquest (1)	Green (1)	Triggered for inquest automatically due to patient being under MHA
Complication of procedure (1)	Amber (1)	Referred into PSIRF #31453: LA toxicity during elective scalp SCC removal, actions shared through PSP for surgery and radiology (weigh patients and results checking pre-op mandatory).

5.2 HMC referrals and outcomes 2025/2026

Data collection for HMC outcomes through InPhase has only been collected since Q3 2025. For purposes of the annual report, data shows from Q3 2025 to Q2 2026 (inclusive). HMC outcome for earlier quarters is unavailable because improvements to InPhase were implemented in Q1 2026:

	TOTAL	Discontinued	Narrative	Accidental	Misadventure*	Natural Causes
Q3 (Oct-Dec 2025)	**23**	**-**	**-**	**-**	**-**	**-**
Q4 (Jan-Mar 2026)	**27**	**-**	**-**	**-**	**-**	**-**
Q1 (Apr-Jun 2026)	**13**	**5**	**3**	**4**	**0**	**1**
Q2 (Jul-Sep 2026)	**20**	**9**	**6**	**2**	**2**	**1**

***Death by misadventure verdicts concern deaths caused by persons accidentally while performing a legal act without negligence or intent to harm

6. PSIRF (Patient Safety Incident Response Framework) Incidents

Incident details	Cause of Death	Lessons Learned	Action taken
#3907 ELR June 2025	Decompensated Alcoholic Liver Disease	Failure to escalate deteriorating patient Failure to MET call despite NEWS trigger	Reinforce deteriorating patient policy and highlight at staff huddles. Digital Team Review of the NEWS protocol. Strengthen clinical handover arrangements by including current NEWS scores. Reinforce

Incident details	Cause of Death	Lessons Learned	Action taken
			information governance requirements.
#130827 PSII May 2025	'Natural causes' HMC CN1A	Failure to escalate difficult venous access for urgent bloods. Incomplete fluid and food balance charts Delayed dietician review Frequent ward moves leading to inconsistent care, including no pre-discharge medical review despite raised CRP	Communication at safety huddle: All patients requiring red tray/assistance for fluid and food balance charts Awareness raised for increased vigilance of patients requiring multiple ward moves
#5799 PSII May 2025	Stercoral perforation	Multifactorial reasons for delayed abdominal X-ray.	Establish a formalised medical electronic handover process, with mandatory documentation of outstanding tasks in CareFlow Ensure correct clinical details entered for X-ray requests to enable correct prioritisation. Radiology review of 'urgency categorisation' and 'hot reporting' processes. New SOP completed clarifying ANP role in remote review for rehabilitation suitability.
#137387/137423 PSII May 2025	1a. PE 1b. DVT	Patient 'Did Not Wait' (DNW) from ED and concern for abnormal results and observations not followed up Unsuitable for SDEC due to NEWS score, triggered for sepsis screen but not completed	Implementation of ED DNW policy covering review of bloods, observations at triage and presenting problem. Safety huddle message to staff reminding to escalate concerns Staff education and training: HCA Bedside Emergency Assessment Course, triage processes, sepsis mandatory training, cardiac arrest SIMs
#6725 ELR Aug 2025	1a. PE 1b. Traumatic right ankle fracture, severe LVH	Prescribing of TED stockings	VTE prophylaxis prescribing review for ward with reporting to governance meeting. VTE guidance to all ward doctors including at induction training.
#7535 PSII July 2025	1a. HAP 2. Asthma, CCF, Frailty	Failure to recognise and treat HAP	Safety huddle communication Improvements to handover process on ward Review delayed CXR
#4924 FLR July 2025	Subdural haematoma and	Missed opportunity to review falls risk assessment after fall	Strengthening handover procedure and supplementary care policy adherence through

Incident details	Cause of Death	Lessons Learned	Action taken
	cerebral haemorrhage	and clinical deterioration. Utilise MCA policy.	monthly audits. Ensure MCA mandatory training compliance >85%
#9713 FLR October 2025	1a. HAP 1b. Immobility 1c. NOF# 2. CCF, AKI, multiple myeloma, prostate cancer	Implement and document falls prevention measures. MCA assessment to be completed on admission.	Improved compliance with falls prevention measures through routine falls audits and monthly nursing care indicator reviews. FLR findings presented at Harm Free Care Panel for assurance.
#16355 FLR October 2025	1a. Aspiration Pneumonia 1b. Hip fracture, rib fracture 1c. Trauma 2. Dementia, CAP, HTN, CKD	Missed opportunities to identify, escalate and respond to increasing falls risk	Improved staff awareness through monthly staff safety huddle for falls risk in high-risk patient groups. Daily housekeeper checks of falls alarms. Individual staff reflections.
#14827 IPLR March 2026	1a. Clostridium Difficile infection 2. Frailty	Missed opportunities to escalate suspected infectious diarrhoea and inconsistent implementation of infection prevention measures	Promote use of Vital system input of bowel movements, use of Bristol Stool Chart. Ensure reporting of IPC issues on InPhase.
#13247 PSII February 2026	1a. Massive GI haemorrhage 1b. AF, PPM, on apixaban	Highlighted need for early haematology involvement and need to activate Major Haemorrhage protocol	Anticoagulation reversal guidance reshared on Trust Intranet and ED/Surgical safety briefs for circulation. Escalation protocols updated to include on-call contacts.
#22788 FLR January 2026	Subdural Haematoma	FLR incomplete with no falls care plan in place prior to fall	Ensure falls policy adherence. Falls team arranged teaching sessions for staff in ED. Ongoing falls audits with assurance feedback at governance.

6.1 Themes in learning from deaths from PSIRF 2025/26

During 2025/26, Learning from Deaths reviews identified recurring themes relating to the recognition and escalation of deteriorating patients, communication and handover processes, timely investigation and treatment, falls prevention, infection control, and adherence to established clinical policies.

The principal lessons learned centred on strengthening clinical escalation pathways, improving multidisciplinary communication and handover, enhancing monitoring of outstanding investigations, reinforcing falls prevention measures, and ensuring consistent compliance with Trust policies and national safety standards. Specific learning with actions taken included:

- 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 through the Trust sepsis lead, with regular input into CEC.
- Improving advanced care planning. An ongoing DNACPR audit and a review of palliative care services are in progress.

General actions taken across the organisation included targeted staff education, policy reinforcement, development of standardised handover processes, enhanced use of safety huddles, improved governance oversight, and routine auditing of compliance with key safety requirements. Learning has been disseminated through divisional governance meetings, safety huddles, training programmes, and Trust-wide quality and safety forums to support continuous improvement and reduce the risk of recurrence.

Overall, the reviews demonstrate a strong organisational focus on translating learning into measurable improvement actions, with common themes informing Trust-wide initiatives to enhance patient safety, clinical effectiveness, and quality of care.

7. Vulnerable Groups

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

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

All LeDeR deaths undergo an SJR. There were 19 deaths subject to a LeDeR review during 25/26.

There were no concerning outcomes from completed SJRs for LD deaths for the year, with all graded Green or Green with Learning. The most frequent learning theme involves adherence with the Mental Capacity Assessment Policy. Awareness has been strengthened through safety huddles and LFD bulletin, along with the introduction of the Capacity Assessment form available on the Trust website. Continued assurance from the LD specialty team with input into the MOG meetings.

7.2 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 were 6 reportable child deaths in 25/26, all of which went for patient safety investigations:

Case number	Description	Outcome
24996	Child known to the Trust and referred for PSIR as per policy	No lapses in care or learning identified.
7281	Child death – cardiac arrest	No lapses in care or learning identified.
14512	Notified by CDOP of child death in PICU @ another Trust but the child was known to this trust.	No lapses in care or learning identified.
15066	Notified by CDOP of child death	No lapses in care or learning identified.
17522	Standby call to resus. SUDIC protocol followed.	No lapses in care or learning identified.
17922	CDOP Notification, child admitted to CHWD and was then transferred to another Trust due to suspected leukaemia, died on 23/9/25 at another Trust.	No lapses in care or learning identified.

- No specific learning was identified from the child deaths reviewed during 2025/26.

7.3 Neonatal Deaths

There were 7 neonatal deaths in 25/26 reviewed by MWL (note all during Q3-4, there were no neonatal deaths during Q1-2):

Case number	Description	Outcome
19562	Term Antepartum Haemorrhage Unsuccessful resuscitation	Referred to Coroner and MNSI.
26262	Extreme prematurity	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 another Trust (the unit where the baby died). As there was no labour, the case did not meet the requirement for MNSI.

During 25/26, 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.

7.4 Learning from Neonatal Deaths

Learning is captured and monitored in the Maternity and Neonatal reports to Quality Committee and Trust Board. There was no learning from neonatal deaths throughout Q1-4 2025/26.

7.5 Maternal Deaths

There were no maternal deaths in 2025/26.

7.6 Learning from Maternal Deaths

Learning is captured and monitored in the Maternity and Neonatal reports to Quality Committee and Trust Board. As there were no maternal deaths for the year 25/26, there has been no learning.

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 rare and unusual.

- **Diagnosis group** – HSMR and SHMI alerts are escalated to the AMD for LFD for further investigation and report for presentation at CEC.

- **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.

Appendix 2: Mortality Statistics

Crude Mortality Rate – or Crude Death Rate, is the total number of deaths divided by the total number of inpatient discharges.

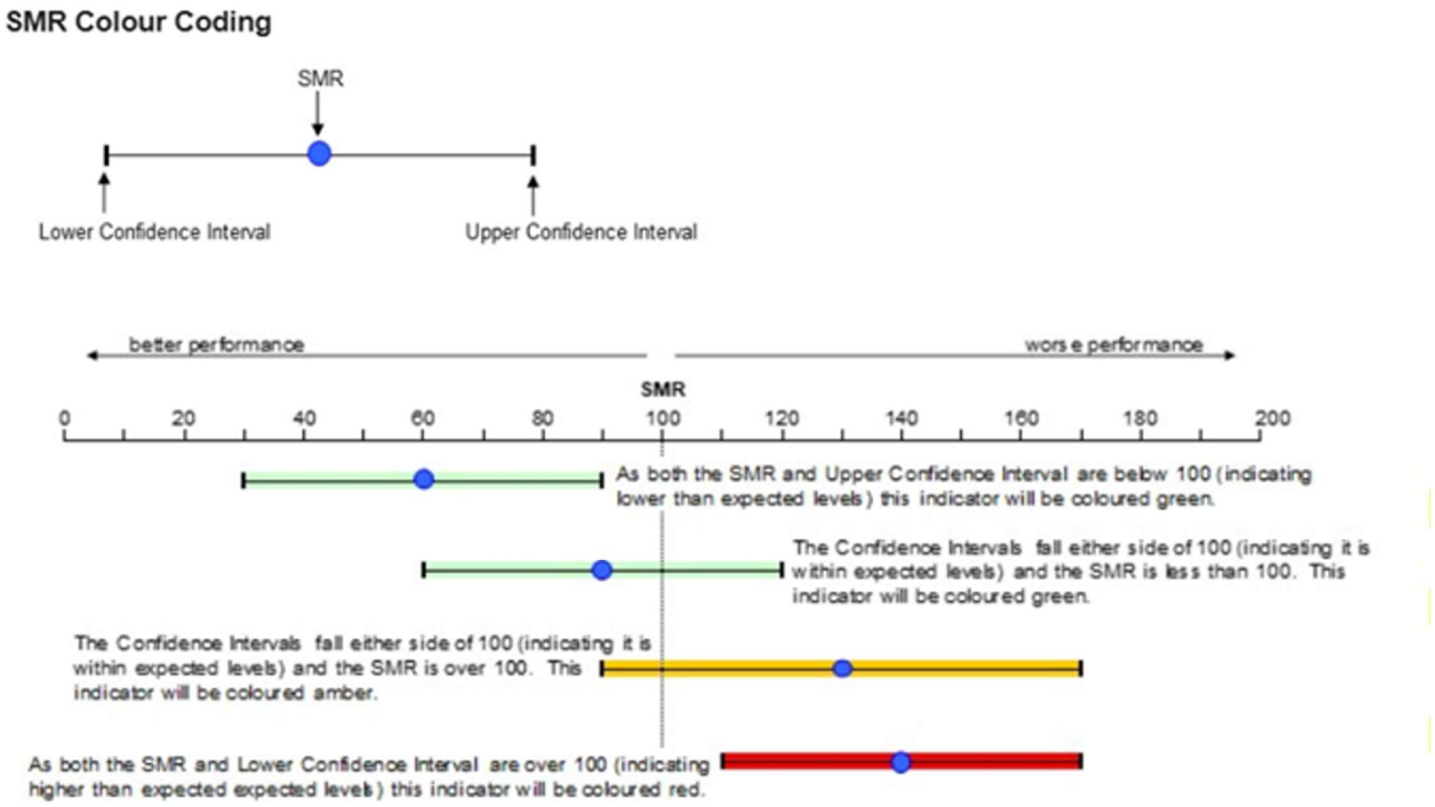
HSMR – Hospital Standardised Mortality Ratio is a healthcare indicator that compares the actual (observed) number of patient deaths in a hospital to the number of deaths predicted.

- **The Ratio:** It is calculated as the ratio of observed deaths to expected deaths (multiplied by 100).
- **Benchmark Score:** A score of **100** means the number of deaths matches what was predicted for that hospital's specific patient mix.
- **Higher vs. Lower:**
    - A score **above 100** means there were more deaths than predicted. A score above 100 can still be within expected levels, as the calculations use Confidence Intervals to determine statistical significance.
    - A score **below 100** means there were fewer deaths than predicted.

SHMI – Summary Hospital-level Mortality Index is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers patients that were admitted to hospitals in England who died either while in hospital or within 30 days of being

discharged. The SHMI is not a measure of the quality of care. A higher-than-expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a ‘smoke alarm’ which requires further investigation.

[Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS England Digital]



Title of Meeting	Trust Board		**Date**	28 October 2026
Agenda Item	TB26/079			
Report Title	NHS Oversight Framework Provider Capability Self-Assessment 2026			
Executive Lead	Rob Cooper, Chief Executive			
Presenting Officer	Rob Cooper, Chief Executive			
Action Required		To Approve	X	To Note

Purpose

To present, for assurance, the Trust's final 2026 NHS England Provider Capability Self-Assessment, which was considered by the Board on 30 September 2026 and submitted to NHS England on 02 October 2026.

Executive Summary

In 2025, as part of the NHS Oversight Framework (NOF), NHS England introduced a new annual capability self-assessment.

The assessment is intended to strengthen Board assurance, support a "no surprises" relationship between providers and regulators and inform NHS England's assessment of organisational capability and oversight requirements. The Trust received an NHS England assessed capability rating of 'Amber-Green' following the 2025 assessment.

Updated self-assessment criteria was issued for 2026, with Trust Board expected to assess their capability across six domains:

1. Strategy, leadership & planning
2. Quality of care
3. People & culture
4. Access & delivery of services
5. Productivity & value for money
6. Financial performance & oversight

Changes to the assessment process for this year included:

- The self-assessment ratings were changed from 'confirmed, not confirmed or partially confirmed' to ratings of 'Green, Amber-Green, Amber-Red, and Red'.
- An emphasis on demonstrating the effectiveness of processes.
- The self-assessment for 2026 was to include a rationale, supporting evidence and details of any changes since the 2025 assessment.

A detailed assessment was undertaken against NHS England's key lines of enquiry by Executive Directors, and this was used to develop the proposed Board self-assessment. The self-assessment was informed by existing Board assurance arrangements, committee oversight, performance reporting, audit findings and external reviews.

The proposed submission was reviewed and approved at Closed Board on 30 September 2026.

The final version was submitted to NHS England on 2 October 2026. The Trust assessed itself as Green across all six capability domains, with the submission considered to represent a fair, balanced and evidence-based assessment of the Trust's organisational capability. A copy of the Trust's final submission is included at Appendix 1.

No feedback has been received from NHS England at the time of the report. However indicative timeframes are that these will be shared between November and December 2026.

Financial Implications

There are no direct financial implications arising from this report. The Trust's assessed capability rating forms part of NHS England's oversight approach and may influence the nature and intensity of future regulatory engagement.

Quality and/or Equality Impact

The assessment considers the Trust's capability across a range of areas, including quality, patient safety, workforce, health inequalities and financial performance. No separate Quality or Equality Impact Assessment is required for this report.

Recommendations

The Board is asked to:

- Note the final version of the Trust's 2026 NHS England Provider Capability Self-Assessment;
- Note that the outcome from NHS England is expected to be received between November and December 2026.

Strategic Objectives

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

NHS Oversight Framework Provider Capability Self-Assessment 2026

1. Purpose

1.1 To present the Trust's final 2026 NHS England Provider Capability Self-Assessment, submitted to NHS England on 2 October 2026, to the Board for information.

2. Background

2.1 NHS England introduced the Provider Capability Assessment in 2025 as part of the NHS Oversight Framework.

2.2 Following submission of its 2025 self-assessment, the Trust received an NHS England assessed capability rating of 'Amber-Green' in February 2026. No specific feedback was provided regarding the rationale for the final rating.

2.3 Updated criteria was issued for 2026, and the Trust carried out a self-assessment, which was due for submission to NHS England by 02 October 2026.

2.4 Trust Boards were required to assess their capability across six domains included within the Insightful Provider Board guidance:

1. Strategy, leadership & planning
2. Quality of care
3. People & culture
4. Access & delivery of services
5. Productivity & value for money
6. Financial performance & oversight

2.5 The assessment was intended to:

- Strengthen Board assurance.
- Promote a "no surprises" culture between providers and regulators.
- Provide a framework for regional teams to consider the required level of oversight based on the agreed capability rating.

2.6 Changes to the assessment process for this year included:

- The self-assessment ratings were changed from 'confirmed, not confirmed or partially confirmed' to ratings of 'Green, Amber-Green, Amber-Red, and Red'.
- An emphasis on demonstrating the effectiveness of processes.
- The self-assessment for 2026 was to include a rationale, supporting evidence and details of any changes since the 2025 assessment.

2.7 Oversight teams will review the self-assessment, triangulate information with their own views and based on views across the domains, propose an overall capability rating for the Trust shown in figure 1 (slightly updated for 2026).

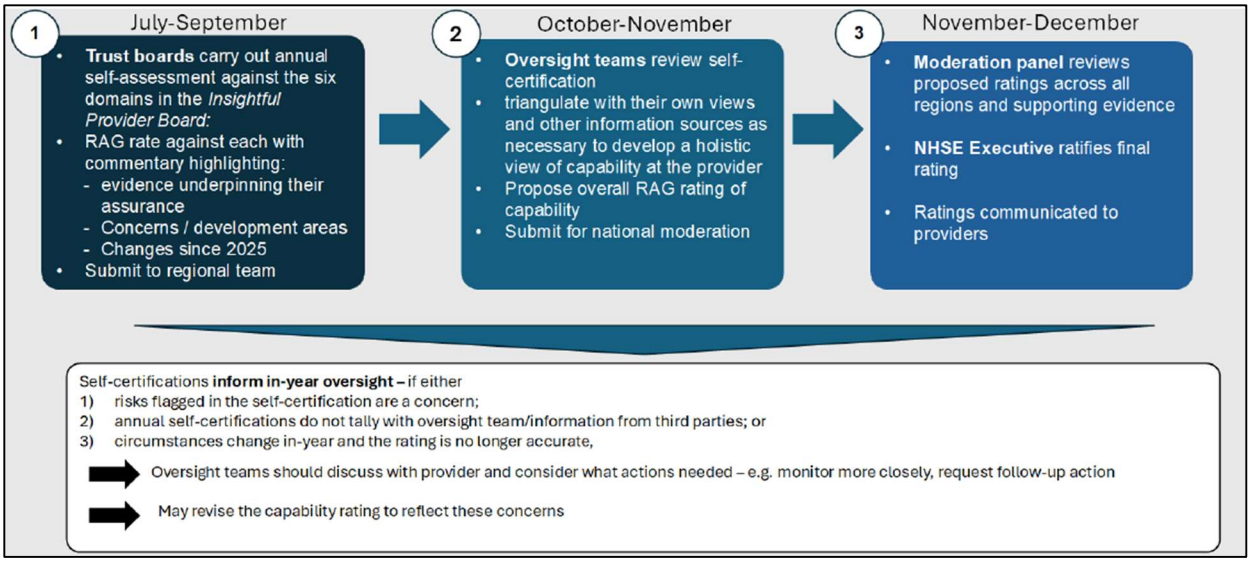
Figure 1

Rating - in either a specific domain or overall	**Indicative characteristics**
Green High confidence in management	• Strong track-record across management team • No concerns with board's grip, • No reputational issues, system partner or other third-party concerns
Amber-green Some minor issues that should be addressed	• No material concerns, but some areas may require a watching brief and as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS, **or** • Trust in 'probation' – no concerns but trust capability recovering from previous concerns before final assurance.
Amber-red Material issue needs addressing or failure to address major issues over time	• Serious governance/capability issues in at least one domain or capability statement **and/or** • Trust recovering from red-rating below, with serious issues still present but evidence of improvement and grip
Red Significant and persistent concerns	• Serious issues in multiple domains **and/or** • Serious ongoing issues in a single domain that management has been unable to address sufficiently over time • Trust in breach of governance licence condition or likely to be.

2.8 Proposed ratings will be submitted for review with supporting evidence to the provider capability moderation panel comprising regional and national directors. The panel will then recommend ratings for ratification by NHS England's executive board.

2.9 Following ratification, oversight teams will communicate the capability rating to the NHS trust, and this will lead to any follow-up action with providers. An overview of the assessment cycle is included at Figure 2.

Figure 2



3. The Self-Assessment

3.1 The assessment was completed using NHS England's published capability statements, key lines of enquiry and ratings guidance.

3.2 To support the process, a detailed assessment was undertaken against each of the individual key lines of enquiry by the lead Executive Director. This included consideration of the available evidence mapped against each key line of enquiry.

3.3 The detailed assessment against the key lines of enquiry was used to develop the overarching self-assessment. A copy of this is included at Appendix 1.

3.4 The assessment considered:

- Trust Board and Committee assurance processes;
- Integrated Performance Reporting;
- Board Assurance Framework and Corporate Risk Register;
- Internal Audit and External Audit findings;
- Quality governance arrangements;
- Workforce and culture indicators;
- Operational performance reporting;
- Financial performance reporting;
- External reviews and independent assurance activity.

4. Review and scrutiny

4.1 As part of the Trust's Developmental Well-Led Review, the draft Provider Capability Assessment and supporting detailed assessment against the key lines of enquiry were reviewed by GGi.

4.2 GGi advised that they had not identified any material inconsistencies between the proposed assessment and evidence observed during interviews, document review and meeting observations undertaken as at the point of review, recognising that their review was still ongoing and not concluded.

4.3 The detailed self-assessment against the key lines of enquiry and the proposed final submission was reviewed at Executive Committee, and subsequently at Closed Board on 30 September 2026.

4.4 A copy of the final self-assessment was submitted to NHS England on 02 October 2026, and a copy is included at Appendix 1.

4.5 No feedback has been received from NHS England at the time of the report. However indicative timeframes are that these will be shared between November and December 2026.

5. Recommendations

5.1 The Trust Board is asked to:

- Note the final version of the Trust's 2026 NHS England Provider Capability Self-Assessment;
- Note that the outcome from NHS England is expected to be received between November and December 2026.

Appendix 1

Provider capability self-assessment template 2026

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	**Proposed domain rating**
	Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	**Rationale** The Board considers the Trust to have a strong and coherent strategy that aligns organisational priorities with those of the wider health and care system. During 2026, the Trust approved its new Strategy 2026-2031 and uses the established annual corporate objectives to provide a clear framework for delivery and performance oversight. Strategic risks to the delivery of the Trust's strategy are monitored through a mature Board Assurance Framework and Corporate Risk Register, with regular review by the Executive Committee and Board, ensuring effective oversight of delivery and emerging risks. The Trust continues to demonstrate a significant system leadership role. It is an active participant in the Cheshire and Mersey Provider Collaborative and Alliance Partnership arrangements. The Chief Executive chairs the Alliance Partnership Board and leads several system-wide programmes, whilst Executive Directors convene several Cheshire and Mersey professional leadership groups. The Trust is represented across all major provider collaborative programmes and professional groups and contributes to the development and delivery of shared objectives across Cheshire and Mersey. The Trust continues to demonstrate its ability to recognise and respond to changing strategic developments. During 2026 the Trust acquired West Lancashire Community Services and additional Pathology Services, established a dedicated Community Division to deliver Trust initiatives and support the delivery of the NHS 10-Year Health Plan, expanded shared corporate services, continued development of the Mid-Mersey Digital Alliance, which is hosted by the Trust, and created a Strategic Transformation Council to oversee delivery of major transformation programmes. These developments support the strategic shift towards prevention, neighbourhood health and care closer to home, in line with system priorities, and demonstrate the Board's ability to adapt organisational arrangements to deliver strategic objectives.
2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of	

the system(s) and population served	Board capability remains strong. Executive and Non-Executive succession planning arrangements are in place, substantive appointments have strengthened the Board, and clear Executive accountability exists for all areas, including quality, performance, workforce and finance. The Board has demonstrated its agility in adapting organisational structures to meet emerging strategic priorities as detailed in this assessment. Digital transformation and cyber resilience are embedded within the Trust's governance arrangements. The Director of Informatics is an established member of the Executive Team; cyber security risks are included within the Board Assurance Framework and corporate risk register (CRR). The Board receives regular assurance regarding cyber security, digital maturity, Electronic Patient Record development and major digital programmes. The Trust's digital strategy is aligned with local and national priorities, and the Trust continues to provide leadership through the Mid-Mersey Digital Alliance. The Board has identified that an alternative solution is required to enable one Electronic Patient Record across the Trust as there are currently two in place from legacy organisations. External funding has not been agreed and therefore, the Trust is exploring alternative solutions. The Board has also identified further system transformation opportunities as a key priority for 2026/27. The Trust is not subject to licence conditions, enforcement action, statutory undertakings or national improvement programmes. The Board is satisfied that the Trust demonstrates strong strategic leadership, effective governance, strong system partnerships and the capability required to deliver its strategic ambitions. **Evidence:** • Trust Strategy 2026-2031 and Annual Objectives; • Board Assurance Framework and Corporate Risk Register; • Board and Executive Committee papers and minutes; • Cheshire and Mersey Provider Collaborative papers and minutes; • Alliance Partnership Board papers and minutes; • Strategic Transformation Council papers and minutes; • Digital Strategy; • Mid-Mersey Digital Alliance governance arrangements; • Shared services arrangements including lead employer, payroll, recruitment and digital services.
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	

	Changes Since 2025 Assessment • Approval and implementation of the Trust Strategy 2026-2031. • Acquisition of West Lancashire Community Services & Pathology Services. • Establishment of a dedicated Community Services Division. • Expanded shared service arrangements and system leadership responsibilities. • Increased focus on digital transformation, cyber resilience and Electronic Patient Record planning.

II. Quality of care

Capability statements	**Proposed domain rating**
	Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	**Rationale** Effective governance arrangements are in place to monitor and continuously improve the quality and safety of care provided by the Trust. Quality governance is supported through a comprehensive Board-to-Ward framework, including Patient Safety, Patient Experience, Clinical Effectiveness and Risk Management Councils, which provide assurance to the Quality Committee, Executive Committee, and Board. These arrangements ensure that quality issues are identified early, escalated appropriately and addressed through structured improvement processes. The Trust uses national guidance, clinical audit, getting it right first time (GIRFT) recommendations, National Institute for Health and Care Excellence (NICE) compliance monitoring, patient safety incident response framework (PSIRF) investigations and ward accreditation processes to drive continuous improvement. Learning is reviewed through established governance structures and areas of concern are subject to investigation, improvement planning and ongoing monitoring. The Board receives both quantitative and qualitative information and actively triangulates intelligence from multiple sources. This includes quality metrics within the Integrated Performance Report, patient stories, patient feedback, complaints, compliments, incidents, national surveys, Quality Ward Rounds, Chief Nursing Officer quality walkabouts and direct engagement with staff and patients. These
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	

8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	arrangements provide confidence that emerging issues are identified early and addressed before they become significant concerns. A Board Visibility Programme is commencing in September 2026, with Board meetings rotating across sites and Board visits included to clinical and non-clinical areas. Patient safety and experience remain central to governance arrangements. The Patient Safety Incident Response Framework (PSIRF) is fully embedded across the organisation and supports a structured approach to incident investigation, organisational learning and improvement. Patient safety assurance is provided through divisional governance arrangements, the Patient Safety Panel and Patient Safety Council, which receive information regarding incidents, investigations, learning and improvement actions and escalate matters through the Quality Committee to the Board where required. The Board receives regular assurance regarding patient safety through incident reporting, patient safety investigations, complaints, claims, Freedom to Speak Up intelligence, Quality Ward Rounds and the Chief Nursing Officer's monthly quality walkabouts. Risks and themes are triangulated through governance structures and the Corporate Risk Register where appropriate. Feedback from the Friends and Family Test (FFT), national surveys, complaints, patient advice and liaison service (PALS) contacts and Healthwatch engagement is routinely reviewed, with improvement actions monitored through established governance structures. The positive improvements demonstrated in the 2026 CQC inpatient survey further evidences the impact of these arrangements. The Trust also actively considers health inequalities and protected characteristics through its Health Inequalities Strategy, dedicated dashboard and quality and equality impact assessment processes. The Board actively reviews learning from national inquiries, external reviews and NHS-wide quality concerns to ensure lessons are embedded locally. Arrangements are in place to receive, manage and respond to complaints, patient safety investigations and risk escalation. Substantive appointments have been made to the Chief Nursing Officer (started July 2025) and Chief Medical Officer roles (started November 2025), which has supported further governance developments. A Developmental Well-Led Review has been commissioned, further demonstrating the Trust's commitment to strong quality governance, continuous improvement and objective independent assessments of progress to support additional insights.

	While work continues to strengthen reporting consistency following the merger, and to maximise the benefits of future digital solutions, the Board is satisfied that governance, assurance and quality improvement arrangements are effective. **Evidence** • Quality Committee papers and minutes; • Trust Board papers and minutes; • Integrated Performance Report; • Patient Safety, Patient Experience and Clinical Effectiveness Council papers and minutes; • Risk Management Council papers and minutes; • Corporate Risk Register; • Clinical audit programme; • NICE compliance reports; • GIRFT reviews; • Ward Accreditation Programme; • Patient experience, complaints and FFT reports; • 2026 CQC Inpatient Survey results; • Health Inequalities Strategy and dashboard. **Changes Since 2025 Assessment** • Significant improvement demonstrated within the 2026 CQC inpatient survey results. • All Board roles substantively appointed to. Substantive Chief Medical Officer started in post in November 2025. New Director of Corporate Services started in June 2026. • Commissioning of a Developmental Well-Led Review to support continuous improvement. • Further development of quality governance following organisational integration.

III. People and culture

Capability statements	Proposed domain rating
	Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	**Rationale** The Board has a comprehensive understanding of staff experience, culture and workforce risks and receives regular assurance through established governance processes. Workforce information including NHS Staff Survey results, Freedom to Speak Up intelligence, training survey outcomes, workforce metrics and equality standards are routinely reviewed through Strategic People Committee, Executive Committee and Board to identify opportunities for improvement. In the 2025 NHS Staff Survey, MWL performed above the national average in four People Promise themes including staff engagement, was average in one, and below average in four, with 'We Work Flexibly' an area for improvement in 2026. When looking at individual questions, staff remain extremely positive about the standard of care provided by the Trust ranking it as the highest performing Acute Trust in the North West. In response to the survey results, the Trust adopted a new Theory of Change approach to define long-term improvements in culture, behaviour and staff experience for 2026. Staff feedback is actively sought through a wide range of engagement mechanisms including staff networks, Team Talks, staff survey feedback sessions, Joint Negotiating Committees, Freedom to Speak Up processes and direct engagement with Executive and Non-Executive Directors. The Executive team use regular informal visits to wards and departments to support triangulation with information seen in formal meetings. Feedback is used to improve both staff experience and the quality of care delivered. The Board has also commenced a Structured Board Visibility Programme to provide Board members with regular opportunities to engage directly with frontline staff, gain insight into local challenges and successes, and strengthen Board visibility across the Trust. The Trust has strong arrangements in place to support workforce development, training, capability and capacity planning. A Trust-wide Training Needs Analysis has been completed and mandatory training, appraisals, safe staffing indicators and workforce

	development metrics are routinely monitored through established governance processes. Further development opportunities are available across all staff groups. The Board receives regular assurance regarding safe staffing levels and workforce capacity through the Integrated Performance Report, Quality Committee, Strategic People Committee and Executive Committee. Workforce establishment, vacancies, turnover, sickness absence and safe staffing indicators are routinely reviewed, with targeted interventions implemented where risks are identified. Divisional performance arrangements provide additional scrutiny and ensure that staffing concerns are escalated and addressed promptly. The Board is satisfied that staff are able to raise concerns in an open and constructive environment. The Trust promotes a strong speaking up culture. Freedom to Speak Up arrangements are well established and intelligence from speaking up, staff surveys and incident reporting is triangulated to provide assurance regarding organisational culture and psychological safety. The Chief Executive is accessible to staff and conducts regular informal visits. There is also the ability for staff to ask the Chief Executive questions through a process called 'Ask Rob' where people can submit questions and get a response directly from the Chief Executive. Freedom to Speak Up is the theme of the September 2026 Board visits as part of the Board Visibility Programme. Further staff feedback is being sought as part of the Developmental Well-Led Review that is currently underway, further demonstrating the Trust's commitment to staff feedback, continuous improvement and objective independent assessments of progress to support additional insights. **Evidence** • NHS Staff Survey results and action plans; • Freedom to Speak Up reports and annual reports; • Strategic People Committee papers and minutes; • Workforce Race Equality Standard reports; • Workforce Disability Equality Standard reports; • GMC and National Education and Training Survey results; • Trust-wide Training Needs Analysis; • Mandatory training and appraisal reports; • Workforce dashboards within the Integrated Performance Report; • Safe staffing reports; • Vacancy, turnover and sickness absence reports; • Staff network and engagement reports; • Team Talk and staff engagement feedback.

	Changes Since 2025 Assessment • Launch of staff networks and enhanced staff engagement arrangements. • Introduction of the Board Visibility Programme. • Continued development of workforce equality, inclusion and speaking up arrangements. • Ongoing strengthening of safe staffing oversight and workforce planning processes.

IV. Access and delivery of services

Capability statements	**Proposed domain rating**
	Green
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	**Rationale** The Board maintains robust oversight of operational performance and access standards through a well-established performance management framework. Performance against national standards is reviewed regularly, with recovery plans in place where required. Progress is monitored through Divisional Performance Reviews, Executive Committee, Finance and Performance Committee and Trust Board. The Trust works collaboratively with system partners to improve urgent and emergency care, elective recovery and patient flow through system-wide improvement plans and Trust transformation programmes. The Board understands the causes of performance variation and receives assurance regarding actions being taken to improve performance. The Trust has a strong understanding of variation in access and outcomes across its population. A comprehensive Health Inequalities Dashboard has been developed and is now hosted through the Cheshire and Merseyside Business Intelligence Portal, providing information across multiple organisations, places and population groups. This enables the Trust and system partners to identify unwarranted variation, monitor inequalities and target improvement activity. The Trust works closely with Healthwatch, VCFSE organisations, local authorities and ICB colleagues to address barriers to access and improve outcomes for local communities. The historic configuration of services across Southport and Ormskirk Hospital sites has been recognised through clinical senate and independent reviews as suboptimal and contributing to service fragility. Following the formation of MWL, the Trust worked with system partners through the Shaping Care Together Programme to

	review future service configuration, initially focusing on urgent and emergency care services. A comprehensive public consultation resulted in an agreed model for future urgent and emergency care provision across the two sites. This provides a clear strategic framework to improve resilience, reduce variation and support sustainable services for local communities, with the Board continuing to oversee implementation of the agreed changes. Whilst formal population health targets continue to evolve with system partners, the Trust has demonstrated strong leadership in health inequalities, prevention and population health through its Health Inequalities Strategy, Health Inequalities Dashboard, anchor institution role, participation in neighbourhood health programmes and community services expansion. **Evidence** • Integrated Performance Report; • Committee Performance Reports; • Divisional Performance Review documentation; • Finance and Performance Committee papers and minutes; • Strategic Transformation Council papers and minutes; • UEC Delivery Board papers and minutes; • Health Inequalities Strategy and Dashboard; • Shaping Care Together Programme consultation evidence and outcome; • Equality and Quality Impact Assessments **Changes Since 2025 Assessment** • Agreement reached through the Shaping Care Together Programme to progress service reconfiguration. • Continued development of Health Inequalities reporting and dashboards. • Expansion of neighbourhood health and prevention initiatives. • Acquisition of West Lancashire Community Services supporting delivery of care closer to home.

V. Productivity and value for money

Capability statements	Proposed domain rating
	Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Rationale** The Board demonstrates a clear understanding of the drivers of productivity and uses benchmarking information to identify opportunities for improvement and reduce unwarranted variation. Benchmarking data, including Model Health and getting it right first time (GIRFT) information, is routinely considered through governance processes and supports performance improvement planning. Productivity improvement is embedded within operational, financial and transformation planning processes. The Board considers productivity opportunities in the context of quality, patient experience and staff wellbeing to ensure that efficiencies support sustainable service improvement. The Trust is currently assessed within Segment 1 for Finance, Productivity and Innovation within the NHS Oversight Framework, providing external assurance regarding organisational performance in these areas. The Trust has a strong track record of delivering productivity improvements through service redesign, expansion of shared services, digital innovation, workforce transformation and collaborative working across Cheshire and Mersey. Notable examples include shared corporate services, further development of the Mid-Mersey Digital Alliance, community services expansion, digital automation initiatives and collaborative transformation programmes delivered through the Provider Collaborative and Alliance Partnership. **Evidence** • Integrated Performance Report; • Committee Performance Reports; • Model Health benchmarking reports; • GIRFT reviews and recommendations; • Board and Committee papers and minutes; • Strategic Transformation programme reports; • Alliance Partnership Board papers; • Cheshire and Mersey Provider Collaborative papers.

	Changes Since 2025 Assessment • Increased use of benchmarking information within governance reports. • Expansion of shared service arrangements. • Further system collaboration and service redesign initiatives.

VI. Financial performance and oversight

Capability statements	**Proposed domain rating**
	Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	**Rationale** The Board is satisfied that the Trust demonstrates strong financial governance, effective oversight and a good understanding of the factors influencing financial performance. Financial performance, risks and forecasts are routinely scrutinised through established governance arrangements. The Board receives regular information linking financial performance, operational delivery, workforce capacity and quality outcomes, enabling informed decision-making and effective challenge. The Trust has a track record of delivering its financial plans, recurrent cost improvement programmes (CIPs), and maintaining financial control and managing financial risks in a structured and proactive manner. The Board understands the underlying drivers of financial performance, including activity levels, workforce costs and inflationary pressures, and receives assurance regarding the credibility of forecasts and recovery actions where required. Internal Audit provided a Substantial Assurance opinion for 2025/26, and External Audit issued an unqualified opinion, providing additional independent assurance regarding the effectiveness of financial governance, internal controls and financial reporting arrangements. The Board ensures that financial decisions are considered alongside their potential impact on quality of care, patient outcomes and staff wellbeing. Quality Impact Assessment and Equality Impact Assessment processes are embedded within financial planning and efficiency programmes, supported by regular monitoring of quality, workforce and operational indicators. Financial plans are aligned with those of system partners, and the Trust participates fully in system planning and resource allocation discussions. The Trust is working collaboratively with the ICB to develop and implement schemes designed to reduce, and
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	

	ultimately remove, the requirement for transaction support funding, in support of the wider system financial position, demonstrating its commitment to balancing organisational priorities with the best use of NHS resources across the system. Whilst a small number of contractual issues were discussed relating to transaction support funding following the Southport & Ormskirk acquisition, alongside national PFI funding, this has been substantially resolved, and all contract queries were concluded. **Evidence** • Finance and Performance Committee papers and minutes; • Trust Board papers and minutes; • Audit Committee papers and minutes; • Head of Internal Audit Opinion (Substantial Assurance); • External Audit reports and unqualified audit opinion; • Monthly financial forecast reports; • Quality Impact Assessments; • Equality Impact Assessments; **Changes Since 2025 Assessment** • Receipt of a Substantial Assurance Head of Internal Audit Opinion for 2025/26. • Receipt of an unqualified External Audit Opinion. • Continued improvement in financial governance and forecasting arrangements.

Signed on behalf of the Board of Directors

Chair: Steve Rumbelow, Mersey & West Lancashire Teaching Hospitals NHS Trust (MWL)

Signature dated: 30 September 2026

Signed on behalf of the Board of Directors

Chief Executive: Rob Cooper, MWL

Signature dated: 30 September 2026

Title of Meeting	**Trust Board**		**Date**	**28 October 2026**
Agenda Item	**TB26/080 (15.1)**			
Report Title	Workforce Race Equality Standard Report 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

This report provides an overview and analysis of the Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) Workforce Race Equality Standard (WRES) for 2025-2026 (March 2026).

Executive Summary

Summary: The following is an overview of the WRES highlights for 2025-2026.

The Trust continues to progress on its journey towards becoming an anti-racist organisation, achieving Bronze Status under the North West Race Equity Assembly Anti-Racism Framework in December 2025.

Work is ongoing to embed anti-racist principles across the organisation. Key initiatives include the roll-out of Active Bystander Training, the expansion of Cultural Competence Training, and the continuation of the Band 5 BAME Career Progression Workshops for nurses and midwives.

Looking ahead, the Trust is committed to progressing towards Silver and Gold Status over the coming years in the Anti-Racism Framework. This will be supported by sustained efforts to further embed anti-racist practices, strengthen organisational culture, and deliver meaningful, measurable improvements for staff and service users.

Overall, the proportion of Ethnic Minority staff continues to increase, with some improvements in the progression of Ethnic Minority staff into higher bands. Staff Survey results are mixed, with reported increases in harassment and discrimination experienced by Ethnic Minority staff.

Overall, key metrics from the WRES assessment are:

Workforce data metrics:

- An increase in the proportion of total Ethnic Minority staff to 17.7%; Non-Clinical staff to 4.5%; Clinical Non-Medical staff to 18.4%; and Clinical Medical & Dental staff to 51.7%
- There was an increase in the proportion of Ethnic Minority Non-Clinical staff on bands 2-6, 8b and 8d. There were no declared Ethnic Minority staff on bands 1, 8c, 9 or VSM. Compared nationally, the proportion of Ethnic Minority staff is below the national average across all band groups.
- Non-Clinical progression disparities have reduced substantially at middle-to-senior grades, but significant ethnic disparities persist in progression into the most senior leadership roles, with the

2026 Senior-to-VSM disparity ratio (2.85) and overall Support-to-VSM ratio (3.37) both exceeding national benchmarks.

- There was an increase in the proportion of Clinical Non-Medical Ethnic Minority staff on bands 2-8b. There were no declared Ethnic Minority staff on bands 8d, 9 or VSM. Compared nationally, the proportion of Ethnic Minority staff is below the national average across all band groups.
- Clinical Non-Medical ethnic minority staff experience comparatively favourable progression from support to middle grades. The 2026 Support-to-VSM ratio of 4.79 and Senior-to-VSM ratio of 3.12 indicate that ethnic minority staff remain underrepresented in progression to the highest levels of leadership.
- There was an increase in the proportion of Ethnic Minority Clinical Medical & Dental staff on Trainee roles, Non-Consultant and Consultant roles.
- Ethnic Minority applicants as a population are less likely to be appointed from shortlisting compared to White applicants.
- Ethnic Minority staff are less likely to enter disciplinary process than White staff.
- Ethnic Minority staff are more likely than White staff to access non-mandatory training or CPD
- 10% of the Trust Board is from an Ethnic Minority, lower than the workforce, but double the local population, and the Non-Clinical workforce.

Staff survey data:

- 26.8% Ethnic Minority staff state they have experienced bullying and harassment from a patient, family member or member of the public (29.2% nationally), compared to 19.3% of White staff, a difference of 7.5 points.
- 22.0% Ethnic Minority staff state they have experienced bullying and harassment from a colleague or manager, compared to 18.8% of White staff, a difference of 3.2 points.
- 49.9% Ethnic Minority staff state they believe the Trust offers equality of opportunity in career progression (49.7% nationally), compared to 56.8% of White staff, a difference of 6.9 points
- 15.7% Ethnic Minority staff state they has experience discrimination from a manager or other colleague (13.9% nationally), compared to 5.2% of White staff, a difference of 10.5 points.

Financial Implications

None

Quality and/or Equality Impact

This report is a regulatory requirement under the NHS Contract. It forms part of the Trust's work to promote race equality in line with the Equality Act 2010.

Recommendations

The Trust Board is asked to:

1. Note the Workforce Race Equality Standard Report 2025-2026
2. Approve the Workforce Race Equality Standard Action Plan 2026-2027

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Workforce Race Equality Standard Report

April 2025 – March 2026

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1. Executive Summary

This report provides the Board with the annual Workforce Race Equality Standard (WRES) data for the Mersey & West Lancashire Teaching Hospitals Trust (MWL). The publication of this report is for the period 2025-2026 in line with the NHS Standard Contract requirements to publish the WRES indicators.

2. Introduction

NHS England introduced the Workforce Race Equality Standard (WRES) in 2015. The WRES exists to highlight any differences between the experiences and treatment of White staff and Ethnic Minority staff in the NHS and places an onus on NHS organisations to develop and implement actions to bring about continuous improvements. The main purpose of the WRES is:

- to help NHS organisations to review performance on race equality, based on the nine WRES indicators,
- to produce action plans to close any gaps in workplace experience between white and Ethnic Minority staff,
- to improve Ethnic Minority representation at the Board level of the organisation.

3. A year in review: 1st April 2025- 31st March 2026

The Trust has worked to implement anti-racism actions agreed within the 2025 WRES report, as well as the MWL People Strategy 2025 -28, activity to support the implementation of the NHS EDI High Impact Actions[1] (HIA), the Equality Delivery System[2] (EDS) and our ongoing commitment to achieve bronze (and now silver) status of the NW Anti-Racism Framework[3].

Key activities that have taken place between 1st April 2025- 31st March 2026 include:

- **Anti-Racism Statement**: In August 2025 the Trust adopted its first Anti-Racism Statement and Commitment, with Rob Cooper (CEO) taking on the role of Senior Race Sponsor. In addition, development sessions were held with the Trust Board on the meaning of anti-racism (action support HIA1).

- **North West Race Equity Assembly Anti-Racism Framework**: the Trust successfully achieved bronze status in the North West Race Equity Assembly Anti-Racism Framework, recognising our ongoing commitment to creating an anti-racist, inclusive, and equitable workplace for all staff and service users.

- **EDI SMART Training Objective (HIA1):** In 2025 we introduced a personal EDI Training and Development Objective into all AfC Appraisal Forms which was completed by 56% of staff.

- **Active Bystander Training:** piloted in 2025 by Freedom to Speak Up to develop staff members confidence to safely de-escalate and respond to incivility, this course has been rolled out across the Trust with approximately 144 staff members having now completed the training.

[1] NHS EDI Improvement Plan High Impact Actions
[2] NHS Equality Delivery System
[3] North West Race Equity Assembly

- **Cultural Competence Training**: building on last year, the course has now been embedded in the Southport preceptorship programme, and has been rolled out across the trust as an open bookable course. A blend of online and face to face training sessions have been offered with 77 staff attending an open session, and 245 a preceptor session.

- **Race Awareness Training:** introduced in 2025-2026, the course was offered extensively at Ormskirk and Southport as part of our response to the race riots in 2024. The course was attended by 24 members of staff. (actions support HIA3 & 5).

- **Band 5 BAME Career Progression Workshop**: following the 2024 pilot, the course was scheduled again over 2026 with an additional 10 staff attending by March 2026 (action supports HIA2, 3, 5).

- **Cultural Awareness**: The Trust has worked to raise awareness of race equality topics by engaging in events including Black History Month and Wear Red Day; as well as promoting/marking dates such as South Asian History Month, Ramadan, Eid, and Diwali.

- **Ethnicity Pay Gap (HIA3)**: Having completed the Ethnicity Pay Gap since 2022, in March 2026 the Trust published its 2025 Ethnicity Pay Gap on the public website. Overall, the Trust and Agenda for Change Ethnicity Pay Gaps are in favour of our ethnic minority staff population, with the pay gap for Medical & Dental staff in favour of our White medics.

4. The 9 WRES Indicators

The WRES is an analysis of the following 9 data indicators, relating to workforce, recruitment, disciplinary, staff satisfaction, and board diversity:

1. **Staff Population**: Percentage of White and Ethnic Minority staff who are Non-Clinical, Clinical Non-Medical, by Agenda for Change (AfC) pay bands, and Clinical Medical & Dental roles.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Disciplinary**: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. **Training**: Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD).
5. **Harassment from Patients**: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months,
6. **Harassment from Staff:** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months,
7. **Equality in Career Progression**: Percentage of staff believing that the trust provides equal opportunities for career progression or promotion,
8. **Discrimination**: In the last 12 months have you personally experienced discrimination at work from any of the following, a manager/team leader, or other colleagues,
9. **Board Representation**: Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board; By executive membership of the Board.

4.1. Data and Methodology

Before reading the report, please familiarise yourself with the following information which provides a summary of the data sources and limitations. The time periods for the data sets are as follows:

- **Indicators 1 and 9**: snapshot date of the 31st of March,
- **Indicators 2-4**: period from the 1st of April to 31st March,
- **Indicators 5-8:** the relevant staff survey that took place between October and November 2025.
- The Trust collates data for Indicators 1-4 and 9 directly from Employee Staff Record (ESR), the TRAC recruitment system and HR Business Partners to create a final data set.

Benchmarking data has been sourced from the national staff survey website and Trust Staff Survey data[4] (2021-2025), Model Health System[5] (2023-2025), and the 2025 national WRES report[6].

4.1.1. Scope of reported population

The following data principles are applied to the WRES data:

- Data relates to the total substantive workforce on the relevant snapshot date except for Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Bank staff are not included.
- WRES data is only reported on the broad ethnicity categories of Ethnic Minority (aka Black and Minority Ethnic (BME), White, and Unknown.

The WRES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups, for example staff group is not analysed, nor data disaggregated by UK/Overseas domiciled or educated.

4.1.2. Note on Benchmarking data

Workforce Data: Workforce data including population levels, disparity ratios, recruitment, disciplinary and board data has been sourced from either the National WRES data set (available on the NHS WRES website), or from the Model Health data warehouse.

Comparable data if not available for a number of the benchmarks in the Model Health system e.g. ratios for North West, but individual Trust's data is. In these circumstances an average/mean figure has been calculation from these published percentages or fractions. Where these "averages" are used, this is being indicated by an asterisk (*)

Staff Survey Data: All staff survey benchmarking data has been source from the National Staff Survey Dashboard.

[4] NHS Staff Survey
[5] Model Health System
[6] NHSE WRES 2025 Data

4.1.3. Note on terminology

The report uses the term Ethnic Minority to refer to all staff from a non-white ethnic minority group. This would include all staff who have identified as Asian, Black, Mixed/Dual Heritage, and Other. The term is comparable with Black, Asian & Minority Ethnic (BAME), People of Colour (PoC), Global Majority, Ethnic Minority, and Minority Ethnic.

4.1.4. Note on Jewish and Sikh data

The Lord Mann report into Anti-Semitism and Racism in the NHS (2026) recommended that Trusts should include additional analysis within their WRES reports on their Jewish and Sikh populations. Additional content has been included within this report where relevant.

5. Workforce WRES Data

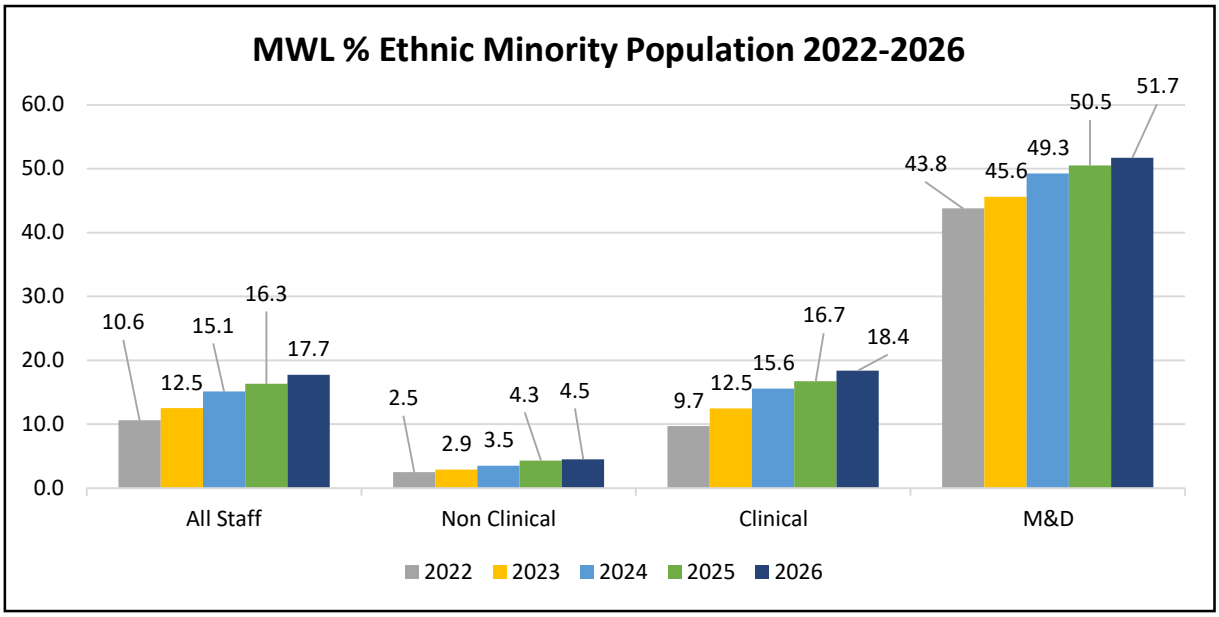
5.1. Staff Profile Workforce Overview

In the snapshot date of 31st March 2026, Mersey & West Lancashire Teaching Hospitals Trust (MWL) employed 11,116 staff which consisted of:

- 17.74% Ethnic Minority staff
- 79.82% White staff
- 2.44% Not stated/ unspecified / prefer not to answer.

Over the past 5 years (2022 v 2026), MWL has seen a year-on-year increase in the number and proportion of Ethnic Minority staff in the total workforce (1057/10.6% to 1972/17.7%), Non-Clinical (70/2.5% to 135/4.5%), Clinical Non-Medical (614/9.7% to 1312/18.4%) and Clinical Medical & Dental (M&D) (373/43.7% to 525/51.7%) (Figure 1). Further details for each category are set out below.

Figure 1: MWL % Ethnic Minority Population 2022-2026



5.1.1. Staff Jewish Population

The Trust's Jewish population is ≤10 or 0.09%. Due to the small population size no further analysis is provided in this report. Similarly, the Jewish population size within the Staff Survey results was ≤10 and is unreportable.

5.1.2. Staff Sikh Population

The Trust's Sikh population is ≤10 or 0.07%. Due to the small population size no further analysis is provided in this report. Similarly, the Sikh population size within the Staff Survey results was ≤10 and is unreportable.

5.2. Indicator 1: Non-Clinical and Clinical Workforce

Indicator 1 is a review of the staff population by Non-Clinical Workforce by Agenda for Change (AfC) pay bands; Clinical Non-Medical workforce by AfC pay bands; and Clinical Medical and Dental workforce.

From March 2025 to March 2026, there was an increase in the number and proportion of Ethnic Minority staff:

- The total workforce from 1795 (16.3%) to 1972 (17.7%).
- Non-Clinical roles from 131 (4.3%) to 135 (4.5%).
- Clinical non-medical roles from 1163 (16.7%) 1312 (18.4%).
- Clinical Medical & Dental roles from 501 (50.5%) to 525 (51.7%).

Overall, the proportion of non-clinical staff who are from an Ethnic Minority is 4.5% (Table 1), higher than the local Ethnic Minority population in all boroughs that MWL is located in, with the exception of Knowsley (Table 2). The proportion of Ethnic Minority staff in clinical roles is significantly higher than the local population and reflects national trends in nursing and medicine specifically, as well as previous overseas recruitment activities.

Table 1: Staff Headcount

Staff Headcount March 2026	White	Eth Min	Unk	% Eth Min MWL (2026)	% Eth Min National (2025)
Total	8873	1972	271	17.7%	30.7%
Non-Clinical Workforce (AfC)	2770	135	72	4.5%	20.7%
Clinical Non-Medical Workforce (AfC)	5655	1312	157	18.4%	31.5%
Medical and Dental Workforce	448	525	42	51.7%	50.0%

Table 2: Population Benchmarks

Benchmarks	%White	% Eth Min	%Unk
MWL Total (2026)	79.8%	17.7%	2.4%
National (2025)	65.4%	30.7%	3.9%
North West (2025)	75.4%	21.4%	3.2%
C&M ICB (2025)	82.2%	15.5%	2.2%
National Census: Sefton	95.8%	4.2%	-
National Census: St Helens	96.5%	3.5%	-
National Census: Knowsley	95.3%	4.7%	-
National Census: West Lancashire	96.9%	3.1%	-
National Census: C&M ICB Area	93.0	7.0%	-
National Census: Liverpool City Region	91.7	7.3%	-

5.2.1. Indicator 1a: Non-Clinical workforce

The non-clinical workforce includes staff in administration, clerical and estates type of roles. Key observations:

- The total number of Ethnic Minority Non-Clinical staff increased from 131 to 135, with an increase in the proportion of Ethnic Minority staff on bands 2 and 4-6, 8b and 8d (Table 3).
- There were no declared Ethnic Minority staff on Bands 1, 8c, 9, and VSM.
- Compared nationally, North West and C&M ICB, the proportion of Ethnic Minority staff is lower for all band ranges (Table 4).

Table 3: Staff Headcount Non-Clinical Workforce

	MWL 2025		MWL 2026	
	%White	%EthMin	%White	%EthMin
Band 1	100.0%	0.0%	100.0%	0.0%
Band 2	90.1%	5.7%	90.0%	6.0%
Band 3	91.8%	5.4%	92.5%	5.2%
Band 4	96.1%	2.1%	95.9%	2.3%
Band 5	92.7%	5.2%	93.2%	5.6%
Band 6	94.5%	3.4%	94.2%	3.6%
Band 7	95.3%	4.0%	96.1%	3.9%
Band 8A	95.9%	2.7%	95.9%	2.7%
Band 8B	93.5%	3.9%	92.1%	5.3%
Band 8C	96.8%	0.0%	96.8%	0.0%
Band 8D	100.0%	0.0%	93.3%	6.7%
Band 9	100.0%	0.0%	100.0%	0.0%
VSM	92.3%	0.0%	100.0%	0.0%
Band 1-4	92.4%	4.5%	92.6%	4.7%
Band 5-7	93.9%	4.4%	94.3%	4.6%
Band 8A-8	94.7%	3.3%	94.0%	4.0%
Band 8C-VSM	97.1%	0.0%	97.1%	1.4%
Total	92.9%	4.3%	93.0%	4.5%

Table 4: Non-Clinical Workforce % Ethnic Minority Benchmarking by band range

	MWL 2026	National 2025	North West 2025	C&M ICB 2025
Band 1-4	4.7%	21.1%	12.9%	6.2%
Band 5-7	4.6%	21.4%	11.2%	6.9%
Band 8A-8	4.0%	17.8%	7.5%	5.1%
Band 8C-VSM	1.4%	13.6%	5.8%	3.7%
Total	4.5%	20.7%	12.0%	6.2%

5.2.1.1 Race Disparity Ratio Non-Clinical Workforce

A race disparity ratio is used to measure whether Ethnic Minority staff are progressing through the organisation at the same rate as White staff. It focuses on representation across band groupings rather than simply comparing percentages at individual bands. These band groupings are:

- Support (band 1-4) v Middle (band 5-7)
- Middle (band 5-7) v Senior (band 8a/8b),
- Senior (band 8a/8b) v VSM (band 8c, 9, VSM)
- Support (band 1-4) v VSM (band 8c, 9, VSM)

A ratio value of 1 means that there is no difference, a ratio of <1 means Ethnic Minority staff are more represented in the higher bands, and a ratio of >1 means that White staff are more represented in the higher bands.

MWL has made notable progress in reducing racial disparities in progression from middle grades (Bands 5-7) to senior grades (Bands 8A/8B), with the Race Disparity Ratio improving from 1.69 in 2024 to 1.15 in 2026. This indicates that progression opportunities at this level are becoming more equitable and now compare favourably to the national benchmark of 1.27 (Table 5).

However, significant disparities remain at the most senior levels. The 2026 ratio of 2.85 for progression from senior grades to VSM indicates that White staff are almost three times more likely to progress to executive-level roles than ethnic minority staff.

This is reflected in the overall Support-to-VSM ratio of 3.37, which is considerably higher than the national benchmark of 1.71. These findings suggest that while progress has been made in the middle of the talent pipeline, barriers to progression into the most senior leadership roles remain and should continue to be a focus for targeted EDI interventions.

Table 5: Non-Clinical Race Disparity

	MWL			National
	2024	2025	2026	2025
Support to Middle (1-4 to 5-7)	0.96	1.05	1.03	1.00
Middle to Senior (5-7 to 8A/8B)	1.69	1.33	1.15	1.27
Senior to VSM (8A-8B to 8C/VSM)	1.50	-	2.85	1.35
Support to VSM (1-4 to VSM)	2.42	-	3.37	1.71

5.2.2. Indicator 1b: Clinical workforce: Non-Medical

The Clinical Non-Medical workforce includes all allied health professionals, nursing and midwifery staff and relevant support staff. Key observations:

- The total number of Ethnic Minority Clinical Non-Medical staff increased from 1163 (16.7%) to 1312 (18.4%), with an increase in the proportion of Ethnic Minority staff on bands 2-8b (Table 6).
- There were no declared Ethnic Minority staff on Bands 8d, 9 or VSM.
- Compared nationally, the proportion of Ethnic Minority staff is below the national average for all Band ranges. Compared to C&M ICB, MWL has a higher proportion of Ethnic Minority staff in band ranges 5-7 and 8A-8B (Table 7)

Table 6: Staff Headcount Clinical Non-Medical Workforce

	MWL 2025		**MWL 2026**	
	%White	**%EthMin**	**%White**	**%EthMin**
Band 1	100.0%	0.0%	100.0%	0.00%

	MWL 2025		MWL 2026	
	%White	%EthMin	%White	%EthMin
Band 2	80.4%	15.5%	75.3%	21.2%
Band 3	90.4%	6.6%	87.5%	9.9%
Band 4	93.7%	4.4%	92.1%	5.9%
Band 5	64.6%	32.6%	63.9%	34.0%
Band 6	85.7%	12.6%	84.8%	13.8%
Band 7	91.3%	6.4%	90.6%	7.3%
Band 8A	87.9%	9.5%	88.7%	9.9%
Band 8B	90.3%	4.8%	90.0%	5.0%
Band 8C	90.0%	10.0%	94.7%	5.3%
Band 8D	88.9%	0.0%	87.5%	0.0%
Band 9	100.0%	0.0%	100.0%	0.0%
VSM	0.0%	0.0%	100.0%	0.0%
Band 1-4	85.7%	10.8%	83.8%	13.4%
Band 5-7	77.0%	20.6%	76.1%	22.0%
Band 8A-8	88.3%	8.8%	88.9%	9.2%
Band 8C-VSM	90.9%	6.1%	93.8%	3.1%
Total	80.6%	16.7%	79.4%	18.4%

Table 7: Clinical Non-Medical Workforce % Ethnic Minority Benchmarking by band range

	MWL 2026	National 2025	North West 2025	C&M ICB 2025
Band 1-4	10.8%	30.0%	20.0%	13.0%
Band 5-7	20.6%	33.8%	23.7%	18.8%
Band 8A-8B	8.8%	18.3%	9.3%	7.1%
Band 8C-VSM	6.1%	14.7%	11.0%	4.1%
Total	16.7%	31.5%	21.5%	16.1%

5.2.2.1. Race Disparity Ratio Clinical Non-Medical Staff

The Clinical Non-Medical Race Disparity Ratios demonstrate a mixed picture across the workforce pipeline. Progression from support grades (Bands 1-4) to middle grades (Bands 5-7) remains favourable for ethnic minority staff, with ratios below 1.0 across all three years.

However, this position is not sustained at more senior levels. Progression from middle grades to senior grades remains a significant challenge, with White staff around 2.8 times more likely to progress than ethnic minority staff, a position that is consistently worse than the national benchmark.

The greatest disparity is evident in progression to the most senior leadership roles. In 2026, the Senior-to-VSM ratio increased to 3.12, while the overall Support-to-VSM ratio rose sharply to 4.79 (Table 8)

Table 8: Clinical Non-Medical Race Disparity

	MWL			National
	2024	2025	2026	2025
Support to Middle (1-4 to 5-7)	0.39	0.47	0.55	0.83
Middle to Senior (5-7 to 8A/8B)	2.84	2.69	2.78	2.35
Senior to VSM (8A-8B to 8C/VSM)	2.39	1.50	3.12	1.30
Support to VSM (1-4 to VSM)	2.64	1.89	4.79	2.54

5.2.3. Indicator 1c: Clinical workforce: Medical & Dental

The Clinical Medical & Dental workforce includes all staff on a medical and dental terms and conditions and includes Foundation, Resident Doctors and Consultants. Data does not include Lead Employer Resident Doctors, including those on placement at the Trust.

Key observations:

- The total number of Ethnic Minority Clinical Medical & Dental staff has increased from 501 (50.5%) to 525 (51.7%) and the total number of White staff has increased from 442 (44.5%) to 448 (44.1%) (Table 9).
- The main increase of Ethnic Minority staff was for Trainee Grades (188 to 192), and Consultants (210 to 224).
- Compared to national benchmarks the medical workforce is comparable overall, with the Trust having a larger proportion of Non Consultants from an Ethnic Minority, in particular when compared to C&M ICB (Table 10).
- Compared to the local population, the medical workforce is significantly overrepresented by Ethnic Minority individuals. This reflects national trends on the medical workforce, as well as overseas recruitment into the NHS.

The WRES data does not calculate a race disparity ratio for medical and dental roles and is therefore not reported.

Table 9: Staff Headcount Clinical Medical & Dental Workforce

	MWL 2025		MWL 2026	
	%White	%EthMin	%White	%EthMin
Consultants	52.7%	43.6%	51.6%	44.6%
Consultants also Senior medical manager	100.0%	0.0%	100.0%	0.0%
Non-consultant	24.5%	67.6%	22.0%	71.3%
Trainees	70.5%	54.3%	42.3%	54.6%
Other	78.6%	7.1%	63.6%	18.2%
Total	44.5%	50.5%	44.1%	51.7%

Table 10: Clinical Medical & Dental Workforce % Ethnic Minority Benchmarking by band range

	MWL 2026	National 2025	North West 2025	C&M ICB 2025
Consultants	44.6%	42.1%	56.4%	52.8%
Non-consultant	71.3%	63.2%	67.1%	56.6%
Trainees	54.6%	53.7%	44.4%	39.6%
Total	51.7%	50.0%	52.7%	45.9%

5.2.4. Indicator 2: Relative likelihood of Ethnic Minority and White staff being appointed from shortlisting across all posts

Indicator two is an assessment of the Trust's recruitment and selection practices, and whether Ethnic Minority applicants are as likely as White applicants to be successfully shortlisted and appointed. See Tables 11, 12.

This indicator is assessed at "whole organisation" level and does not disaggregate the recruitment trends by job group or department where Ethnic Minority individuals may be more or less likely to form part of the talent pool e.g., Ethnic Minority people are overrepresented in the medical and dental profession.

Key observations:

- 32% of white applicants who were shortlisted where successful compared to 17% of Ethnic Minority applicants who were shortlisted (Table 11, 0.32 v 0.17).
- This represented a decrease in the relative likelihood of white applicants from 37% (0.37) to 32% (0.32) or a 5 point drop; compared to a decrease for Ethnic Minority applicants from 23% (0.23) to 17% (0.17) or a 6 point drop (Table 11).
- Compared to benchmarks, a larger proportion of white applicants are successful at MWL when compared to the national, North West and C&M ICB comparators (Table 11)
- Compared to benchmarks, a larger proportion of Ethnic Minority applicants are successful at MWL when compared to national and North West benchmarks, and equal to the C&M ICB.

- The relative likelihood of White applicant being appointed compared to Ethnic Minority applicants stands at 1.8 times more likely, meaning White applicants are more likely to be successful (Table 12).
- Compared to benchmarks the Trust performs better than the national and the North West.

Caution should be used when comparing these benchmarks. Recruitment trends and the volume of recruitment activities vary widely across Trusts, and these figures are based on an average of fractions and ratios, rather than using raw data.

Table 11: Relative likelihood of appointment from shortlisting

	White				Eth Min			
	MWL	Nat*	NW*	C&M ICB*	MWL	Nat*	NW*	C&M ICB*
2023-2024	0.36	0.27	0.26	0.26	0.20	0.19	0.16	0.18
2024-2025	0.37	0.27	0.25	0.26	0.23	0.17	0.15	0.17
2025 -2026	0.32	0.28	0.24	0.26	0.17	0.14	0.14	0.17

NB: An asterisk (*) indicates that the figure has been calculated from a group of percentages or fractions, and not from original data. Therefore caution must be used when comparing with these figures.

Table 12: Relative likelihood of White candidates being appointed from shortlisting compared to Ethnic Minority candidates

	MWL	National	North West*	C&M ICB*
2023-2024	1.79	1.62	1.89	1.82
2024-2025	1.61	1.77	2.23	2.57
2025 -2026	1.81	1.94*	1.87	1.74

NB: An asterisk (*) indicates that the figure has been calculated from a group of percentages or fractions, and not from original data. Therefore caution must be used when comparing with these figures.

A value <1 means that Ethnic Minority applicants are more likely to be appointed, and value >1 means they are less likely to be appointed. For example, a value of "2.0" would indicate that White candidates were twice as likely as Ethnic Minority candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as Ethnic Minority candidates to be appointed from shortlisting.

5.3. Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Indicator 3 is an assessment of whether Ethnic Minority staff are more likely to face formal disciplinaries compared to White staff. There are few formal disciplinaries each year (Table 12).

Key observations:

- Overall the number of staff entering a formal disciplinary process is small at 0.26% of the workforce; of which 16.7% are from an Ethnic Minority and 83.4% are White.
- The likelihood of a White member of staff entering a formal disciplinary was 0.25, a decrease from 0.60 the previous year. The likelihood of an Ethnic Minority member of staff was 0.28, a decrease from 0.50 the previous year (Table 13)

- The relative likelihood of Ethnic Minority staff entering the formal disciplinary process compared to White staff was 0.89, a slight increase from 0.84 the previous year (Table 14).
- Compared to benchmarks, relative likelihood in smaller than national, North West and C&M ICB levels (Table 14).
- Overall Ethnic Minority staff are less likely than White staff to enter a formal disciplinary process.

Caution should be used when comparing this these benchmarks as these figures are based on an average of fractions and ratios, rather than using raw data.

Table 13: Likelihood of staff entering the formal disciplinary process

YES	White	Eth Min	Unknown
2023-2024	1.81%	0.98%	0.76%
2024-2025	0.60%	0.50%	0.00%
2025-2026	0.25%	0.28%	0.00%

Table 14 Relative likelihood of Ethnic Minority staff entering the formal disciplinary process compared to White staff

	MWL	National	North West*	C&M ICB*
2023-2024	0.54	1.09	1.37	1.28
2024-2025	0.84	1.11	1.40	1.23
2025 -2026	0.89	1.55*	1.69	1.98

NB: An asterisk (*) indicates that the figure has been calculated from a group of percentages or fractions, and not from original data. Therefore caution must be used when comparing with these figures.

A value <1 means that Ethnic Minority staff are less likely to enter formal disciplinary processes, and value >1 means they are more likely to enter formal disciplinary processes. For example, a value of "2.0" would indicate that Ethnic Minority staff were twice as likely as White staff to enter a formal disciplinary process, whilst a value of "0.5" would indicate that Ethnic Minority staff were half as likely as White staff to enter a formal disciplinary process.

5.4. Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

Indicator 4 is an assessment of whether Ethnic Minority staff have the same access to non-mandatory training and development as White staff.

Non-mandatory training refers to any learning, education, training, or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement nor mandated by the organisation. All training and development recorded on ESR that is not classed as mandatory training has been included in this data.

The relative likelihood measure for this indicator was 98.1% for Ethnic Minority staff and 97.6% for White staff, meaning that Ethnic Minority staff were more likely than White staff to access non-mandatory training and CPD in the reporting period. See table 15.

Table 15 Relative likelihood of White staff accessing non-mandatory training and CPD compared to Ethnic Minority staff.

	MWL	National	North West
2023-2024	0.80	1.06	0.99
2024-2025	0.89	1.02	0.98*
2025-2026	1.00	0.99*	0.98*

6. Staff Survey Questions

The 2025 NHS Staff Survey was conducted between October and November 2025 and completed by 3,835 staff (35.34% response rate), of which 3787 provided their ethnicity (98.7%).

For the purposes of this report, the 2025 staff survey results have been sourced from the Trust's staff survey reports, with benchmarking data being sourced from the National Staff Survey Dashboard. See Table 16.

6.1 Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (Staff Survey, Q14a)

Table 16: Harassment by patients

		2022	2023	2024	2025	Change
MWL	Eth Min	30.2%	25.9%	25.6%	26.8%	+1.2
	White	26.4%	21.4%	19.2%	19.3%	+0.1
	All	26.9%	23.7%	21.5%	21.9%	+0.4
National	Eth Min	30.4%	27.8%	28.6%	29.2%	+0.6
	White	26.8%	24.1%	23.5%	23.5%	0
	All	27.9%	25.3%	25.1%	25.3%	+0.2
North West	Eth Min	27.2%	25.2%	26.9%	27.8%	+0.9
	White	24.6%	21.8%	21.5%	21.6%	+0.1
	All	24.9%	22.3%	22.5%	22.7%	+0.2
C&M ICB	Eth Min	29.6%	26.8%	26.0%	27.5%	+1.5
	White	24.4%	20.4%	19.4%	19.5%	+0.1
	All	24.9%	21.2%	20.3%	20.5%	+0.2
Acute & Community	Eth Min	30.4%	27.6%	28.4%	28.7%	+0.3
	White	26.7%	23.8%	23.2%	23.1%	-0.1
	All	27.9%	25.2%	24.9%	25.0%	+0.1

In 2025, 21.9% of MWL staff reported experiencing harassment, bullying or abuse from patients, relatives or members of the public during the previous 12 months, representing a small increase from 21.5% in 2024. MWL continues to perform more favourably than National, North West and Acute & Community benchmarks overall, although performance is slightly above the Cheshire and Merseyside ICB average.

The proportion of ethnic minority staff reporting harassment increased whilst the proportion of White staff reporting harassment remained largely unchanged. See Table 16.

Specifically:

- 21.9% of all MWL staff reported experiencing harassment, bullying or abuse from patients, relatives or the public, an increase of 0.4 percentage points from 2024 (21.5%).
- The proportion of ethnic minority staff reporting harassment increased from 25.6% in 2024 to 26.8% in 2025 (+1.2pp).
- The proportion of White staff reporting harassment increased slightly from 19.2% to 19.3% (+0.1pp).
- The gap between ethnic minority and White staff increased from 6.4 percentage points in 2024 to 7.5 percentage points in 2025.
- Ethnic minority staff are approximately 39% more likely than White staff to report experiencing harassment, bullying or abuse from patients, relatives or the public.
- The widening disparity has been driven by increasing reports of harassment amongst ethnic minority staff alongside relatively stable reporting levels for White staff.
- For ethnic minority staff, MWL performs 2.4pp below the National benchmark, 1.0pp below North West, 0.7pp below Cheshire & Merseyside ICB, and 1.9pp below the Acute & Community benchmark.
- For White staff, MWL continues to perform favourably: 4.2pp below the National average, 2.3pp below North West, 0.2pp below Cheshire & Merseyside ICB, and 3.8pp below the Acute & Community benchmark.
- Overall, MWL performs 3.4pp below the National average, 0.8pp below North West, and 3.1pp below the Acute & Community benchmark, but is 1.4pp above the Cheshire & Merseyside ICB average.

6.2 Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (Staff Survey, Q14b/c)

This indicator is based on the amalgamation of questions 14b and 14c in the staff survey.

Table 17: Harassment from Staff (Managers and Colleagues)

YES		2023	2024	2025	Change
MWL	Eth Min	17.6%	20.0%	22.0%	**+2.0**
	White	17.6%	17.9%	18.8%	**+0.9**
National Benchmark Median	*Eth Min*	*25.2%*	*24.8%*	*24.1%*	***-0.7***
	White	*22.1%*	*21.5%*	*20.5%*	***-1.0***
North West	Eth Min	26.8%	23.6%	23.3%	**-0.3**
	White	20.7%	18.9%	18.3%	**-0.6**
C&M ICB	Eth Min	27.7%	23.1%	22.2%	**-0.9**
	White	21.6%	18.2%	17.3%	**-0.9**

In 2025, the proportion of MWL staff reporting harassment, bullying or abuse from managers or colleagues increased across both ethnic minority and White staff groups. Whilst MWL continues to perform more favourably than National, North West and Cheshire & Merseyside ICB benchmarks for ethnic minority staff, the direction of travel is negative and the gap between ethnic minority and White staff has widened. The proportion of ethnic minority staff reporting harassment increased at a greater rate than White staff. See Table 17.

Specifically:

- The proportion of ethnic minority staff reporting harassment from managers or colleagues increased from 20.0% in 2024 to 22.0% in 2025 (+2.0pp).
- The proportion of White staff reporting harassment increased from 17.9% to 18.8% (+0.9pp).
- The gap between ethnic minority and White staff increased from 2.1 percentage points in 2024 to 3.2 percentage points in 2025.
- Ethnic minority staff are approximately 17% more likely than White staff to report experiencing harassment, bullying or abuse from managers or colleagues.
- The widening disparity has been driven by a larger increase in reported harassment amongst ethnic minority staff compared to White staff.
- For ethnic minority staff, MWL performs 2.1pp below the National Benchmark Median, 1.3pp below the North West average, and 0.2pp below the Cheshire & Merseyside ICB average.
- For White staff, MWL performs 1.7pp below the National Benchmark Median, but is 0.5pp above the North West average and 1.5pp above the Cheshire & Merseyside ICB average.
- Whilst comparator organisations have seen reductions in reported harassment during 2025, MWL experienced increases across both ethnic minority and White staff groups, narrowing the gap between MWL and external benchmarks.

6.3 Indicator 7: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Staff Survey, Q15)

This staff survey question asks; *"Does your organisation act fairly with regard to career progression / promotion, regardless of age, disability, ethnic background, gender reassignment, religion, sex, or sexual orientation?"* with the options to answer; Yes, No or Don't Know.

Table 18: Equal Opportunities in Career Progression

YES		2022	2023	2024	2025	Change
MWL	Eth Min	46.5%	52.2%	49.5%	49.9%	+0.4
	White	61.3%	61.4%	59.4%	56.8%	-2.6
	All	59.5%	59.9%	58.1%	55.6%	-2.5
National	Eth Min	46.4%	48.9%	49.5%	49.7%	+0.2
	White	59.1%	59.4%	58.9%	55.9%	-3
	All	56.0%	56.4%	55.9%	53.7%	-2.2
North West	Eth Min	45.5%	47.4%	49.4%	47.9%	-1.5
	White	58.9%	59.0%	59.0%	55.3%	-3.7
	All	56.9%	56.9%	57.0%	53.7%	-3.3
C&M ICB	Eth Min	44.9%	46.2%	48.9%	48.1%	-0.8
	White	59.2%	59.1%	59.4%	56.3%	-3.1
	All	57.6%	57.3%	57.8%	54.9%	-2.9
Acute & Community	Eth Min	46.1%	48.6%	49.2%	49.4%	0.2
	White	58.7%	59.0%	58.6%	55.3%	-3.3
	All	55.4%	55.8%	55.4%	53.2%	-2.2

In 2025, 55.6% of MWL staff believed that the Trust provides equal opportunities for career progression or promotion, representing a decrease from 58.1% in 2024. Whilst MWL continues to perform more favourably than National, North West, Cheshire & Merseyside ICB and Acute & Community benchmarks overall, confidence in fair career progression has declined across the workforce. The

proportion of ethnic minority staff reporting that the Trust provides equal opportunities increased slightly, whilst the proportion of White staff reporting positively decreased. See Table 18.

Specifically:

- 55.6% of all MWL staff reported that the Trust provides equal opportunities for career progression or promotion, a decrease of 2.5 percentage points from 2024 (58.1%).
- The proportion of ethnic minority staff reporting positively increased from 49.5% in 2024 to 49.9% in 2025 (+0.4pp).
- The proportion of White staff reporting positively decreased from 59.4% to 56.8% (-2.6pp).
- The gap between ethnic minority and White staff reduced from 9.9 percentage points in 2024 to 6.9 percentage points in 2025.
- White staff remain more likely than ethnic minority staff to believe the Trust provides equal opportunities for career progression and promotion.
- The narrowing disparity has been driven by declining positive perceptions amongst White staff alongside a small improvement for ethnic minority staff.
- For ethnic minority staff, MWL performs 0.2pp above the National benchmark, 2.0pp above the North West average, 1.8pp above Cheshire & Merseyside ICB, and 0.5pp above the Acute & Community benchmark.
- For White staff, MWL performs favourably at 0.9pp above the National average, 1.5pp above North West, 0.5pp above Cheshire & Merseyside ICB, and 1.4pp above the Acute & Community benchmark.
- Overall, MWL performs 1.9pp above the National average, 1.9pp above the North West average, 0.7pp above Cheshire & Merseyside ICB, and 2.4pp above the Acute & Community benchmark.

6.4 Indicator 8: Staff who have personally experienced discrimination at work from a manager, team leader or other colleagues in the last 12 months (Staff Survey, Q16b)

Table 19: Discrimination from Manager or Colleague

YES		2022	2023	2024	2025	Change
MWL	Eth Min	18.0%	12.0%	14.3%	15.7%	+1.4
	White	4.5%	4.4%	5.4%	5.2%	-0.2
	All	5.9%	5.7%	6.7%	6.9%	+0.2
National	Eth Min	16.6%	15.5%	15.2%	13.9%	-1.3
	White	6.7%	6.7%	6.8%	6.5%	-0.3
	All	9.0%	9.1%	9.2%	8.8%	-0.4
North West	Eth Min	17.4%	16.2%	16.2%	15.2%	-1
	White	6.4	6.1%	6.2%	6.0%	-0.2
	All	8.0%	7.8%	8.1%	7.8%	-0.3
C&M ICB	Eth Min	18.4%	16.9%	15.5%	15.7%	+0.2
	White	5.6%	5.5%	5.6%	5.4%	-0.2
	All	6.9%	6.9%	7.0%	6.8%	-0.2
Acute & Community	Eth Min	17.2%	16.0%	15.7%	14.3%	-1.4
	White	6.8%	6.8%	6.8%	6.5%	-0.3
	All	9.4%	9.5%	9.6%	9.1%	-0.5

In 2025 6.9% of MWL staff reported experiencing discrimination from a manager, team leader or colleague during the previous 12 months, representing a small increase from 6.7% in 2024. Whilst the Trust continues to perform more favourably than national, regional and Acute and Community sector benchmarks overall, this position is driven largely by positive results for White staff.

The proportion of ethnic minority staff reporting discrimination increased whilst the proportion of White staff reporting discrimination reduced slightly.

Specifically:

- 6.9% of all MWL staff reported experiencing discrimination from a manager or colleague, an increase of 0.2 percentage points from 2024 (6.7%).
- The proportion of ethnic minority staff reporting discrimination increased from 14.3% in 2024 to 15.7% in 2025 (+1.4pp).
- The proportion of White staff reporting discrimination reduced slightly from 5.4% to 5.2% (-0.2pp).
- The gap between ethnic minority and White staff increased from 8.9 percentage points in 2024 to 10.5 percentage points in 2025.
- Ethnic minority staff are approximately three times more likely than White staff to report experiencing discrimination from a manager or colleague.
- The widening disparity has been driven by increasing reports of discrimination among ethnic minority staff alongside a small reduction for White staff.
- For Ethnic Minority staff MWL performs 2.8pp higher than the National benchmark. 0.5pp above North West, is equal to the Cheshire & Merseyside ICB, and higher than 1.4pp higher than Acute & Community.

- For White staff MWL continues to perform favourably: 1.3pp below the National average, 0.8pp below North West, 0.2pp below C&M ICB, and 1.3 pp below the Acute & Community.

7. Trust Board

7.1. Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce

Overall, 10% of Board Members or 22.2% of Non-Executive Board Members are from an Ethnic Minority, representing a doubling from 2024 of 5.6% and 12.5% respectively. No Executive members of the Board are from a Ethnic Minority.

In 2024 (most current benchmark data), nationally 17.3% of Board Members of NHS Trusts were from an ethnic minority background, including 21.7% of Non-Executive and 12.8% of Executive Board Members.

The Board remains less ethnically diverse compared to the overall workforce, but is twice as diverse as the local population. See Table 22.

Table 20: Board Membership 2023-2024

	EthMin	White	Unknown
Total Board	4.2%	79.2%	16.7%
Of which Voting Board Members	0.0%	100%	0.0%
Non-Voting Board Members	5.3%	73.7%	21.1%
Of which Executive Board Members	0.0%	100%	0.0%
Non-Executive Board Members	5.3%	73.7%	21.1%
Difference Total Board v Workforce	-11	-2	+13
Difference Voting Members v Workforce	-15	+19	-4
Difference Executive Members v Workforce	-15	+19	-4

Table 21: Board Membership 2024-2025

	EthMin	White	Unknown
Total Board	5.6%	94.4%	0.0%
Of which Voting Board Members	0.0%	100%	0.0%
Non-Voting Board Members	14.3%	85.7%	0.0%
Of which Executive Board Members	0.0%	100%	0.0%
Non-Executive Board Members	12.5%	87.5%	0.0%
Difference Total Board v Workforce	-10.8	+13.7	-3.0
Difference Voting Members v Workforce	-16.3	+19.3	-3.0
Difference Executive Members v Workforce	-16.3	+19.3	-3.0

Table 22: Board Membership 2025-2026

	EthMin	White	Unknown
Total Board	10.0%	90.0%	0.0%
Of which Voting Board Members	8.3%	91.7%	0.0%
Non-Voting Board Members	12.5%	87.5%	0.0%
Of which Executive Board Members	0.00%	100.00%	0.0%
Non-Executive Board Members	22.2%	77.8%	0.0%
Difference Total Board v Workforce	-8%	10%	-2%
Difference Voting Members v Workforce	-9%	12%	-2%
Difference Executive Members v Workforce	-18%	20%	-2%

8. Conclusion

Overall, the trust saw improvements in the proportion of Ethnic Minority staff (Indicators 1, 1a, 1b, 1c), disciplinary (Indicator 3), access to training (Indicator 4), Staff Survey Equality in Career Progression (Indicator 7) and the ethnic diversity of the Trust Board (Indicator 9). However, challenges remain with recruitment (Indicator 2), and a higher proportion of Ethnic Minority staff experiencing harassment and discrimination (Indicator 5, 6, 8).

The Trust has taken important and meaningful steps on its journey to becoming a truly anti-racist organisation. This commitment is reflected in the progress made to date, including successfully achieving bronze status within the North West Anti-Racism Framework accreditation, as well as the development of our Anti-Racism statement, rolling out training on Active Bystander and Cultural Competency, and our ongoing programme of awareness raising and engagement events and activities.

Overall, the WRES indicators show the following:

Workforce data metrics:

- An increase in the proportion of total Ethnic Minority staff to 17.7%; Non-Clinical staff to 4.5%; Clinical Non-Medical staff to 18.4%; and Clinical Medical & Dental staff to 51.7%.
- There was an increase in the proportion of Ethnic Minority Non-Clinical staff on bands 2, 4-6, 8b and 8d. There were no declared Ethnic Minority staff on Bands 8d, 9 or VS. Compared nationally, the proportion of Ethnic Minority staff is below the national average for all banding groups.
- Non-Clinical progression disparities have reduced substantially at middle-to-senior grades, but significant ethnic disparities persist in progression into the most senior leadership roles, with the 2026 Senior-to-VSM disparity ratio (2.85) and overall Support-to-VSM ratio (3.37) both exceeding national benchmarks.
- There was an increase in the proportion of Ethnic Minority Clinical Non-Medical staff on Bands 2-8b. There were no declared Ethnic Minority staff on Bands 8d, 9 or VSM. There were no declared Ethnic Minority staff on Bands 8d, 9 or VSM. Compared nationally, the proportion of Ethnic Minority staff is below the national average for all banding groups.
- Clinical Non-Medical ethnic minority staff experience comparatively favourable progression from support to middle grades. The 2026 Support-to-VSM ratio of 4.79 and Senior-to-VSM ratio of 3.12

indicate that ethnic minority staff remain underrepresented in progression to the highest levels of leadership.

- There was an increase in the proportion Ethnic Minority Clinical Medical & Dental staff on Trainee roles, Non-Consultant and Consultant roles. Compared to the local population, the medical workforce is significantly overrepresented by Ethnic Minority individuals. This reflects national trends on the medical workforce, as well as overseas recruitment into the NHS.
- Ethnic Minority applicants as a population are less likely to be appointed from shortlisting compared to White applicants.
- Ethnic Minority staff are less likely to enter disciplinary process than White staff.
- Ethnic Minority staff are more likely than White staff to access non-mandatory training or CPD
- 10% of the Trust Board is from an Ethnic Minority, lower than the workforce, but comparable with the local population, and the Non-Clinical workforce.

Staff survey data:

- 26.8% Ethnic Minority staff state they have experienced bullying and harassment from a patient, family member or member of the public (29.2% nationally), compared to 19.3% of White staff, a difference of 7.5 points.
- 22.0% Ethnic Minority staff state they have experienced bullying and harassment from a colleague or manager, compared to 18.8% of White staff, a difference of 3.2 points.
- 49.9% Ethnic Minority staff state they believe the Trust offers equality of opportunity in career progression (49.7% nationally), compared to 56.8% of White staff, a difference of 6.9 points
- 15.7% Ethnic Minority staff state they has experience discrimination from a manager or other colleague (13.9% nationally), compared to 5.2% of White staff, a difference of 10.5 points.

9. Action Plan

The Trust has developed a new People Strategy within which Equality, Diversity and Inclusion are embedded. The key **Race related objectives** set out in the People Strategy delivery plan include:

People Plan: Theme	2026-27 Delivery Plan Actions	Sub Actions
Looking after our people: We will develop a culture that empowers individuals to lead healthy lives and thrive in work by providing holistic wellbeing support	**Health Inequalities** - To measure and report on health inequalities in our workforce and educate our leaders on the impact of health inequalities.	**Establish a staff health inequalities dashboard** combining workforce and wellbeing data to identify racial disparities and support targeted improvement activity
		Develop and implement integrated workforce health inequalities reporting to identify disparities, monitor trends, and inform targeted interventions.
Belonging in the NHS: We will develop an inclusive culture where everyone's voice is represented and celebrated	**Inclusive Language Guide -** Create an inclusive language guide that can be published across the Trust to support all staff in learning and understanding the impact of language.	**Undertake research across the NHS** to identify existing areas of good practice and inclusive language guides. This will include exploring content, format and impact of resources to ensure they are accessible and usable.
		To develop and implement a comprehensive Inclusive Language Guide that promotes respectful, culturally competent, and person-centred communication across the Trust. Included in this will be a range of resources and formats to ensure the information is accessible, understood, and able to be consistently applied by all staff.
		To engage with a broad range of internal stakeholders as part of the development and delivery process to ensure that we consider the views and feedback of our workforce
	Zero Tolerance - Bring together a focussed group of individuals to understand the issues faced by our staff and to design, develop and launch a Trust-wide Zero Tolerance Campaign	**The Zero Tolerance Working Group** to review the workforce data on all forms of abuse, discrimination, and unacceptable behaviour to understand the areas of concern that need to be addressed.
		The working group will oversee the design and delivery of clear messaging, staff engagement activities, and accessible reporting mechanisms, ensuring that all individuals understand expected standards of behaviour and feel supported to raise concerns. The working group will agree a set of metrics for monitoring the success of the campaign.
		Trust will launch the Zero Tolerance Campaign and monitor reporting and feedback to understand the success and, where necessary, take additional actions.
	Patient Information - Work in collaboration with Corporate Nursing colleagues to develop	**To develop a robust, long-term, plan in collaboration with Corporate Nursing and Patient Experience colleagues** to review, update, and

	clear, accessible and inclusive patient-facing leaflets and information materials which support the Trust's position on respectful behaviour,	improve patient-facing leaflets, ensuring clear, accessible, consistent messaging that is aligned with inclusive and Zero Tolerance principles
		Review other Trust leaflets across C&M and wider to understand the work they have done regarding zero-tolerance approach to abuse and discrimination in patient leaflets.
		Add in zero-tolerance approach to abuse and discrimination to use on Trust website and leaflets going forwards.
		Create a process for reviewing leaflets for services that transfer into MWL in the future (i.e. community following the West Lancs tender).
	Workforce Policies - Work in collaboration with HR Operations, Staff Side and Leaders to review our existing workforce policies and procedures to ensure that they are robust in the delivery of zero tolerance regarding abuse, discrimination, violence, harassment and unacceptable behaviours.	**Review the existing core workforce policies** (disciplinary, grievance, capability, respect & dignity at work and sexual misconduct) to understand their scope in relation to addressing abuse, discrimination, violence, harassment and / or unacceptable behaviours.
		Make changes to the core policies to ensure there is detailed reference to MWL Values & Behaviours and zero tolerance regarding abuse, discrimination, violence, harassment and unacceptable behaviours.
		Undertake a gap analysis to understand whether there is a need for an Anti-Racism Policy following the amendment to policies and the launch of the Trust's Zero Tolerance Campaign.
	Creating an Inclusive Community - EDI Governance and Staff Voice - To launch a revised EDI Governance Framework which provides focus, scrutiny and an opportunity for Senior Leaders to work collaboratively with the Trust's Staff Networks on creating meaningful change for our staff.	**Launch an EDI Council** for MWL which brings together all equality, diversity and inclusion work for both staff and patients into one focussed meeting.
		Re-launch our Building a Multi-cultural Environment Network – with agreed protected time each month for chairs to build and strengthen the networks and an allocated budget to support engagement.
		Network chair to attend the Trust Steering Groups on Anti-Racism, to support the delivery of actionable projects to support the experience of staff within the Trust.
Growing for the future: We will embrace new ways of working and create opportunities to enable our people to achieve their potential	**EDI Leaders Development -** Develop the knowledge, skills and confidence of EDI network and governance leaders to effectively influence organisational priorities and drive inclusion.	**To create and deliver a development programme** for our network and steering group chairs and executive sponsors that supports them with the necessary skills knowledge and experiences to contribute effectively to the agenda and organisational priorities.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	**28 October 2026**
Agenda Item	**TB26/080 (8.2)**				
Report Title	Workforce Disability Equality Standard 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

This report provides an overview and analysis of the Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) Workforce Disability Equality Standard (WDES) for 2025-2026 (March 2026).

Executive Summary

Summary: The following is an overview of the WDES highlights for 2025-2026.

Overall, the proportion of known disabled staff continues to increase across all staff groups, and most grades. Staff Survey results show that overall disabled staff are less satisfied than non-disabled staff across all questions, although the majority report being provided with workplace reasonable adjustments.

Overall, key metrics from the WDES assessment are:

Workforce data metrics:

- An increase in the proportion of total disabled staff reported to 7.5%; Non-Clinical staff to 9.7%; Clinical Non-Medical staff to 7.1%; and an increase in Clinical Medical & Dental staff to 3.0%.
- An increase in the proportion of Non-Clinical Disabled staff on all bands excluding 8d, 9 & VSM.
- An increase in the proportion of Clinical Non-Medical disabled staff on bands, excluding 8b, 8c, 9 & VSM
- An increase in the proportion of Clinical Medical & Dental disabled staff on all grades.
- Disabled applicants are less likely to be appointed than non-disabled applicants. The likelihood of disabled staff being appointed improved compared to previous year.
- Disabled staff are more likely than non-disabled staff to enter a formal capability process.
- There are no known disabled individuals on the Trust Board.

Staff Survey data

- 25.1% of disabled staff reported experiencing harassment from patients et al, compared to 17.9% of Non-Disabled staff.
- 13.1% of disabled staff reported experiencing harassment from a manager, compared to 6.4% of Non-Disabled staff.

- 21.1% of disabled staff reported experiencing harassment from colleagues, compared to 12.7% of Non-Disabled staff.
- Disabled staff were marginally less likely than Non-Disabled staff to report harassment if they had experienced it.
- 48.8% of disabled staff believe the Trust provides equality in career progression, compared to 59.2% of Non-Disabled staff.
- 26.7% of disabled staff reported feeling pressured to come to work when ill, significantly higher than non-disabled staff at 17.7%.
- 32.0% of disabled staff reported feeling that the trust valued their work, compared to 45.2% of non-disabled staff.
- 74.8% of disabled staff that require workplace adjustments reported being provided with them.

Financial Implications

None

Quality and/or Equality Impact

This report is a regulatory requirement under the NHS Contract. It forms part of the Trust's work to promote disability equality in line with the Equality Act 2010.

Recommendations

The Trust Board is asked to:

1. Note the Workforce Disability Equality Standard Report 2025-2026.
2. Approve the Workforce Disability Equality Standard Action Plan 2026-2027.

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

Mersey and West Lancashire Teaching Hospitals NHS Trust

Workforce Disability Equality Standard Report

April 2025 – March 2026

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1. Executive Summary

This report provides the Trust Board with the Annual Workforce Disability Equality Standard (WDES) data for the Mersey & West Lancashire Teaching Hospitals Trust. The publication of this report is for the period 2025-2026 in line with the NHS Standard Contract requirements to publish the WDES indicators.

2. Introduction

NHS England introduced the Workforce Disability Equality Standard (WDES) in 2019. The WDES exists to highlight any differences between the experiences and treatment of disabled staff and non-disabled staff in the NHS and places an onus on NHS organisations to develop and implement actions to bring about continuous improvements. The main purpose of the WDES is:

- to help NHS organisations to review performance on disability equality, based on the ten WDES indicators.
- to produce action plans to close any gaps in workplace experience between disabled and non-disabled staff.
- to improve the disabled representation at the Board level of the organisation.

3. A year in review: 2025-2026

The Trust has worked to implement disability inclusion actions agreed within the 2025 WDES report, as well as the MWL People Strategy 2025-28, activity to support the implementation of the NHS EDI High Impact Actions[1] (HIA), the Equality Delivery System[2] (EDS) and our work as a Disability Confident Leader[3].

Key actions that have been achieved between 1st April 2025 - 31st March 2026 include:

- **EDI SMART Training Objective (HIA1):** In 2025 we introduced a personal EDI Training and Development Objective into all AfC Appraisal Forms which was completed by 56% of staff.

- **Active Bystander Training:** piloted in 2025 by Freedom to Speak Up to develop staff members confidence to safely de-escalate and respond to incivility, this course has been rolled out across the Trust with approximately 144 staff members having now completed the training.

- **Disability Reasonable Adjustments Campaign** – All members of staff who have disclosed a disability in ESR were contacted as part of a targeted awareness campaign to promote the reasonable adjustments policy and passport.

[1] NHS EDI Improvement Plan High Impact Actions
[2] NHS Equality Delivery System
[3] Disability Confident

- **Disability Advice Service**: The EDI (Workforce) team have provided information and advice on workplace reasonable adjustments to staff, managers, OH and HR Business Partners. This value-added service is helping to increase disability disclosure and ensure staff are provided with reasonable adjustments and completed passports.

- **Disability Pay Gap (HIA3)**: The Trust published the 2025 Disability Pay Gap in March 2026. Overall, the Disability Pay Gaps are in favour of Non-Disabled staff.

- **Widening Recruitment (HIA4):** The Trust hosted its first 'Ways to Work' placement with St Helens Council/College.

- **Cultural Awareness**: The Trust has worked to raise awareness of disability equality topics by engaging in events including Disability History Month, Neurodiversity Week, Carers Week, and Menopause Awareness Week.

4. The 10 WDES indicators

The WDES is an analysis of the following 10 data indicators, relating to workforce, recruitment, capability, staff satisfaction, and board diversity:

1. **Staff Population**: Percentage of Disabled/Non-Disabled staff who are Non-Clinical, Clinical Non-Medical, and Clinical Medical by Agenda for Change (AfC) pay bands or grade codes.
2. **Recruitment & Selection**: Relative likelihood of staff being appointed from shortlisting across all posts.
3. **Capability**: Relative likelihood of staff entering the formal capability process, as measured by entry into a capability process.
4. **Harassment**: Percentage of staff experiencing harassment, bullying or abuse from patients et al, managers, colleagues
5. **Equality in Career Progression**: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
6. **Presenteeism**: Percentage of staff stating that they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties
7. **Being valued**: Percentage of staff reporting that they are satisfied with the extent to which their organisation values their work.
8. **Reasonable Adjustments**: Percentage of staff reporting that reasonable adjustments have been provided.
9. **Disabled staff voice**: activities to engage disabled staff and facilitate staff voice
10. **Board Representation**: Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board; By executive membership of the Board.

4.1. Data and Methodology

Before reading the report, please familiarise yourself with the following information which provides a summary of the data sources and limitations. The time periods for the data sets are as follows:

- **Indicators 1 and 10**: snapshot date of the 31st March,
- **Indicators 2-3**: period from the 1st April to 31st March,
- **Indicators 4-9:** the relevant staff survey that took place between the 1st April to 31st March, usually in the November/December.

The Trust collates data for Indicators 1-3 and 10 directly from the Employee Staff Record (ESR), the TRAC recruitment system and HR Business Partners to create a final data set.

Benchmarking data has been sourced from the national staff survey website and Trust Staff Survey data[4] (2021-2026), Model Health system[5] (2020-2026). Where 2026 data is not available, 2025 data has been provided.

4.1.1. MWL Trended Data

The previous years reports were provided for both legacy Trusts. Where it has been possible to do so, data from the legacy trusts has been combined to create a MWL data set for previous years. Where this has not been possible the legacy data has been provided.

4.1.2. Scope of reported population

The following data principles are applied to the WDES data:

- Data relates to the total substantive workforce on the relevant snapshot date with the exception of Indicator 1 which disaggregates the data by Non-Clinical, Clinical Non-Medical and Clinical-Medical, and by Pay Band.
- Medical staff are included, but Lead Employer Resident Doctors are excluded.
- WDES data is only reported on the broad categories of Disabled, this being where ESR has a disability flag; No Disability, this being where ESR has No Known Disability flag; and Unknown, where ESR has a blank, unknown or decline flag.

The WDES submission does not provide an in-depth analysis of the different demographics of the NHS workforce or the different source population and talent pipelines that make up the career groups.

4.1.3. Note on Benchmarking data

Workforce Data: Workforce data including population levels, disparity ratios, recruitment, disciplinary and board data has been sourced from either the National WDES data set (available on the NHS WDES website), or from the Model Health data warehouse. For a number of these data sets, the results are provided at institution level only with national comparators provided e.g. Cheshire & Mersey ICB.

[4] NHS Staff Survey
[5] Model Health System (log in required)

Staff Survey Data: All staff survey benchmarking data has been source from the National Staff Survey Dashboard.

4.1.4. Note on terminology

In data derived from ESR and HR processes, the term Disability is a reference to an employee that has disclosed and been recorded in ESR as having a disability (Yes), which is taken to mean "a physical or mental impairment, which has a substantial, adverse effect, on a person's ability to carry out normal day-to-day activities" (Equality Act 2010).

In data derived from the Staff Survey, the term Disability is a reference to respondents who stated YES to the question "Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?".

5. WDES Indicators

5.1. Staff Profile Workforce Overview

In the snapshot date of 31st March 2026, Mersey & West Lancashire Teaching Hospitals Trust (MWL) employed 11,116 staff which consisted of:

- 7.5% Known Disability,
- 85.1% No Known Disability,
- 7.4% Not Stated/ unspecified / prefer not to answer.

Over the past 5 years (2022 v 2026) (Figure 1), MWL has seen a year-on-year increase in the total number and in the proportion (%) of known disabled staff in the total workforce. From March 2025 to March 2026 the number and proportion of known disabled staff increased from 733/6.7% to 830/7.5% (Total), 266/8.7% to 291/9.7% (Non-Clinical), 442/6.3% to 509/7.1% (Clinical Non-Medical) and a small increase in the Clinical Medical & Dental (M&D) 25/2.6% to 30/3.0% (Table 1).

Further details for each category are set out below.

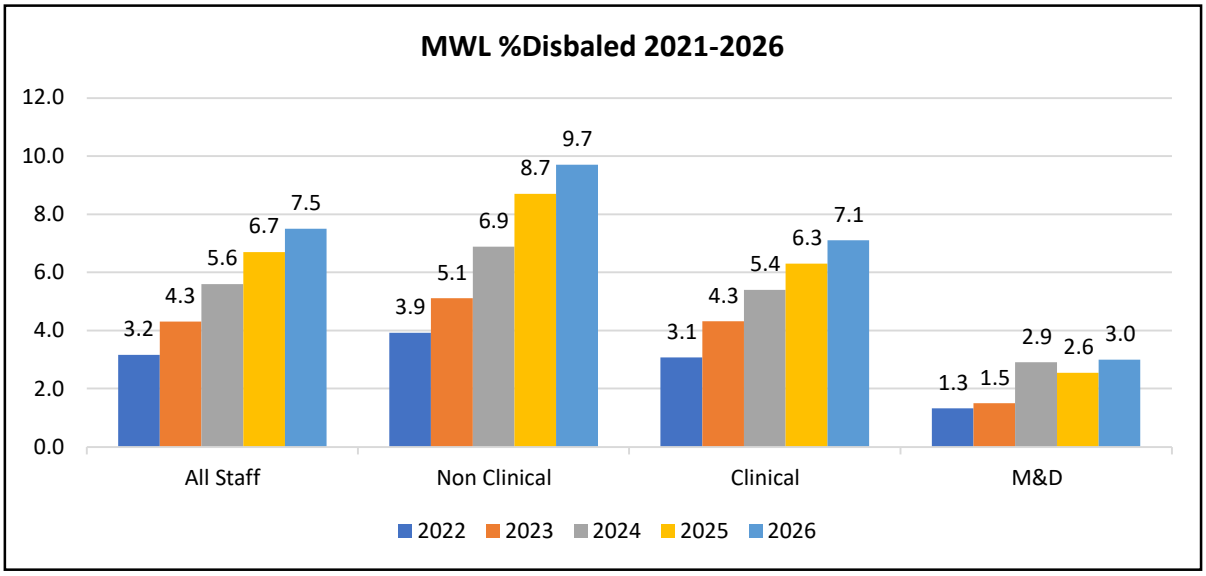


Figure 1

Table 1: 5-year trend and benchmarking

	2022	2023	2024	2025	2026
% MWL	3.2%	4.3%	5.6%	6.7%	7.5%
% National	4.2%	4.9%	5.7%	6.7%	-
% North West	4.2%	4.9%	5.7%	6.2%	-
% C&M ICB	3.8%	4.7%	5.7%	6.8%	-
% Acute	3.8%	4.7%	5.7%	5.6%	-

5.2. Indicator 1: Workforce Staff Data

Indicator 1 is a review of the staff population by Non-Clinical by Agenda for Change (AfC) pay bands; Clinical Non-Medical by AfC pay bands; and Clinical Medical & Dental.

From March 2025 to March 2026, there was an increase in the number and proportion of known disabled staff (Table 2) as follows:

- The total workforce from 733 (6.7%) to 830 (7.5%),
- Non-Clinical staff from 266 (8.7%) to 291 (9.7%),
- Clinical Non-Medical roles from 442 (6.3%) to 509 (7.1%),
- Clinical Medical & Dental roles from 25 (2.6%) to 30 (3.0%),

Overall, the local populations (Table 3) are far more likely to report having a disability and long-term medical condition than the Trusts workforce, both for the total population and the working age population.

Table 2: % Disabled by Staff Group

Staff Headcount March 2026	Dis	No Dis	Unk	% Dis	% Dis National (2025)
Total Workforce	830	9464	822	7.5%	6.7%
Non-Clinical AfC Workforce	291	2431	264	9.7%	8.0%
Clinical AfC Workforce	509	6135	482	7.1%	6.7%
Medical and Dental Workforce	30	898	76	3.0%	2.7%

Table 3: Census Population Benchmarks

Benchmarks %Disabled	Total Population (16+)	Working Age Population (16-64)
MWL Total (2026)	7.5%	
National (2025)	6.7%	
Acute (2025)*	5.6%	
North West (2025)	6.8%	
C&M ICB (2025)	6.7%	
National Census: Sefton	20.6%	18.8%
National Census: St Helens	22.1%	19.9%
National Census: Knowsley	23.7%	20.8%
National Census: West Lancashire	18.7%	16.3%
National Census: C&M ICB Area	20.5%	18.1%
National Census: Liverpool City Region	20.7%	19.9%

NB: An asterisk (*) indicates that the figure has been calculated from a group of percentages or fractions, and not from original data. Therefore caution must be used when comparing with these figures.

5.2.1. Indicator 1a: Non-Clinical workforce

The Non-Clinical workforce includes staff in administration, clerical and estates type of roles. Key observations

- The total number of Disabled Non-Clinical staff increased from 266 (8.7%) to 291 (9.7%), with an increase in the number and proportion of Disabled staff on bands 2 -5, 7, 8a (Table 4).
- There were no known disabled staff on Band 9 or VSM.
- A larger proportion of Band 1, 3, 4, 6, 7, and 8d staff are known to have a disability compared to the Non-Clinical average.
- Compared to 2025 Benchmarking data, in 2026 the Trust had a larger proportion of Non-Clinical disabled staff than nationally(Table 5), and a larger proportion of known disabled staff across all pay band groupings (Table 6).

Table 4: % Disabled Non-Clinical Workforce

	2025 MWL		2026 MWL	
	% Disabled	% No Dis	% Disabled	% No Dis
Band 1	10.6%	59.6%	11.4%	59.1%
Band 2	8.2%	76.4%	9.1%	77.8%
Band 3	10.1%	82.3%	10.4%	82.8%
Band 4	8.8%	83.0%	10.2%	82.1%
Band 5	5.2%	88.4%	7.6%	83.5%
Band 6	11.6%	82.2%	12.2%	81.0%
Band 7	10.7%	82.7%	12.4%	87.8%
Band 8A	5.4%	90.5%	8.1%	84.2%
Band 8B	7.8%	85.7%	9.2%	87.1%
Band 8C	9.7%	87.1%	9.7%	80.0%
Band 8D	14.3%	78.6%	13.3%	91.7%
Band 9	0.0%	90.9%	0.0%	88.9%
VSM	0.0%	92.3%	0.0%	90.9%
Band 1-4	9.0%	79.6%	9.8%	80.1%
Band 5-7	8.5%	85.0%	10.1%	84.7%
Band 8A-8	6.6%	88.1%	8.7%	86.0%
Band 8C-VSM	7.2%	87.0%	7.5%	86.6%
Total	8.7%	81.2%	9.7%	81.4%

Table 5: % Disabled Non-Clinical Workforce National Comparators

	MWL 2026	National 2025	North West 2025	C&M ICB 2025
Band 1-4	9.8%	8.0%	7.7%	7.6%
Band 5-7	10.1%	8.3%	8.2%	8.3%
Band 8A-8	8.7%	7.7%	7.1%	6.1%
Band 8C-VSM	7.5%	6.1%	6.2%	5.8%
Total	9.7%	8.0%	7.7%	7.6%

5.2.1.1. Disability Disparity Ratio Non-Clinical Staff

A disability disparity ratio is used to measure whether Disabled staff are progressing through the organisation at the same rate as Non Disabled staff. It focuses on representation across band groupings rather than simply comparing percentages at individual bands. These band groupings are:

- Support (band 1-4) v Middle (band 5-7)
- Middle (band 5-7) v Senior (band 8a/8b),
- Senior (band 8a/8b) v VSM (band 8c, 9, VSM)
- Support (band 1-4) v VSM (band 8c, 9, VSM)

A ratio value of 1 means that there is no difference, a ratio of <1 means Disabled staff are more represented in the higher bands, and a ratio of >1 means that Non-Disabled staff are more represented in the higher bands.

The non-clinical disability disparity data presents a generally positive picture of career progression for disabled staff across the Trust. In 2026, disabled staff remained proportionately represented, or over-represented, at most levels of the non-clinical workforce when compared with non-disabled staff. The Trust continues to perform above national benchmarks for progression from middle to senior grades (Bands 5-7 to 8A/8B) and across the overall pipeline from support roles to Very Senior Manager (VSM) level.

Whilst disabled staff continue to progress through the workforce, the data indicates that representation becomes less consistent at the most senior leadership levels. Although the Senior to VSM ratio improved in 2026 following a decline in 2025, it remains below the national benchmark.

Table 6: Non-Clinical Disability Disparity

	MWL			National
	2024	2025	2026	2025
Support to Middle (1-4 to 5-7)	1.16	1.13	1.03	1.00
Middle to Senior (5-7 to 8A/8B)	1.48	1.33	1.19	1.08
Senior to VSM (8A-8B to 8C/VSM)	1.04	0.90	1.17	1.27
Support to VSM (1-4 to VSM)	1.80	1.36	1.43	1.37

5.2.2. Indicator 1b: Clinical workforce: Non-Medical

The Clinical Non-Medical workforce includes all allied health professionals, nursing and midwifery staff and relevant support staff. Key observations:

- The total number of Disabled Clinical Non-Medical staff increased from 442 (6.3%) to 509 (7.1%), with an increase in the number and proportion of disabled staff on bands 3-8a (Table 7).
- There were no known disabled staff on Bands 8c, 9 and VSM.
- Compared to 2025 Benchmarking data, in 2026 the Trust had a larger proportion of Clinical Non-Medical disabled staff compared to the national average (Table 8) and a larger proportion of known disabled staff across pay band groupings 1-4 and 5-7 (Table 9).;

Table 7: % Disabled Clinical Non-Medical Workforce

	2025 MWL		2026 MWL	
	% Disabled	% No Dis	% Disabled	% No Dis
Band 1	0.0%	0.0%	0.0%	0.0%
Band 2	6.2%	85.8%	6.7%	86.2%
Band 3	6.2%	83.7%	7.3%	84.8%
Band 4	7.0%	83.7%	7.9%	83.5
Band 5	6.6%	87.7%	7.3%	87.9
Band 6	7.6%	84.1%	8.3%	84.0%
Band 7	5.2%	86.0%	6.4%	86.4
Band 8A	4.0%	89.3%	4.4%	89.8%
Band 8B	4.8%	77.4%	3.3%	78.3%
Band 8C	0.0%	95.0%	0.0%	95.7%
Band 8D	0.0%	100.0%	12.5%	87.5%
Band 9	0.0%	100.0%	0.0%	100.0%
VSM	0.0%	0.0%	0.0%	100.0%
Total	6.3%	85.9%	7.1%	86.1%

Table 8: % Disabled Clinical Non-Medical Workforce National Comparators

	MWL 2026	National 2025	North West 2025	C&M ICB 2025
Band 1-4	7.2%	6.9%	6.9%	6.7%
Band 5-7	7.4%	6.8%	7.0%	7.0%
Band 8A-8	4.3%	6.1%	6.0%	5.3%
Band 8C-VSM	3.1%	4.8%	3.2%	3.3%
Total	7.1%	6.7%	6.9%	6.8%

5.2.2.1. Disability Disparity Ratio Clinical Non-Medical Staff

The Clinical Non-Medical Disability Disparity Ratios provide strong evidence that disabled staff are progressing successfully through the clinical non-medical workforce and into senior leadership roles. In 2026, the Trust outperformed national benchmarks across all reported career transition points.

The strongest performance is seen in progression from Bands 5-7 to Bands 8A/8B, where the disparity ratio increased from 1.58 in 2024 to 1.78 in 2026, significantly above the national benchmark of 1.12.

The ratio from Bands 8A/8B to Bands 8C/VSM was 1.45, exceeding the national figure of 1.26, whilst the overall progression pathway from Bands 1-4 to VSM recorded a ratio of 2.52, substantially higher than the national benchmark of 1.43.

Overall, these findings suggest there are no significant workforce barriers to progression for disabled staff within the clinical non-medical workforce and that representation at senior grades compares favourably with national performance. See Table 9.

Table 9: Clinical Non-Medical Disability Disparity

	MWL			National
	2024	2025	2026	2025
Support to Middle (1-4 to 5-7)	1.03	0.97	0.98	1.01
Middle to Senior (5-7 to 8A/8B)	1.58	1.62	1.78	1.12
Senior to VSM (8A-8B to 8C/VSM)	-	-	1.45	1.26
Support to VSM (1-4 to VSM)	-	-	2.52	1.43

5.2.3. Disparity Ratio Limitations

The interpretation of Clinical Non-Medical Disability Disparity Ratios should be considered alongside recent improvements in disability disclosure rates. Increased disability declarations across clinical grades, particularly within senior leadership bands, have had a material impact on the reported ratios.

The Clinical Non-Medical disability disclosure rate increased from 5.4% in 2024 to 7.1% in 2026, including on most pay bands. The presence of disabled staff at Band 8C+ in 2026 has enabled more robust reporting and contributed to stronger disparity ratios. As disclosure rates change, the composition of the workforce changes and this can influence disparity ratios independently of actual promotion/progression activity.

5.2.4. Indicator 1c: Clinical workforce: Medical & Dental

The Clinical Medical & Dental workforce includes all staff on a medical and dental terms and conditions and includes Foundation and Specialist Doctors and Consultants. Key observations:

- The proportion of Clinical Medical & Dental staff has increased from 2.6% to 3.0%, total headcount has increased from 25 to 30 (Table 10, 11).

- By career stage, trainee doctors are far more likely to have disclosed a disability (4.0%) compared to Consultants (2.4%).
- Compared to the known population of disabled people in the 1) population, and 2) workforce, there remains significant underreporting of a disability by medics.
- Compared to 2025 Benchmarking data, in 2025 and 2026 the Trust had a larger proportion of disabled staff on Trainee and Consultant roles (Table 11).

Table 10: % Disabled Clinical Medical & Dental Workforce and National Comparators

	MWL 2024	MWL 2025	MWL 2026	National 2025	North West 2025	C&M ICB 2025
Consultants	1.5%	2.3%	2.4%	2.2%	2.8%	4.8%
Non-consultant	3.4%	2.0%	2.7%	2.7%	2.0%	2.2%
Trainees	4.7%	3.2%	4.0%	3.2%	2.2%	1.7%
Total	2.9%	2.6%	3.00%	2.7%	2.3%	2.4%

5.3. Indicator 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Indicator 2 assesses whether disabled applicants are as likely as non-disabled applicants to be successfully appointed following shortlisting and therefore provides an indication of the fairness and inclusivity of the Trust's recruitment and selection processes. This measure is calculated at whole organisation level and does not identify variations by staff group, pay band, profession, directorate or department.

Overall disabled staff are slightly less likely to be appointed from interview, at 1.13. Nationally, disabled applicants are slightly more likely to be appointed at 0.95 (2025), and in the North West slightly less likely at 1.05 (2025). See Tables 10, 11.

Table 7: Relative likelihood of being appointed from interview

MWL	Disabled	No Disability	Unknown
2023-2024	28.9%	31.5%	69.3%
2024-2025	26.1%	32.5%	53.2%
2025-2026	23.3%	26.2%	43.8%

Table 8: Relative likelihood of a non-Disabled staff being appointed from shortlisting compared to disabled staff

	MWL	National	Northwest	C&M ICB
2023-2024	1.09	0.98	1.08	1.17
2024-2025	1.24	0.95	1.05	1.11
2025-2026	1.13	-	-	-

A value <1 means that Ethnic Minority applicants are more likely to be appointed, and value >1 means they are less likely to be appointed. For example, a value of "2.0" would indicate that White candidates were twice as likely as Ethnic Minority candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as Ethnic Minority candidates to be appointed from shortlisting.

5.4. Indicator 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Indicator 3 is an assessment of whether disabled staff are more likely to be subject to formal capability processes compared to non-disabled staff for non-health related reasons. The data used for this indicated is the average number of cases over a 2-year period e.g. 2023/24 + 2024/25 average, and 2024/25 + 2025/26 average.

For 2025-2026 period, the relative likelihood increased substantially from 0.58 to 2.85, meaning disabled staff were almost three times more likely than non-disabled staff to enter the formal capability process. *Due to small population sizes, benchmarking data is not published.* See Table 12.

Table 9: Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff

	MWL
2022/23 + 2023/24	0.00
2023/24 + 2024/25	0.58
2024/25 + 2025/26	2.85

A figure above 1.00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.

However, given the relatively small numbers involved, this indicator can be highly sensitive to changes involving only a few individuals. The increase from an average of three disabled staff (2024-2025) entering the process to 5.5 individuals (2025-2026) has resulted in a significant change in the relative likelihood ratio. As such, caution should be exercised when interpreting year-on-year movements.

It is important to note that disability declaration rates increased significantly over the reporting period, from 601 employees (5.6% of the workforce) in 2024 to 830 employees (7.5% of the workforce) in 2026. This increase has expanded the pool of staff identified as disabled within workforce systems and is therefore likely to have contributed to an increased number of disabled staff being captured within formal capability processes.

6. Staff Survey Questions

The 2025 NHS Staff Survey was conducted between October and November 2025 and completed by 3,835 staff (35.34% response rate), of which 1115 (29.1%) stated that they had a long term medical condition or disability (aka disabled staff).

For the purposes of this report, the 2025 staff survey results have been sourced from the National Staff Survey Dashboard. See Tables 13-21.

6.1. Indicator 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public (Staff Survey, Q14a)

Table 10: Harassment by Patients et al

		2022	2023	2024	2025	Change
MWL	Disabled	33.7%	26.5%	24.2%	25.1%	+0.9
	No Dis	24.6%	20.0%	18.3%	17.9%	-0.4
	All	26.9%	23.6%	21.5%	21.9%	+0.4
National	Disabled	33.1%	33.0%	29.5%	29.7%	+0.2
	No Dis	25.9%	23.3%	23.3%	23.4%	+0.1
	All	27.8%	25.3%	25.1%	25.3%	+0.2
North West	Disabled	31.0%	27.6%	27.3%	27.6%	+0.1
	No Dis	22.9%	20.4%	20.6%	20.7%	+0.1
	All	24.9%	22.3%	22.5%	22.7%	+0.2
C&M ICB	Disabled	30.9%	26.4%	25.2%	25.3%	+0.1
	No Dis	22.8%	19.2%	18.4%	18.5%	+0.1
	All	24.9%	21.2%	20.3%	20.5%	+0.2
Acute & Community	Disabled	32.9%	29.6%	29.2%	29.2%	-
	No Dis	26.0%	23.3%	23.3%	23.4%	+0.1
	All	28.0%	25.2%	25.0%	25.0%	-

MWL continues to perform better than national, regional, ICB and sector benchmarks for harassment, bullying and abuse from patients and the public. There has been significant improvement since 2022, particularly for disabled staff. However, the slight increase in reports among disabled staff in 2025 and the widening disability gap indicate that challenges remain. See Table 13.

Specifically:

- 25.1% of disabled staff reported experiencing harassment from patients et al, compared with 17.9% of non-disabled staff.
- This represents a 7.2 percentage point disparity between disabled and non-disabled staff, indicating disabled colleagues remain significantly more likely to experience negative behaviours from the public.
- While the disabled staff figure increased slightly from 24.2% to 25.1% (+0.9 percentage points) in 2025, it remains substantially below both the national average (29.7%) and the Acute & Community sector average (29.2%).

- MWL reports the lowest rate across all comparator groups being 4.6 percentage points better than the national average, 4.1 percentage points better than the Acute & Community average, 2.5 percentage points better than the North West average, and performance is broadly aligned with the Cheshire & Merseyside ICB average
- Since 2022 the disability gap narrowed year on year, however, the gap widened again in 2025 due to a rise in reports from disabled staff while rates for non-disabled staff continued to fall.

6.2. Indicator 4b: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers (Staff Survey, Q14b)

Table 11: Harassment by Managers

		2022	2023	2024	2025	Change
MWL	Disabled	13.4%	11.4%	11.9%	13.1%	+1.2
	No Dis	7.9%	6.5%	6.4%	6.4%	-
	All	9.3%	8.0%	8.1%	8.6%	+0.5
National	Disabled	16.4%	14.6%	14.1%	13.6%	-0.5
	No Dis	9.4%	8.3%	7.8%	7.4%	-0.4
	All	11.1%	9.9%	9.5%	9.1%	-0.4
North West	Disabled	15.8%	14.0%	13.4%	13.0%	-0.4
	No Dis	8.8%	7.2%	6.9%	7.0%	+0.1
	All	10.6%	9.1%	8.7%	8.7%	-
C&M ICB	Disabled	14.7%	13.6%	13.0%	12.4%	-0.6
	No Dis	8.5%	7.2%	6.6%	6.7%	+0.1
	All	10.1%	8.9%	8.4%	8.4%	-
Acute & Community	Disabled	17.4%	15.2%	14.7%	14.2%	-0.5
	No Dis	9.9%	8.7%	8.1%	7.7%	-0.4
	All	11.7%	10.4%	9.8%	9.4%	-0.4

MWL continues to perform favourably against national and sector benchmarks for harassment, bullying and abuse from managers, particularly among non-disabled staff. However, there was an increase in negative experiences reported by disabled staff in 2025. While comparator organisations have generally continued to improve, MWL has seen a reversal of progress, resulting in the widest disability gap observed since 2022. See Table 14.

Specifically:

- 13.1% of disabled staff reported experiencing harassment from managers, compared with 6.4% of non-disabled staff.
- This represents a 6.7 percentage point disparity between disabled and non-disabled staff, highlighting a continued inequality in experience.
- The disabled staff figure increased from 11.9% in 2024 to 13.1% in 2025 (+1.2 percentage points), while the non-disabled staff figure remained unchanged at 6.4%.
- The increase among disabled staff contrasts with the improving trend seen nationally and across comparator organisations.

- MWL remains slightly better than both the national and Acute & Community averages, with performance broadly in line with the North West average, but now performing slightly worse than the Cheshire & Merseyside ICB average.

6.3. Indicator 4c: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Colleagues (Staff Survey, Q14c)

Table 12: Harassment by Colleagues

		2022	2023	2024	2025	Change
MWL	Disabled	23.6%	20.5%	21.2%	21.1%	-0.1
	No Dis	14.8%	12.2%	11.6%	12.7%	+1.1
	All	17.0%	15.0%	14.7%	15.9%	+1.2
National	Disabled	25.1%	23.8%	23.6%	22.9%	-0.7
	No Dis	16.6%	15.4%	15.3%	14.8%	-0.5
	All	18.7%	17.7%	17.6%	17.1%	-0.5
North West	Disabled	23.8%	22.2%	21.9%	21.1%	-0.8
	No Dis	15.2%	13.5%	13.5%	13.2%	-0.3
	All	17.4%	15.9%	15.8%	15.5%	-0.3
C&M ICB	Disabled	22.7%	21.7%	20.9%	20.3%	-0.6
	No Dis	14.9%	12.8%	12.5%	12.1%	-0.4
	All	17.0%	15.2%	14.9%	14.5%	-0.4
Acute & Community	Disabled	27.0%	25.5%	25.3%	24.5%	-0.8
	No Dis	17.9%	16.5%	16.3%	15.7%	+0.6
	All	20.0%	18.8%	18.6%	18.0%	-0.6

MWL continues to perform better than national and Acute & Community benchmarks for harassment, bullying and abuse from colleagues and remains broadly aligned with regional performance. However, the 2025 results show a deterioration in overall staff experience driven by increased reports from non-disabled staff, while experiences of disabled staff remain largely unchanged at a relatively high level. Although the disability gap has narrowed slightly, this reflects worsening outcomes for non-disabled staff rather than improved experiences for disabled colleagues. See Table 15.

Specifically:

- 21.1% of disabled staff reported experiencing harassment from colleagues, compared with 12.7% of non-disabled staff.
- This represents an 8.4 percentage point disparity, indicating disabled staff remain substantially more likely to experience negative behaviours from colleagues than their non-disabled peers.
- The rate for disabled staff remained largely unchanged in 2025 (21.2% to 21.1%), while the rate for non-disabled staff increased from 11.6% to 12.7% (+1.1 percentage points).
- As a result, the overall staff figure increased from 14.7% to 15.9% (+1.2 percentage points), reversing some of the progress achieved in previous years.
- MWL performs better than both the national and Acute & Community averages, with performance identical to the North West average, and slightly above the Cheshire & Merseyside ICB average

6.4. Indicator 4d: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it (Staff Survey, Q14d)

Table 13: Reporting Harassment

		2022	2023	2024	2025	Change
MWL	Disabled	52.3%	49.3%	52.0%	53.4%	+1.4
	No Dis	48.8%	51.9%	49.4%	54.1%	+4.7
	All	49.8%	50.8%	50.2%	54.6%	+4.4
National	Disabled	51.0%	52.5%	54.4%	54.9%	+0.5
	No Dis	49.2%	51.4%	53.8%	54.9%	+1.1
	All	49.9%	51.8%	54.0%	54.9%	+0.9
North West	Disabled	51.9%	53.3%	55.0%	55.6%	+0.6
	No Dis	49.7%	51.5%	53.9%	55.2%	+1.3
	All	50.4%	52.2%	54.4%	55.4%	+1.0
C&M ICB	Disabled	54.3%	52.9%	56.1%	57.5%	+1.4
	No Dis	51.4%	52.3%	53.9%	55.4%	+1.5
	All	52.3%	52.6%	54.8%	56.3%	+1.5
Acute & Community	Disabled	48.5%	50.5%	52.3%	52.9%	+0.6
	No Dis	46.9%	49.3%	51.5%	52.7%	+1.2
	All	47.6%	49.8%	51.8%	52.8%	+1.0

MWL has demonstrated a strong improvement in reporting rates during 2025, with the overall figure increasing by 4.4 percentage points. Reporting levels are now broadly in line with national and regional benchmarks, although they remain marginally below the strongest comparator organisations. Encouragingly, there is little difference between disabled and non-disabled staff in relation to reporting incidents, suggesting that confidence in speaking up is relatively equitable across staff groups. See Table 16.

Specifically:

- 53.4% of disabled staff and 54.1% of non-disabled staff said that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
- Reporting rates increased for both groups in 2025, with a particularly notable increase among non-disabled staff (+4.7 percentage points).
- The gap between disabled and non-disabled staff is now minimal (0.7 percentage points), indicating broadly similar levels of confidence in reporting incidents.
- The Trust's overall reporting rate rose from 50.2% to 54.6% (+4.4 percentage points), representing a significant improvement compared with previous years.
- MWL remains slightly below national, regional and ICB averages, and the Trust performs above the Acute & Community benchmark.

6.5. Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion. (Staff Survey, Q15)

Table 14: Career Opportunities

		2022	2023	2024	2025	Change
MWL	Disabled	54.4%	57.7%	52.9%	48.8%	-4.1
	No Dis	61.3%	60.9%	60.2%	59.2%	-1.0
	All	59.5%	59.8%	58.1%	55.6%	-2.5
National	Disabled	51.7%	52.2%	51.5%	48.6%	-2.9
	No Dis	57.5%	58.1%	57.7%	55.7%	-2.0
	All	56.0%	56.4%	55.9%	53.7%	-2.2
North West	Disabled				48.1%	
	No Dis				56.0%	
	All				53.7%	
C&M ICB	Disabled	51.4%	51.7%	51.7%	48.9%	-2.8
	No Dis	59.7%	59.5%	60.2%	57.5%	-2.7
	All	57.6%	57.3%	57.8%	54.9%	-2.9
Acute & Community	Disabled	50.9%	51.3%	50.7%	47.7%	-3.0
	No Dis	56.8%	57.4%	57.1%	55.1%	-2.0
	All	53.3%	55.8%	55.4%	53.2%	-2.2

The 2025 results indicate a deterioration in disabled staff perceptions of equal opportunities for career progression and promotion at MWL. While overall performance remains broadly aligned with national, regional and system benchmarks for disabled staff, confidence has fallen sharply since 2023 and fewer than half of disabled colleagues now believe opportunities are equal. In contrast, non-disabled staff continue to report significantly more positive experiences than comparator organisations. Consequently, the disability gap has widened to its highest level since 2022, suggesting that disabled staff are increasingly less likely to perceive career progression opportunities as fair and accessible.

Specifically:

- 48.8% of disabled staff at MWL believe the organisation provides equal opportunities for career progression or promotion, compared with 59.2% of non-disabled staff.
- This represents a 10.4 percentage point gap, indicating a significant difference in perception between disabled and non-disabled staff.
- The widening disparity is driven primarily by declining confidence among disabled staff rather than deterioration among non-disabled staff.
- Both groups reported a decline in 2025, with the largest reduction occurring among disabled staff (-4.1 percentage points compared with -1.0 percentage point for non-disabled staff).
- The decline among disabled staff means fewer than half now believe opportunities for progression are equal.
- MWL remains broadly in line with all comparator organisations, performing marginally above the national, North West and Acute & Community averages, and virtually identical to the Cheshire and Merseyside ICB average.

6.6. Indicator 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism)(Staff Survey, Q11e)

Presenteeism refers to where employees come to work despite being physically or mentally unwell, underperforming due to illness, stress, or other issues that affect their ability to function effectively. Unlike absenteeism, where an employee is absent from work, presenteeism is characterised by being present but not fully productive.

Table 15: Presenteeism

		2022	2023	2024	2025	Change
MWL	Disabled	26.4%	26.2%	25.6%	26.7%	+0.9
	No Dis	18.6%	16.2%	16.3%	17.7%	+1.4
	All	21.2%	19.9%	20.1%	21.8%	+1.7
National	Disabled	28.0%	26.6%	25.4%	25.6%	+0.2
	No Dis	20.1%	18.5%	17.8%	17.5%	-0.3
	All	22.6%	21.3%	20.3%	20.3%	-
North West	Disabled	27.1%	26.1%	24.6%	25.4%	+0.8
	No Dis	19.6%	17.4%	17.3%	17.6%	+0.3
	All	22.1%	20.5%	19.9%	20.4%	+0.5
C&M ICB	Disabled	26.4%	25.5%	24.0%	23.9%	-0.1
	No Dis	18.9%	16.9%	16.6%	17.0%	+0.4
	All	21.4%	20.0%	19.3%	19.6%	+0.3
Acute & Community	Disabled	29.9%	28.3%	27.0%	27.2%	+0.2
	No Dis	21.2%	19.5%	18.6%	18.3%	-0.3
	All	23.8%	22.4%	21.3%	21.2%	-0.1

In 2025, more than one in four disabled colleagues reported feeling pressure from their manager to attend work despite not being well enough to perform their duties. While performance is broadly aligned with external benchmarks for non-disabled staff, MWL performs less favourably than national, regional and ICB comparators for disabled staff. The Trust has seen an increase in overall presenteeism during 2025 and continues to report a substantial disability gap. See Table 18.

Specifically:

- 26.7% of disabled staff reported feeling pressure from their manager to attend work despite not feeling well enough to perform their duties, compared with 17.7% of non-disabled staff.
- This represents a 9.0 percentage point disparity, indicating disabled staff are considerably more likely to experience presenteeism-related pressure.
  Presenteeism increased in 2025 for both groups, rising by 0.9 percentage points for disabled staff and 1.4 percentage points for non-disabled staff.
- The overall Trust figure increased from 20.1% to 21.8% (+1.7 percentage points), reversing the gradual improvements seen since 2022.
- MWL performs worse than the national, regional and Cheshire & Merseyside ICB averages, with reported presenteeism rates 2.8 percentage points higher than the ICB average.

6.7. Indicator 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work (Staff Survey, Q4b)

Table 16: Feeling Valued

		2022	2023	2024	2025	Change
MWL	Disabled	32.9%	37.7%	32.6%	32.0%	-0.6
	No Dis	45.4%	48.0%	47.4%	45.2%	-2.2
	All	42.2%	44.7%	42.9%	41.2%	-1.7
National	Disabled	34.7%	36.9%	36.3%	34.4%	-1.9
	No Dis	44.6%	47.8%	47.4%	46.1%	-1.3
	All	42.1%	44.9%	44.4%	43.0%	-1.4
North West	Disabled	33.9%	36.8%	36.3%	33.3%	-3.0
	No Dis	44.5%	47.7%	47.4%	45.0%	-2.4
	All	41.8%	44.7%	44.4%	41.6%	-2.8
C&M ICB	Disabled	34.3%	36.9%	36.6%	34.4%	-2.2
	No Dis	44.8%	48.2%	48.4%	46.0%	-2.4
	All	42.1%	45.1%	45.1%	42.7%	-2.4
Acute & Community	Disabled	32.4%	34.7%	34.2%	32.3%	-1.9
	No Dis	43.0%	46.5%	46.2%	44.9%	-1.3
	All	40.4%	43.6%	43.2%	41.8%	-1.4

The 2025 results highlight a persistent challenge around staff feeling valued, particularly among disabled colleagues. Only 32.0% of disabled staff report satisfaction with the extent to which the organisation values their work, representing the lowest score among comparator organisations and a substantial 13.2 percentage point gap compared to non-disabled staff. While perceptions among non-disabled staff remain broadly in line with national and regional benchmarks, disabled staff continue to report significantly less positive experiences. See Table 19.

Specifically:

- 32.0% of disabled staff at MWL reported being satisfied that the organisation values their work, compared with 45.2% of non-disabled staff.
- This represents a 13.2 percentage point gap, the largest disability disparity seen across the staff survey indicators.
- Satisfaction levels declined for both groups in 2025, with a larger reduction among non-disabled staff (-2.2 percentage points) than disabled staff (-0.6 percentage points).
- MWL reports the lowest score across all comparator groups for disabled staff, which were 2.4 percentage points below the national average, 2.4 percentage points below the Cheshire and Merseyside ICB average and 1.3 percentage points below the North West average.
- The disparity gap remain consistent, with the reduction between 2024 and 2025 being largely due to declining scores among non-disabled staff rather than meaningful improvement for disabled staff.

6.8. Indicator 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Staff Survey, Q31b)

The reported figures for this question are only based on those staff that stated that they had a long-term medical condition, and that they required workplace reasonable adjustments

Table 17: Reasonable Adjustments

%YES	2022	2023	2024	2025	Change
MWL	71.3%	73.2%	75.8%	74.8%	-1.0
National	72.9%	74.5%	75.0%	74.9%	-0.1
North West	71.3%	73.4%	74.9%	74.9%	-
C&M ICB	71.7%	73.1%	75.6%	75.1%	-0.5
Acute & Community	71.5%	73.0%	73.9%	73.7%	-0.2

Reasonable adjustments remain one of MWL's stronger disability-related staff experience indicators. In 2025, 74.8% of disabled staff requiring workplace adjustments reported that their employer had made adequate arrangements to support them in carrying out their role. Although this represents a small decline from 2024, the Trust has achieved a sustained improvement of 3.5 percentage points since 2022 and remains closely aligned with national, regional and Cheshire and Merseyside benchmarks. See Table 20.

Specifically:

- 74.8% of disabled staff reported that the Trust had made adequate adjustments to enable them to carry out their work, an increase from 71.3% in 2022.
- This represents a slight decrease from 75.8% in 2024 (-1.0 percentage point).
- The Trust remains closely aligned with national, regional and system benchmarks, indicating generally positive performance in this area.
- MWL performs almost identically to national, regional and ICB benchmarks with a difference of only 0.3 the highest-performing comparator (C&M ICB)
- The close alignment across all comparators suggests a consistent level of reasonable adjustment provision across the NHS, with MWL performing broadly in line with expected standards.

When considering these findings, it should be noted that 29.9% of respondents to the NHS Staff Survey reported having a long-term medical condition or disability, compared to an ESR disability declaration rate of 7.5%. This suggests that a substantial proportion of staff may be more willing to disclose a health condition or disability anonymously than through workforce records. The broader wording used within the Staff Survey may also capture staff who do not identify with the formal ESR disability declaration categories. This disparity highlights the importance of interpreting survey findings as representative of a wider group of staff with lived experience of disability and long-term health conditions than is reflected in ESR data alone.

6.9. Indicator 9a: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

The NHS Staff Survey engagement theme is a composite score, standardised to give a value out of 10, with a higher value indicating better performance

It draws from responses to 9 questions across 3 subscales: motivation (I look forward to going to work, I am enthusiastic about my job, time passes quickly when I am working), involvement (there are frequent opportunities for me to show initiative in my role, I am able to make suggestions to improve the work of my team/department, I am able to make improvements happen in my area of work) and advocacy (care of patients/service users is my organisation's top priority, I would recommend my organisation as a place to work, if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation) (questions Q2abc, Q3cdf, Q23acd) (Table 21).

Table 18: Staff Engagement

	MWL		National	
	Disabled	**No Dis**	**Disabled**	**No Dis**
2022	6.9	7.3	6.4	6.9
2023	6.7	7.2	6.5	7.0
2024	6.5	7.1	6.4	7.0
2025	6.4	6.9	6.3	6.9

Staff engagement scores have continued to decline for both disabled and non-disabled staff since 2022. In 2025, disabled staff reported an engagement score of 6.4 compared with 6.9 for non-disabled staff, maintaining a persistent engagement gap. Although MWL performs slightly better than the national average for disabled staff and is aligned with national performance for non-disabled staff, there is a downward trend.

Taken alongside other indicators, particularly declining perceptions of career progression opportunities and feeling valued, the results suggest that disabled staff continue to experience the organisation less positively than their non-disabled colleagues. See Table 21.

Specifically:

- The staff engagement score for disabled staff was 6.4, compared with 6.9 for non-disabled staff at MWL.
- Both groups experienced a decline in engagement since 2022, although the reduction was greater for disabled staff.
- The gap between disabled and non-disabled staff stood at 0.5 points in 2025, indicating lower levels of engagement among disabled colleagues across the organisation.
- Despite the decline, disabled staff at MWL continue to report slightly higher engagement than disabled staff nationally.
- MWL performs marginally better than the national average for disabled staff engagement with engagement among non-disabled staff identical to the national benchmark.

6.10. Indicator 9b: Has your Organisation taken action to facilitate the voices of Disabled staff in your organisation to be heard (yes or no)?

Indicator 9b is an open question asking how the Trust has engaged disabled staff.

The Trust reported doing the following:

- The Trust supports the Building Abilities Network staff network, which is open to disabled staff and allies.
- The Trust approved protected time for the network chair, and funding for network activities.
- A trust wide recruitment process was successfully completed to appoint a new Network chair after a number of years without a dedicated lead.
- A new Disability Inclusion Steering Group has been established which reports into the new EDI Council. The Staff Network has dedicated positions on the steering group to ensure staff voice is heard.
- Sarah O'Brien, the Chief Nurse, is the new Senior Disability Sponsor and will meet quarterly with the staff network chair, along with the chair of the steering group to discuss the experience of disabled staff.

6.11. Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

In March 2025 there were no known disabled members of the Trust's Board (Table 22, 23). This means that there is a 7% difference between the proportion of disabled people on the Board, and the overall workforce.

Table 19: Trust Board Trend

	MWL Disabled	National Disabled
2024	5.6%	6.5%
2025	0.0%	7.3%*
2026	0.0%	-

Table 20: Trust Board 2025/26

	Dis	No Dis	Unknown
Total Board	0.0%	90.0%	10.0%
Of which Voting Board Members	0.0%	83.3%	16.7%
Non-Voting Board Members	0.0%	100%	0.0%
Of which Executive Board Members	0.0%	90.9%	9.1%
Non-Executive Board Members	0.0%	88.9%	11.1%
Difference Total Board v Workforce	**-7**	**+5**	**+3**
Difference Voting Members v Workforce	**-7**	**-2**	**+9**
Difference Exec Members v Workforce	**-7**	**+6**	**+2**

7. Conclusion

Overall, the proportion of known disabled staff at the Trust continues to improve, with the gap between MWL and the national average reducing to 0.1% in 2024 and the Trust increasing to +1% point when comparing MWL 2025 with National 2024 figures. The Medical Workforce however, continues to have low disclosure rates, and this year in fact decreased.

Overall, the WDES indicators show the following:

Workforce data metrics:

- An increase in the proportion of total disabled staff reported to 7.5%; Non-Clinical staff to 9.7%; Clinical Non-Medical staff to 7.1%; and an increase Clinical Medical & Dental staff to 3.0%.
- An increase in the proportion of Non-Clinical Disabled staff on all bands excluding 8d, 9 & VSM.
- An increase in the proportion of Clinical Non-Medical disabled staff on bands, excluding 8b, 8c, 9 & VSM
- An increase in the proportion of Clinical Medical & Dental disabled staff on all grades.
- Disabled applicants are less likely to be appointed than non-disabled applicants. The likelihood of disabled staff being appointed improved compared to previous year.
- Disabled staff are more likely than non-disabled staff to enter a formal capability process.
- There are no known disabled individuals on the Trust Board.

Staff survey data:

- 25.1% of disabled staff reported experiencing harassment from patients et al, compared to 17.9% of Non-Disabled staff.
- 13.1% of disabled staff reported experiencing harassment from a manager, compared to 6.4% of Non-Disabled staff.
- 21.1% of disabled staff reported experiencing harassment from colleagues, compared to 12.7% of Non-Disabled staff.
- Disabled staff were marginally less likely than Non-Disabled staff to report harassment if they had experienced it.
- 48.8% of disabled staff believe the Trust provides equality in career progression, compared to 59.2% of Non-Disabled staff.
- 26.7% of disabled staff reported feeling pressured to come to work when ill, significantly higher than non-disabled staff at 17.7%.
- 32.0% of disabled staff reported feeling that the trust valued their work, compared to 45.2% of non-disabled staff.
- 74.8% of disabled staff that require workplace adjustments reported being provided with them.

8. Action Plan

The Trust has developed a new People Strategy within which Equality, Diversity and Inclusion are embedded. The **key disability related objectives** set out in the People Strategy delivery plan are:

Table 21: Action Plan

People Plan: Theme	2026-27 Delivery Plan Actions	Sub Actions
Looking after our people: We will develop a culture that empowers individuals to lead healthy lives and thrive in work by providing holistic wellbeing support	**Health Inequalities** - To measure and report on health inequalities in our workforce and educate our leaders on the impact of health inequalities.	**Establish a staff health inequalities dashboard** combining workforce and wellbeing data to identify disability disparities and support targeted improvement activity
		Develop and implement integrated workforce health inequalities reporting to identify disparities, monitor trends, and inform targeted interventions.
	Disability Reasonable Adjustments – To scope out proposals to improve the disability reasonable adjustments process for employees and managers	**Updated Reasonable Adjustments Policy** to incorporate lessons learned over the past 3 years.
		Proposals for the future to be developed for consideration by Trust decision makers outlining different reasonable adjustment case management models to address weaknesses within the process.
Belonging in the NHS: We will develop an inclusive culture where everyone's voice is represented and celebrated	**Inclusive Language Guide -** Create an inclusive language guide that can be published across the Trust to support all staff in learning and understanding the impact of language.	**Undertake research across the NHS** to identify existing areas of good practice and inclusive language guides. This will include exploring content, format and impact of resources to ensure they are accessible and usable.
		To develop and implement a comprehensive Inclusive Language Guide that promotes respectful, culturally competent, and person-centred communication across the Trust. Included in this will be a range of resources and formats to ensure the information is accessible, understood, and able to be consistently applied by all staff.
		To engage with a broad range of internal stakeholders as part of the development and delivery process to ensure that we consider the views and feedback of our workforce
	Zero Tolerance - Bring together a focussed group of individuals to understand the issues faced by our staff and to design, develop and launch a Trust-wide Zero Tolerance Campaign	**The Zero Tolerance Working Group** to review the workforce data on all forms of abuse, discrimination, and unacceptable behaviour to understand the areas of concern that need to be addressed.
		The working group will oversee the design and delivery of clear messaging, staff engagement activities, and accessible reporting mechanisms, ensuring that all individuals understand expected standards of behaviour and feel supported to

		raise concerns. The working group will agree a set of metrics for monitoring the success of the campaign.
		Trust will launch the Zero Tolerance Campaign and monitor reporting and feedback to understand the success and, where necessary, take additional actions.
	Patient Information - Work in collaboration with Corporate Nursing colleagues to develop clear, accessible and inclusive patient-facing leaflets and information materials which support the Trust's position on respectful behaviour,	**To develop a robust, long-term, plan in collaboration with Corporate Nursing and Patient Experience colleagues** to review, update, and improve patient-facing leaflets, ensuring clear, accessible, consistent messaging that is aligned with inclusive and Zero Tolerance principles
		Review other Trust leaflets across C&M and wider to understand the work they have done regarding zero-tolerance approach to abuse and discrimination in patient leaflets.
		Add in zero-tolerance approach to abuse and discrimination to use on Trust website and leaflets going forwards.
		Create a process for reviewing leaflets for services that transfer into MWL in the future (i.e. community following the West Lancs tender).
	Workforce Policies - Work in collaboration with HR Operations, Staff Side and Leaders to review our existing workforce policies and procedures to ensure that they are robust in the delivery of zero tolerance regarding abuse, discrimination, violence, harassment and unacceptable behaviours.	**Review the existing core workforce policies** (disciplinary, grievance, capability, respect & dignity at work and sexual misconduct) to understand their scope in relation to addressing abuse, discrimination, violence, harassment and / or unacceptable behaviours.
		Make changes to the core policies to ensure there is detailed reference to MWL Values & Behaviours and zero tolerance regarding abuse, discrimination, violence, harassment and unacceptable behaviours.
	Creating an Inclusive Community - EDI Governance and Staff Voice - 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.	**Launch an EDI Council** for MWL which brings together all equality, diversity and inclusion work for both staff and patients into one focussed meeting.
		Re-launch our Building Abilities Network – with agreed protected time each month for chairs to build and strengthen the networks and an allocated budget to support engagement.
		Network chair to attend the Trust Steering Groups on disability, to support the delivery of actionable projects to support the experience of staff within the Trust.
Growing for the future: We will embrace new ways of working and create opportunities to enable our people to achieve their potential	**EDI Leaders Development -** Develop the knowledge, skills and confidence of EDI network and governance leaders to effectively influence organisational priorities and drive inclusion.	**To create and deliver a development programme** for our network and steering group chairs and executive sponsors that supports them with the necessary skills knowledge and experiences to contribute effectively to the agenda and organisational priorities.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	Trust Board			**Date**	28 October 2026
Agenda Item	TB26/081				
Report Title	Clinical Strategy 2024-26 Review				
Executive Lead	Simon Dowson, Chief Medical Officer				
Presenting Officer	Simon Dowson, Chief Medical Officer				
Action Required		**To Approve**	X	**To Note**	

Purpose

This paper reviews the MWL Clinical Strategy 2024-26 considering achievements, ongoing objectives and the further development of the Clinical Service Strategy.

Executive Summary

The MWL Clinical Strategy 2024–26 was developed as a transitional strategy following the formation of Mersey and West Lancashire Teaching Hospitals NHS Trust. It prioritised clinical governance and safety, integration of services and pathways, stabilisation of fragile services, and delivery of urgent care, cancer and elective recovery priorities.

Significant progress has been made. Services were organised across four clinical divisions and recently expanded to five, with specialties aligned across sites. Corporate and divisional clinical governance arrangements have been unified, clinical pathways are increasingly aligned, and good practice is being shared. Clinical leadership arrangements are in place, education and research have developed, while the Shaping Care Together strategic case has been approved and further work is underway to implement the changes arising from the decision.

Pathway integration and stabilisation of fragile services remain ongoing. The Trust has not yet realised all the potential benefits of operating as a larger organisation. These issues require continued attention, alongside further service transformation.

The next Clinical Service Strategy will cover 2027–31 and align with the wider Trust Strategy. It will move the organisation's focus from integration and stabilisation towards improvement and transformation as one MWL. Its development will reflect national and regional priorities, commissioning intentions and service reconfiguration.

Financial Implications

There are no direct financial implications arising from this review. Any financial implications associated with the development and implementation of the Clinical Service Strategy 2027–31 will be considered through the relevant business planning and approval processes.

Quality and/or Equality Impact

This review identifies ongoing quality and equality considerations relating to fragile services, clinical pathway integration and health inequalities. The Clinical Service Strategy 2027–31 will be subject to appropriate quality and equality impact assessment as it is developed.

Recommendations
The Board is asked to note the Clinical Strategy 2024-26 Review and a new Clinical Service Strategy 2027 to 2031 is in development with the intention of launching it in quarter 1 of 2027/28.

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
x	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
x	**SO9** Strategic Plans

Review of the MWL Clinical Strategy 2024-26

1. Introduction

This paper reviews progress against the MWL Clinical Strategy 2024-26 considering the key achievements and progress against the stated clinical principles and objectives. It identifies the areas for ongoing work and the intention to develop a further clinical service strategy aligned to the Trust Strategy.

2. Review of the MWL Clinical Strategy 2024-26

2.1 Summary

The Clinical Strategy for Mersey and West Lancashire Teaching Hospitals NHS Trust was written as a transitional clinical strategy with an explicit commitment to develop a longer-term strategy once clinical integration had progressed.

The strategy appropriately prioritised:

- Clinical governance and safety
- Integration of clinical services and pathways
- Stabilisation of fragile services
- Delivery of urgent care, cancer and elective recovery priorities

These objectives reflected the immediate requirements of the newly formed Trust and provided a coherent framework for managing post-transaction clinical risk. A review in October 2026 found that significant progress has been made.

2.2 Key Achievements

Divisional Operating Model - The Trust has organised services across sites into four clinical divisions (Medicine and Urgent Care, Surgery, Women's and Children's and Clinical Support Services) latterly adding a Community Services Division with specialties and services aligned.

Clinical Integration - The Trust has made significant progress in integrating clinical services by unifying clinical governance support, aligning clinical pathways and sharing good practice.

Ongoing delivery of urgent care, cancer and elective recovery priorities - Overall operational performance has been maintained across the Trust.

Shaping Care Together - The Trust has supported a strategic plan for the future location of A&E services in Southport, Formby and West Lancashire, which has been approved and further work is underway to implement the changes arising from the decision.

2.3 Clinical ambitions 2024 – 2026

The Clinical Service Strategy stated the clinical ambitions for the organisation based on principles and objectives.

2.3.1 Our principles

The following principles underpinned the clinical strategy and guided the development of the clinical objectives linked to the Trust's strategic aims.

Domain	Progress
Best Practice, Policy, and Guidance	• Common standards, policies and guidelines have increased across MWL with better progress in response to clinical need (e.g. maternity) in specific areas. • National audit, quality standards and best practice guidelines have been benchmarked across MWL with action plans in response. • Services in Ophthalmology and Rheumatology have reopened since the merger. • No services have relocated across the estate but several strategic developments are in progress. • IMPACT improvement methodology is in place with a continuous improvement strategy in development. • Research performance has been maintained across all sites. • Learning opportunities have continued with increasing work across sites.
Service Delivery and Workforce	• Most local services have been maintained with more services delivered close to the patient (e.g. OPAT, virtual wards, community services). • Shaping Care Together strategic case has been approved and further work is underway to implement the changes arising from the decision.
System and National Responsibilities	• ICB priorities have been supported with elective recovery. • MWL has been an active participant in the CMPC and the development of the Alliance blueprint. • Performance and outcome data is reported as a single organisation, site-based data is used when it contributes to understanding. • There continues to be significant fragility around several services at MWL.
Clinical Leadership, Education and Research	• MWL clinical leaders are in post with a development programme in support. • Undergraduate and Postgraduate education has developed across a range of clinical disciplines. • The Trust has a single research strategy making a significant contribution to National Institute for Health and Care Research (NIHR) portfolio studies and commercial collaborations.

2.3.2 Our clinical objectives

Having considered the national, regional and local context, the vision was to provide 5 Star Patient Care and deliver the following clinical objectives over the first 3 years of the newly formed Trust.

Objective	Progress
Ensure clinical governance structures are in place to continue to deliver safe and effective clinical care across the Trust	**Completed:** The Trust has unified corporate and divisional clinical governance structures
Review and align pathways to enable integration of clinical services across the Trust	**Ongoing:** Clinical pathways are being reviewed by specialist teams with reference to national best practice.
Complete the stabilisation of fragile clinical services and address any inequalities, delivering high quality and effective care to patients who use any of our hospitals	**Ongoing:** Fragile services are under review, with risks identified and mitigations in place. Services are being developed using both MWL resources and external pathways.
Achieve national, regional and local NHS priorities to: • Improve Emergency Department waiting and ambulance turnaround times • Reduce waiting times for elective treatments and diagnostic tests • Reduce the time to diagnose or exclude cancer in patients who are referred to hospital	**Improved** **Improved** **Improved**

3. Ongoing work

Review of the strategy has identified a number of areas requiring additional focus in the future.

3.1 Fragile Services

The Clinical Strategy 2024–2026 identified fragile services at Southport and Ormskirk Hospital NHS Trust. MWL continues to recognise fragile services in the organisation.

The Trust is engaged with the Cheshire and Merseyside Provider Collaborative (CMPC) to stabilise services and the risk is mitigated by Service Level Agreements.

3.2 Inequality

Reducing health inequalities is a core ambition of the NHS and the Trust, and significant inequalities persist in the population we serve.

3.3 Service Transformation

The Trust is yet to realise many of the benefits of a larger organisation to improve clinical services. The Trust has initiated a service transformation plan with five workstreams focused on recovery, transformation and sustained performance.

4. Development of the Clinical Strategy

- The Clinical Service Strategy will be developed to align with the Trust Strategy. It will represent a shift from integration and stabilisation to improvement and transformation moving forward as one MWL. The Clinical Strategy will cover 2027 to 2031 to align with the Trust Strategy.
- The NHS 10 Year Plan was published in July 2025 and will be central to the MWL Clinical Service Strategy 2027–2031. The strategy will also consider regional clinical strategy, commissioning intentions, ongoing service reconfiguration and the opportunity to deliver the three big shifts.
- The Clinical Service Strategy will be developed using a hybrid approach, combining ‘top down’ and ‘bottom up’ development to encourage engagement and ownership.
- Development will involve seeking views from senior leaders, lead clinicians, specialties, clinical professional groups and external partners.
- The Clinical Service Strategy 2027 to 2031 is in development with the intention of launching it in quarter 1 of 2027/28.

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Clinical Strategy

2024-2026

“Delivering 5 star patient care at MWL”

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Executive Summary

This clinical strategy sets out the priorities for the new organisation combining St Helens and Knowsley Teaching hospitals and Southport and Ormskirk hospitals to form Mersey and West Lancashire Teaching Hospitals NHS Trust. As the new Trust progresses, this strategy will guide the development of clinical services over the initial post-transaction period, allowing time for engagement with our larger workforce and our local healthcare system as the working relationship continues to evolve with 'Places', as part of two Integrated Care Systems (Cheshire and Merseyside ICS and Lancashire and South Cumbria ICS). As our organisation consolidates and the emerging healthcare landscape becomes clearer, the Trust will develop a long-term strategy which aligns with the new organisation and the new health and social care system.

The Clinical Objectives outlined in this strategy are based around the local and national healthcare system challenges and our priorities for delivery of care. They reflect the strategic direction for the Trust and the patient centred care delivered by clinical staff, both of which will improve quality and safety for those using our services.

Clinical Objectives

- Ensure clinical governance structures are in place to continue to deliver safe and effective clinical care across the Trust
- Review and align pathways to enable integration of clinical services across the Trust
- Complete the stabilisation of fragile clinical services and address any inequalities and barriers to delivery of high quality and effective care to patients
- Achieve national, regional and local NHS priorities to:
    - Improve Emergency Department waiting and ambulance turnaround times
    - Reduce waiting times for elective treatments and diagnostic tests
    - Reduce the time to diagnose or exclude cancer in patients who are referred to hospital





1. Introduction

The formation of a new NHS Trust is a unique opportunity for both patients and staff members. As Medical Director, it is my privilege to help to shape the direction of clinical services in the new Trust through the development and delivery of the Trust Clinical Strategy. This strategy document outlines the background to the transaction between the St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust, as well as the national and regional context which have set the performance standards which NHS trusts must deliver. To deliver those standards, while also ensuring patients receive safe, effective and compassionate patient care, will be a challenge we will all work together to meet and will require us to work collaboratively with colleagues in primary care, social care, community services, mental health services and the voluntary sector. The document also explains how the strategy has been developed, the principles which will underline the way we deliver care and the clinical objectives for the first two years in the new Trust.

The delivery of clinical services in our Trust is only possible through every member of staff putting patients at the centre of what we do. I am delighted to have the chance to work with colleagues, including medical, nursing, Allied Health Professionals and all other staff in Mersey and West Lancashire Teaching Hospitals NHS Trust and our partner Integrated Care Systems, to deliver this strategy and to provide 5 star care to everyone who uses our services.



Dr Peter Williams
Medical Director



2. About our new Trust

a. Background

Mersey and West Lancashire Teaching Hospitals NHS Trust is a new NHS Trust formed following the long-term collaboration between St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust.

St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) provided acute and community healthcare services to approximately 360,000 people living in St Helens, Knowsley, Halton and Liverpool, as well as neighbouring areas, in three hospitals: elective and emergency services at Whiston Hospital, elective services at St Helens Hospital, intermediate care and community services at Newton Hospital, and Primary Care at Marshalls Cross Surgery. In addition to general and acute adult, maternity and paediatric services, the Trust also provided community services to patients in the boroughs of St Helens, Halton and Knowsley and burns and reconstructive plastic surgery services to patients across Cheshire, Merseyside, North Wales and the Isle of Man. In addition, the Trust hosted the Mid-Mersey Neurological Rehabilitation Unit at St Helens Hospital.

Southport and Ormskirk Hospitals NHS Trust (S&O) provided healthcare services to approximately 258,000 people across Sefton and West Lancashire at two hospitals: Acute adult clinical services at Southport Hospital, with an adult Emergency Department and inpatient specialty facilities, and women and children's services, including obstetric-led maternity care, paediatric Accident and Emergency Department and elective adult clinical services at Ormskirk Hospital. The Trust also provided the regional spinal injuries unit at Southport Hospital.

When S&O began to struggle to provide clinical services in several specialties, an Agreement for Long Term Collaboration (ALTC) began, in order to allow these services to continue to be delivered through collaborative working and sharing of best practice. Following this period of successful collaboration, a decision was made to bring the two organisations together to form one single, new Trust through a formal transaction.

b. Our new Trust and drivers for the change

The drivers for closer working and the move to become one Trust came from national, regional and local challenges which will be addressed with collaborative solutions.

National and Regional Challenges

- Increasing demand for healthcare due to an ageing population with more complex needs
- Challenges following the COVID-19 pandemic during which elective activity was reduced to prioritise acute services
- Workforce shortages across all disciplines within the NHS
- Health inequalities caused by high population levels of social deprivation

Local challenges

- Providers unable to provide required level of patient care in some specialties which may lead to reduced service to the population who require them ("Fragile Services")
- Proliferation of Service Level Agreements between providers which may reduce individual Trusts' ability to establish their own services.
- Financial sustainability issues and an underlying financial deficit at Southport and Ormskirk Hospital NHS Trust leading to challenges in sustainable service improvement
- High vacancy rates and agency spend reflecting a workforce recruitment and retention problem at S&O

Opportunities exist within a new, larger Trust to address a number of these issues through:

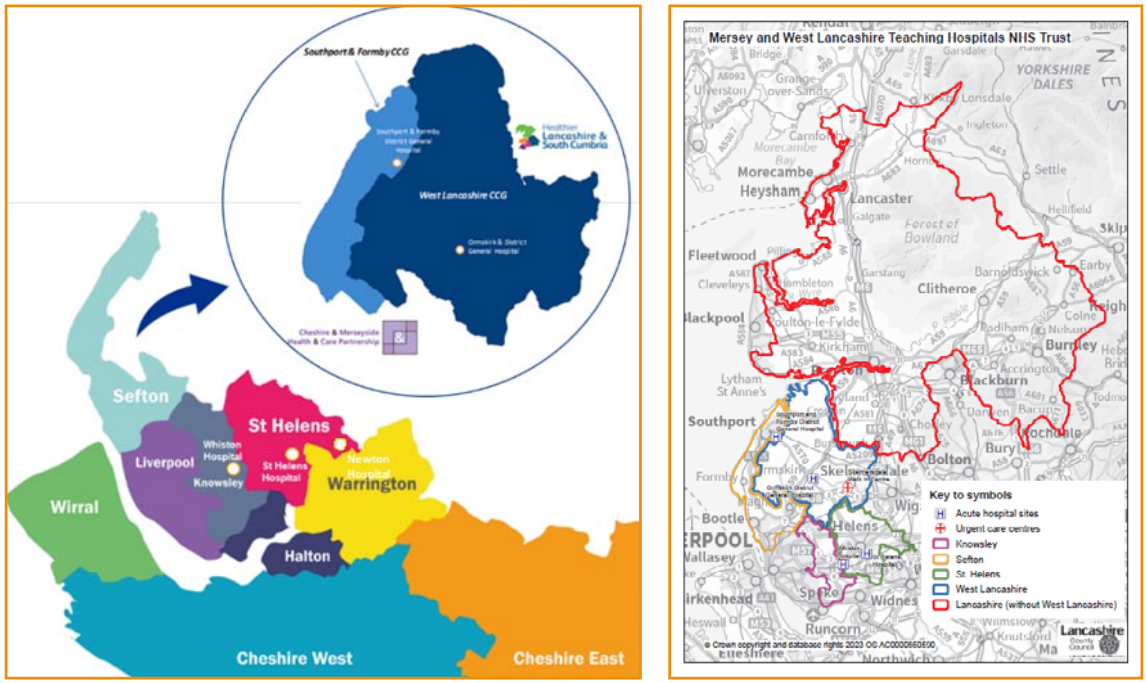
- Improvement in clinical sustainability to achieve the best possible performance across the whole Trust
- Clinical service review and alignment to achieve optimal clinical pathways and patient flow
- Workforce development and growth to attract and retain a higher number of staff
- Economies of scale allowing a larger organisation to leverage its increased scale and purchasing power (eg. during procurement)
- Improved digital services and integration will increase the Trust's level of digital maturity

The formation of Mersey and West Lancashire Teaching Hospitals NHS Trust will ensure that patients receive the best care available across the whole area which our Trust serves based on the model of 5 Star patient care.



c. The areas we serve

This infographic shows the areas covered by Mersey and West Lancashire Teaching Hospitals NHS Trust which is based directly in four of the nine Place-based partnerships within Cheshire and Merseyside Integrated Care System (St Helens, Knowsley, Halton, Sefton) and the Central and West Lancashire locality within the Lancashire Place-based partnership in the Lancashire and South Cumbria Integrated Care System.



Geographical area of the Trust's sites across Cheshire and Merseyside and West Lancashire

The Trust consists of five hospital sites:

- Whiston Hospital
- St Helens Hospital
- Southport Hospital
- Ormskirk Hospital
- Newton Hospital

Additionally, we deliver care in and from a number of community sites including:

- Lowe House Health Centre
- Marshalls Cross GP Practice
- St Helens Millennium Centre
- Southport Centre for Health & Wellbeing

d. Health systems and partners

Mersey and West Lancashire Teaching Hospitals operates in two Integrated Care Systems: Cheshire and Merseyside Integrated Care System (C&M ICS) and Lancashire and South Cumbria Integrated Care System (L&SC ICS).

Our new organisation covers four of the nine Places in C&M ICS and also part of the Central and West Lancashire locality within the Lancashire Place in L&SC ICS. In the context of integrated care systems (ICSs), "Place" refers to a smaller geographic footprint within a system which often aligns with a local authority area or patient flows for acute care. The aim of Place-based care is to encourage local health and care providers to work more closely together, providing "joined up care" to improve the health of their local communities.

As our new organisation sits across two ICSs, it interacts and collaborates with multiple partners across the health and social care sectors. The future of health care delivery is dependent upon the strengthening of pathways and care delivery models between providers, and collaboration between different organisations. The complexity of delivering care across multiple providers in different Place areas will be one of the key challenges faced by the new Trust.

The table below lists some of the healthcare providers which interact with the Trust and how we work together.

Provider	Relationship
Liverpool University Hospitals NHS Foundation Trust	SLA for some clinical services eg. North Mersey Stroke Alliance, Ear, Nose and Throat (ENT) services and regional specialist centre for some specialities
Merseycare NHS Foundation Trust	Delivers community and mental health services in some areas
Bridgewater NHS Foundation Trust	Delivers community services in some areas
Liverpool Heart and Chest NHS Trust	Regional Specialist Centre
Clatterbridge Cancer Centre NHS Foundation Trust	Regional Specialist Centre
Walton Centre NHS Foundation Trust	Regional Specialist Centre
Warrington and Halton Hospitals NHS Foundation Trust	Neighbouring Trust, collaborative working through shared pathology services
HCRG Care Group	Delivers community services and urgent care services in West Lancashire
Lancashire and South Cumbria NHS Foundation Trust	Delivers mental health services in West Lancashire

Local Authorities:
St Helens, Knowsley, Halton, Liverpool, Sefton, Lancashire and West Lancashire Councils.

Additionally, we work with many private and voluntary sector organisations within each PLACE to supplement, support and enhance pathways of care.

e. Our patients and the population we serve

The vision of C&M ICS is "To ensure that everyone in Cheshire and Merseyside has a healthy start in life and receives the support they need to stay healthy and live longer". A significant challenge to achieving this vision is the high levels of deprivation across the region; 33% of the population of Cheshire and Merseyside is currently in the most deprived 20% of neighbourhoods in England. The area of West Lancashire is in the Lancashire and South Cumbria Integrated Care System, and has its own specific issues and areas of inequality across its neighbourhoods. Sefton and West Lancashire both have populations which are older than the national average which is often associated with increased health problems, falls, frailty and risk of hospital admission.

	Sefton	St Helens	Knowsley	Halton	West Lancs
Population	279,233	181,000	156,481	128,625	118,200
Proportion of patients aged 65+	23.6%	20.6%	17.3%	18.4%	22.1%
Deprivation	58th most deprived local authority out of 317	26th most deprived local authority out of 317	2nd most deprived local authority out of 317	23rd most deprived local authority out of 317	155th most deprived local authority out of 317
Life expectancy	Male life expectancy at birth 78.9 years Female life expectancy at birth is 82.9	Male life expectancy at birth 77.5 Female life expectancy at birth is 81.0	Male life expectancy at birth 76.2 Female life expectancy at birth is 79.7	Male life expectancy at birth 77.3 Female life expectancy at birth is 81.3	Male life expectancy at birth 78.6 Female life expectancy at birth is 82.5
Alcohol	Admissions to hospital for alcohol specific conditions is 1,187 per 100,000 population	Admissions to hospital for alcohol harm is 8th highest in the NW	Admissions to hospital for alcohol harm is 13th highest in England	Admissions to hospital for alcohol specific conditions is 995 per 100,000	Admissions to hospital for alcohol specific conditions is 749 per 100,000
Smoking	15% of adults smoke England average 14%	13% of adults smoke England average 14%	16% of adults smoke England average 14%	14.9% of adults smoke England average 14%	13.9% of adults smoke England average 14%
Obesity	Approximately 71.5% of adults in Sefton were classified as overweight or obese	Approximately 69% of adults in St Helens were classified as overweight or obese	Approximately 74% of adults in Knowsley were classified as overweight or obese	Approximately 61% of adults in Halton were classified as overweight or obese	Approximately 66% of adults in West Lancashire were classified as overweight or obese


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3. Developing our clinical strategy

This clinical strategy will address key challenges faced by the new Trust in providing safe, high quality patient care. Some of these relate to the challenges previously faced within Southport and Ormskirk Hospital NHS Trust while others follow national, regional and local priorities.

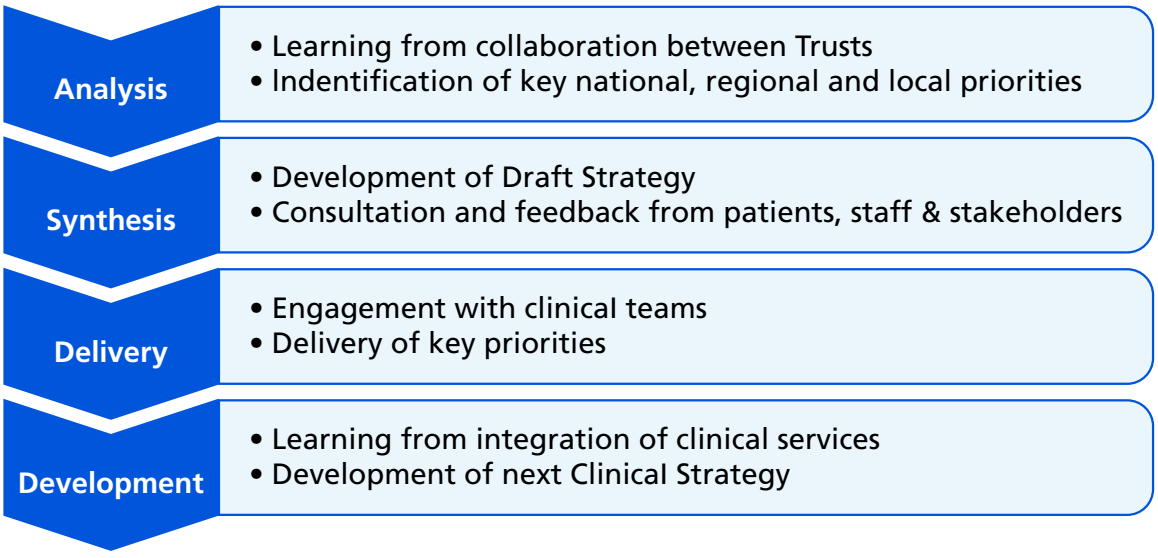
One key driver for the Clinical Strategy is the elective recovery programme, which addresses the impact of the COVID-19 pandemic on NHS Trusts to deliver outpatient care and elective surgery. Another is the ongoing challenge in the delivery of Urgent and Emergency Care, which will require collaborative working between providers to ensure that patients receive care quickly, safely and in the most appropriate place. Finally, cancer care, with growing numbers of referrals and the need to diagnose and treat cancer at an earlier stage is of critical importance following the reduction of patient presentation and diagnostic activity during the pandemic.

a. How this strategy was developed

As Mersey and West Lancashire Teaching Hospitals NHS Trust is a newly formed organisation, the clinical strategy has been brought together to reflect the immediate priorities in the newly formed Trust. For that reason, the clinical objectives are deliberately aimed at delivering those immediate priorities: forming a new organisation with safe, effective clinical services which work towards meeting the local, regional and national priorities. Once our new divisional structure has been created, clinical services integrated and fragile services stabilised, a longer-term clinical strategy will be developed reflecting the clinical priorities of each division.

This strategy was developed by the Medical Director in consultation with senior clinical leaders from both organisations. It has taken into account the learning and experience gained during the period of collaboration between the two Trusts which preceded the transaction and the areas identified for action in the Post-Transaction Implementation Plan submitted to and approved by NHS England.

Consultation on the completed strategy has been undertaken with representatives of local patient groups to ensure that their views are heard and incorporated into the services which they will use. It has also been shared with leaders from the Integrated Care Boards in Cheshire and Merseyside, and Lancashire and South Cumbria to ensure this strategy aligns with the wider strategy within the Integrated Care Systems.



b. National policy and strategic context

National NHS strategy, delivery plans and performance framework ensure that organisations provide clinical services along the same principles of access and delivery. The shared clinical access targets allow Trust performance to be benchmarked across the NHS and ensure providers are delivering care in a timely and effective way.

The NHS Delivery plans for tackling the COVID-19 backlog of elective care and for recovering urgent and emergency care services have set out the priorities for NHS organisations to the targets set out in the NHS Long Term Plan. Along with the NHS planning guidance for 2022/23, these strategies have outlined how NHS organisations will deliver the changes required to meet the healthcare needs of the population in the post-pandemic period. The alignment of clinical services and pathways will work within the planning guidance to ensure we deliver the expected performance in elective care.

The Elective Recovery Plan published in February 2022 sets out an ambitious national delivery plan to address the COVID-19 backlog through increasing staff capacity, prioritising those with greater need and transforming care settings. The COVID-19 pandemic had a significant impact on healthcare delivery, diverting resources usually used for elective care and preventing patients attending hospital for planned surgery and outpatient appointments. Closer working between providers will allow clinical teams to deal with the backlog more efficiently with better utilisation of resources. There are opportunities for the new Trust to optimise capacity and resources across both Trusts to address the backlog through initiatives such as the streamlining of pathways to increase clinical effectiveness and the implementation of a clinical prioritisation strategy to increase productivity and clinical efficiency.

The Urgent and Emergency Care Recovery Plan was published in January 2023 to help NHS Trusts meet the extreme demands on non-elective clinical services. Despite the best efforts of Trusts and Social Care partners, problems discharging patients to the appropriate care settings has seen hospital occupancy reach record levels slowing patient 'flow' through hospitals. To support recovery, the plan sets out a number of ambitions, including patients being seen more quickly in emergency departments and ambulances getting to patients more quickly. Delivery of these ambitions will require sustained focus on five areas:

- Increased capacity (investing in more hospital beds and ambulances and improving flow)
- Growing the workforce
- Improving discharge (working jointly with all system partners to strengthen discharge processes)
- Expanding and joining up health and care outside hospital (increasing use of Urgent Community Response and Virtual Wards)
- Making it easier for patients to access the right care

The NHS Planning Guidance for 2023/23 outlines key areas to improve patient safety, outcomes and experience: improving ambulance response and Emergency Department waiting times, reducing elective and cancer backlogs, improving performance against the core diagnostic standard, and making it easier for people to access community services, particularly general practice.

c. Cheshire and Merseyside ICS priorities

Cheshire and Merseyside Integrated Care System has four key strategic objectives which align with those of the new organisation:

- Improve population health and healthcare
- Tackle health inequality, improving outcomes and access to services
- Enhancing quality, productivity, and value for money
- Helping the NHS to support broader social and economic development

These strategic objectives will be delivered by the Integrated Care Board through its Provider Collaboratives and programmes of work across a wide range of clinical and non-clinical areas in which the Trust will be involved. Several of these programmes are detailed in the table below:

Programme	Description
Ageing Well	Improving urgent community response for older patients, enhanced health in care homes and helping people with complex needs stay healthy.
Diabetes	Improving treatment targets, multi-disciplinary footcare teams, specialist nursing and flash glucose monitoring.
Diagnostics	Improving access to all diagnostic tests including, pathology, imaging, endoscopy, cardiorespiratory and neurophysiology.
Elective Recovery	Reducing waiting lists, restoring services to pre-COVID levels, and embedding sustainable services.
Respiratory	Quality assured diagnostic spirometry, pulmonary rehabilitation and psychological support to manage respiratory disease
Stroke	Reducing the number of strokes in Cheshire and Merseyside by focusing on prevention, reducing health inequalities, improving access and community rehabilitation.
Women's Health and Maternity	Transforming and improving support for women's health, improving wellbeing, life chances and outcomes for women and babies.

The Trust is a member of both the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and the Community and Mental Health Provider Collaborative, due to the breadth of care which it delivers. The Provider Collaboratives bring together NHS Trusts to work collaboratively to deliver on ICB Objectives across the whole system.

The Trust is also part of the C&M Health and Care Partnership, a committee of health and care partners from across the region, working together to improve health and care outcomes, and reduce variation in experience of care. By working together across the region the health and care partnership aims to reduce health inequalities and promote wellbeing to all of our residents. The Trust is a signatory to the Prevention Pledge which has a focus on not just treating patients but preventing future admission and promoting self-care and management of an individual's health.



Lancashire and South Cumbria ICB Priorities

The Trust is also part of Lancashire and South Cumbria ICS and works together with partners across the whole region to help deliver the priorities which have been set out by the ICB and the integrated care partnership. The integrated care partnership brings together healthcare providers (including Mersey and West Lancashire Teaching Hospitals NHS Trust), local government, the voluntary, community, faith and social enterprise sectors, education organisations, people that represent local businesses, Healthwatch and residents together to work to a set of agreed priorities to improve the lives of people in Lancashire and South Cumbria.

The priorities will be focused on the life course of residents: Starting Well, Living Well, Working Well and Ageing Well.

- Starting Well: Giving children the best start in life, supporting them and their families with problems that affect their health and wellbeing, and getting them ready to start school.
- Living Well: Reducing ill health and tackling inequalities across mental and physical health for people of all ages by understanding the cause of these unfair differences.
- Working Well: Increase ambition, aspiration and employment, with businesses supporting a healthy and stable workforce and employing people who live in the local area.
- Ageing Well: Supporting people to stay well in their own home, with connections to their communities and more joined up care.
- Dying Well: Encouraging all residents to feel comfortable in talking about planning for dying, and to be well-supported when a loved one dies.

As part of the Integrated Care Partnership, Mersey and West Lancashire Teaching Hospitals will work alongside partner organisations to help deliver these priorities for residents living in Lancashire Place. The work to reduce health inequalities for residents sits with all providers and organisations in the ICB and the healthcare providers are uniquely positioned to be able to deliver interventions aimed at both primary and secondary prevention of ill health. The Trust will work alongside colleagues in primary and community care to work with patients to help reduce their risk of developing or worsening illnesses in the future.



d. Shaping Care Together

The Shaping Care Together programme is aimed at changing the way we provide health and care services in Southport, Formby and West Lancashire, so that we can continue to provide high-quality services that are both safe and sustainable, now and in the future.

Patients, staff and stakeholders have told us through engagement that has seen almost 2,500 responses they want to see:

- Reduced waiting times for outpatient appointments.
- Care provided closer to home and in the local community wherever possible.

However, funding challenges, staffing shortages, and the aftermath of the Covid-19 pandemic are making it harder for us to do this.

We have an ageing population, high rates of disease, high demand for services and significant health inequalities. In some areas, services are operating with substantial annual deficits.

Following detailed evaluation, several services have been identified as 'fragile', meaning that we are simply not able to continue offering these services as they are today. In 2023, as a first step to stabilising these fragile services, two former Trusts were joined together to form Mersey and West Lancashire Teaching Hospitals NHS Trust. The Shaping Care Together programme is looking at how we can make the best use of our resources - money, staff, and estates – in a way that provides stability to these services today, and in the longer term. Shaping Care Together will be doing more engagement with patients, staff and stakeholders as the programme progresses.

e. Fragile services

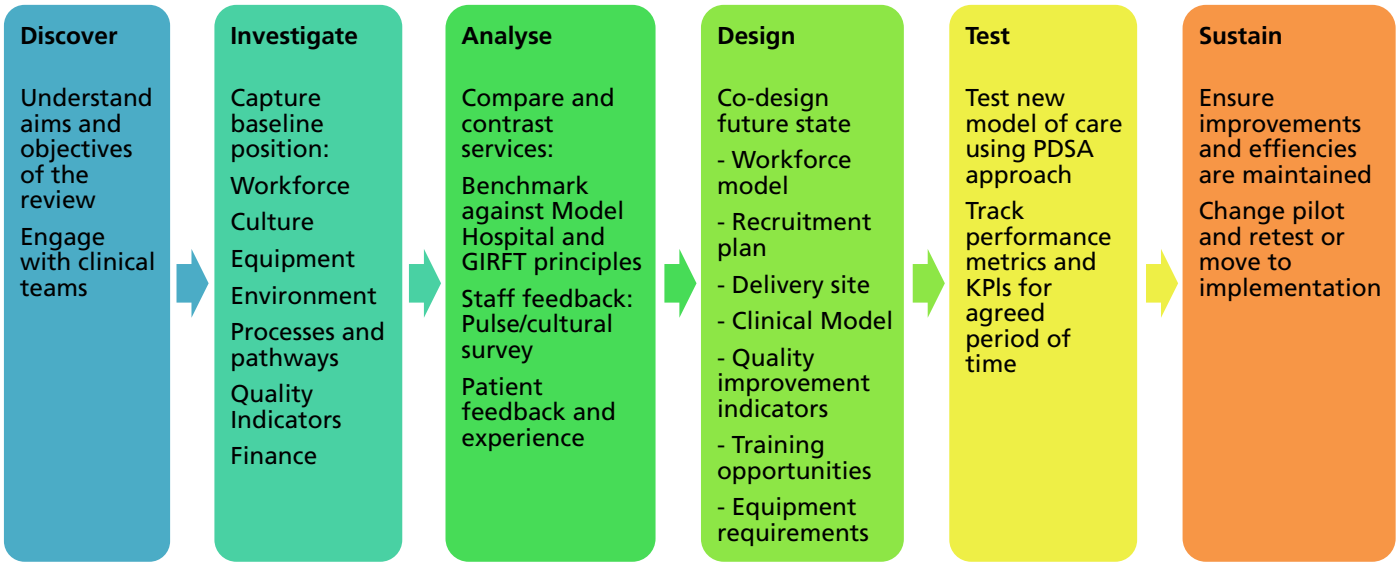
In January 2022, several clinical services provided by Southport and Ormskirk Hospital NHS Trust were identified as "fragile" due to workforce or other challenges following a quality impact assessment. This meant that they were at risk of no longer being able to deliver the level of service required to continue or had closed to new referrals. Since the Agreement for Long Term Collaboration (ALTC) several of these have been stabilised (green) whereas others still remain at risk of not being able to deliver the required standard of clinical care. Each of these services have individual challenges in their delivery and detailed plans to meet these were contained in the Post Transaction Implementation Plan (PTIP), the Trust's plan to ensure we smoothly transition into a single organisation.

High Risk Fragile Services	Fragile Services	Stabilised Services
ENT	Oral Surgery	Haematology
Ophthalmology	Dermatology	Paediatric Dietetics
Vascular Surgery	Pain	Stroke
	Medicine for Older People	Orthodontics
	Rheumatology	
	Cardiology	
	Diabetes	
	Paediatric A&E	
	Paediatric Ophthalmology	
	Optometry	
	Clinical Physiology	

A critical objective for the new organisation is the stabilisation of the existing fragile services to ensure that patients can continue to access these services across the whole area which the Trust serves. Where possible, this will be done in the way that ensures services will continue to be delivered as close to patients as possible. Where this is not possible, they will be delivered as close to the population as is clinically viable. The stabilisation of fragile services will draw on experience and learning from the ALTC and be carried out by clinical leaders within those specialties supported by members of the senior leadership team.

Service Development Strategy

In addition to stabilisation of fragile services, the new organisation will undertake a standardised approach to integration of all clinical services, reviewing and agreeing the future delivery model of care across the organisation, in consultation with patients, local communities and partners. Using the principles of service improvement and led by clinicians, we will collaborate to understand the challenges and identify the opportunities for clinical delivery then develop a transformation plan to move the service forward. Each specialty will have their own unique journey of integration which will reflect the individual challenges for their service. This will be supported by a senior leadership team with a remit to oversee the integration of clinical services and ensure this is done in a way which maximises the effectiveness and efficiencies outlined ahead of the transaction. The diagram below outlines the principles which will underline the integration of services in a systematic way.



Model of clinical service integration



4. Our clinical ambition

a. Our principles

The following principles underpin the clinical strategy and guide the development of the clinical objectives. They are linked to the Trust's strategic aims and ensure that the clinical strategy aligns with the aims and objectives of the new organisation.

Domain	Principles	Linked Strategic Aim
Best Practice, Policy, and Guidance	• Services will operate to a common set of clinical standards, quality metrics, policies and guidelines across the new Trust, wherever they are delivered • Good practice will be shared to ensure that services achieve the best of what is currently delivered by the two Trusts and comply with standards set by national professional bodies eg. National Institute of Clinical Excellence (NICE), Getting It Right First Time Programme (GIRFT) and the Academy of Medical Royal Colleges • Closed services will re-open to referrals and enhance the care delivered to the population of Sefton and West Lancashire where this is clinically and financially viable • Utilisation of estate and clinical facilities will be optimised across the four main hospital sites if beneficial to patients • Improvement practice will be embedded in each clinical service and developments will be supported where these will enhance the health of the local population or reduce health inequalities • Participation in clinical trials and research will be supported and encouraged • Excellent opportunities for teaching, training and development will be provided throughout the new Trust	Be the Trust of choice for patients Deliver high quality, personalised care
Service Delivery and Workforce	• Clinical services will continue to be delivered as close to patients as possible • Where services cannot be delivered locally, they will be delivered as close to the population as is clinically viable • Other than the proposed strategic clinical service reconfiguration between Southport and Ormskirk Hospitals (subject to public consultation led by the ICBs), there is no intention to move services between sites. If this does occur, it should only be where there are clear patient and clinical benefits which outweigh any potential disruption and following consultation	Be the Trust of choice for patients Respond to local health needs Attract and develop caring, highly skilled staff
System and National Responsibilities	• C&M and L&SC ICS priorities will be supported including elective recovery and restoration • Sustainable solutions to the remaining fragile services at S&O will be found through collaboration with system partners where appropriate • Report performance and outcome measures as a single organisation • Provide timely and accurate information about activity, performance and outcomes to allow clinical teams to continuously improve.	Work in partnership to improve health outcomes

Clinical Leadership, Education and Research	• Clinical Leadership will feature prominently in the workforce strategy as we develop a clinical leadership programme which will focus on equipping new and aspirant clinical leaders with tools and resources to take further steps in leadership in the organisation. • Clear, visible and easily accessible reporting and escalation structures will be embedded across the new Trust with an integrated, compassionate approach to leadership • We will continue to develop our undergraduate and postgraduate education services, with closer links between the Trust and our partner Educational Institutions and through the use of innovative methods of teaching to ensure that every clinical service is able to maximise the educational offer for students of all healthcare disciplines. • The Trust will continue to expand its portfolio of research studies and will work with University colleagues to develop relationships which will enable increased collaboration between the Trust and partner academic institutions. The Research, Development and Innovation Team will identify new research opportunities in all clinical areas and our work with Clinical Research Network North West will place the Trust be at the forefront of clinical research in the region.	Attract and develop caring, highly skilled staff Work in partnership to improve health outcomes

b. Our clinical objectives

Having considered the national, regional and local context, our vision is to provide 5 Star Patient Care and deliver the following clinical objectives over the first 2 years of the new Trust.

Clinical Objectives for Mersey and West Lancashire Teaching Hospitals NHS Trust
• Ensure clinical governance structures are in place to continue to deliver safe and effective clinical care across the Trust
• Review and align pathways to enable integration of clinical services across the Trust
• Complete the stabilisation of fragile clinical services and address any inequalities, delivering high quality and effective care across to patients who use any of our hospitals
• Achieve national, regional and local NHS priorities to: o Improve Emergency Department waiting and ambulance turnaround times o Reduce waiting times for elective treatments and diagnostic tests o Reduce the time to diagnose or exclude cancer in patients who are referred to hospital

National benchmarking tools including data from the Getting It Right First Time (GIRFT) Programme and Model Hospital System will provide many of our services the information to identify where each service will focus interventions for improvement. This will be supplemented with guidance from NICE, NCEPOD and professional bodies to support the safe and efficient delivery of clinical services.

5. Our clinical services

Work will be undertaken across 2023/24 to align our services and pathways to be led and overseen by the most appropriate division. This will allow a greater focus on integration, understanding of the gap in equitable provision for our population and the mitigation of clinical risk.

Clinical services will be divided into divisions which will be led by a triumvirate of nursing, operational and medical leaders. This leadership model and the departmental leadership structure which sits beneath it will help to unify specialty delivery across the new organisation.

The services will be allocated to one of the following divisions:

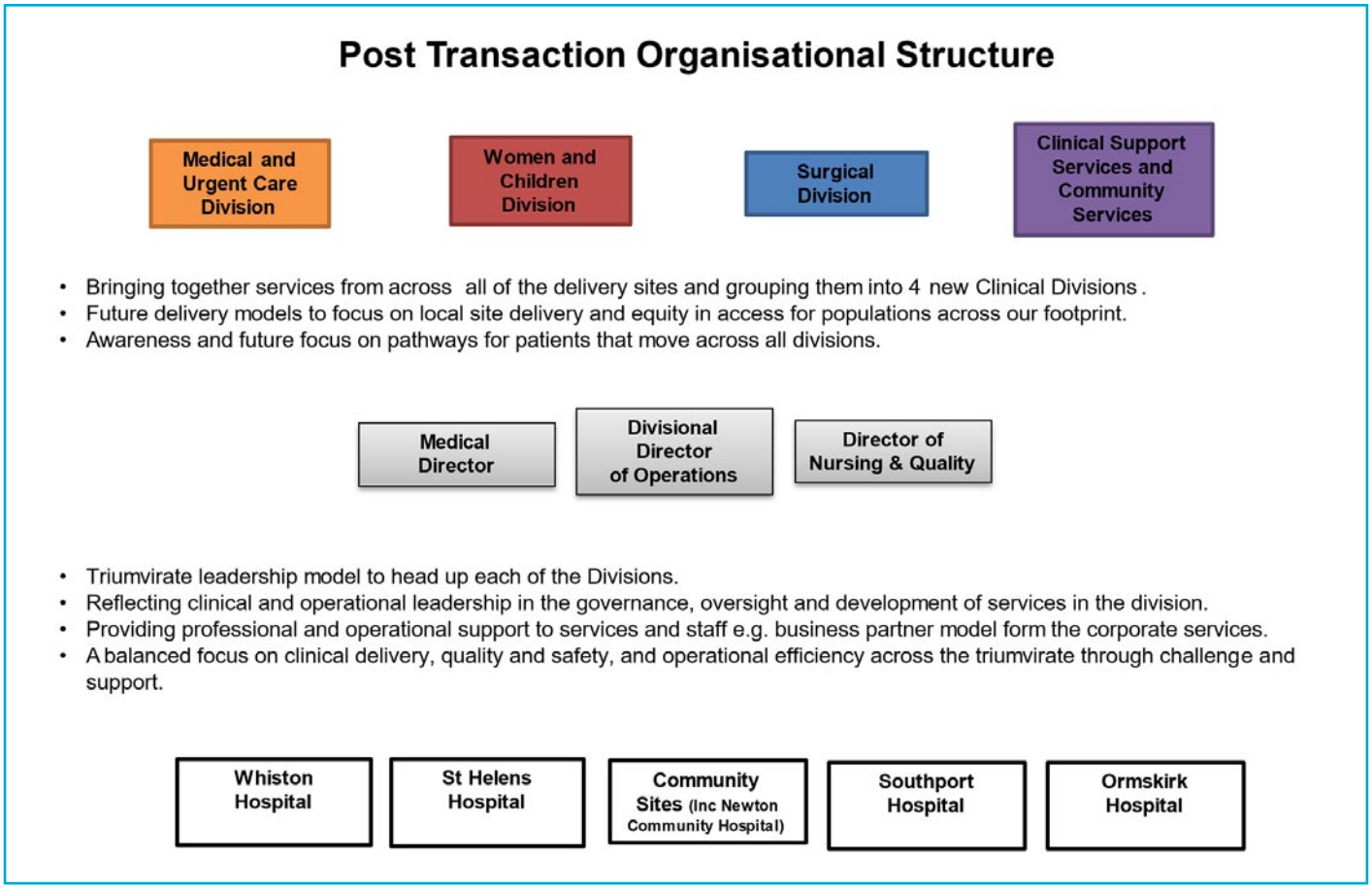
- Medicine and Urgent care
- Surgery
- Women and Children's Services
- Community and Clinical Support Services

Consideration has been given within this model to factors such as:

- Site management and presence
- Specialty oversight when accountable for delivery across multiple sites
- The spread of high risk and fragile services across portfolios
- The introduction of roles to improve the architecture of the leadership teams and to support career progression

The divisional structures will be kept under constant review in accordance with the clinical transformation plan to ensure that they are delivering the optimal model for clinical and operational leadership.

Corporate leadership roles will remain and report directly to the Medical and Nursing Directors as in the previous model to ensure safety and quality remains at the top of the Trust agenda and has executive oversight and accountability.



a. Enabling strategies

The Clinical Strategy is only one of the strategies for the new Trust to deliver the benefits which will be realised through the transaction. It is through close, collaborative working between clinical and non-clinical services which will allow us to deliver the Trust's objectives, give patients high quality care and create a working environment which attracts and retains the best possible employees.

The Trust strategies which will enable the delivery of the clinical strategy include:

- Digital Strategy
- Workforce Strategy
- Estates Strategy
- Environmental Sustainability Strategy

6. Monitoring and review

The clinical objectives will be monitored through the regular committee and council meetings which make up the Trust's Corporate Governance Structure. Each committee will provide assurance to its Executive and Non-Executive members that teams are working safely and effectively to deliver this Clinical Strategy. As stated previously, this Trust Clinical Strategy will be reviewed and updated ahead of the publication of the next Clinical Strategy in 2025 when integration of clinical services is completed, allowing objectives to be set within individual clinical divisions to develop their services.

Delivery of the Post-Transaction Implementation Plan (PTIP), developed prior to the transaction and approved by NHS England, will be monitored by the Transaction Board to ensure that the patient and organisational benefits identified for the new Trust are realised. This will run in parallel with reporting to NHS England to provide assurance that the PTIP delivery is on track.



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Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	Trust Board	**Date**	28 October 2026
Agenda Item	TB26/082		
Report Title	National Quality Board Nurse Establishment Reviews		
Executive Lead	Sarah O'Brien, Chief Nursing Officer		
Presenting Officer	Sarah O'Brien, Chief Nursing Officer		
Action Required		**To Approve**	X **To Note**

Purpose

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

Executive Summary

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

The paper details the outcome of the bi-annual establishment reviews for May 2026 for acute inpatient wards based on the configuration and clinical pathways currently in place, providing the assessment of current staffing levels, using a nationally recognised nurse to patient ratio methodology (SNCT - Safer Nursing Care Tool), and is based on the established bed capacity only.

The paper outlines the methodology applied to provide assurance to the Board of the robust process followed, this involved a triangulated approach aligned to NQB recommendations which included a check on right staff, right skills, right place and time, with relevant workforce information and the patient safety, patient experience and clinical effectiveness indicators for each specific clinical area (NQB Safe sustainable and productive staffing, 2016)

The outcome from the SNCT is that no changes are required for 34 of the inpatient wards and changes are recommended to 14 areas, most of these involve repurposing roles from within existing establishments but for five wards there is a recommendation to increase the establishment, the cost of this will largely be offset by reductions in bank spend as temporary staffing is currently being used to meet care demands, but it will also require some investment.

The paper also flags the ongoing challenge of operational pressures and staff sickness and the impact this has on nurse staffing levels.

Financial Implications

The changes recommended for five areas require investment, although most of the cost will be met by reductions in temporary staffing costs, which are high in these areas. The total cost of meeting these establishment requirements is approximately £251,000

Quality and/or Equality Impact

Not applicable

Recommendations
Trust Board is asked to: I. Note the assurance regarding Trust compliance with the NQB recommendations. II. Note the assurance that no changes are required for 34 of the 48 wards assessed. III. Note the changes recommended based on the SNCT review and the approved establishment amendments on the following wards: IV. 7B, 9A, 15A, 10A, 10B, 14A, E, G, H and F ward, 3Alpha, 3E, 3F and Neonatal Unit at Whiston. V. Note the additional investment required in Medicine, Urgent Care and Paediatrics that Executive Committee have reviewed and supported. VI. Note the ongoing operational pressures requiring additional escalation beds, the challenges with sickness and the impact this has on safe nurse staffing across the Trust.

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

1. Introduction

The purpose of this paper is to present the findings of the nurse staffing inpatient ward establishment review which was undertaken in May 2026 for all 48 inpatient wards across MWL.

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

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

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

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

It presents the outcomes of the establishment review conducted in May 2026 and recommendations where required pertaining to nurse staffing establishments.

2. Background and Methodology

The aim of the establishment review is to assess nurse staffing and skill mix across inpatient areas against patient acuity using the SNCT (Safer Nursing Care Tool) which is a nationally recommended (NICE), evidence-based tool. Other factors at MWL that continue to influence staffing reviews includes the ongoing work post transaction to align approaches to nurse staffing establishments to ensure nationally mandated reviews, latest staffing guidance for clinical wards from NICE guidance, NHSi guidance (Developing Workforce Safeguards 2018) and the RCN nursing workforce standards (2021) are incorporated in the reviews.

The SNCT (2023) data collection was undertaken throughout the month of May/June 2026, the tool is used across the NHS to identify safe staffing levels for:

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

A national safe staffing tool for community nursing has been developed and is being piloted across the NHS. MWL have trained 80% of community staff to use the tool and data collection is planned to start in November 2026.

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

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

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

The process at MWL is robust and follows the national guidance. Ward staff trained in the use of the tool, collected the data, the information and findings were then validated by the specialty matrons, to give assurance that the information was captured accurately.

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

Board members should note that the establishment review currently does not take into consideration the use of escalation beds. However, it is recognised that additional temporary staffing has been utilised regularly to safely manage the opening of additional beds in times of extreme operational pressures and this contributes to ongoing use of temporary nurse staffing and impacts on morale, care and sickness levels.

3. Care Hours per Patient Per Day (CHpPD)

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

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

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

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

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

- Differences in baseline staffing levels in some areas
- Variations in the provision of hostess and housekeeper roles.
- Differences in ward layouts across sites.

4. Establishment Review – Outcome summary by Division

For assurance, overall, the reviews from May / June 20026 have supported maintaining current establishments on most wards with a few recommended changes in each division. A number of these changes require no financial investment but movement or changes to type of staff for some ward establishments. A small number of recommendations require a financial uplift to a current ward establishment, most of which will be met with reductions in the use of bank and agency staff which is being used to cover care gaps. Executive Committee has reviewed the recommendations and approved the financial investment and agreed reductions in temporary staffing spending.

The sections below summarise the outcome of the nursing establishments by Division.

4.1 Medicine and Urgent Care Division:

The Medicine Division holds the most significant operational risk across the Trust, driven by demand and complexity with increased patient falls, complex enhanced observation requirements, and high dependency profiles (SNCT Levels 1c and 1d).

For assurance, the review affirmed existing establishments across most wards and only recommended changes for 4 wards (table 1).

For Urgent & Emergency Care, the review identified some additional requirements on ward 10A at Southport (table 1). Furthermore, Board should note that there is ongoing work outside the establishment review process to assess nurse staffing levels within both Emergency departments, and a paper is expected at Executive Committee imminently.

To support the financial impact of the recommendations for Medicine and Urgent Care the Division has recommended an ‘Invest to Save’ approach, these wards currently have high levels of bank and agency spend ,and this would be reduced to offset the uplift to establishments, Executive Committee have supported this approach and the division will be held to account for the reduction in bank spend.

Table 1

Ward	SNCT Recommendation	WTE	Gross Investment	Bank savings	Net Investment
7B	1 HCA long day early & 1 HCA long day night	5.37 WTE	£223.7K	£170.1K	£53.6K
9A	1 HCA Long Day Night	2.68 WTE	£122.7K	£85K B4 saving - £12k	£25.7K
15A	1 HCA Long Day Night	2.68WTE	£122.7K	£85K B4 saving £12.8K	£24.9K
10A	1 RN Long Day early & 1HCA Long Day Night	4.46WTE	£210.7K	£150K	£60.4K

4.2 Surgical Care Division:

For the Surgical Division the review identified 7 wards that required a change to the establishments, the division can implement these through skill-mix changes and CIPs across the division and there are no additional costs so no financial investment is required. Table 2 outlines the recommended changes for the surgical wards. There is ongoing work in the division reviewing on call in theatres and rostering but no recommendations from this review, critical care on both sites work within mandated staffing levels and consideration of band 4 roles and succession planning is ongoing.

Table 2

Ward	SNCT Recommendation	Rationale
Ward 10B	Remove 4 x RN Short shifts Mon-Fri to create 4 x RN Long Days Mon-Fri. Removed 5 x HCA Short shifts Mon-Fri.	Different working area now due to relocation of SAL and staff being moved to staff the area – before this was part of 10B so covering area for staffing was flexible to cover the service.
Ward 14A	Shifts remain how they have been previously. B4 shifts need to be included in Unregistered Hours for roster to match ledger.	Convert them to B3s release a small CIP and the budget would be correct. There would no longer be a need for the 2x 4s.
E Ward	HCA Shifts on the weekend to be dropped from 2 per day to 1 per day Saturday and Sunday.	HCAs not required as decreased activity at weekends.
G Ward	Removed 2x RN Short shifts Mon-Tue and drop HCA Long day from 5 Mon-Sun to 4. To create 1x Additional RN Long day Mon to Fri.	Professional judgement and increased complex discharge patients.
H Ward	Has 0.6wte Management Time Included in Roster - Remove as shared with another ward.	Not required
F Ward	Has 0.6wte Management Time Included in Roster - Remove as shared with another	Not required

Ward	SNCT Recommendation	Rationale
	ward.	
3Alpha	Additional HCA for night shift (x 7 days)	Due to acuity and increased risk of falls with patients. 1:1 patients have increased.

4.3 Women and Children's Division

The review affirmed the existing establishments for all paediatrics areas at Ormskirk and CHOBS at Whiston. There are recommendations for changes to the Gynaecology ward (3E) and Neonatal Ward at Whiston, but these can be achieved without financial investment.

The main recommendation is for the paediatric ward at Whiston (3F) which has a higher patient-nurse ratio than the comparable Ormskirk paediatric ward despite managing greater patient acuity, enhanced observation requirements, greater nonelective/elective demand, higher HDU capacity. It is proposed that an additional Registered Nurse on each long day shift would improve patient safety, support workforce resilience, reduce cancelled training opportunities/ward manager non-clinical time, and align staffing more closely with the level of demand and complexity seen within the service. Executive Committee were presented with two options to enact this change and supported Option 1 which will involve movement of some posts from Ormskirk site and an investment of £85,411.

Table 3 summarises the changes recommended for three areas in this Division.

Table 3

Area	Request	Rationale
Ward 3E	Funding within budget for a 0.6 WTE Band 5 RN to convert to Clinical Educator 0.4 Band 6	Education being facilitated by Matron and Ward Manager, deflecting from their roles. Challenges to maintain compliance rates for Core and Compulsory training. PEF roles across Divisions are Band 6
Ward 3F	Additional 1 x RN per Long Day	Complexity of care, enhanced observations and complexity of environment. Staffing ratios at Whiston CYP ward is 1:6/7 and at Ormskirk 1:3-1:5/6. Potential for reduction in cancelled study time and improvements in sickness.
Whiston NNU	Repurpose 2.76 WTE of Band 4 vacancies to increase the current Band 5 nursing establishment by 1.96WTE alongside a Band 2, 1.0 WTE. Short term proposal to fill the current Band 3 establishment of 3.48 WTE to 5.43WTE (1 staff member per shift 24/7) with 1.89 WTE registered nursing staff to bring unit more in line with regional staffing models.	Quality Indicators – IPC compliance, higher acuity at Whiston. Aim to reduce overall bank spend and create a resilient workforce, meeting BAPM Standards. Changes suggested improve compliance with regional Level 2 staffing standards further work is then required to move to full compliance.

4.4 Maternity Services

Birthrate Plus® is the only midwifery-specific evidence based national tool using a workforce planning calculation to determine the required total midwifery workforce establishment for all hospital and community services

Planning meetings between Maternity Divisional Director and Deputies and Birthrate Plus® commenced in May 2026. The assessment phase includes live case mix data collection between July and September 2026 and the final report is anticipated in December 2026.

This represents the first full Birthrate Plus workforce planning undertaken across the integrated MWL Maternity Service; previous reviews were completed separately within the legacy organisations.

4.5 Clinical Support Services

There are no recommended changes to current establishments from this review but work is ongoing regarding outpatient workforce and opportunities for different ways of working to maximise productivity.

5. Next Steps

A task and finish group is being established, led by Estates & Facilities with Divisional collaboration to review and harmonise the role of catering assistants across the Trust as there is variation in these roles and it does impact on nursing establishment requirements.

6. Risks

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

- Absence from work due to sickness is higher in nursing than the overall Trust rate
- Operational demand and requirement to open escalation beds
- Attrition rate for HCA workforce
- Harmonisation of establishments across MWL sites to reduce variation
- Ongoing requirements for Enhanced Therapeutic Care (supplementary care)

7. Recommendations

Trust Board is asked to:

I. Note the assurance regarding Trust compliance with the NQB recommendations.

II. Note the assurance that no changes are required for 34 of the 48 wards assessed.

III. Note the changes recommended based on the SNCT review and the approved establishment amendments on the following wards:

IV. 7B, 9A, 15A, 10A, 10B, 14A, E, G, H and F ward, 3Alpha, 3E, 3F and Neonatal Unit at Whiston.

V. Note the additional investment required in Medicine, Urgent Care and Paediatrics that Executive Committee have reviewed and supported.

VI. Note the ongoing operational pressures requiring additional escalation beds, the challenges with sickness and the impact this has on safe nurse staffing across the Trust.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	Trust Board			**Date**	28 October 2026
Agenda Item	TB26/083				
Report Title	Thirlwall Inquiry Overview				
Executive Lead	Sarah O'Brien, Chief Nurse				
Presenting Officer	Sarah O'Brien				
Action Required		**To Approve**	**X**	**To Note**	

Purpose

This paper presents a summary of the Thirlwall Inquiry findings including the seventeen recommendations for noting and discussion at Trust Board.

Executive Summary

The Thirlwall Inquiry published on 15 September 2026 is the independent public Inquiry established to examine events at the Countess of Chester hospital from 2015-2018. The Inquiry made 17 principal recommendations, several of which contain sub-recommendations, many of which apply to NHS Trusts although some are for NHS England (NHSE) or the Care Quality Commission (CQC).

Appendix 1 presents the 17 principal recommendations, several of which contain sub-recommendations, and highlights those potentially applicable to the Trust. On 21 September 2026 in response to the publication of the Inquiry, NHSE wrote to all Trusts (appendix 2) asking them to take some immediate action including a discussion at a public Trust Board and some urgent communication to staff about SUDIC (Sudden Unexpected Death in Infancy and Childhood) processes. MWL has shared its SUDIC policy with staff and Board members, and this summary paper is presented at Board today to facilitate a discussion. The Trust has started to develop an action plan against the recommendations but is anticipating further clarification for some recommendations and will finalise the plan as further guidance is received from NHSE. A finalised plan will be presented to Quality Committee.

A fundamental finding from the Thirlwall Inquiry is that serious patient safety failures are rarely caused solely by the acts of an individual; they are enabled when organisations fail to listen, escalate concerns, investigate effectively, and act promptly and effectively to protect patients.

The Inquiry determines that Trust Boards should focus on fostering openness, psychological safety, professional curiosity, transparency, and learning. Effective Boards should be relentlessly curious about patient safety, seek out signs of risk, listen to frontline staff and ensure concerns are acted upon quickly. A healthy culture enables organisations to identify risks early and act decisively to prevent harm.

Financial Implications

Several recommendations may have financial implications for the Trust, including requirements relating to in-cot monitoring and secure insulin storage. The financial impact is being assessed alongside further national guidance, including clarification of any centrally funded implementation arrangements.

Quality and/or Equality Impact

N/A

Recommendations	
The Trust Board is asked to note and discuss the Thirlwall Inquiry findings.	
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
	SO9 Strategic Plans

1. Background

In 2023 and 2024 (following a retrial) neonatal nurse Lucy Letby was convicted of killing seven babies and attempting to kill eight others at the Countess of Chester Hospital between June 2015 and June 2016. The Thirlwall Inquiry published on 15 September 2026 is the independent public Inquiry established to examine events at the hospital from 2015-2018. The Inquiry made 17 principal recommendations, several of which contain sub-recommendations; the purpose of this paper is to provide an overarching summary of the key findings from the Inquiry.

2. Inquiry Purpose and Scope

The purpose of the Inquiry was to investigate what happened in the neonatal unit at the Countess of Chester, determine why concerns were not acted upon sooner, and identify any systemic failures in management, governance, and safeguarding that prevented earlier action by Trust leaders. The Inquiry scope included:

- Examine clinical events and patient safety issues at the hospital between 2015 and 2018.
- Investigate management decisions, escalation processes, and safeguarding failures.
- Review regulatory oversight, including the Care Quality Commission and NHS structures.
- Provide recommendations to prevent similar failures in the future.

3. Summary of Findings

For NHS Trust Boards, the Inquiry is fundamentally a report about culture, leadership, patient safety, and accountability. It concluded that multiple opportunities to protect babies were missed because concerns raised by clinicians were not acted upon quickly or effectively. Organisational culture, ineffective escalation processes, inadequate governance, and a failure to prioritise patient safety over organisational reputation contributed to the continuation of harm. Furthermore, the Inquiry highlighted the need for Boards to ensure that they were equally sighted on paediatric data as they are adult data.

4. Key Messages and Actions Required by Trust Boards

1. Patient safety must always come before reputation

The Inquiry found that organisational reputation and managing conflict were too often prioritised over investigating serious clinical concerns. Senior leaders did not respond adequately when clinicians repeatedly raised concerns about unexpected deaths and deteriorations in babies. Trust Boards must create a culture where concerns about patient safety are prioritised above reputational, financial, or operational considerations.

2. Staff must be listened to when raising concerns

Consultants raised concerns on multiple occasions, but these warnings were not escalated appropriately. The Inquiry highlighted the importance of creating cultures where staff can speak up and where leaders respond with curiosity rather than defensiveness. Boards should seek

assurance that staff can raise concerns safely, that concerns are triangulated across multiple intelligence sources, and that escalation processes are effective.

3. Early warning signs were missed

The Inquiry concluded that there were clear indicators, including increases in mortality and unexpected clinical events, that should have triggered earlier investigation and intervention.

4. Boards need stronger oversight of quality and safety

Trust Boards must have timely, accurate intelligence on mortality, safety incidents, staffing, and patient outcomes. The report emphasises stronger board-level scrutiny and ownership of safety data. Assurance should be based on triangulated evidence and early warning indicators rather than relying solely on positive performance reports

5. Incident reporting and governance systems were inadequate

Systems failed to identify patterns and provide assurance. Serious incidents were not always appropriately categorised, investigated, or escalated, limiting organisational learning and action.

6. Safeguarding is everyone's responsibility

The Inquiry stresses that concerns about deliberate harm, however unlikely they may seem, must be treated as safeguarding issues and escalated appropriately, including to external agencies where necessary.

7. NHS leadership accountability needs strengthening

The Inquiry highlights that leaders are accountable for responding appropriately to safety concerns and it supports stronger accountability mechanisms for senior leaders and managers, including consideration of regulatory or barring arrangements for managers who fail in their responsibilities. Boards should ensure there is clear accountability for decision-making, escalation, safeguarding, and risk management throughout the organisation.

8. Learning from inquiries must result in action

A significant concern in the report is that recommendations from previous NHS inquiries have often not been implemented. The Inquiry calls for stronger monitoring and assurance that recommendations lead to measurable change.

5. Next Steps

The Inquiry made 17 principal recommendations, several of which contain sub-recommendations, many of these will require action by NHS Trusts and some are only applicable to NHSE or the CQC. The recommendations are presented in appendix 1. The Trust is anticipating further guidance from NHSE regarding these recommendations and once this is received will finalise an action plan against the relevant recommendations and take this for approval through Quality

Committee. The Chief Nurse will oversee development of this action plan and lead on reporting progress to Executive Committee and Quality Committee. On 21st September 2026 in response to the publication of the Inquiry, NHSE wrote to all Trusts (appendix 2) asking them to take some immediate action including a discussion at a public Trust Board and some urgent communication to staff about SUDIC processes. MWL has shared its SUDIC policy with staff and Board members

6. Conclusions

A fundamental finding from the Thirlwall Inquiry is that serious patient safety failures are rarely caused solely by the acts of an individual; they are enabled when organisations fail to listen, escalate concerns, investigate effectively, and act promptly and effectively to protect patients.

The report strongly highlights the challenges with NHS culture and determines that Trust Boards should focus on fostering openness, psychological safety, professional curiosity, transparency, and learning. Effective Boards should be relentlessly curious about patient safety, seek out signs of risk, listen to frontline staff and ensure concerns are acted upon quickly. A healthy culture enables organisations to identify risks early and act decisively to prevent harm.

7. Recommendations

Board are asked to note and discuss the report and the Thirlwall Inquiry findings

Appendix 1

Thirlwall Inquiry Recommendations		
No	**Recommendation**	**Agency**
1.	All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestream video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.	NHS Trusts
2.1	Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. I acknowledge that steps are being taken to achieve this. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, *GIRFT Neonatology: Guide to insulin use.*	NHS Trusts
2.2	Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days.	NHS Trusts
2.3	The GIRFT *Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia* guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.	NHSE / NHS Trusts
3.	The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.	NHS Trusts
4.1	All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff.	NHS Trusts
4.2	By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.	NHS Trusts
5.	NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.	NHSE
6.1	By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board -level monitoring of all deaths of children and babies.	NHS Trusts
6.2	By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.	NHS Trusts
7.1	All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians.	NHS Trusts

Thirlwall Inquiry Recommendations		
No	**Recommendation**	**Agency**
7.2	Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise: a. whether any alerts or a need for investigation has arisen. b. the investigation or action plan in place.	NHS Trusts
8.1	NHS England must: a. Immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital. b. Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board.	NHSE / NHS Trusts
8.2	DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. The guidance must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital.	DHSC
8.3	SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what is essential to know.	DHSC
9.1	**Protocol** By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. The Suspicion of Deliberate Harm Protocol must be explicit that: a. It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure. b. Where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately. c. Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified. d. Pending investigation of a member of staff, action to protect patients by moving the person suspected of causing harm is likely to be the first step. e. The moving of a person suspected of causing harm and the investigation into suspicions and concerns about a member of staff is a neutral act. f. Safeguarding steps must be followed, as a result of which the police will become involved.	NHSE

Thirlwall Inquiry Recommendations		
No	**Recommendation**	**Agency**
9.2	**Guidance** Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with the investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.	NHSE
9.3	**Implementation** Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.	NHS Trusts
10.	Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialities to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. A team from any speciality or combination of specialities would be drawn from the panel to conduct a swift, technical investigation into concerns raised. This may most often be necessary where there are concerns that harm is being or has been caused inadvertently. The precise make-up of the panel should be determined by DHSC but could include, for example: a. two doctors and two nurses from each clinical speciality b. four senior managers c. four pathologists including paediatric and perinatal pathologists d. other experts as decided by DHSC. Where necessary, a small team (always including clinicians from the relevant speciality/specialities) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always include safeguarding considerations (including contacting police). In addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings that may follow.	DHSC
11.1	The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.	NME
11.2	The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.	NME
11.3	Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.	NHS Trusts

Thirlwall Inquiry Recommendations		
No	**Recommendation**	**Agency**
11.4	There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose.	NME
11.5	The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.	DHSC
12	DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 *Paediatric and Perinatal Pathology Workforce Report.* The incentive scheme should remain in place and funded until at least 37 doctors are in training posts as paediatric and perinatal pathologists.	DHSC/NHSE
13.1	DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032.	DHSC/NHSE
13.2	NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that: a. The move is not proposed because of the manager's lack of capability or misconduct. b. The manager meets the fit and proper person test. NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.	NHSE /Trusts
13.3.	In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.	NHS Trusts
13.4	The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the controversial duty of every manager to put patients first. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk'. What matters is that patients come first.	NHSE
13.5	In the leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "*I put patients first and report safety concerns and incidents.*"	NHSE
14.1	CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practicing experts in the relevant field (in this case paediatrics/neonatology).	CQC
14.2	Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value. Where processes are being inspected, questions must be asked to elicit the effectiveness of those processes.	CQC

Thirlwall Inquiry Recommendations		
No	**Recommendation**	**Agency**
14.3	Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patients safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine the babies in hospital are safe.	CQC
15.	There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.	HSCC
16.	The functions of the National Guardians Office should be taken over by the Parliamentary and Health Ombudsman in England. The Ombudsman's powers must be increased to include: a. investigating complaints that whistleblowing in the NHS has not been dealt with adequately b. assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.	Ombudsman
17.	A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.	NAO

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

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

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's report is a sobering moment for all of us working in the NHS. From the devasting failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

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This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children** (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

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expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death**.** This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

- **Insulin**: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

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The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow**.** It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,





Duncan Burton

Chief Nursing Officer for England

Sarah-Jane Marsh

NHS England Chief Operating Officer

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